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Steven K. Chough

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CHALLENGE OF PSYCHIATRIC SOCIAL WORK WITH THE DEAF

STEVEN K. CHOUGH*

In our modern times, the increased collaboration between psychiatry and social work has done much to expand the scope of mental hygiene programs. In many psychiatric facilities, the psychiatric social worker is an integral part of the tripartite clinical team, consisting of the psychiatrist, clinical psychologist, and himself.

But why are there so few social workers who are either interested or actually working with deaf patients? All of us know that it is not always easy to help hearing persons who suffer from mental or emotional disturbances. It is, however, much more difficult to deal with emotionally disabled deaf individuals because of the serious communication problem. The less ability the deaf patients have in communication, the greater burden the professional worker may face in helping them. The matter of working with mentally disordered deaf patients, therefore, presents a great challenge for mental health services.

How are social work and mental health related? Are there particular problems inherent in psychiatric casework that prevent the full use of professional skills? What are the distinguishing characteristics of social work in a psychiatric setting? Where does social casework fit into this picture? The primary aim of this paper is to better acquaint the readers, mostly professional rehabilitation workers who are probably

STEVEN J. CHOUGH is Senior Psychiatric Social Worker, Mental Health Services for the Deaf, New York State Psychiatric Institute

not social work-oriented, with the functions of the psychiatric social worker in the treatment of deaf psychiatric patients.

The Growth of Psychiatric Social Work

The term "social casework" refers to a process used by certain welfare agencies to help individuals to cope more effectively with their problems in social functioning (Perlman, 1957). Psychiatric social work is social casework practiced in teamwork with members of the psychiatric professions in the treatment program planned for the patient. Since many people possibly think that the field of psychiatric social work is a relative newcomer, a history of the rise and development of psychiatric social work as a profession needs to be taken into consideration.

Historically, individualized services for the poor were developed through the activities of charitable agencies. By friendly visits to the poor, an investigation of their needs for material and spiritual help was carried out and a few days' temporary employment was also provided. Most of the "friendly visitors" were at first volunteers but later became paid agents, representing their charitable organizations. Such paid agents were later called social caseworkers.

Around 1905 several psychiatrists in Massachusetts General Hospital in Boston, Bellevue Hospital and Cornell Clinic in New York, believing in the significance of reaching into families and communities, employed "agents" to attain more detailed information concerning mentally ill patients' family background and living experiences. These agents, later called psychiatric social workers, helped the family of the patient prepare better for his return home (Schroeder, 1965). The following year, Miss E. H. Horton, after graduating from the New York School of Philanthropy (now Columbia University School of Social Work), became the first professional psychiatric social caseworker to work in a state-supported institution for the mentally ill (Bellsmith, 1959). By 1914, there were eleven social caseworkers in mental hospitals in New York on state payroll, since the hospitals widely recognized that mental illness was influenced by so-

cial, economic, and personal difficulties of the patients in everyday experiences.

Over a half-century ago, Mary Richmond first provided a comprehensive statement of practical suggestions to "friendly visitors." She later published a famous book, *Social Diagnosis*, in 1917, introducing a new theory that the poor man was not the cause of poverty, crimes, and unemployment as was supposed, but his personality, his physical composition, and his environment were responsible for his manifest problems. She further insisted that the social worker should think in a diagnostic manner, like the physician, and should determine the underlying causes of the patient's social, economical, and moral problems. Consequently, she formulated the first all-inclusive principles of social casework: the initial interview with the pending client (or patient), social diagnosis of the information obtained from the investigation of his home and his surroundings, and a systematic plan for treatment or rehabilitation of the patient and his family. Her philosophy was hailed by our social workers as the first step toward the professionalization of social casework. Her masterpiece made it possible to move forward with a focus on the psychological components of clinical diagnosis.

Following the two world wars, since there were large numbers of patients being troubled with war neuroses, facilities for psychiatric social work training were expanded rapidly in order to relieve the critical shortage of clinical workers. Today, approximately 3,500 psychiatric social workers, out of an estimated total of about 8,000 social workers, are employed in public mental hospitals and clinics in this country.

The Need for Acquiring Communication Skills

An inexperienced professional worker assigned to work closely with deaf patients will inevitably encounter the greatest difficulty in communicating with them unless he is capable of using manual language fluently. Interpersonal communication, of course, is not only the key to intellectual comprehension but also a medium for the free expression of feelings and emotions (Chough, 1964). We know that the

responsive interview in social casework also requires a high order of skill in communication, and that every human being needs appropriate interpersonal relations and a stable contact with others in order to feel "right" and assure himself that he is not alone or likely to be rejected. Brosin (1963) states that if incoming messages from human associations contain components of love, affection, admiration, hope, and feeling that the person to whom they are directed is really needed or very important, the receiver is likely to feel much more alive and stimulated to activity. Mental illness is marked by a failure in human relations and, in this sense, by a difficulty of communication.

Although it is a natural tendency to feel more sympathy for the blind than for the deaf, Dr. Ruesch (1956) elucidates that "the deaf are usually more unfortunate than the blind, because the loss of hearing isolates them almost completely from others." Needless to say, deafness produces a major problem in interpersonal communication. Ernest Jones (1961) mentions Sigmund Freud as having acknowledged the communication disorders among the deaf. Because of the communication problem, for the deaf there can be nothing but a life of emotional deprivation, social loneliness, and psychological frustration. Deaf people, Joseph Solomon (1943) voices, often find it very difficult to verbalize their own shortcomings or their resentments against society for their frustrations, but feel them very deeply.

Since many deaf adults rely on manual communication methods, psychiatrists working with deaf patients have placed great emphasis upon the manual method as follows: Adequate diagnostic evaluation of the deaf requires familiarity with manual communication; manual language enhances rapport and facilitates a free flow of ideas (Rainer et al., 1963). The professional worker is required, I firmly believe, to master skills in manual communication to attain a better understanding of the deaf patient's personality structure, his intrapsychic conflicts, and their influence upon his behavior. On the other hand, he should not assume that acquisition of this skill makes him automatically an expert at

helping the deaf and he must respect the choice of some patients to communicate in their most relaxed way, whether it is speech, lip reading, or other means of communication. Proper communication is very vital to a deaf person during the formative phases of development into a *human being* from his infancy and childhood.

In working with a hearing parent, especially a mother, of a deaf child or adolescent, the psychiatric social worker should help the parent to acknowledge fully the paramount importance of relaxed, meaningful communication during the child's early childhood, to improve and maintain her relationship with the handicapped child. The caseworker should continue to assure the parent, too, that the deaf child, just like the ordinary child, needs love, reassurance, respect, and acceptance to insure that he is not abandoned. Finally, the worker holds the responsibility for encouraging the parents to use all forms of communication and to accept their hearing-impaired child as a whole person, with his basic needs, and his right to be self-directing.

Responsibilities in Direct Service

What is the particular pattern of social casework responsibility? What are its proper and useful functions? When aiming one's efforts at establishing a meaningful relationship with a patient, maintaining a good communicative climate, and understanding the social diagnosis, every psychiatric caseworker acknowledges the following statement:

It is essential for the psychiatric social worker to be able to *recognize* indicator symptoms of incipient or marked disturbances, to *know when* to call for psychiatric diagnosis and treatment, and to *understand the limitations* of psychiatric and casework treatment techniques (Lowrey, 1950).

It is widely recognized that the importance of the casework relationship cannot be overestimated. Accomplishments through the professional relationship depend heavily upon the establishment of an emotional response in the patient which allows communication between him and his caseworker.

In short, the worker should keep in mind that the relationship is not an end in itself but a dynamic process. The patient is not a "problem," but a human being with a problem.

Every time a new deaf patient is admitted to the hospital ward, the first thing one should do is to ask him if he knows why he came to the hospital so as to determine the degree of insight he has. In the initial interview, the caseworker explains the available services and discusses *clearly* with the new patient in what way he can utilize the hospital facilities. Many deaf patients referred to the hospital may not have the choice of accepting or rejecting psychiatric treatment and may not voluntarily seek help; nevertheless they need to have some feeling that they know what is happening to them and why, and that they have a voice in the decisions. Since they may have more trouble in realizing or being able to state their sufferings than we might anticipate, the first requisite in the beginning interview is to make them feel welcome or fairly comfortable and to let them express themselves or talk freely. Annette Garrett (1960) believes that the psychiatric social caseworker should always "begin where the patient is." Usually, the new patients would ask him when they can leave the hospital. The caseworker can tell them, "It depends upon how much you strive to improve yourself," but should always avoid giving false reassurances. He continues by encouraging them, if possible, to discuss their difficulties to alleviate their inner conflicts and to mobilize their ego strengths.

The casework-therapeutic techniques are very useful in working directly with those who have limitations of language, limited social experience, and with those who have not had any experience in discussing their problems in a professional setting. Techniques used are: supportive therapy, including advice and guidance, reassurance, demonstrating behavior, emotional support, ventilation, and setting realistic limits. Deaf patients need to be supported and strengthened. The worker, however, needs to be well prepared himself for facing frustrations or feelings of inadequacy when his hard work aimed at expediting the patient's recovery meets with unexpected setbacks.

Acceptance is one of the effective elements in the professional relationship. In order to achieve acceptance of the handicapped patient as he is, the worker must always see him as a person whose physical disability is an integral part of his personality. The caseworker's acceptance of the deaf patient's resentment against their original hospitalization may give them some degree of security by demonstrating that there are also understanding people in the world in which they live.

When discussing perceptual disturbances, such as hallucinations and delusions, with a deaf patient at the beginning phase, the professional staff never says, "You imagine too much," but just says, "You 'suspect' too much" or "You 'daydream' too much," because the word "imagine" has certain connections with insanity to deaf patients and even to hearing patients. A number of deaf patients are very sensitive and can easily become upset, agitated, and insulted by such a word. If they once accept the word "suspect" (or "daydream") or keep themselves silent in the interview, the psychiatric social worker can further talk over their perceptual disturbances deeper and can eventually ask, "Why do you imagine this and that?" Their response to this question may be more positive and favorable.

The psychiatric social caseworker keeps in mind that the relationship between him and the patient is not that of ordinary friendship. For instance, an individual's prejudices, personal habits, morals, and manners can have some effect upon friendship, but these things should never have influence upon the professional relationship which is that of genuine and warm interest. I recall that an untrained person at our ward for the deaf fell into the undesirable habit of telling our deaf patients sarcastic or unappropriate remarks or jokes on their personalities and behavior. They became violently upset and, consequently their recovery that had progressed over months and years, was set back in a few minutes. All of us are sensitive about our personal lives, past mistakes, and peculiarities in one way or another. The clinical worker dealing with the deaf should maintain his

professional respect and professional dignity, though a good sense of humor is desirable. Needless to say, both controlled emotional involvement and nonjudgmental attitudes are extremely significant factors in professional development.

The psychiatric staff takes responsibility for explaining and discussing with a deaf patient why he misbehaved before they deprive him of some privileges, such as ground privileges. Appropriate discipline or constructive criticism is occasionally effective to motivate him for therapy. Most deaf patients are frequently resentful and often throw temper tantrums toward those who do not bother to explain to them, considering the fact that they have had so many years of rejection, and therefore relieve their anquished feelings of frustration by uncontrolled outbursts of temper.

In dealing with deaf adolescents, the caseworker needs to know that the majority of residential and day schools for the deaf are almost entirely unequipped to help troubled children. Hans Furth (1966) feels that the deaf child, for the most part, feels more secure in his school than with his own family, which does not understand and cannot communicate with him satisfactorily. The large residential schools, Furth goes on, willingly or unwillingly, become for most deaf children substitutes for society and family. Keeping the above fact in mind, the social worker can make the interview with these adolescents more effective by deciding in advance what kinds of questions or information he wants to know and by understanding the problem as fully as possible. When they ask the caseworker a personal question, this may indicate the possible sign of the beginning of a good relationship being established between them. More often, deaf adolescents have unfavorable conceptions of themselves, many of which can be traced to the similar attitudes of their parents. The parent's ambition or goal for the deaf child is more or less unrealistic in many cases and it is rather difficult to assist the parent in changing his attitudes and accepting the limitations of his child, but the psychiatric caseworker is still in a position of responsibility to straighten them out with professional skill.

One major characteristic of psychiatric social work in our Mental Health Services for the Deaf is the application

of interdisciplinary teamwork, sharing responsibility with the rehabilitation counselor, in planning, consulting, and providing rehabilitative service aimed at expediting the deaf patient's social adjustment. The rehabilitative provisions for Vocational Evaluation and Personal Adjustment Training, workshops, such as Association of Retarded Handicapped Children, family care and foster homes, Industrial Home for the Blind, rehabilitation centers, New York Society for the Deaf for Vocational Evaluation and Personal Adjustment Training, state divisions of vocational rehabilitation, local departments of public welfare, and so on, for the purpose of restoring and maintaining our patients to their highest level of social functioning. With the after-care program, our rehabilitation counselor has been mainly responsible for making referrals to other community agencies and interpreting the functions of the hospital ward to the referral source, whereas I carried a major responsibility for promoting social adaptation of the patient. We helped, as much as possible, to reduce anxieties of the hospital-leaving patients, aroused by the loss of the hospital's protective surroundings and their unrealistic attitudes with regard to the degree of their disability. Also, we kept in contact with these patients at the clinic, home, work, and school, assisting them to achieve more satisfactory human relations and stimulating their interest in social, educational, and vocational activities.

Obviously, the home visit is very desirable, for the visit produces significant social data about the patient's environment and is also an invaluable tool to see his family interaction at first hand—something the psychiatric social worker could not obtain in the office visit. Follow-up visits to the homes of families of discharged or convalescent patients are made at the request of the supervising psychiatrist or the assigned therapists. Recognizing that the home visit is most profitable from the clinical point of view, Dr. Ackerman (1958), outstanding authority on family therapy, suggests that the written report on the visit be divided into five parts: (1) a summary of chronological events of the visits; (2) the family as a group, which covers the visitor's impression of the interaction patterns and role behavior; (3) a

short description of each member of the household; (4) the physical and community environment; and (5) miscellaneous information.

In other words, the social worker has the priceless opportunity in the home visit to get an accurate picture of the climate of family communication, points of stress, and cultural values and standards, and can then address a report to psychiatric colleagues at the staff conference. On visiting the home, the worker contributes what he can to the welfare of the patient and/or his family. For example, when a deaf patient, a middle-aged divorced woman, was admitted to the hospital ward, her older sister took advantage of her hospitalization, removing a new rug worth \$450 from the patient's apartment without permission and presenting it to a nephew as a wedding gift. Upon the protest and demand of another younger sister at the home visit, I quickly reported it to the assigned therapist, who in turn took action immediately. As a result, the rug was placed back in the apartment. The home visit is, to sum up, an important aid in collecting relevant information for social diagnosis. Mary Richmond warns, however, that even insights thus obtained by the use of home visits are not infallible and can sometimes give the social caseworker a false sense of certainty.

Psychiatric Social Worker as Group Therapist

Group therapy is an indispensable process, rendered by the group therapist or leader in a controlled environment, to help the individual deaf patient, who has spent most of his life in isolation and loneliness, develop a healthy relationship with other members of the group. It gives the group members an opportunity for alleviation of strangeness or embarrassment and, above all, a feeling of being a part of an "in-group" which yields emotional security. Also, this therapy enables the individual member to identify better with his group as having capacities, disabilities, needs, and problems similar to his own. Therefore, group therapy is an important process both as an adjunctive aid to individual psychotherapy and as a treatment procedure.

There are two major schools of group therapy as follows :

(A) "Therapist-centered" therapy means that the therapist plays a more direct and authoritarian role, keeps within bounds communication between members, limits the member's intra-group activities, and presents interpretations.

(B) "Group-centered" therapy refers to the group in itself having the primary authority. The therapist only takes a consultative role, is less active, encourages the group members to rotate their leadership, and does not intervene in the relationship between the members. A combination of the above methods can be employed, which is flexible, according to the group structure and situation. It is, however, essential for the therapist to grant the deaf patients an opportunity to relieve themselves of tension by expressing negative feelings, complaints, or criticism. These patients can gain more insight into things if the therapist occasionally asks them for their opinion of others, reasons for their hospitalization, their problems or misbehavior occurring in the ward, their feelings toward being about to leave the hospital, and their future plans.

All psychiatric social workers, whether or not majoring in group work, are required to be trained in basic principles of social group work in graduate schools of social work. This training emphasizes an understanding of the values in groups, analysis of group interactions, and the role of the worker with the family group, and in informal education, leisure-time and treatment groups. I have had three years of experience doing group counseling with older boys, under the supervision of a well-qualified social worker, at a residential school for the deaf. I am presently assigned in our ward for the deaf to do group therapy with deaf patients for about one hour every Friday, under the guidance of our senior psychiatrist who also does group therapy every Wednesday. I have made it a rule to have at least one individual preparatory session with each new patient before he is introduced to the group. An attempt to choose a homogeneous group of our patients was not made because of the relatively small number of group members; hence the group had a

widely differing composition. Ages ranged from sixteen to seventy-six, educational backgrounds ranged from illiteracy to college education, and there were differences in social experience, occupation, and social class. On the average, almost half of the thirty patients (both men and women), attended the sessions and their attendance was spontaneous, for I took it for granted that they could attend the group at will, and I did not insist if they did not. The following case illustration is an example of what our deaf patients, especially Janet, who was a middle-aged white woman, discussed and how they expressed themselves freely, with profitable results:

As the therapist came into the meeting room, fourteen members were sitting down quietly. Bob threw himself into a state of excitement by announcing that he just got a new honor card. He acted as if he was the happiest boy in the world, but no response from the other members was made.

All of a sudden, Janet became furious and ejected saliva into the air. Mary, puzzled, asked her why she spat that way. Janet said with anger, "I saw angels. I hate God! F--- Him!" Several members seemed shocked and dumbfounded at what she had said. She continued, saying that she abominated God who threw her into this awful place. Anna declared with a giggle, "Yes, God punish you! I know, I know." Janet quickly replied that what Anna said was absolutely true and turned her head, asking the therapist if he believed in God. The therapist gently put the question, "Why do you ask me? How important is it for you to know whether or not I believe in God? Would you please tell me why?" Janet replied with a cynical smile, "How can I know if you don't tell me?" Barbara interrupted the conversation and began speaking of her own opinion of God. He must exist, for all living things cannot exist without God, who created them. When she finished this lecture, Janet told her that she was damn right.

Interrupting her, Johnny said he felt that children were not eligible to go to Heaven. The therapist wondered where he got the information. Johnny explained that he learned it from a book, but could not remember the title of the book, apparently attempting to avoid such answers. Ruth disagreed

with Johnny, declaring that all children are welcome to Paradise, for God always loves them so much. Janet, showing almost uncontrollable temper, insisted that God was never fond of them at all. The therapist wondered why, but she gave no explanation, shrugging her shoulders. Barbara recalled excitedly that the Bible said—people, over thirteen years old, who act like kids are not allowed to go up to Heaven. At this point, Ruth raised her hand, saying she was very tired of such hot debates about God and suggested a change of the subject. She went on muttering that He might feel hurt if we discussed this further. Janet became angry again and said loudly, "He is all-powerful! How could you be so stupid?" She continued, expressing her belief in the evil one in everybody. With a languishing eye, Barbara accused God of being at fault and cruel, because a mother superior sent her to a mental hospital five years ago. She claimed again that she was neither crazy nor sick. Janet added to her opinion by saying that all nuns were "fresh." Again, she was very disgusted with God, "He spends an easy, comfortable life in the seventh heaven, enjoying to see our deaf, blind, crippled people suffer their lives. And He enjoys watching our people commit many sins, such like sexual intercourse, ha." She burst out laughing to herself.

The two different therapists continued during subsequent sessions to encourage group interaction in an atmosphere conducive to fostering a free expression of feelings and emotions. Janet was helped to combat her confusions and anxieties and to explore and modify her unspoken attitudes. Three months later, she was able to be aware of her distorted social perceptions and maladaptive responses and thus gained more insight into her troubles as experienced in her early life and stormy married life which warped her emotional growth. Janet stated in the session, one month before she left the hospital, that she had fought very hard with God who made her bad and miserable, but now realized that she just "imagined" it. One member asked her, "Don't ya remember ya spat into the air above the table before?" But she was not angry and kept smiling at the group members. Their reaction to her statement was interesting and profitable in general. As can

be seen, the group interactions and discussions were useful to expose and correct disordered attitudes and to achieve more mature ways of expression.

As mentioned earlier, the therapist helps the new patient find that there are no social taboos on subjects usually avoided in everyday living, and helps him share his problems with other members in the group without feeling rejected. The psychiatric social worker should cultivate pasimology (the science of gestures), including a symbolic gesture, an empathic gesture, an expressive gesture, and a functional gesture (Berne, 1966). The ability to observe non-communicative behavior—where patients sit, whom they face and from whom they turn away, even lighting each other's cigarettes—requires special alertness on the part of the therapist (Frank and Powdermaker, 1959). The most common mistakes are that the therapist often concentrates on individual patients rather than group interactions and intervenes too soon, which can block the full development of their interchanges. A high order of ability to handle resistance, hostility, agitation, grief and unreasonably savage criticism is vital in a successful therapy. Finally, the caseworker is responsible for seeing that the deaf patient is not alone in his problems and for straightening out some misconceptions in his ideas concerning human behavior (Wolberg, 1967).

Social Work Trainee Program

The Joint Commission on Mental Health described in its final report, entitled *Action for Mental Health* (1961), to the Congress in late 1960 that the demand for psychiatric social workers is about five times as great as the present supply. The report goes on to indicate that "because of the great shortage, there is a good deal of competition for the services and there is apt to be a rapid turnover in any given job." As stated before, few psychiatric caseworkers are currently providing specialized services to deaf patients because of the unusual requirements. Apparently, most deaf patients have a natural tendency to place a great deal of confidence and trust in deaf staff members, more than in non-deaf personnel, for a barrier to full participation is per-

haps their fear that they cannot be understood by the latter. How can we catch up?

Our Mental Health Services for the Deaf has in recent years launched a recruitment program for deaf social work trainees, as it was believed that training and manpower were closely associated, as in any effort to recruit persons for a mental hygiene career for the deaf. I gave deaf students at Gallaudet College several lectures on the need for more social workers, why they are in a severe shortage, and the problem of the lack of clear-cut definition of the social worker's role. Thanks to the kind arrangement of its dean of students, I was able to interview more than fifteen applicants, both juniors and seniors, who majored in either psychology or sociology and who were interested in being trainees at our special ward for the deaf during their summer vacation. The criteria for selecting four trainees among these students were based on academic standing, goal-oriented motivation, social and emotional maturity, and healthy personality. This trainee program was considered as educational in nature rather than merely summer employment, although the chosen trainees received adequate salary.

To begin with, the four deaf trainees were trained in an orientation to a developmental approach to human growth and behavior, particularly dynamic personality theory, and were assigned to read reference texts on social work and introductory psychiatry, under my supervision with the close cooperation of our psychiatrists and psychologist. These students had the opportunity to observe individual and group therapies and then discuss with the above professionals. They held weekly conferences with me for specific discussion on social casework methods. They were appointed to help our in-patients develop communicative skills, teach the out-patients practical abilities such as the use of public transportation, cooking and executive recreational programs for the in-patients.

Two beginning trainees were requested to write weekly reports on their social casework activities, and other experienced trainees learned how to organize and write up so-

cial history summaries, based on information derived from psychiatric charts. All of them were encouraged to discuss with our professionals their own feelings about their work performances and also accompanied them on field trips, such as to other state hospitals and rehabilitative agencies. They finally appreciated that working directly with the deaf patients was a challenge, but a rewarding occupation. Such experience was vital for their future professional opportunities. In general, the social work trainee program turned out to be successful, but of course it is too early in this new venture for any definite plans to be made.

Meanwhile, schools of social work have been considering the possibility of professional education of deaf students for the master's degree in social work. It is our hope that this objective will be achieved in the near future, overcoming the difficult tasks of accompanying the deaf students to social work education and arranging highly qualified and efficient field work placement, possibly at Rockland State Hospital, New York Society for the Deaf, and two nearby schools for the deaf where professional social workers currently work.

Volunteer Service and the Public Education

The services of deaf volunteer workers, two organizations and several individuals, have recently become a very important force in helping discharged and convalescent deaf patients make proper adjustments to the outside world (Chough, 1967). Both our rehabilitation counselor and I jointly worked to integrate and give over-all direction to the volunteer program within the hospital ward. Under our supervision, the deaf volunteers were utilized in a one-to-one relationship with the hospital-leaving patients, after receiving adequate orientation training. Considering the fact that deaf people constitute a small minority in any given city and they may know many other deaf persons, the volunteer workers were trained to build up and practice respect for the confidential nature of their relationship with deaf patients.

The volunteer service was able to mobilize public interest and support for our mental health program for the deaf

in the New York metropolitan area. Educating the public in the deaf community through the volunteers' activities was eventually effective in replacing many misconceptions, such as shame, fear, or superstition, with scientific facts and psychiatric knowledge. Also, it enabled a large number of deaf parents to understand better the paramount significance of early childhood experiences in the emotional development of their children, whether hearing or deaf. In short, many deaf people were well informed as a result of the appropriate public education and activities of the volunteers and were able to comprehend the importance of healthy emotional life.

Summary

This article focuses on the caseworker's responsibilities for working more effectively with deaf patients in direct services. Describing the historical shift in psychiatric social work from the status of "friendly visitor" to the professional career of today, the paper emphasizes (1) the paramount importance of mastering skills in manual communication for effective interviewing, (2) the establishment of the caseworker-patient relationship, (3) the maintenance of professional decorum, (4) the improvement of the patient's current levels of functioning through the close collaboration with the rehabilitation counselor, and (5) the use of the home visit. An efficient, currently active group-therapy program was discussed, and a case illustration used to demonstrate the significance of the free expression of feelings and emotions in group interaction. The beginnings of a social work trainee program that has turned its attention to meeting the demand posed by the tremendous shortage of social workers for the deaf are described. A volunteer program together with education of the public were also outlined, designed to stimulate the deaf community and awaken the need for humanitarian services for the less fortunate patients.

Every psychiatric social caseworker working with the deaf needs a generous endowment of such special equipment as empathy, sensitivity, awareness, and understanding. He *must* be ready to respond to emotions, the need for support

and the double dependency of deaf persons who are burdened with both the physical handicap and emotional disturbance—and he must do this without making these patients weaker or more dependent. Ideally, the background of the psychiatric social worker should include at least a few years of experience working as a school social worker—or in related clinical work—at a school or social agency for the deaf, in addition to a master's degree from an accredited school of social work. Such experience would help him to cultivate skills in manual communication, to appreciate better the psychology of deaf children and adults, and to analyze better the social behavior patterns of deaf people, and in these ways would increase his ability to grasp intimate feelings with sensitivity and to work more effectively with the emotionally disabled deaf.

It should be pointed out that skill in communication is but one phase of the social casework process and is basic to the use of other aspects of counseling and therapy. Our active recruitment efforts to attract qualified students who plan to undertake social work education is a challenge because of the number of unusual, and difficult requirements. However these efforts must succeed because the task of restoring abilities for self-support and self-direction in deaf patients cannot be avoided any longer. Success leads to a furtherance of human dignity and is both a challenging and rewarding job for the psychiatric social worker.

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