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

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

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CERTIFICATION

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

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

PREFACE

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

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

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

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

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

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

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

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

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

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

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

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

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

ABSTRACT

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

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

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

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