

Deaf People and Society

Psychological, Sociological,
and Educational Perspectives

2nd
Edition

Irene W. Leigh and Jean F. Andrews

ROUTLEDGE



Deaf People and Society

Deaf People and Society incorporates multiple perspectives related to the topics of psychology, education, and sociology, including the viewpoints of deaf adults themselves. In doing so, it considers the implications of what it means to be deaf or hard of hearing and how deaf adults' lives are impacted by decisions that professionals make, whether in the clinic, the school, or when working with family. This second edition has been thoroughly revised and offers current perspectives on the following topics:

- Etiologies of deafness and the identification process
- The role of auditory access
- Cognition, language, communication, and literacy
- Bilingual, bilingual/bimodal, and monolingual approaches to language learning
- Educational, legal, and placement aspects
- Childhood psychological issues
- Psychological and sociological viewpoints of deaf adults
- The criminal justice system and deaf people
- Psychodynamics of interaction between deaf and hearing people

Each chapter begins with a set of objectives and concludes with suggested readings for further research. This edition contains ten new and original case studies, including ones on hearing children of deaf adults, sudden hearing loss, a young deaf adult with mental illness, and more. Written by a seasoned deaf/hearing bilingual team, this unique text continues to be the go-to resource for students and future professionals interested in working with deaf and hard-of-hearing persons.

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Preface

People take their sense of hearing for granted, at least until they encounter someone who has trouble hearing them, or who communicates differently because they do not hear, or who wears hearing aids or cochlear implants. And there are more of these individuals than one might realize. Actually, hearing loss is increasingly common. Recent statistics indicate that there are approximately 48 million Americans with hearing loss (Lin, Niparko, & Ferrucci, 2011). This represents a significant increase when one considers that only a decade earlier, almost 28 million Americans were identified with hearing loss. Most of them fall into the hard-of-hearing category or the ever-increasing category of late-deafened due to genetics, noise-induced hearing loss, infections, drugs, head injuries, as well as the aging process. You've seen persons with hearing issues all around you. Indeed, they are everywhere. You may have elderly family members who wear hearing aids and use amplifiers on their telephones. Or you may have a neighbor with a noise-induced hearing loss from playing loud music constantly. You may even have friends with deaf family members. Possibly you have seen a deaf actress in a movie or a commercial or seen a sign language interpreter in an emergency warning session or in your college classroom. Or you may be deaf or hard of hearing yourself. Such encounters, ranging from superficial to significant, are bound to stimulate thoughts or raise questions, questions we hope to address in this revised book with updated information. As we attempt to answer these questions, our intent is also to focus on the unique issues surrounding what it means to be deaf. We hope these questions will stimulate discussion among our readers and the next generation of students as well as propel future teachers and researchers to explore these issues in their classrooms and research laboratories. We present a sampling of questions to whet your appetites.

What causes hearing to change? Is it always a good idea to "fix it"? Are hearing aids or cochlear implants really effective? Genetic engineering is happening. Is it a good idea to use genetic manipulation to stimulate hearing? Can deaf persons read lips? How well does sign language convey information? Should deaf children go to special schools or mainstream public schools that supposedly provide appropriate services? Just what are appropriate services? How do deaf children think and learn? How do they learn to read without being able to hear words? Are deaf people stuck at low levels educationally? Are they able to get the jobs they want? Is there such a thing as a medical doctor who is deaf? How do deaf people wake up in the morning or know when someone is ringing their doorbell? What kind of visual assistive devices are there? What does it mean for a deaf person to be monolingual, bilingual, or even trilingual? What is Deaf culture all about? Do deaf people consider themselves bicultural or multicultural? Is there a "deaf" personality that differentiates deaf people from hearing people? Do deaf communities isolate deaf people from the hearing world? What does "hearing world" really mean? Does being deaf cause mental illness? How do deaf parents parent their children? Is the Internet accessible to deaf people? What kind of life does an elderly deaf person have—one of isolation or of community? If deaf individuals have a cognitive disability, a learning disability, or vision loss, how do they cope in our society?

So many people wonder how deaf individuals manage their lives and what society does for them. Perhaps you wonder as well? We have thought about the responses to all these questions and have attempted to address these inquiries, thereby adding to your awareness and understanding of issues that arise from being deaf or hard of hearing.

What is this book about? Essentially, it is about trying to understand what it means to be deaf. This is based on our own years of study and experiences working in the fields of psychology and deaf education. Historians, philosophers, and scientists have pondered what it means to be deaf for centuries. Deaf people have fascinated psychologists, who have studied their behaviors, personalities, and intelligence. More recently, linguists have analyzed the structure of signed languages. Developmental psychologists, cognitive scientists, and sociolinguists have studied how deaf children acquire, learn, and remember languages. Teachers experiment with recently suggested ways to encourage student learning, hopefully based on applied research results. Anthropologists and sociologists have investigated Deaf culture and how deaf communities¹ in the United States and throughout the world are formed and change over time. Geneticists and biologists explore hereditary causes of hearing loss and map the different genes involved in hearing. Speech pathologists and audiologists have researched the impact of different auditory input on the acquisition of speech. Deaf artists have created visual media, and deaf writers have composed stories, poems, plays, skits, and histories about the deaf experience.

Portrayal of deaf people in the media has highlighted public awareness of the issues they face. After years of arguing that hearing actors should not assume roles as deaf persons, deaf actors are now increasingly in the limelight. The TV series *Switched at Birth* has deaf main characters played by deaf actors; these characters show what deaf people can do. The film *Through Deaf Eyes*, a panorama of the history of Deaf people, has been broadcast on PBS. Irene Taylor produced and directed *Hear and Now*, a documentary about her deaf parents' experiences as they went through the process of getting cochlear implants to get a sense of what hearing means, a film that garnered multiple awards and an Oscar nomination. A storm of controversy was created by the use of the fake sign language interpreter who stood feet away from heads of government attending Nelson Mandela's funeral. This unfortunate incident served to publicize the importance of qualified sign language interpreters for prominent interpreting roles. Former New York City Mayor Michael Bloomberg had a sign language interpreter who was televised and became a star overnight while interpreting Mayor Bloomberg's report about the dangers of Hurricane Sandy in 2012, illustrating the importance of access to emergency information for deaf people. And ABC News on March 27, 2014, reported on a deaf couple who received an apology from American Airlines after they objected to the airline's use of "Deaf and Dumb" on a note attached to their lost luggage, showing how deaf people are using advocacy to counter negatively toned attitudes and educate the public.

How do these varied insights of different disciplines, personal histories, and media stories mesh together? Although many books have been written that cover a breadth of issues concerning the development of deaf, hard-of-hearing, and DeafBlind people throughout the life span, there have been few books that have looked under the surfaces of these issues related to the deaf experience from a more culturally Deaf perspective. In this book, more so than in others, the focus is on what they *can* do: grow, think, learn, create, and become contributing members of society. This book explains how being deaf affects people's lives, not only from the professional perspective, but also from the adult deaf persons' viewpoint.

The deaf experience is a reflection of people who do not hear and who by virtue of this fact have to adjust to life in different ways. Experiences, interpersonal relationships, and ways of communication are altered. Auditory experiences are not a given. All too often, there may be cognitive and linguistic deprivation, not because of diminished hearing, but because of a society that creates environments without ensuring visual or auditory access to language and communication. Understanding these causes and consequences as well as healthy ways to facilitate

optimal development has fallen under the purview of a broad range of disciplines: psychology, linguistics, sociology, anthropology, and education, all of which are covered in this book.

Although the lives of a significant number of people who are deaf do not necessarily center on access to auditory experiences, we will not ignore this issue as it has profound meaning for many others. Hearing levels range on a continuum from mild to profound, and an increasing number of deaf individuals do benefit from advances in auditory technology (digital hearing aids, cochlear implants, and other assistive devices). Nor can we ignore the medical aspects. Many of the varied etiologies of hearing loss, whether congenital or adventitious, also result in health problems such as ear infections, heart malfunctions, psychiatric issues, and cognitive and behavioral difficulties, among others. These warrant medical attention, treatment, and special services.

Special services are also warranted for another group, specifically the population of Deaf-Blind individuals. This population deals with issues related to diminishing vision and hearing, that is, if they are not born completely DeafBlind. Special considerations are needed, such as mobility, technology access, vocational and employment training, counseling, transportation, housing, literacy, life-skills, and interpreter services.

Far too many people think that once medical and/or auditory fixes take place for the deaf person, all will end well. But understanding the deaf or hard-of-hearing person goes beyond that level. This is where the authors of this book, one deaf and one hearing, enter the picture. The deaf author has experienced what it means to be deaf in a multitude of ways. She is the consequence of what professional advice was given to her hearing parents at the time her deafness was identified. She has grown up with auditory amplification. She is the product of special education and mainstream systems, and in the process, she has explored different communication and language parameters. She has interacted with deaf individuals from different walks of life and with different ways of adapting. She is part of the deaf community and intimately aware of Deaf culture. The hearing author is also intimately aware of Deaf culture, having immersed herself in the deaf community and participated in Deaf culture activities. She has encouraged deaf people to enter training programs and achieve professional status in the deaf education field. She has observed the development of deaf children in a wide variety of educational settings and noted the need of attention to children from diverse cultural backgrounds, including the increasing number of deaf immigrants who bring their sign languages and Deaf cultures to the U.S. The information and life experiences of people who are deaf that are presented in this book have been filtered through our eyes.

The concept of *Deaf culture* has strongly impacted the way deaf persons are viewed by the societies around them and how they view themselves. For many, Deaf culture provides a pathway for achieving a healthy psychosocial development and adjustment to life. Deaf culture has the potential both to prevent and limit social isolation, contrary to what a number may think if they view deaf people as being isolated from the world around them. Deaf culture allows for a shared experience and a sense of commonality among deaf people that they find hard to experience in the majority hearing society. Many deaf people use American Sign Language (ASL) and its contact variations (Lucas & Valli, 1992).² Not only does this permit easy communication through vision, gestures, and movement unfettered by speech that becomes difficult to produce without clear access to auditory feedback, but it also strengthens the bonding within the deaf community.

So, what are the perspectives we emphasize in this book? Here they are:

- Historical perspective of Deaf people and psychology
- The deaf community as a diverse entity
- Etiologies of deafness and the identification process
- The role of auditory access

- Cognition, language, communication, and literacy
- Bilingual and monolingual approaches to language learning
- Educational, legal, and placement aspects
- Childhood psychological issues
- Psychological viewpoints of deaf adults
- Sociological viewpoints of deaf adults
- The criminal justice system and deaf people
- Psychodynamics of interaction between deaf and hearing people
- Future thoughts

Each of these topics represents puzzle pieces that, when arranged together, form a coherent whole through which you, the reader, can better understand deaf people and their experiences. In the last decade, significant changes have taken place in many of the areas we cover, particularly in deaf education, linguistics related to ASL and English bilingualism, Deaf culture perspectives, neuroscience, and evolving access to new technology that has transformed the lives of many deaf and hard-of-hearing individuals at home, in schools, and at work, and awareness of psychological aspects. This book aims to address these changes.

A word about terminology: In common parlance, people tend to use the word *deaf* in a narrow sense to mean persons who cannot hear, and who may be mute. Many audiologists and medical professionals are also reluctant to use the word *deaf* due to misinterpretations of the word as it can imprint in one's mind a sense of discomfort based on association of the word *deaf* with a person isolated and apart from the world, unable to communicate. As mentioned earlier in this Preface, the airline personnel at American Airlines who wrote "Deaf and dumb" on a note attached to a deaf person's luggage illustrates the subtle attitude of "dumb," and in turn "deaf," thereby reinforcing what many see as a stigmatized perception. Deaf people may struggle to achieve academically because of limitations in environmental access, but there are deaf individuals who have become, for example, financial analysts, restaurant owners, lawyers, medical doctors, and small plane pilots. As a matter of fact, in July 2014, legislation was introduced for consideration by the House Armed Service Committee in the U.S. Congress to the effect that qualified deaf individuals be allowed to serve in the Air Force as part of a pilot program (www.military.com/daily-news/2014/08/11/new-bill-would-open-air-force-to-deaf.html). So "deaf and dumb" is clearly a problematic description of deaf people.

Deaf people vary in their ability to speak clearly or to use whatever level of residual hearing they have, depending on a multitude of factors that we elaborate on in this book. Often, audiologists and medical professionals may be shortsighted in counseling parents or deaf people themselves as they try to translate audiogram information into lay terms. They may on some level unintentionally mislead parents about realistic limitations on optimal use of auditory aids for everyday communication in noisy classroom situations, for example. In this kind of situation, as movingly illustrated in *El Deafo*, a children's book about a deaf girl by Cece Bell (2014), it often turns out that these children end up not understanding everything and feeling lonely and different even with the best of intentions, though many do manage to have active social lives. While parents may understand that cochlear implants will enable their deaf baby to hear beyond what hearing aids can provide, they may not realize that cochlear implants are imperfect ears, thus necessitating intensive auditory training for optimal use. Simply putting amplification on a child and expecting the child to function as a typically hearing child, without additional spoken language and auditory training or visual support services, can jeopardize the child's academic progress, emotional adjustment, and social relationships. In this book, we describe educational programs that build on all the strengths the child has, including both auditory and visual access. Many parents dream of deaf children hearing and speaking, but again, the reality is that there is much variability in

a deaf child's abilities to speak and hear. Professionals would do well to remember this and communicate the special and unique nature of the child to parents, rather than imply that all deaf people can talk, hear, speechread, and read.

We acknowledge the pride that culturally Deaf people have when it comes to the term *deaf*. They prefer to use the term *Deaf* to represent them, even if some of them are audiotically hard of hearing. These individuals proudly identify themselves as being *culturally Deaf*. To culturally Deaf people, the term *hearing impaired* is offensive, implying as it does that something is wrong with them. In contrast, they view themselves as fully functioning human beings, able to learn, work, play, and love. Those Deaf people who consider themselves as part of that culture are identified as *Deaf* with the uppercase *D* letter, whereas those who are not affiliated with Deaf culture are viewed as being just *deaf*, with the lowercase letter *d*. This distinction is important and respected in Deaf culture but not known by most of the general population. This uppercase *Deaf* and lowercase *deaf* terminology reflects fundamentally different ways of coping with and feeling about hearing loss.

Our intended readership is a wide range of undergraduate and graduate students, parents, and professionals interested in working with deaf and hard-of-hearing persons, including psychologists, linguists, social workers, medical personnel, educators and administrators, special educators, artists, anthropologists, sociologists, and other interested persons. We hope that researchers will be stimulated by our efforts to raise and examine key issues that puzzle us all in terms of the Deaf/deaf experience and its implications on how we think, socialize, learn, behave, and acquire languages, whether we hear or not.

We use the term *deaf* in a positive manner to mean a person who does not necessarily rely on audition for everyday conversations but can also benefit from the use of visual means of communication in relating with the people around them. We use the term *hard of hearing* to mean a person who can use audition to understand speech but who can also make use of visual forms of communication and support services. Our use of the words *deaf* and *hard of hearing* also encompasses the positive values of identity and inclusion in a vital support group—the Deaf culture and the deaf community. Most Deaf Americans would like physicians, other medical personnel, audiologists, and speech-language pathologists to learn about their Deaf culture and to share this information with parents and other professionals. We also hope that deaf and hard-of-hearing people and their families will be interested in comparing their own personal experiences with what we present in this book.

Notes

- 1 The lowercase *d* reflects the inability to hear, whereas a capital *D* is frequently used to represent a group of people who share a signed language and culture.
- 2 Contact signing in the Deaf community is that kind of signing that results from the contact between ASL and English and exhibits features of both languages (Lucas & Valli, 1992, p. xiv).

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Acknowledgments

This book reflects the observations and knowledge culled from lifetimes of experience. It also reflects a collective endeavor, and we gratefully acknowledge the help of those who contributed in bringing this book to completion.

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Both of us have taught university undergraduate and graduate students. The inspiration for our work came from our students, who challenged us to teach them using the most recent knowledge. We are also inspired by the desire to impart to all students our dedication to the training of new generations of professionals working with deaf children, youth, and adults. To these students, we give profound thanks. We know that our students, both deaf and hearing, are our future. We hope this book stimulates them to question traditional practices, look critically and thoughtfully at our varied perspectives, and add to our research base in their future work.

Even though one of us is deaf and the other is hearing, we both know in our own ways what it means to be deaf and how deaf people live their lives in different ways. Our perceptions are not always in agreement, because we come from divergent backgrounds. But these perceptions definitely have been enlarged by our varied experiences with the deaf community and Deaf culture. Without knowing the deaf community, our lens would have had a much more narrow focus, and finding common ground would have been more arduous. We thank the deaf

community for enriching us with their zest for life, their worldviews, and their confidence in their own abilities to assert themselves in the face of a world that is not always accommodating.

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1 Historical Perspectives of Deaf People and Psychology¹

Study the past if you would define the future.

Confucius (551 BC–479 BC)



Figure 1.1 Dr. Gabriel Lomas administers an intelligence test

Source: Courtesy of Dr. Gabriel Lomas. Used with permission.

A 1943 book about deaf people had the following inscription for its dedication:

To Deaf People:
The most misunderstood among the sons of men,
But the gamest of all

(Best, 1943, with apologies for gender)

It took centuries for deaf people to break out of the shackles of misunderstanding. And even today, there continues to be misunderstanding, notwithstanding the fact that deaf people more than ever are achieving their potential in education, communications (thanks to ever-evolving

2 *Historical Perspectives of Deaf People*

technology), theater, law, and many other areas and can psychologically move on in their efforts to live productive and happy lives. This progress has come about as a consequence of the presence of a more enlightened era and populace that understand diversity and multiculturalism. Within the domains of psychology, sociology, anthropology, linguists, education, and mental health, psychologists, social workers, mental health counselors, sociologists, neuroscientists, anthropologists, linguists, educators, psychiatrists, and allied mental health professionals have served as catalysts that propelled the changes we see today.

Chapter Objectives

In this chapter, we describe historical highlights that played significant roles in facilitating the mental health and well-being of deaf people with primary focus starting in the 1950s and onward. We review critical court decisions in the areas of education and mental health access that have played prominent roles in these historical changes. We also review the impact of the use of sign language by professionals in mental health settings. Readers will learn about the way in which professionals highlighted and tied together American Sign Language (ASL), Deaf culture, and the positive nature of the deaf community, thereby enhancing the quality of service delivery to deaf individuals in need of psychological/mental health services.

Before 1950

Just prior to the 1950s, there were fewer than ten psychologists and no psychiatrists in the United States with full-time commitment to the mental health of deaf and hard-of-hearing people (Levine, 1977). The few available psychologists were located in residential schools for deaf children that had been established in the United States, starting in the 1800s. During those early decades, most of these schools utilized sign language as a vehicle for educating deaf children. Despite the fact that these schools existed to provide deaf children with skills needed to manage their lives, general nineteenth-century perceptions about deaf people's abilities reflected the belief that because deaf persons had problems with speaking and relied on signing, their intellectual functioning was limited and they were educationally deficient (Pollard, 1992–1993).

In the late 1800s and early 1900s, there were individuals who demonstrated the fallacy of this belief system, starting with William James, a well-known philosopher/psychologist. James encountered two deaf men who demonstrated to him through personal correspondence that abstract cognition could exist even without the mastery of spoken words, explaining how they thought even before starting school and learning language (James, 1893, as cited in Pollard, 1992–1993). For the first time, this upended the belief that language was required prior to abstract cognition. However, it would be decades before cognitive psychologists confirmed the possibility that the existence of thought was not necessarily dependent on internalized language.

In the meantime, the pendulum was swinging towards the use of spoken language, encouraged by Alexander Graham Bell (1847–1922), most popularly known as the inventor of the telephone. With the advent of behaviorism and the stimulus-response theory of learning, psychologists were beginning to focus on how language acquisition was impacted by the inability to hear. Rudolph Pintner (1884–1942) and Donald Paterson (1892–1961) (1915, as cited in Pollard, 1992–1993) were in the forefront of psychologists who noted the unfairness of linguistic requirements in IQ tests used to evaluate the intelligence of deaf children. As an interesting aside, during that time, psychologists not only were testing deaf people but were also testing immigrants at Ellis Island with the ultimate goal of evaluating the use of IQ tests and other psychological instruments with different populations. In many cases, they gave verbal IQ tests in English to both groups, thinking that was appropriate and, as a result, inappropriately classified many individuals as mentally retarded (currently referred to as having an intellectual disability).

Pintner went on to develop a variety of performance-based psychological tests for deaf students, including primary and preschool intelligence tests, a test of educational achievement, as well as research projects focusing on tests to measure deaf children's personalities and psychosocial functioning. Together with a group of psychologists, he also took a lead in recommending the development of tests covering intellectual abilities and academic achievement that would be standardized with deaf people. Additional recommendations included studies of deaf children's psychosocial and emotional development within different educational approaches and parenting styles. Finally, the need to research approaches to deal with adult psychopathology was acknowledged (National Research Council, 1929, as cited in Pollard, 1992–1993).

Unfortunately, despite a spate of studies following these recommendations, these studies contradicted each other to the point of creating dissension (Levine, 1977). This was primarily due to limited familiarity with deaf people and their communication needs as well as problematic validity of the measures used with deaf subjects. Reviewing the progress in 1941, after a decade of research, Pintner, Eisenson, and Stanton (1941) concluded that, while variability in IQ scores existed, deaf children on average scored lower compared to hearing peers. This conclusion was to stand until McCay Vernon (1928–2013) (1969) reviewed 21 studies involving IQ results and found that, contrary to popular opinion, if nonverbal performance-type tests were used, the IQs of deaf and hearing children did not significantly differ. This had a significant impact on how schools for the deaf perceived the intellectual functioning of deaf students.

Pintner and colleagues also cautioned that the use of personality measures developed for hearing children would unduly pathologize deaf children. As a matter of fact, this is exactly what happened. Prior to 1950, for example, there had been only 18 studies on behavioral aspects of deafness, all done on children (Vernon & Andrews, 1990). Most of these investigations involved the use of grossly inappropriate psychological tests, many of which were verbal or based on the knowledge of English, which many deaf children were unfortunately deficient in, or behavioral checklists with many items that were biased against deaf youth. The results seemed to demonstrate that multiple types of pathology were present. It took decades to show that many of these studies have been proven false by subsequent, more valid types of testing and assessment (see Chapter 8 for further details). It seems that what was left out of the equation was the lack of awareness that deaf children were in difficult communication situations to which they reacted and that of course reflected different types of adjustment, some of which were pathological. It was not the deaf aspect that was the issue; rather it was the inaccessible environment and the negative attitudes to deaf children that all too often prevailed.

Sadly, between that time and the 1950s, no formal research was done on deaf adults because psychologists working with deaf individuals tended to be employed in schools where they essentially functioned as psychometrists, with the primary responsibility of administering IQ tests to incoming students in order to identify those with low IQs or severe behavior problems. The intention was to exclude from school enrollment those with mental retardation, the label used at the time (currently labeled as intellectual disability) or severe mental illnesses and to refer them to hospitals. Although the state hospitals serving individuals with mental illness or mental retardation were required by law to accept these deaf patients, these deaf patients were not offered access to treatment nor were the hospital staffs trained to provide treatment to deaf inpatients or to communicate with them in sign language (Levine, 1977).

This unfortunate state of affairs had two negative consequences. First, deaf people with mental illness or mental retardation (intellectual disability) got, at best, what was essentially antitherapeutic custodial care, or in other words, they were “warehoused” with no treatment. The second consequence of this dearth of psychologists and psychiatrists was a lack of any quality research into the ways being deaf influenced psychological functioning. That was to change starting in the 1950s.

After 1950

Starting in the 1950s, interest in the implications of being deaf began to increase, partly as the outgrowth of audiological training in response to the influx of World War II veterans returning home with hearing loss. Helmer Myklebust (1910–2008) was a well-known psychologist who did research on deaf children and young adults that exemplifies research done up to 1960. For example, he did work on diagnosing aphasia in deaf youth and wrote on educating aphasic children. He also conducted personality studies using the Minnesota Multiphasic Personality Inventory (MMPI, 1960), a verbal-based psychological instrument, with deaf participants, for which he was vilified because of the inappropriateness of using such a verbally loaded measure that resulted in a negative personality picture of deaf youth. Even though much of his research was not supported by later findings, in part because of the inappropriate use of existing instrumentation at the time, he was a psychological pioneer in the effort to understand the psychological functioning of deaf people. His work and that of his students at Northwestern University were important stages in the process of this effort. In particular, Myklebust (1964) was among the first to emphasize that there might be functionally different ways in which deaf children interact with the world compared with hearing peers. This of course has implications for psychological development. Current neuropsychological research demonstrates this phenomenon, meaning that deaf children function differently, but not in inferior ways compared with hearing peers.

Edna Simon Levine (1910–1992), a contemporary of Myklebust, was for many years a psychologist at the Lexington School for the Deaf in New York City, at that time a prominent school that focused on spoken language for deaf children, and later became a professor at New York University. In the latter role, she conducted research projects on the personalities of deaf children and on children who were deaf due to rubella (popularly known as German measles) that affected their mothers during the first trimester of pregnancy. Most importantly, she was among the first to suggest that the environment was a critical factor in the development of the deaf child, and therefore its influence required critical study (Levine, 1981). In addition to these contributions, Levine also was a major factor in the establishment of the National Theater of the Deaf in 1966, which enhanced the careers of deaf actors. She also authored a fictional story about a deaf child—*Lisa and Her Soundless World* (1974), which oriented hearing children to what it meant to be deaf.

Psychopathology and Mental Health

Most importantly, Levine played an influential role in determining federal policies impacting deaf children and adults. She spearheaded efforts to develop research and treatment programs for deaf people with mental health problems by taking advantage of some of the funding opportunities created by post-World War II rehabilitation legislation (Levine, 1977). How was this accomplished?

In the early 1950s, Edna Levine and Boyce Williams (1910–1998), the Rehabilitation Services Administration (RSA) administrator, who happened to be deaf, approached Franz Kallman, M.D. (1897–1965), a psychiatrist affiliated with Columbia University in New York City who had done genetic and schizophrenia research with deaf persons, to discuss the establishment of such a program (Vernon & Andrews, 1990). Funding was obtained for the establishment of the first outpatient psychiatric treatment program for the deaf at the New York State Psychiatric Institute in New York City as well as for an inpatient unit at Rockland State Hospital located north of the city. Together with psychiatrists John Rainer, M.D., and Ken Altshuler, M.D., Kallman published the first significant research projects on psychopathology and its identification and treatment in deaf people (Vernon & Daigle-King, 1999).

This has to be considered groundbreaking, as prior to the mid-1950s, there was only one research study on the psychopathology of deaf people to appear in the psychiatric literature, done by a late-deafened Danish psychiatrist, V. C. Hansen (1929). In Denmark, he gathered data on 36 deaf patients in psychiatric hospitals and reported that his numbers represented a 10 times greater prevalence of deaf inmates than would be expected based on the prevalence of deafness in Denmark. He also found deaf patients to be significantly more chronic than hearing patients, with hospital stays being 20 years on average. Almost one-third (31 percent) of the deaf patients were undiagnosed. This is understandable, considering that there was no hospital staff able to communicate with them in sign language, that is, if the patients themselves even knew sign language. It is possible that some had no language.

The work done by the New York State Psychiatric Institute was in the forefront of other research and clinical projects that began shortly afterwards. These projects were located at St. Elizabeth Hospital in Washington, DC; Langley Porter Psychiatric Institute in San Francisco, California; Michael Reese Hospital in Chicago, Illinois; and John Denmark's psychiatric program in England. The results of their research projects as well as later studies are reported in some detail in a 1999 paper (Vernon & Daigle-King, 1999). They were landmark studies that have had a profound impact on our knowledge of deaf people and mental health as well as on the care these patients receive.

A major finding was that, when deaf patients with mental health issues are placed within a general hospital population and provided no staff or therapists who can communicate with them in sign language, their stays are much longer than those of hearing patients. More recent studies (Daigle, 1994; Trumbetta, Bonvillian, Siedlecki, & Haskins, 2001) indicate that, when provided care by psychologists, psychiatrists, social workers, and nursing staff who can sign and/or when provided round-the-clock sign language interpreting services, deaf patients who know sign language are no more chronic than their hearing counterparts. It is this access to sign language and professional staff knowledgeable about deafness that has been legislated by the Americans with Disabilities Act of 1990 (ADA, amended in 2008) and other civil rights laws. Unfortunately, such services have been provided in only a minority of states. Consent decrees, which involve a settlement of a lawsuit in which hospitals agree to take specific actions without admitting guilt, have had to be used to force compliance when hospitals are sued for lack of access (Katz, Vernon, Penn, & Gillice, 1992).

Even though deaf people generally have not been well served by the mental health system, deaf members of minority ethnic backgrounds have been even more poorly served (Pollard, 1994). In the psychiatric studies reported in the literature, minimal attention has been paid to the relationship between ethnic background and diagnostic categorization for these individuals (Leigh, 2010). However, in these studies, it is important to note that one conclusion was generally agreed upon. The limited availability of American Sign Language (ASL) in the schools and the difficulties deaf people experience when communicating with hearing people, including family members as well as outsiders, were partially responsible for both the type and amount of psychopathology seen in deaf patients and in the educational retardation and lack of general knowledge found in these individuals (Vernon & Daigle-King, 1999).

Much of that literature also suggests that, while the publications of the 1950s and early 1960s on the mental health of deaf adults reflected focus on those who had psychiatric diagnoses, the implication that their pathology was caused in part by their being deaf continued to be perpetuated. In these studies, they were perceived as being concrete thinkers, emotionally immature, and egocentric and having problematic relationships and a tendency to act out. These results permeated general perspectives of the general, nonpsychiatric deaf population, thanks to the "spread" effect.

The only psychiatrist to do a significant amount of research with deaf children was Hilde Schlesinger, who worked together with sociologist Kay Meadow to conduct studies of deaf

children and their families (Schlesinger & Meadow, 1972). Their clinical research focused on three primary areas—language acquisition, using sign language, and mother/child interaction comparing deaf and hearing children—in addition to a comparative study of deaf children whose parents were deaf with those deaf children having normally hearing parents. Among their conclusions was that the controversy then raging over methods of communication (spoken versus signed) was detrimental to the mental health of the children involved. They recommended that a combination of signed communication and speech/speechreading be used. This recommendation predates what is being implemented today in the bilingual programs within the educational setting with the focus on ASL and English, as indicated in Chapter 6.

Schlesinger and Meadow (1972) also found that when families used sign language with their young deaf children, acquisition generally paralleled milestones in spoken language acquisition. Knowledge of sign language did not interfere with speech acquisition. Instead, spoken words and speechreading facility increased with sign language acquisition. In addition, the level of communication frustration was decreased in the families they observed who used both spoken and signed communication in combination. Among their other findings were the distinct advantages deaf children with deaf parents enjoyed versus deaf children with hearing parents. The difference manifested in areas such as educational achievement, family climate, maturity, and a number of other variables.

Finally, it is important to note that, even though inpatient and outpatient services have increased in the United States and Europe over the last few decades, most of the significant and relevant research was done more than two decades ago (Vernon & Daigle-King, 1999). However, this has changed, with an emerging number of new research data as described in Chapter 9.

Influence of Psycholinguistics

You will note the frequent references to the role of sign language in working with deaf mental health clients. How has this role emerged, considering the fact that many schools for the deaf were geared towards the use of spoken language? Prior to the 1960s, the typical professional perspective of sign languages was that of an unsophisticated communication system or a crude visual representation of English. There were many deaf people who endorsed this view, feeling that mastery of spoken English was the ideal in order to interact with hearing society.

Then along came William Stokoe's (1960) assertion that there were structural elements in American Sign Language (ASL), meaning that it was a bona fide language. This was a revolutionary concept, causing significant controversy at the time considering that ASL had typically been framed as a degenerate form of English. As time passed, the recognition of ASL as a formal language became the foundation of Deaf culture and its legitimacy in the eyes of many hearing people, including those in the mental health field, as well as deaf people. Psychologists' earlier, negative views of the linguistic, intellectual, and psychological characteristics of deaf people were profoundly affected such that there was more consideration of how language impacted these characteristics and how ASL needed to be incorporated in research projects. As Pollard (1992–1993, p. 40) states, "Stokoe made the premise of deaf psychological health a far more viable one than it had ever been before."

Subsequently, the literature showed more evidence of studies evaluating the use of ASL in school classrooms as well as investigations into the appropriate use of psychological assessments. McCay Vernon, mentioned earlier, was a pioneer in this effort with his seminal publications on the importance of nonverbal assessment methods to demonstrate that in fact the distribution of intelligence scores among deaf testees approximated that of hearing peers, countering the heretofore prevailing notion of deaf intellectual inferiority.

The first major psychology texts reflecting the impact of Stokoe's work appeared in the early 1970s (Mindel & Vernon, 1971; Schlesinger & Meadow, 1972, mentioned earlier). The focus of these publications was on the importance of early parent-child communication in the development of healthy cognitive and emotional functioning in deaf adults. This notion fed into the increasing attention to the environment as a significant influence on the psychosocial functioning of the deaf child/adult, whether healthy or pathological.

Hans Furth (1920–1999) personifies the advent of psycholinguistics into the field. He, together with Vernon, was ahead of their times in challenging the notion that thought was possible only with internalized language. Through his research, he noted that deaf individuals, even those with no formal language system, sign or otherwise, still were capable of successful problem-solving strategies similar to those of hearing peers (Furth, 1966). Additionally, at that time, the noted Ursula Bellugi of the Salk Institute in La Jolla, California, together with her linguist husband Edward Klima, confirmed the true language nature of ASL, complete with grammar and syntax (Klima & Bellugi, 1979). Later studies run under her purview at the Salk Institute demonstrated that ASL is processed by parts of the brain that also processes spoken language, contradicting the belief that ASL is solely right-hemisphere based (Poizner, Klima, & Bellugi, 1987). The work of these early psycholinguists has contributed to today's understanding of ASL as a rich, complex, and evolving language, similar to many other languages in this regard. These earlier studies also laid the groundwork for current research in neurosciences and neurolinguistics that uses brain-imaging technology to substantiate findings published by Bellugi and her colleagues related to how ASL is processed in the brain (Campbell, MacSweeney, & Waters, 2008; MacSweeney, Capek, Campbell, & Woll, 2008).

The Role of Court Decisions and Legislation

Despite the advances in the psychological understanding of deaf people, they continued to be viewed as a burden to society, with their civil rights hardly taken into account. As mentioned earlier, in the 1950s, Levine had to work with the RSA to get the first significant governmental involvement in the mental health needs of deaf people. It was not until the 1970s when court decisions and congressional legislation began to positively affect the lives of deaf people, specifically, two major court decisions and a series of laws enacted by Congress from the 1970s onward. The court decisions were the *Pennsylvania Association for Retarded Citizens v. Commonwealth of Pennsylvania* (1972) and *Mills v. Board of Education* (1972), both of which represented a victory for children with disabilities, including those children with IQs below 70, behavior disorders, or multiple physical disabilities, who had previously been denied access to public education. These court decisions laid the foundation for the 1975 Education of All Handicapped Children Act (Public Law 94–142), which brought changes to educational programming by requiring free and appropriate public education for all children with disabilities. In 1990, this law was renamed the Individuals with Disabilities Act of 1990 (IDEA); it added the mandate that an individual family service plan be developed for each child, required that children with disabilities be educated with nondisabled children to the greatest extent possible, and stated that parents have an active role in the decisions related to their children's educational plan.

Unfortunately, the concept that children with disabilities be educated with nondisabled children to the greatest extent possible can result in potential harm to children who are deaf when less than ideal communication access is provided. In 2000, the 11th Circuit Court provided the largest single award in special education history to date, approximately \$2.5 million to two deaf children who were placed in a generic special education setting for children with multiple disabilities without the benefit of communication access, the services of a professional teacher of the deaf, or related services (Easterbrooks, Lytle, Sheets, & Crook, 2004; National

Association of the Deaf, 2014a). The impact on the social, emotional, communication, and academic development and earning potential of the students was catastrophic. To this day, the right to a free, appropriate public education, particularly one that is accessible, remains unrealized by a considerable number of deaf and hard-of-hearing children who are in mainstream settings.

What does this have to do with psychology? The influx of multiply disabled children, particularly after the rubella epidemic in the early 1960s that caused neurological and behavioral difficulties as well as hearing loss created a demand for psychological services. By 1977, 178 people were working as school psychologists with deaf children, based on a survey by Cantor and Spragins (1977). However, only 9 percent of these persons were credentialed as school psychologists. Of these, none had any special training in working with deaf children. Not only that, the research base regarding assessment methods appropriate for this population was still inadequate. Edna Levine (1977) deserves most of the credit for highlighting the need for trained psychologists and what the training and professional expectations should be. She organized what came to be known as the acclaimed 1975 Spartanburg Conference on the Functions, Competencies, and Training of Psychological Service Providers to the Deaf.

In response to this obvious need for qualified professionals, starting in 1972, Gallaudet University established a social work program to prepare social workers to work with deaf and hard-of-hearing children. In 1979, programs were established to prepare both school psychologists and school counselors for work with these children. As graduates of these and other programs have gone out into the field, a nucleus of well-qualified social workers, educational psychologists and school counselors now exists, although there is no information on these professionals currently employed. These trained individuals are providing direct services, some are doing research, and a number have gone on to complete doctoral work and serve on university faculties. One such individual, Dr. Jeffrey Braden (1994), formerly a school psychologist, has also researched the intellectual functioning of deaf people. His treatise on the implications of being deaf for IQ differences between groups represents a significant contribution to the literature.

As the supply of psychologists increased, it reached a level that would have been sufficient to meet the needs of deaf children who were in state and private residential and day schools for the deaf. However, since the early 1950s, the trend is for deaf children to be placed in local public school settings. This accelerated as part of the least restrictive environment for children with disabilities as mandated in PL 94-142 and a series of court dates based on it, which has favored the placement of deaf children in their home school districts (though some have argued that limited access to language and communication in the classroom make this a more restrictive environment compared to specialized schools). As we discuss further in this book, there may be only one or a few students with profound hearing losses in an entire school system. In these situations, psychologists, teachers, and administrators who have little or no experience with deaf children and who may not always be able to communicate with them are making critical decisions regarding these deaf children. In such situations, the results potentially may be catastrophic for the child, both educationally and psychologically. There have been challenges to this practice both in the courts and in the literature, but stronger test cases such as the ones mentioned earlier in this section need to be brought to court before this practice can be stopped. It has been suggested that instead of setting up school-based counseling for students who are deaf, the school counselor in the public school might contact an outside agency that provides counseling services by school counselors or social workers who are knowledgeable about what it means to be deaf. In this way, deaf students could have their needs met by a provider who is working collaboratively with the public school counselor. Another suggestion is to have school-based counseling in sign language available to all students via a signing counselor hired by the centralized deaf education program (Andrews, Shaw, & Lomas, 2011).

Since it has been argued that early identification of deaf children is critical to facilitate the development of language and communication, Congress passed the Newborn Infant Hearing Screening and Intervention Act of 1990. This law provided for funding for state grants for newborn hearing screening and intervention programs (Joint Committee on Infant Hearing, 2013). Considering that children typically were identified as deaf or hard of hearing at ages 2, 3, or even later, the implications for earlier access to language are significant.

Section 504 of the Rehabilitation Act of 1973 mandated that institutions receiving federal funding could no longer deny services based on physical disability. As a consequence, deaf students were increasingly able to access higher education institutions that received federal funding, and deaf patients could now access public mental health programs for the same reason. The presence of those deaf individuals stimulated further growth in psychological research and service activity.

The Americans with Disabilities Act (ADA) was signed into law in 1990 and amended in 2008 to provide more clarity. This Act served the purpose of expanding the provisions of Section 504 to the private sector, since Section 504 covered only entities receiving federal support. This law also gave deaf persons the right to greater access to public accommodation, transportation, employment, and telecommunications. More details are provided in Chapter 9, including an examination of the true benefits and difficulties related to the ADA that have sociological and psychological implications.

Suffice it to say that, overall, considering the need for court cases and legislation, all too often education and mental health service providers and policymakers generally have little understanding of the complex language and communication needs of this population and the implications for program design and service delivery. This leads us to a consideration of the human right to health that is recognized and protected by international rules (García & Bravo, 2015). Case in point, the International Convention on the Rights of Persons with Disabilities was approved by the United Nations General Assembly. It incorporates the right to enjoy the highest attainable standard of health without discrimination as part of the general purpose of ensuring the full and equal enjoyment of human rights and fundamental freedoms by all persons with disabilities. The importance of recognizing limitations in equal access needs to be acknowledged in order to facilitate action in providing equitable services.

Professional Training

In addition to its accredited programs to prepare school psychologists (1979), social workers (1989), and counselors (1986) at the master's level to work in schools with deaf children, Gallaudet University now has an accredited doctoral program in clinical psychology, started in 1990 (Brice, Leigh, Sheridan, & Smith, 2013). Rochester Institute of Technology, which houses the National Technical Institute for the Deaf, has a master's program in school psychology. Few other specialized programs exist.

Increasingly, in part thanks to legislation mandating access to public services, more and more deaf students are attaining graduate degrees in psychology, counseling, and social work at other universities offering accredited programs. An increasing number of deaf social workers (250; Sheridan, White, & Mounty, 2010), mental health counselors (approximately 200; Kendra Smith, personal communication, December 6, 2014), and doctoral level psychologists (80+; Carolyn Corbett, personal communication, December 8, 2014) with deaf-related knowledge and experience among others are currently working in mental health and counseling centers and hospitals, thereby addressing the ongoing shortage of qualified professionals. There is a new specialization: Certified Peer Support Specialist, which refers to individuals who have experienced mental health issues being trained to provide counseling and support services (Gournaris, 2016). These developments facilitate the slowly burgeoning improvement in services,