VISUALLY SPEAKING:
ART THERAPY AND THE DEAF

Photo by N. Bachrach.

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VISUALLY SPEAKING

Art Therapy and the Deaf

Edited by

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Dedicated to my wonderful, albeit complicated children,
Kaitlyn Leah Darby and Bryan James Darby,
whose language I have yet to speak.

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FOREWORD

In my first job as an art therapist, I worked on an inpatient unit for youngsters who had been diagnosed with "childhood schizophrenia." Four-year-old Johnny was a sweet little boy who, like the others, seemed to be living in his own private world. He loved his individual art sessions, and quickly became attached to working at the easel with tempera paints on the largest size of paper available. Although he clearly enjoyed the process, he was rigidly stuck on using all of the jars in the easel tray, going from left to right, and moving the brush up and down to make a blob of each color. As this ritual was repeated week after week with no variations, I began to wonder how I could help him to give up such a compulsive way of working. So one day I suggested that he use the paper vertically instead of horizontally, showing him by placing it that way myself.

Because the paper was not wide enough for him to use each color above its jar in the tray, he was forced to work differently. For the first time, his brush moved in many directions, sweeping freely in horizontal, vertical, and diagonal arcs. And the colors, which had thus far been used straight out of the jar, began to mingle. Initially, the color mixing was involuntary, but as Johnny responded with pleasure to the new tones, he began to blend colors intentionally. The paintings became more interesting, and more attractive as well. Although Johnny did not talk, he was clearly happy with the results.

When Johnny–whose silent withdrawal had been attributed to schizophrenia–moved to Chicago, his parents took him to another medical center to be evaluated. Much to their surprise (and the embarrassment of the staff in Pittsburgh), it was found that he had a profound hearing loss. Instead of being treated as a youngster with a severe psychotic illness, he was then treated appropriately as a Deaf child, and given the kind of help he really needed to be able to relate to others. This kind of tragic misdiagnosis was not uncommon in 1963; alas, it even happens at times today.

It was a powerful lesson for me, as I was just beginning my work as a therapist, about the power of expert opinions and resultant expectations. Four years later, I was invited to start an art program at a place then called the "Home for Crippled Children." Because of my previous experience, when the administrators told me that only about ten percent of the residents would be capable of participating, I suggested that each of them be assessed for possible inclusion. Although it is no surprise now, in 1967 the staff was amazed that everyone could do something in art, given creative adaptations.

But the biggest surprise for the teachers and therapists was that the art assessments revealed talents and potentials they had not known about in a number of children. One was a girl named Claire. At age ten, she had been withdrawn from both school and speech therapy, since the staff was sure from her behavior that she must be profoundly retarded–unteachable and unreachable.

Claire's art evaluation was scheduled right after a visit to the dentist. She wheeled herself up to the table, grabbed a marker and paper, and drew a picture that–more eloquently than any words–told what it feels like to be invaded by the dentist's tools, to be open and vulnerable and terrified. Though helpless, like any patient in a dentist's chair, Claire could master the traumatic event by expressing her feelings in art, effectively turning passive into active (see figure P–1).

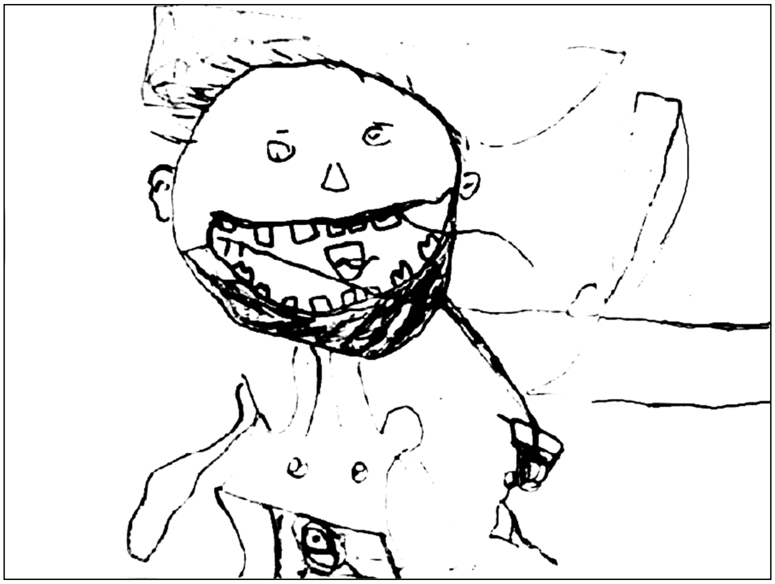

Figure P–1.

More important for her future, the age-appropriate drawing revealed that Claire's intelligence was much higher than anyone had imagined. As a result, she was put back in a classroom and resumed speech/language therapy. In both settings, she used a "talking book" to communicate with others (see figure P–2). The pictures were drawn by Claire and then labeled by the teacher or speech therapist, as in this drawing of the doctor and the nurse.

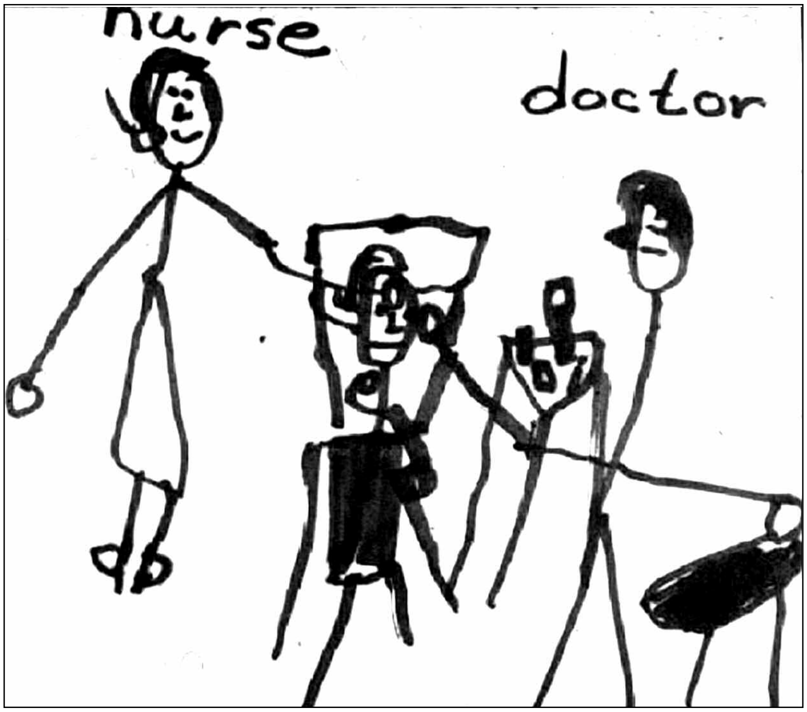

Figure P–2.

Unlike Johnny, Claire's Deafness was already known and her mute behavior was evident. But her drawings revealed an intellect, which had not been visible in any of the assessments then available. Thanks to her articulate art, Claire gained a new lease on growing, eventually learning gestures and sign language, through which she entered into the community of her peers (see figure P–3).

There are lessons to be learned from both of these stories. From Johnny, that a child who neither speaks nor understands may not be able to hear, an obvious but overlooked diagnosis. It was also clear that his defensive maneuvers were not psychotic, but that like many youngsters under stress, he had developed a compulsive ritual. He needed to find ways to create order, albeit rigidly, in a confusing and chaotic world in which he could not yet participate fully.

From Claire, we learn that Deaf is not "dumb," although it is all too easy

Figure P–3.

to assume that someone who doesn't respond can't process information. That fate had befallen Claire, who had been labeled as "profoundly retarded." Art that reveals potentials as often as it reflects problems gave her another way to speak. She was also fortunate that the director of speech therapy at the Home was creative enough to conceptualize the "talking book" idea, which worked amazingly well as Claire began the process of learning to communicate.

One more story . . . In 1983, I was invited to conduct a pilot art therapy program at a school for the deaf. The 16 children referred for diagnostic interviews quickly told me that what they most needed was a chance to express and cope with powerful feelings for which they had no words. Since an art education program was already available for cognitive and creative growth, I was free to encourage the children to use art and drama to express and deal with confused and conflicted feelings and fantasies (see figure P–4).

The intensity of their need for this kind of help was reflected in their ability to relate to me, despite my total lack of signing skills. I could understand some of the speech of the few who talked, and could use writing and drawing with some of the others, but I came away convinced of the need for an art therapist of the deaf to know sign language and, when appropriate, to use an interpreter. It was clear that I could have helped them much more had I been better able to understand their communications.

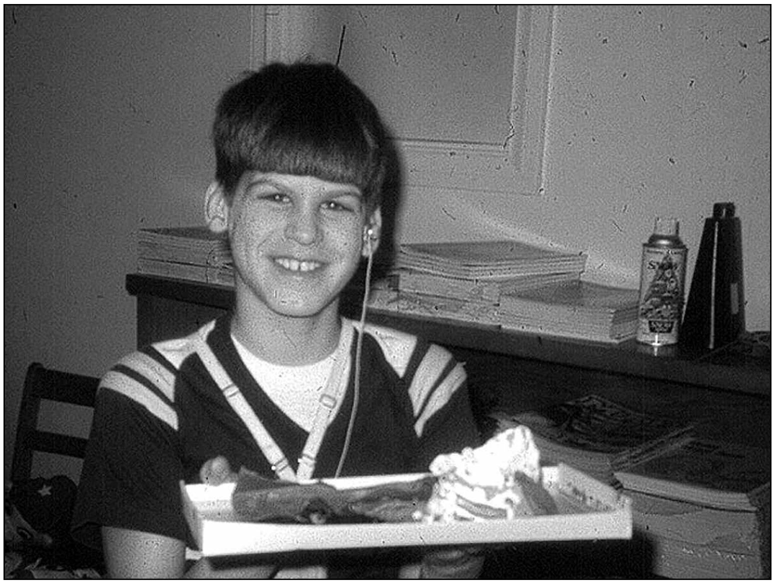

Figure P–4.

Sixteen-year-old Eleanor, whose suicidal impulses had been known to the staff for some time, had tried to cut her wrist the night before our fourth art therapy session. Realizing, after describing to me what had occurred, that she had hurt herself rather than the real target of her rage, she drew–with much excitement–a picture of what she would like to do to the grown-up, who had angered her (see figure P–5)

In the drawing a many-toothed, monstrous creature is holding a huge knife over a small, fearful person. She first said that she was the big one and the adult was the small one; then she reversed herself, explaining that in reality she felt helpless to deal with the power of those in charge of her. I suggested that she might also feel frightened of the extent of her own rage, of what she would really like to do to the grown-up in the picture. I wondered if she had turned the anger on herself as a punishment, as well as a way to protect the adult, who she then said cared a lot about her.

She spent the remaining time in the session drawing a volleyball net, perhaps to screen out the fearful imagery of her first picture, and then made four balloons tied together with colorful finger-paints. Eleanor was thus able to use the art therapy session first to express the feared impulse, and then to defend against it. Both were helpful to her in the ongoing task of self-awareness and self-control.

On the basis of the pilot study, which involved Eleanor and several others seen weekly for a term, a part-time art therapist who knew sign language

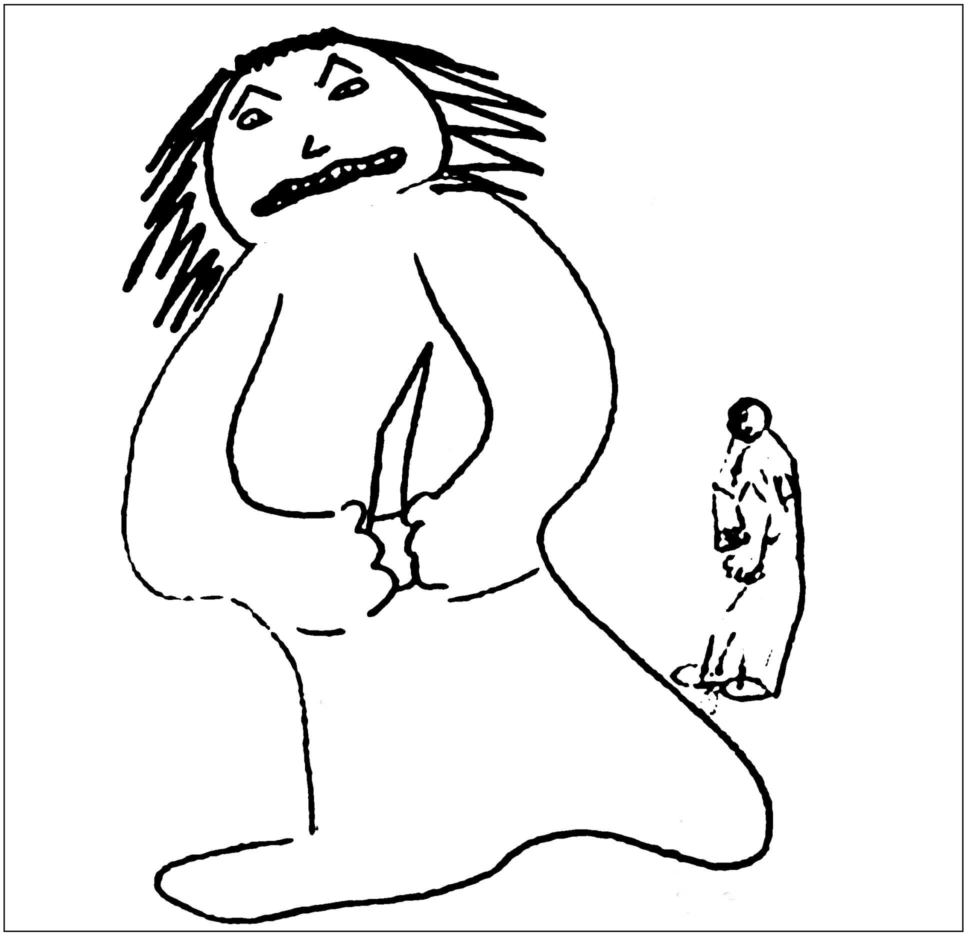

Figure P–5.

was hired and worked at the school for a number of years, seeing both individuals and group. Carole Kunkle-Miller's chapter about that work is one of the many valuable contributions in this book–a volume which was unthinkable when I first met Johnny and Claire in the sixties, and even when I met Eleanor in the early eighties. As many of the contributors note, there was a prejudice against Deaf culture and a reluctance to treat those who are Deaf in an appropriate fashion.

In addition to the mistaken conviction that Deaf individuals could not be creative or intelligent, noted by many authors in this volume, there was an equally insidious but widely-held notion that they were incapable of being helped through psychotherapy. As with those labeled retarded, the low expectations of the experts led to dreadful practices in the arts and in mental health. Either these were absent or, if available, were offered in such a way that the Deaf individual could not be creative and could not grow.

One of the most wonderful things about this book is that finally the Deaf are being recognized as the full human beings they have always been, who deserve full access to all of our resources. A recognition of their uniqueness rather than their deficits is found throughout the pages of this book, which presents an attitude that is both optimistic and realistic. And best of all, there are chapters, which will sensitize, inform, and inspire. Ellen Horovitz has done a service to anyone who offers art therapy to the Deaf. Through promoting better art therapy for the hearing impaired, those who are served will be able to live fuller, more rewarding, and more creative lives.

Judith A. Rubin, Ph.D., ATR–BC, HLM

PREFACE

For ages it has been thought that deaf children are nonverbal and are not capable of having any language. While this belief may still be widespread, a quiet revolution is taking place and changing these concepts. This revolution seems to be spreading.

Some of the insights behind this new thinking has come through the field of creative arts therapy. The creative arts therapists recognize that deaf children can image as well as anyone and perhaps better. There has been an increased awareness developing from the research conducted by Joe Khatena (1984) and others that the ability to image is a critical key to learning and thinking and probably as valuable as that of using words. Deaf children have also excelled in the visual arts where the skills involved are as available to them as to anyone else. Many deaf children have received recognition for the excellence of their work in the visual arts.

Recent developments in the area of kinesthetic learning have also brought a change in attitude about the teaching and learning styles of deaf children. Some children have learned these skills and have gone into creative dance and ballet and have excelled. Here and again the skills are as available to the deaf as well as to the hearing.

However, not all deaf children receive training in movement. Studies with deaf preschool children illustrate that children who have not had much experience with movement do not do as well as on tests of movement. This has been demonstrated using the test of Thinking Creatively in Action and Movement (Torrance, 1981). However, when these children are given training in creative movement, they make significant gains.

The tests that have been typically given to deaf children for placement in school programs have generally shown them to be deficient. This is because the tests do not make a demand on the abilities in which the deaf excel. Through the work of Rawley A. Silver (1978), Bill Kalstounis (1970), and others who have experimented with the Torrance Tests of Creative Thinking (Torrance, 1984), it has been shown that deaf children succeed just as well as hearing children on tests of creative thinking skills. They perform best when they are permitted to respond and express their thoughts in a modality, which is more compatible with their abilities.

People like Walter B. Barbe (1985) are not looking at learning through the perspective of the visual, kinesthetic, and auditory modalities. Unfortunately, schools have tended to place almost exclusive emphasis on the auditory modality. The recognition of the importance of other styles of teaching and learning may lead to better learning experiences not only for the deaf but for all children.

A book such as this on creative arts therapy and language for the deaf gives emphasis to these neglected modalities of expression. As educators gain insights into the language of the deaf, increased understanding and opportunities for the deaf should take place.

E. Paul Torrance
Alumni Foundation Distinguished Professor Emeritus

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Yet, categorically, I need to thank two very important people: Dr. Robert Pollard, of the Deaf Wellness Program, Strong Memorial Hospital at the University of Rochester, who linked me to many of the contributors herein; as well, my dear friend and colleague from Cornell University, Dr. William D. Schulze, who not only read a good deal of this manuscript, but also offered thoughtful suggestions and corrections to the work; his support has been unparallel.

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INTRODUCTION

ELLEN G. HOROVITZ

BACKGROUND

As in all of my books, there is generally a story, a tale that leads me to its beginning. In this case, it is deeply personal and had lifelong ramifications. At the age of six, I developed a very high fever, which consequently left me deaf for close to a week. Discussion was light around the house; my parents carefully tiptoed around the fact that I might indeed be deaf, if the illness had not lifted.

But most discordant for me was not so much the lack of sound, but the inability to hear my brother play the piano. "Close" pales as a descriptor when categorizing my relationship with my brother, Len. As a child, I spent hours listening to his talented fingers lilt across the ebony and white piano keys. What bothered me the most during this small sashay into deafness was my incapacity to hear the purity of this sound.

So one day, when feeling particularly sorry for myself, I leaned against the upright Baldwin piano so I could *feel* the sound since I was unable to hear it. And I cried. But in one miraculous moment, my ears popped, my head spun from the onslaught and I was once again in the hearing world. My pediatrician, Dr. Feinberg, never understood why this happened since he had just informed my mother two days earlier, to expect the worst (possibly an operation). And while my ears have remained ultrasensitive to sound, (sometimes picking up more than I wish) I find it fascinating that perhaps because of this, I oftentimes experience what I would coin auditory recall. So fascinated am I by sound that I have become adept at languages and relish when challenged to learn a new language system.

Ironically, I landed in Rochester, New York shortly after graduate school and secured a job in the metropolis that had invented finger spelling. Because Rochester was home to the Rochester School for the Deaf as well as

National Technical Institute for the Deaf (NTID), it was fairly common to rub elbows with deaf people.

By 1981, I was working at PS 29 (then touted as the largest public school for orthopedically and perceptually challenged children). As a result, I began working with one child who relied principally on bliss boards and sign language for exchange. In order to communicate with him, I had to learn his language system. I signed up at Monroe County Association for the Hearing Impaired (MCAHI) in Rochester, NY in order to facilitate my communication with him.

Soon after, I continued my training at NTID and immersed myself in deaf culture–probably most memorable was a “silent retreat” coupled with a two-day experience of wearing “white-noise” hearing aids and attempting to function in a hearing world without the aid of sound. Most numbing was how difficult it was to not only be understood but also translate the mouthed words of hearing people. I relied on pencil and paper and the occasional word or two that I was able to decipher from reading a person’s lips.

Thereafter, I worked with emotionally disturbed deaf children in a residential treatment facility and in time began to work with the Deaf in private practice. While I could never fully be accepted in the Deaf or hard-of-hearing world since I was not Deaf, I forged many friendships with Deaf clinicians and professionals. I found myself immersed in a world view that seemed incredibly fit for Art Therapy, a profession whose hallmark is indeed nonverbal communication.

A Word about Deaf versus deaf

Before discussing the contents of this book, I want to explain the reason behind capitalization of the word “Deaf.” In order for the reader to understand this, I will quote from the chapter written by Dr. Amy Szarkowski:

> The use of *‘Deaf’* in this chapter, consistent with the form often used by academics and researchers in the area, refers to individuals who identify with Deaf culture. The use of *‘deaf’* is also used, in to the context of referring to those with hearing loss, who do not define themselves as members of Deaf communities. For some, Deafness is a social construction of identity involving the use of Sign Language, understanding the Deaf Culture of one’s country or place of origin, and being involved in the Deaf community. Deaf people who adopt this identity are likely to be against the inclusion of Deafness in this discourse about disabilities. . . . [clarification of] the situation of persons who consider themselves *Deaf*, as well as those who call themselves *deaf*, and identify themselves as persons with a disability [is up for discussion]. Both realities are important and justified in the world as it is today.

In sum, Deafness may or may not be considered a “disability” by those afflicted with auditory loss. But, it is indeed a physical difference that has resulted in a language system. From language springs culture and Deaf language is indeed a cultivation that celebrates such ethnology. As a result, most of the authors in this book, will be capitalizing "Deaf" when referring to this culture.

Contents

In short order, sign language, (clearly a visual language) made abundant sense to me. This silent language of the Deaf vibrates through space as a three-dimensional language system, which arcs in past, present, and future just by mere body positioning and facial expression. It is a magical language, which crosses culture and is indeed classified, codified, and uniquely its own system.

Because of the complexity of this system, (from a developmental, cognitive, and emotional standpoint), I have invited contributions from some of the foremost authorities on Deafness. It is my intent to inspire other art therapists and mental health professionals through these readings. Coupling the exquisite complexity of this beautiful language system with the inner workings of Deaf culture is the bridge to transliteration, understanding and elucidation.

In chapter 1, McCullough and Duchesneau review the historical trends of the mental health Deaf person–who is a Deaf person, what kinds of treatment are available and have been readily accessible in the past, the psychology of the Deaf person, use of interpreters and finally implications of utilizing art therapy with this population. In chapter 2, pioneer art therapist, Silver reviews the use of SDT (Silver Drawing Test) with the Deaf population, vis a vis case studies and cross cultural analysis. Having been one of the first art therapists to work with the Deaf, Silver's contributions are both historical and scientific in nature. In chapter 3, Horovitz reviews family art therapy in the long-term treatment of a talented child and discusses the use of interpreters in this complex familial art therapy anecdote. In chapter 4, Brucker describes the use of art therapy as a treatment modality with Deaf/hearing-impaired adults who suffer from varied forms of mental illness. The majority of the persons described here were patients in a special mental health program for the Deaf at a psychiatric inpatient facility. The focus of this chapter is on the process and content of one art therapy group and the themes of the artwork of another over the course of a four-year period described in terms of the patient population, group characteristics, goals, and treatment effectiveness. In chapter 5, Atkinson and Horovitz describe working with a medically ill KODA ({Hearing} Kids Of Deaf Adults, very young children) who existed in a rather convoluted culture and world. This case was complicated by the child's serious, ongoing medical condition of Eosinophilic Gastroenteritis (EG), which currently prohibited from eating anything other than a few selected fruits and vegetables; as well, this disorder resulted in multiple surgeries and hospitalizations. In chapter 6, Henley articulates his work at a residential school for the Deaf during the 1980s, where he worked with Deaf children who, for various reasons, could not benefit from verbal or language-based therapy. The fascinating case of a Deaf/legally blind boy (age 9) is described in rich detail. In chapter 7, Szarkowski explored the meaning of "Deaf Culture" in several locales, and reflected upon differences found in the definitions of both *Deafness* and *disability* worldwide. Current paradigms in Disability Studies are addressed, as well as the application of Disability Studies to the field of Deafness. In chapter 8, Horovitz examines the possibilities and advantages of computers and culture coupled with hypermedia and computer animation as a specific educational tool in which these resources are applied to the teaching-learning process when working with emotionally disturbed Deaf/hearing-impaired clients. Moreover, Horovitz reviews the methodology of fostering improved spoken and written communication skills of the hearing-impaired via examining language systems (speech, linguistic structure, writing, etc.) and the different communication codes employed when working with this population. In chapter 9, Kunkle–Miller reviews both the theoretical and the practical aspects of establishing an art therapy program within a residential school setting. She offers numerous therapeutic modalities to lead the therapist treating hearing-impaired children in designing an effective treatment program. In the final chapter, Horovitz summarizes her work with two emotionally disturbed adolescents using both individual and family art therapy modalities in the recovery of these amazingly artistic individuals.

Chapter 1

MENTAL HEALTH AND DEAF PEOPLE

Candace A. McCullough and Sharon M. Duchesneau

In order to place art therapy with Deaf people into a meaningful context, it is essential to have a clear understanding of Deaf people as a unique and highly diversified minority group. Equally important is an awareness of the historic and complex relationship between Deaf people and the American mental health system. Even today, entering the twenty-first century, long-entrenched paternalistic and oppressive attitudes toward Deaf people continue to have ramifications on the quality of mental health services they receive. Not only do some clinicians, knowingly or not, persist in misunderstanding or overlooking the needs of Deaf clients, but also so do some Deaf clients lack a sense of entitlement and knowledge of how to obtain adequate and effective mental health services. Accessibility of mental health services for this population remains an ongoing issue. In spite of these obstacles, hopeful signs point to a brightening tableau in the field of mental health and Deaf people. One such sign is the increasing number of graduates of specialized training programs designed to teach students how to work effectively with Deaf clients (Leigh, 1991; Sussman & Brauer, 1999). Another is the growing body of literature on mental health and Deaf people, this book included. An appreciation of the great potential of utilizing art therapy with the Deaf population, thus, begins with an understanding of who Deaf people are, what their experiences have been as marginal members of a hearing society, and how they have fared to date as clients in the mental health system.

Who are Deaf People?

Deaf people are a vibrant community of individuals who share a rich cultural, linguistic, and historical heritage. Contrary to what many hearing people may believe, being Deaf entails far more than simply being without the sense of hearing; defining and interpreting Deaf people's lives in terms of their hearing status is a limiting approach that overlooks just how diverse and remarkable Deaf people are (Padden & Humphries, 1988). Within their community, Deaf people represent a wide spectrum of humanity, shaped by a variety of factors, including family history of Deafness, race, ethnicity, socioeconomic and educational background, and self-perception. One can no more assume that all Deaf people are fundamentally alike than one can assume all shades of green are the same.

A positive definition of Deaf people describes them as primarily visually-oriented people (Bahan, 2004). Beyond this, a definition of Deaf people defies generalization, in the same way that no one definition of African Americans will suffice to define all African Americans, nor will one characterization of women define all women. Deaf people can be descended from families with six or more generations of Deaf relatives or they may be the only Deaf member of their family. They may be native users of American Sign Language (ASL), or if they come from hearing families, they may have learned to sign when they entered school or college, or even afterwards. Everyone in the family may sign, making communication a nonissue; or there may be no signing family members at all, resulting in the Deaf person experiencing a sense of isolation. Deaf people may have been born Deaf or they may have become Deaf later in life. Some Deaf people may opt to use hearing aids or cochlear implants; others choose not to use amplification devices. There are Deaf people with professional degrees and Deaf people with less than eighth grade educations; Deaf people who exhibit healthy self-esteem and confidence and Deaf people who harbor feelings of inferiority likely borne out of years of oppression.

Population data and etiological information on deafness have long been the province of hearing researchers, reflecting their relative lack of importance for Deaf people, who are typically less concerned with pathological aspects of deafness and more concerned with cultural and community issues. For those who are interested, accurate demographic information about the Deaf population is difficult to come by, given the wide range of definitions of deafness employed in different studies. The 1990 and 1991 Health Interview Studies identified around 20 million Americans aged three or older as having "significant hearing loss," a figure that represents 8.6 percent of the population (National Center for Health Statistics, 1994). Approximately 550,000 Americans, or 0.23 percent of the population, do not hear or understand any speech (National Center for Health Statistics, 1994). In gender distribution, males tend to be Deaf or hard-of-hearing more often than females, although this is much more apparent after age 18 (National Center for Health Statistics, 1994). Across racial and ethnic groups, 9.4 percent of Caucasians are Deaf or hard-of-hearing, compared to 4.2 percent of African Americans and 4.2 percent of Hispanics (National Center for Health Statistics, 1994).

The most common causes of deafness in infants and young children are genetics, meningitis, and pregnancy/birth complications, including Rh incompatibility, prematurity, and birth trauma (Annual Survey, 1992–93). Approximately 50 percent of these etiologies are considered genetic (Marazita, Ploughman, Rawlings, Remington, Arnos & Nance, 1993). It has been suggested that deafness may often be attributed to genetics when there is no other obvious cause, hence the actual percentage of genetic deafness may be lower (Moores, 2001).

Views of Deaf People

Hearing professionals and lay people, as well as some Deaf people themselves, generally perceive Deaf people in one of two ways. The largely prevailing pathological perspective considers Deaf people to have an impairment that is in need of correction. The social minority perspective, on the other hand, considers Deaf people to be members of a unique cultural and linguistic minority (Padden, 1980; Padden & Humphries, 1988; Lane, Hoffmeister, & Bahan, 1996).

The pathological, or medical, perspective presumes that deafness is a disabling condition that can and should be corrected by the use of hearing aids, surgical implantation of cochlear implants, or other medical intervention. Adherents of this view believe that it is in the Deaf person's best interest to assimilate as much as possible into the larger hearing culture by learning to speak the majority language and by maximizing hearing ability through amplification devices and surgical intervention. The closer to the hearing norm that Deaf people can mold themselves, the better their lives will be, it is presumed. There are people with hearing loss, whose primary mode of communication is oral, who do live their lives determined to fit into the hearing world.

The implications of the pathological view of deafness, however, can be far-reaching and oppressive. Amplification is not an exact science and does not turn a Deaf person into a hearing person. Deaf children learning to speak may spend countless hours in speech therapy each year, sacrificing not only learning time in the classroom, but socialization opportunities as well. It is not a given that clear speech will be the outcome of all of this effort. It is not uncommon for a Deaf person to be encouraged and praised by teachers and family members for achieving "good speech skills," only to discover when trying to order dinner in a restaurant, that the waiter comprehends nothing of the Deaf person's speech. One Deaf woman, for example, recalled trying to order a glass of milk as a child. She tried several times to enunciate the order to the best of her ability, all the while gauging from the bewildered looks on the waiter's face that she was getting nowhere. Frustrated and humiliated, she gave up and asked instead for a root beer.

The physical and emotional toll of constantly striving to lip-read and voice soundless words can be exhausting and ego-deflating. The typical Deaf person lip-reads about 30 percent of what is being said, filling in the remaining 70 percent of the conversation with guesswork. A common experience of many Deaf people is to rely on the "Deaf nod," acknowledging the hearing person's remarks, even if they did not fully comprehend what was said. After asking the hearing person to repeat the remarks several times and still not understanding, the awkwardness and embarrassment usually lead to the "Deaf nod" as a last resort, hoping that will suffice and end the conversation. Hearing educators, audiologists, and speech therapists, as well as hearing family members, constantly tell the Deaf person to try harder to pronounce words more clearly, to pay closer attention when lip-reading. For some Deaf people, the reality of being Deaf may be pushed aside in favor of making them as "un-Deaf" as possible. With the emphasis on assimilation into the hearing world, people who view Deafness as a pathological condition may interpret using sign language or sign language interpreters as a sign of weakness or a failure to succeed in the hearing world. Little attention is paid to the psychological implications of the ongoing effort to deny or minimize the fact that the person is Deaf.

In contrast to the pathological view of Deaf people, those who view Deaf people as part of a social minority place language and culture, not hearing status, at the center of Deaf people's identity. As Padden and Humphries (1988) note, rather than defining Deaf people according to a central reference point of the hearing world, a more affirmative definition relies instead on a "different center," that of American Sign Language and Deaf culture. The Deaf person is seen as whole, as having the complete ability to function and communicate with others, albeit in a different way than hearing people.

From a historical vantage point, the social minority view of Deaf people is a relatively recent one. Deaf people have recognized for many years the kinship they share, evident in their status as visual people, in the close bonds formed in Deaf residential schools, clubs, and organizations, and in their shared history of oppression (Lane, Hoffmeister, & Bahan, 1996). Even so, it was not until the research of William C. Stokoe and colleagues in the 1960s, that American Sign Language first began to be recognized as formal language (Stokoe, Casterline, & Croneberg, 1965). In the decades that followed, recognition of ASL Deaf culture grew. With this came an emerging sense of Deaf pride, culminating in the 1988 Deaf President Now (DPN) movement at Gallaudet University in Washington, D.C., the premier institution of higher learning for Deaf students from all over the world. Rallying together for a politically charged week of protests and demonstrations, Deaf people and their hearing allies were successful in their quest to see the installment of the University's first Deaf president. The media attention garnered by DPN also brought to light to the larger hearing community, the idea of the social minority perspective of Deaf people. In the years following DPN, the establishment of Deaf studies and linguistics and interpreting graduate programs at universities across the country lent further credibility to Deaf people's vision of themselves as a social minority group.

Early and Current Mental Health Treatment

From a historical standpoint, the American mental health system has woefully neglected to meet the needs of its Deaf clients (Pollard, 1994; Steinberg, Sullivan, & Loew, 1998). Prior to the 1960s, Deaf people in need of serious psychological treatment were often warehoused, or relegated to the back wards of psychiatric hospitals, where they received little more than what can be described as maintenance or custodial care. It was not unheard of for Deaf clients to be misdiagnosed as mentally retarded and confined in psychiatric wards for the large part of their lives. Even today, on occasion, a report will surface about a long-institutionalized client suddenly being found to be Deaf and not mentally retarded or autistic as had previously been thought.

Throughout the mental health system, Deaf clients faced paternalistic and oppressive attitudes from the hearing professionals who directed their treatment. Clinicians were usually unfamiliar with Deaf culture, unable to communicate in sign language, and typically believed their Deaf clients incapable of responding to treatment. Reflective of societal views of Deaf people at the time, these professionals perceived Deaf people as lacking in cognitive and intellectual abilities and incapable of thinking or reasoning abstractly. Treatment, when given, was mostly directive and simplistic in scope and nature, with little expectation for improvement. Psychotherapies oriented toward insight or psychoanalysis, as well as those of cognitive or affective natures, were thought inappropriate for use with Deaf clients (Sussman & Brauer, 1999). Specialized outpatient services for Deaf clients did not develop until the 1960s. Among the first such programs available were St. Elizabeth's Hospital in Washington, D.C., and a New York State Psychiatric Institute clinic (Robinson, 1978; Altshuler, Baroff, & Rainer, 1963).

The growth of the American mental health deinstitutionalization movement in the 1970s, the subsequent shift in focus to community-based mental health services, and the burgeoning political empowerment of Deaf people inspired further changes in the treatment of Deaf people in the mental health system. Emboldened by recognition of ASL as a formal language, the aforementioned history-making and empowering DPN movement at Gallaudet University in 1988, and the signing of the Americans with Disabilities Act in 1992, Deaf people and their hearing allies began speaking up about the gross injustices the mental health system was doing to its Deaf clients. Their demands, along with the emergence of the first graduates of Gallaudet University's counseling and social work programs, led to the establishment of growing numbers of pioneering Deaf day and residential programs in the 1970s and 1980s.

The 1982 case of Nancy Doe (*Doe v. Buck*, 1983) in Maryland illustrates one of first precedents for improving Deaf people's access to inpatient psychiatric services. Sued by the Maryland Disability Law Center and the National Association of the Deaf Legal Defense Fund, the state of Maryland faced charges of confining Doe to 20 years of "antitherapeutic custodial isolation." During Doe's hospitalization for schizophrenia, she was provided with very little, if any, access to interpreters, forced to reside in a housing unit apart from other Deaf clients, and her case given no consultation with mental health professionals with specific training and experience in working with Deaf clients (Raifman & Vernon, 1996, New Rights). The case was settled in 1986 with a Consent Decree mandating that the state of Maryland create an inpatient unit to serve "as a model for treating hearing impaired mentally ill persons using appropriate communication methods" (Raifman & Vernon, 1996, New Rights). In addition to delineating staffing levels for the inpatient treatment team, the Decree also required that a certified interpreter or fluent signing staff member be present in the unit 24 hours a day.

On paper, the mandate reflects a new trend toward recognizing the need for improved quality of services to Deaf clients; in reality, there was, and still remains, a long way to go to ensure this. The presence of an interpreter or signing staff member 24 hours a day does not necessarily mean that Deaf clients have full access to all communication occurring in the unit. It is not a given that every spoken conversation between nonsigning staff will be interpreted for the Deaf clients' benefit. Already stressed by communication issues in the world outside the hospital, Deaf clients may find themselves retraumatized when observing two nurses at the front desk conversing in spoken English, gesturing, and laughing, oblivious to the fact that most of the people in the room have no idea what they find so funny. For clients experiencing paranoia, when the treatment environment presents situations such as the one just described, their level of paranoia may be elevated and their