Mental Health in Children and Young Deaf/HI People: A Review of Current Research & Practice

Dr. Andy Cornes FBPsS
Director
View Psychology Limited

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My Background

PhD in Psychological Medicine & MA in Deaf Studies

Consultant Psychologist/Family & Systemic Psychotherapist

27 years working with deaf/HI children

16 years of clinical work in education

Former CAMHS Lead for mental health in schools

Expert Witness in Family Court Proceedings

Expert WFD (Health)

Fellow BPS/Senior Fellow UoM

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What is Mental Health?

Problems with everyday living

Defined by severity:

Difficulties

Problems

Disorders

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What is Mental Health?

“The capacity to live a full, productive life, as well as the flexibility to deal with its ups and downs. In children and young people, it is especially about the capacity to learn, to enjoy friendships, to meet challenges, to develop talents and capabilities.”

- Young Minds (1996)
Mental Health: Generic

Approximately 1 in 5 (20%) identified with mental health problems

Boys more likely to be identified with ‘externalizing problems’ (e.g., ODD/CD, aggression)

Girls more likely to be identified with ‘internalizing problems’ (e.g., depression, anxiety)

Behaviour problems, ASD, ADHD, mood disorders, DSH, first episode psychosis are major referral concerns

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Mental Health: Deaf

Approximately 40% of deaf children have mental health problems versus 20% of hearing children.

Deaf children more likely to be identified with ‘externalizing problems’ (e.g., ODD/CD, aggression).

ASD/ADHD referral concerns.

Lower incidence of ‘internalizing problems’ (e.g., depression, anxiety).

Significant problems with identification and referral pathways – tend to present in crises.
Risk & Resilience
Risk Factors: Generic

- Poverty
- Bereavements
- Parent-child separation/Parental separation
- Loss of peer relationships
- Child abuse and neglect
- Bullying
- Illness or injury
- Changing schools

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Risk Factors: Deaf

Additional impairments
Limited shared language
Attachment difficulties
Lack of incidental learning opportunities
Limited social opportunities
Limited educational opportunities
Isolation and identity issues
Discrimination

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Protective Factors: Generic

Connectedness to school
Supportive school environment
Participation in after school activities
Effective involvement in the school
Relationship with one significant adult
Positive peer relationships
Protective Factors: Deaf

- Parental adaptation
- Shared communication
- Participation in social events
- Boundaries
- Friends
- Understanding feelings and self

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Common Problems: Deaf

Multiple aetiologies and factors
Not homogenous group
Lack of reflective functioning
Theory of mind (concreteness and literality)
Lack of emotional self-regulation
Aggression (*LD/ASD/ADHD)
The ability to attribute mental states, such as beliefs, intentions, memories, and desires, to oneself and others (Peterson & Siegal, 2000)

Emotional and social learning is premised on the parent encouraging the child to understand other people’s feelings and hold perspectives different from their own

Based on a conversational model of ToM, family communication isolates deaf child and denies them the opportunity to imagine separate mental states
Theory of Mind (ToM)

From age 2-3 years, children develop:

1. Perception – what mum sees
2. Wants
3. Emotions: differentiation in self and others

At age 5 years, children understand false beliefs

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this is Sally
this is Anne
Sally puts her ball in the basket
Sally goes away
Anne moves the ball to her box
where will Sally look for her ball?
Research on ToM

Studies have focused on: false belief, perspective-taking and emotional responses

Deaf children of hearing parents lag on ToM

Deaf children of deaf parents do not lag on ToM

ToM is not linked to language alone (Lundy, 2002)

Deaf kids do have problems with perspective-taking

Early communication essential

Evidence limited

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Adolescence: Deaf

Family problems - disconnection
Lack of emotional understanding
Emotional and behavioural dysregulation
Learning difficulties
Identity issues and isolation
Lack of social and emotional skills – poor self image and esteem
In some cases Hx of neglect and abuse

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Signs of Depression

Changes in eating or sleeping habits
Withdrawal from friends and activities once enjoyed
Persistent low mood
Indecision, lack concentration or forgetfulness
Poor self-esteem or guilt
Frequent physical complaints, such as headaches and stomach aches
Lack of enthusiasm, low energy or motivation

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Signs of Anxiety

Psychological:

Feeling on edge
Sense of dread
Difficulties concentrating
Irritability and impatience
Easily distracted
Persistent worries about the future
Signs of Anxiety

Physical:

Restlessness

Inability to relax

Trembling/shaking

Palpitations and sweating

Shaking

Butterflies/nausea
Psychological Assessment

History taking
Psychometrics
Interpretation
Diagnoses
Feedback
Intervention

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Psychological Assessment: Deaf

- Concepts are difficult to relay & understand
- Significant developmental delays
- Challenged by language and learning
- Lack of suitably qualified clinicians
- Kids are developing beings
- Co-morbidity
- Misdiagnosis, incorrect treatment & poor outcomes common

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ASD: Assessment Deaf

Syzmanski & Brice (2008):

Poor eye contact, difficulty initiating facial expression, difficulty engaging in shared attention, inflexibility to clearly communicate changes to routine and obsessional interests

Edwards & Crocker (2008):

The absence of communicative intent

The absence of joint attention skills

The presence of behavioural disorder unrelated to delay
Mental Health Interpreting

Difficult!
Lack of information makes preparation hard

Unusual terminology – ‘re-framing’ and ‘orientation’

Challenging – touches buttons

Confusing – transference, counter-transference and projection

Potentially damaging without professional support

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The Clinical Relationship

Difficult!

Both de-skilled

Boundary issues

Lack of awareness – both sides

Literal or free interpretation?

Ethical conundrums
VT

Potential for greater likelihood of VT when working in sign language (Bontempo & Malcolm 2012)

Why?

We are all psychologically porous

CODAs and Deaf interpreters may be particularly susceptible to VT

Why?
“Interpreters, as human beings, would be expected to perceive inaccurately and therefore interpret inaccurately content that is highly emotionally loaded for them.”

– Harvey 1985
Vignette

BH was a 10 year old profoundly deaf boy in on-going individual and family therapy in the context of escalating violent behaviour at school. No problems were reported at home. He lived with his mother, a single parent, who was able to sign well. Family life was chaotic with inconsistent limit setting and harsh discipline, including verbal and physical abuse. Interpreters were present for family sessions. In one of the sessions, unexpectedly, BH’s mother began to verbally abuse him. When the therapist checked to see if the interpreter was managing the situation, he was surprised to find her engaged in a pleasant conversation about what types of jams and preserves the boy liked to eat for breakfast. The dialogue had become too emotionally challenging for the interpreter and she had ‘rescued’ BH (and perhaps herself) from further psychological trauma. Post-session, the interpreter explained that BH had initiated the conversation, and stated that she had little recollection of what BH’s mother was saying. She appeared to have little insight into what had transpired.
Interpreting

“Interpreters, as human beings, would be expected to perceive inaccurately and therefore interpret inaccurately content that is highly emotionally loaded for them.”

– Harvey 1985

Remine M, A (2009) Preliminary Investigation of the Mental Health of Young Deaf West Australians. Graduate School of Education, University of Melbourne


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2006 Study

Tasmania (n=11) & NSW (n=43)

29 males, 25 females completed signed YSR twice

31 students in Bilingual-Bicultural schools

23 students in Hearing Impaired Units

33 students also completed written YSR

Parents (n=32) and teachers (n=48) also completed questionnaires

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Internalizing Behaviour

Classifications

50
40
30
Externalizing Behaviour

% Clinical Range Classifications

- Rule-Breaking: 3.6, 16.7
- Aggressive Behaviour: 10.7, 16.7, 13.8, 2.2
- Externalizing: 17.9, 40.7, 24.1, 17.4

Written YSR, Signed YSR, CBCL, TRF
Major findings

Results support the hypothesis that using standard English questionnaires results in a lower prevalence of psychological problems.

The prevalence of emotional and behavioural problems obtained using the signed YSR was over double the rate seen in the non-deaf population.
Results

It is possible to develop computer-administered Auslan versions of psychiatric questionnaires.

The study provides evidence that these psychiatric measures are as reliable and valid (concurrent validity) as the original written English instruments.

The interactive, computer-based administration is easy, minimizes missing data and is liked by deaf adolescents.

When compared with general population estimates, there appears to be a disproportionately high rate of emotional and behavioural problems experienced by Australian deaf youth.

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2009/10 Study: WA

WA (n=66) students age 6-18 years

Parents 15%, Teachers 11% and Deaf students 11%

Parents concerned about anxiety, social & thought problems and school

Teachers concerned about social competence and academic performance

Kids concerned about somatic complaints, social competence and popularity
2012 Study: NSW/TAS

(Written/Signed/Parent/Teacher SDQ)

Emotional Problems 11.8%/14.8%/18.2%/10.4%

Conduct Problems 23.5%/24.1%/24.2%/20.8%

Hyperactivity-Inattention 14.7%/14.8%/18.2%/12.5%

Peer Problems 14.7%/20.4%/33.3%/25%

Prosocial Behaviour 17.6%/11.1%/6.1%/20.8%

Total Difficulties 11.8%/22.5%/30.3%/25%

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2014 Study: WA

YSR: Signed (n=33) & Written (n=2)

Internalizing 40%

Externalizing 37.1%

Total Problems 39.3%
2014 Study: WA

Somatic Complaints 30.3%
Withdrawn 19.1%
Anxiety/Depression 16.9%
Rule-Breaking 24.7%
Aggression 20.2%
Social Problems 28.1%
Thought Problems 21.3%
Attention Problems 15.7%

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International Data

Reflects a higher incidence of mental health disorders

Deafness not the cause of mental health problems but is a risk factor

U.K. 40% prevalence (Hindley, 2005)

USA deaf children higher rate of behavioural problems and ADHD (Haskins, 2000 and Critchfield, 2002)

Canada Axis II (personality disorders and intellectual disability) and childhood behaviour problems are 6 times more prevalent for deaf persons (CAD, 2007)

Netherlands higher rates of anxiety as reported by parents of deaf children (van Eldik, 2004)

Netherlands 46% of deaf children have mental health disorders (van Gent, 2014)
Prevalence (self-report)

- Australia: 42.6%
- Canada: 59.3%
- USA: 36%
- Holland: 37%
Prevalence (parent)

Australia: 27.6%
USA: 48%
Holland: 41%
Germany: 39%
Prevalence (teacher)

Australia: 25
USA: 35
UK: 50
Holland: 32
Conclusions

Mental health assessment of deaf children is highly specialised and generic services are unsuitable.

The use of sign language interpreters is variable and may be problematic.

Research in Australia is limited but results from studies show increased levels of mental health problems compared to hearing peers.

To date age, gender and family history of deafness are not associated with mental health issues.

The most recent Australian study showed that the language used in school was a significant predictor of mental health problems.

Further research and service provision warrants attention.
My Contact Details

Dr. Andy Cornes
Director of View Psychology Ltd
www.viewpsychology.co.uk
director@viewpsychology.co.uk
07505 125 729

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