MENTAL HEALTH AND DEAF LEARNERS- APPROACHES TO INTERVENTION

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Introduction

Mental Health is not only the absence of a mental illness.The World Health Organisation defines mental health as “a state of well being in which the individual realises his or her abilities, can cope with normal stresses in life, can work productively and fruitfully, and is able to make a contribution to his or her community.” (World Health Organisation, 2005, p.2)

The six elements of psychological well being as described by Westerhof (Westerhof&Keyes, 2010, p. 111) guide us in promoting mental health in people who are deaf or hard of hearing.

1. Self-acceptance: a positive and acceptant attitude toward aspects of self in past and present;
2. Purpose in life: goals and beliefs that affirm a sense of direction and meaning in life;
3. Autonomy: self-direction as guided by one’s own socially accepted internal standards;
4. Positive relations with others: having satisfying personal relationships in which empathy and intimacy are expressed;
5. Environmental mastery: the capability to manage the complex environment according to one’s own needs;
6. Personal growth: the insight into one’s own potential for self-development.

Efforts to improve these overlapping dimensions will be described later and are structured according to the WHO’s approaches of prevention of mental health disorders (WHO 2002).

- Primary prevention aims at improvement of mental health of the population at large and promotes positive mental health.
- Secondary prevention refers to interventions of early recognition and effective management of mental health problems and disorders.
- Tertiary prevention includes interventions that reduce disability and all forms of rehabilitation.

Mental health problems in deaf children

Specific prevention of mental health disorders and promotion of positive mental health in children who are deaf or hard of hearing is necessary as numerous studies from differentcountries show about two times higher rates of mental health problems compared to hearing peers.(Dammeyer, 2009; Fellinger, Holzinger, Beitel, & Goldberg, 2009b; Fellinger,

Holzinger, Sattel, Laucht, & Goldberg, 2009a; Hindley, 2000; Van Gent et al, 2007; Stevenson et al., 2011)

Most studies which used the Strengths and Difficulties Questionnaire (SDQ) in different populations of deaf and hard of hearing children worldwide have high scores in thesubcategory peer relationship problems in common. (Dammeyer, 2009; Fellinger, Holzinger, Sattel, &Laucht, 2008; Hintermair, 2007; Stevenson et al., 2011).

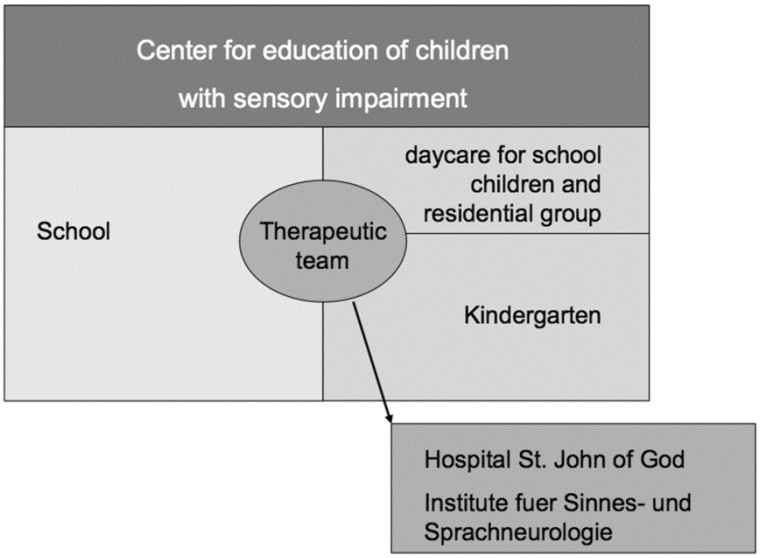
Psychiatric interviews gave insight in high rates of depression (Van Gent et al, 2007). In a representative sample of deaf and hard of hearing school children in Austria 26 % had experienced at least one depressive episode in their life time.Children who could not make themselves understood in their families were four times more likely to be affected by a mental health disorder and more likely to be victims of maltreatment at school (Fellinger et al, 2009)

Background: Education of children who are deaf or hard of hearing in Upper Austria and Salzburg

Before our approaches in promotion of positive mental health and prevention of mental health disorders are described, the current situation in deaf education in Upper Austria and Salzburg is reported and the clinical department involved in providing mental health care is introduced.

Upper Austria and Salzburg are two of nine provinces of Austria with a current population of 1,400.000 and 532.000 inhabitants.Both provinces provide special schools for children who are deaf or hard of hearing as well as education in mainstream settings either as single students or together with other children with different kinds of disabilities. There are also classes which follow a model of reversed mainstreaming in teaching hearing local children together with three to five children with hearing loss at the Centres for special education for children with sensory impairments.

Figure 1: Organizational structure of stakeholders involved in the education of deaf children in Linz



The Institute fuer Sinnes- und Sprachneurologie

The therapeutic teams working at the Centres for special education in Linz and Salzburg consisting of a psychologist, a speech language therapist, an occupational therapist and a deaf professional belong to the Institute fuerSinnes- und Sprachneurologie of the Hospital of St. John of God in Linz.The InstitutefuerSinnes- und Sprachneurologie serves people with disorders of hearing, language and communication including autism (Fellinger & Holzinger 2014).

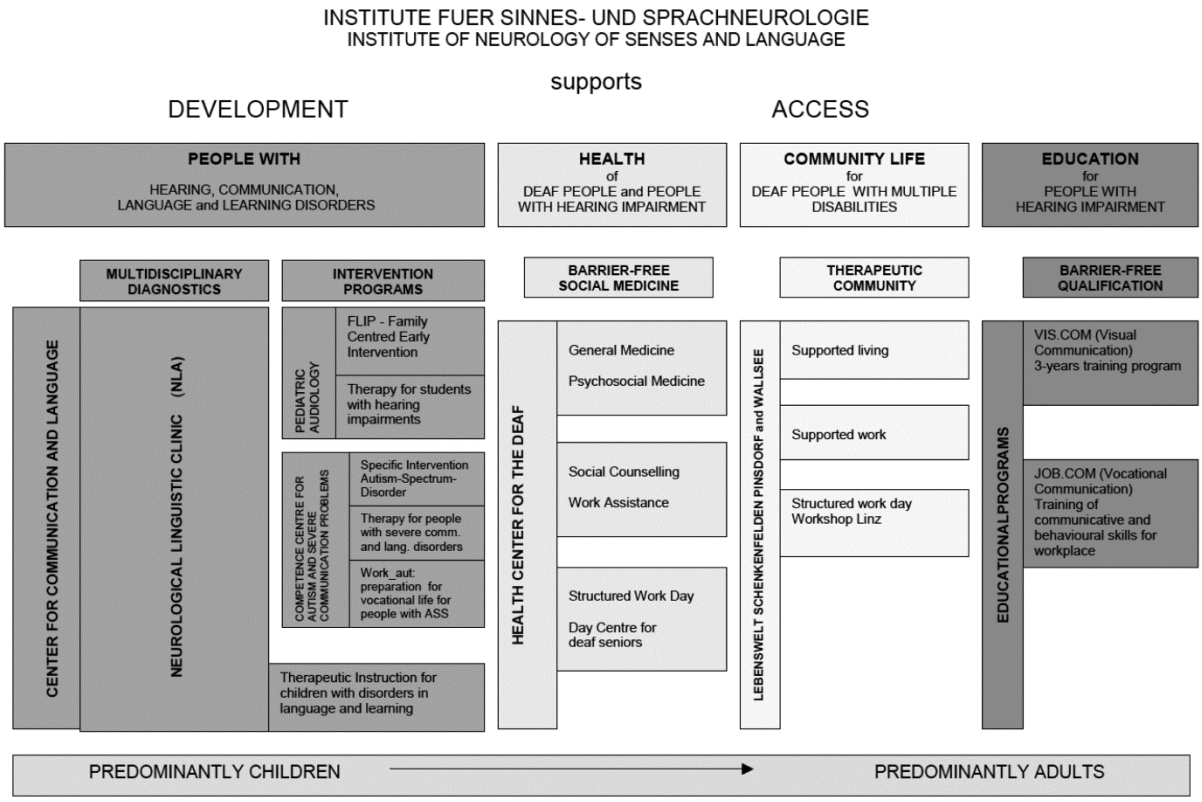
Comprehensive assessments covering different developmental domains which include analyses of individual and social resources are provided by multidisciplinary teams.

Early intervention is provided in a family centred way for children with hearing loss and autism.

At the Institute´s Health Centre Deaf people get direct access to health care, mental health and social services by staff who is able to communicate directly in signlanguage and to adapt to the mode and speed of communication to the level of the patient needs.

Three residential facilities called Lebenswelt where deaf and hard of hearing people with multiple disabilities live together in therapeutic communities and a three years training program for deaf and hard of hearing persons to become professional in the social field are also run by the Institute.

Figure 2: Working fields of the Institute fuerSinnes- und Sprachneurologie



<u>Principal of Mental health care of the Institute fuerSinnes- und Sprachneurologie</u>

Regardless of their specific professional background all staff members focus on and collaborate to meet the mental health needs and to improve quality of life of the individuals any groups they serve.The principles of mental health care are embedded like the DNA in any human cell, in all our efforts and can be summarized as follows.

- Self efficacy is encouraged and social relationships are enhanced.
- the development of abilities in social communication is a central approach to mental health
- Mental health care is provided in a transdisciplinary way
- Therapeutic interventions are based on multidisciplinary assessments
- Specialised professionals treat clinical cases.

Mental health interventions stimulate self efficacy

Self efficacy refers to beliefs in one’s capabilities to organize and execute the courses of action required to manage prospective situations.(Bandura, 1995, p 2).

Four primary sources enhance efficacy beliefs (Bandura 1996; O'Leary 1985): mastery experience, vicarious experience or modelling, verbal persuasion and physiological states. In brief, successful coping with challenges helps a person to believe in his or her abilities to manage difficult situations in future. Therefore we are constantly searching for opportunities where thesekind of experiences can be made by children with and without mental health problems, parents and teachers, while providing support in challenging situations.
The deaf professional with her mastery experiences has a specific role in that context.

Mental health intervention focus on social relationships

Being aware that social proximity and interaction promotes health and that children who are hard of hearing or deaf are at higher risk of lacking satisfying peer relationships the development of satisfying social relationships has become an overarching goal.In our efforts to improve quality of life of deaf and hard of hearing children and their families to become successful in their social dimension of human society communicative skills are essential. Therefore strengthening communicative abilities are the main approach in our attempts to improve mental health.

Abilities in social communication supports mental health

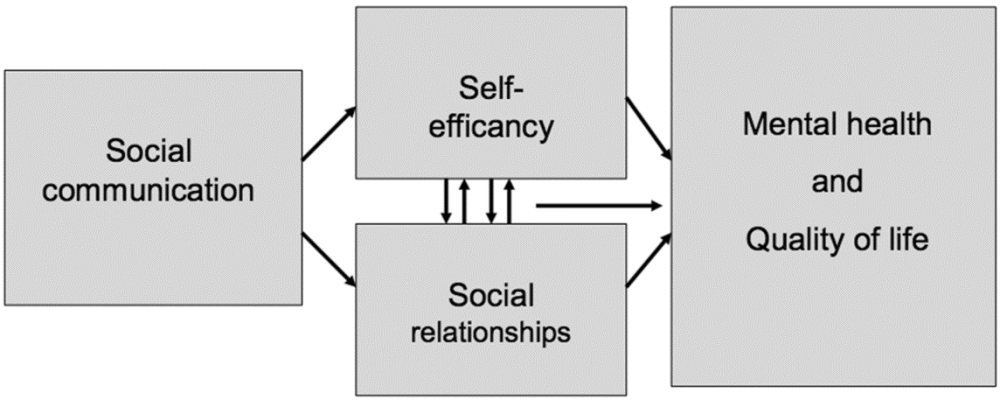
Research has shown that for deaf and hard of hearing children difficulties with language in natural conversations (pragmatics) are usually greater than any delays in linguistic skills like vocabulary or morphosyntacts (Goberis et al, 2012).

The relationship between difficulties in social communication and psychosocial problems such as social isolation, anxiety and low self esteem lasting into adulthood was found to be highly significant (Whitehouse et al 2009, van Agt 2011, Fellinger 2009).

Social communication interventions are a responsibility of all members of the multidisciplinary team and focus on the whole scope of communicative functions such as requiring information, expressing personal opinions, arguing for something, narrative skills as well as on conversational skills like turn taking, initiating conversations, joining conversations of peers and the use of repair strategies, when communication breaks down.

All therapists are trained in language facilitation strategies (responsiveness, expansions, corrective feedback, open questions) and are encouraged to use the technique of "sustained shared thinking" as described by Siraj-Blatchford et al 2002 (creative thinking aloud between adults and children – which is especially useful when talking about feelings).

Figure 3: Models of contributors in mental health



Specific programs of mental health promotion

Specific programs of mental health promotion are described according to the WHO system of primary preventions with the focus on developing inner strength and wellbeing, secondary preventions with the focus to prevent mental health problems and tertiary preventions as the task to treat mental health disorders.

This section resembles a visit in a craftman´s workshop with products in different stages of development, some just started and far from perfect and others in use for longer periods of time but still waiting evaluation.

However this section should stimulate ideas and discussions of practitioners as well as systematic scientific evaluation.

<u>Primary prevention</u>

Interdisciplinary development plan:

For primary school children interdisciplinary meetings of parents, teachers and therapists are organized twice a year which focus also on the importance of socio-emotional health in addressing topics like family communication, self esteem, self efficacy or identity.
This approach has increased the educational involvement and feeling of responsibility for the child's development of parents who had rather limited contact with the school before.

The PATHS curriculum

The Paths curriculum is an evidence based program to promote social competence and emotional development in students who are deaf or hard of hearing (Greenberg &Kusche 1993, Greenberg 2000, S 20).

The program was introduced to the teachers in Linz and Salzburg by the therapeutic teams but could be only partially implemented due to restriction in the educational systems.

However procedures and materials were modified and in addition to class based implementations extra group interventions were established for those with specific social difficulties. This proofed to be effective as far as parents, teachers and therapists report.

Summer Camps

Together with the Deaf organisation and the parents Association of Upper Austria our institute has been organising summer camps for children and adolescents who are deaf and hard of hearing over years. These summer camps last one week and foster interaction with successful deaf adults.Most of the former participants report that these summer camps were essential for their long lasting friendships and the development of selfesteem and identity.

Secondary prevention

Screening

Awareness of the high risk of mental health problems in deaf school children stimulated the introduction of a school wide screening for mental health problems by the use of the SDQ (Strengths and Difficulties Questionnaire) in autumn 2014. Teachers and parents questionnaires are evaluated by the psychologists of the therapeutic team and feedback is given to parents, whose children have scores in abnormal ranges.

Psychoeducational support for teachers and educators:

Therapeutic staff provides training sessions for teachers on relevant topics like bullying or sexual harassment. Teachers and educators approach the clinical psychologist to discuss psychosocial problems they observe in their classes and are coached in dealing with these problems.

Tertiary prevention

Management of mental health disorders:

Easily accessible professional mental health care is one of the main responsibilities of the clinical staff based at the school for the deaf requires high levels of sign language skills and other visual techniques to be able to communicate directly with the clients. The clinical psychologists are supported by medical staff of the institute. A neuropsychiatrist is available for case consultations. The interventions itself are adapted to the respective clients needs and include behavioural observations by the psychologists in the classroom, modified

(dialectical) behavioural therapy based on planning sessions and clearly defined written goals which also involve parents and sometimes teachers. (Glickman, 2009)
Teacher involvement has proofed to be effective although it is sometimes not easy to involve teachers in practice.

Therapeutic work of the clinicians is supported by the deaf staff member who facilitates communication especially in those children with limited sign language skills and rather idiosyncratic signs.

Multidisciplinary group therapies:
Group therapies offer opportunities for social learning by observations of others as proposed by Bandura (Bandura et al. 1966; Furmann 2005).

“Acting together” AT-Group comprise three to five students with hearing loss and two therapists from different professional backgrounds - mostly including the deaf staff member - who assign different tasks in a series of ten sessions of 1,5 hours each. The students create and discuss ideas, develop action plans, distribute roles and find problem solving strategies. Reflect time after the completion of the respective tasks is dedicated to the exchange of the children´s experiences with social aspects like peer interactions and interactions with and among therapists.

So far only observations of improved social skills like better impulse control and of emotional development like awareness of feelings of oneself and peers as well as high levels of acceptance by students and their parents can be regarded as first steps to evaluate this program.

Conclusion
Mental Health and Quality of Life are central dimensions of successful life outcomes.

The time children spend in educational systems can be and should be used to foster mental health especially in its social dimension.Models like that of a clinical team of therapists at a special school setting can contribute to this overarching goal by efforts to improve skills in social communication and self efficacy provided in a transdisciplinary way. Programs to support children in mainstream settings deserve special attention. Further research is necessary to evaluate efficacy and effectiveness of current and future efforts.

The vision of a healthy socially competent deaf of hard of hearing child can have the function of a lighthouse on this journey.

Figure 4: Healthy deaf child

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