

Conference report

The First European Congress on Mental Health and Deafness, Rotterdam, The Netherlands, 9–11 November 1988

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Prelingually deaf people receive inadequate mental health care because most services are poorly equipped to understand them and communicate in sign language. Educational constraints mean that few deaf people are in a position to offer professional help. One hundred and eighty deaf and hearing people, mainly from European countries, met at this congress to learn a little more about the present state and the future of psychiatric services for deaf people.

The opening speeches set the scene: mental health care for deaf people is in its infancy, yet opportunities for improvement are available. Gallaudet University in Washington, USA, is a symbol of how deaf people can break the dual bonds of paternalism and oppression by a hearing, though often well-meaning, society. Dr Yerker Andersson, Professor of Sociology at Gallaudet, gave the keynote speech in his native American sign language. In March 1988, the deaf students at the university forced its governing body to change its decision to appoint a hearing person as president ahead of two highly qualified deaf candidates. He talked about the important role that the deaf community has to play in the prevention and rehabilitation of deaf people with psychiatric problems. Deaf rather than hearing cultural norms should be applied to them.

Communication is a core issue. Dr Filip Loncke, a remedial educationalist at the St Gregorius Institute in Ghent, Belgium, discussed the connection between 'Communication and Deafness'. He proposed that language is a modality-free phenomenon, such that deaf people can have a high linguistic potential. The best way of realising this is to provide deaf children with a range of linguistic environments between verbal and non-verbal extremes. The most important early environment is the family.

Mrs Rita Bruning-de Bruyn, Chairman of the Dutch Federation of Parents of Deaf Children, described her 'Life with a Deaf Child'. The impact of a deaf child on a hearing family is devastating. Inadequate counselling often leads to parents making misguided decisions in an attempt to have a "nor-

mal" (i.e. hearing) child. More preventive measures must be taken with the family both soon after a child's deafness is diagnosed and subsequently at important stages in the child's development.

Mr Claude Malet, a psychologist at the 'Lui et Nous' Centre in Brussels, Belgium, discussed what to do 'When Deaf Children Need Help'. A deaf child born to a hearing family will have difficulties engaging in the mutual interactions that facilitate bonding. Parents must be drawn into confronting feelings of rejection and ambivalence. Realistic aims and goals should be set when the child is first diagnosed as deaf, and these should be reviewed regularly. It should be emphasised that language acquisition is more than just learning speech, so that communication is encouraged by whatever means are most suitable in any situation.

There have been a number of assumptions about the personality of deaf people. Dr George Montgomery, a psychologist at the University Department of Psychology and Donaldson's Research Unit, Edinburgh, set about 'Dissolving the Myths' about deafness and personality development. The incidence of immaturity, regressive tantrums and rigidity was felt to be related more to educational and communication problems than to deafness itself. Assessment by hearing people of the personality of deaf people necessarily involves making transcultural judgements; the validity of such judgements can be called into question.

Difficulties in communicating with deaf people make 'Pitfalls in Diagnosis' all too common occurrences, according to Dr Brendan Monteiro, Consultant Psychiatrist at the Department of Psychiatry for the Deaf, Whittingham Hospital, Preston. Those people working in existing general psychiatric facilities often feel unable to provide an adequate service. A good case was made for special psychiatric services for the deaf.

The important diagnostic issue of personality disorder in deaf people was addressed by Dr Jorgen Remvig, Chief Psychiatrist at Copenhagen County

Hospital in Denmark. The concept of 'Surdophrenia' (literally, a "deaf mind") attempts to psychiatricise features allegedly common in deaf people: concrete thinking and rigid behaviour; projection of guilt and poor judgement; and impulsiveness. However, such value judgements are very difficult to make across a transcultural divide and subsequent discussion revealed that surdophrenia is not widely held to be a useful concept.

The problems of the multidisciplinary team are increased when there is a mixture of deaf and hearing staff. Dr Britta Hegethorn described how these problems can be approached in her 'Psychiatric Department for the Deaf' in Stockholm, Sweden, which runs on psychodynamic lines and uses sign language. Of course, the psychiatric unit itself is only part of a complete service. Social Workers with the Deaf can often communicate better with a deaf person than hearing relatives. However, social workers cannot carry the full burden of 'Rehabilitation and After-care' according to Mr Frank Warren, Principal of Richardson House Rehabilitation Centre in Blackburn. Residential units have an important role, especially in the (re)habilitation of deaf adolescents with behaviour problems, where issues related to separation and individuation from the family can start to be resolved. The importance of adequate psychiatric backup when working with such potentially disturbed individuals was emphasised.

Appropriate mental health care for deaf people must be based on research to identify their needs. This research does not yet exist. Mr Ludo Timmermans, a nursing administrator in Belgium, has looked at these needs in Flanders. He introduced the ambitious and exciting 'Research Project European Society for Mental Health and Deafness' which will bring together experts in this field at each of five stages to create a study of existing services for deaf people and their needs, capable of guiding policy-development on a pan-European basis. The study will look at issues including terminology, assessment and diagnosis, demographic characteristics, the views of the deaf community itself, and recommendations for the future. There are only a few studies in psychiatry which have involved as much international collaboration. It was appropriate, therefore, that the closing address be given on 'Deafness and Mental Health: where do we go from here?' by

Dr Herbert Feuchte, a teacher from Hamburg, West Germany, the parent of a deaf child and one of the founders of the European Society for Mental Health and Deafness. There must be closer cooperation between specialists because of the particularly challenging nature of the psychiatric problems experienced by deaf people. Research must go hand in hand with the acquisition of practical experience and expertise. The true magnitude of the job is, even now, not clear.

Subsequent discussion revealed the whole spectrum of approaches and perspectives in this specialised area of mental health care. Britain appears to lag behind the francophone nations in the provision of psychiatric services for deaf children. Facilities for deaf adults here and in Scandinavia, while inadequate, are probably better developed than in the rest of Europe. However, compared to services for hearing people, there is a *prima facie* case for saying that deaf people are badly served throughout Europe.

The British professionals at the congress agreed on a number of guidelines for the development of services on a national basis:

- (a) Existing services could be better coordinated by increased cooperation between participating agencies, including the voluntary sector.
- (b) A child psychiatry service is long overdue.
- (c) Adequate aftercare is essential to consolidate the work of the psychiatric services and should include long-stay facilities both in hospital and in the community.
- (d) Secure provision is required for offender and dangerous patients who are deaf.
- (e) The removal of unnecessary barriers and the provision of suitable training must occur to allow deaf people themselves to become qualified professionals in mental health care.
- (f) Constraints on local authorities at the moment hinder the training of Social Workers with the Deaf. Central funding would counter this effect.
- (g) Future plans should also meet the mental health care needs of the significant proportion of deaf people with additional physical/mental handicaps.

It was pleasing to note the presence of the medical member of the Department of Health concerned with the provision of psychiatric services for deaf people. The next congress will be in 1990.