In general, the diagnostic procedures at Springfield and Whittingham differ. At Springfield, patients tend to be seen by a number of professionals, whereas at Whittingham, the initial diagnosis is made by the consultant psychiatrist. Another major difference between the hospitals is the position each adopts regarding the use of psychotherapy as a valid form of treatment. Whittingham, like the National Association for Mental Health (MIND), is very sceptical of the ‘Talking Cure’, whereas Springfield sees this as a major area for development with patients. Busfield and Ellenberger are very critical of psychotherapy as a treatment option. Rack sees it as a valid option only for a limited number of cultural groups, excluding by implication marginalized groups such as Black people and Deaf people.

ITQ
We have presented a picture of Deaf people being processed by a mental health system alien to them and operated by hearing professionals. But why should this be problematic for Deaf people? When we talk of differences in language, culture and communication needs, exactly what are these differences and how do they lead to disadvantage for Deaf people? List some of the factors that operate in a deaf-hearing interaction within the mental health system, and think about how they might manufacture a disadvantage for Deaf people.

Comment
Your list may contain such factors as
mis-communication
cultural misunderstanding
a stereotyped view of the abilities of Deaf people
a medical model view of deafness as dysfunction
Bear these in mind as you read through the next section, and consider to what extent these difficulties might be resolved by the introduction into the mental health system of Deaf people as professionals.

12 Deaf professionals within the mental health system

If the therapist is able to communicate fluently in sign language, possess a working knowledge of the psychological aspects of deafness, understand the social reality of the deaf individual, and holds a positive attitude toward deafness and sign language, he or she can hope to be an effective therapist with deaf people.

(Brauer and Sussman, 1980, in Elliott et al., 1987)

Harris (in Elliott et al., 1987) believes that Deaf therapists have a unique contribution to make in helping Deaf people with emotional issues: ‘their fluency in manual communication and their intimate knowledge of the deaf culture ... make them ... invaluable’. However, there are currently no Deaf
psychiatrists in Britain, no psychiatrists with any degree of fluency in BSL, and no Deaf doctors in our mental health system. There are, though, a number of other Deaf professionals working in the two Deaf units and elsewhere. What role do they play professionally, and do they, as Harris suggests, provide something unique?

**Video**

Now watch Video Three again. This time pay attention to Herbert Marvin, the deaf counsellor from Springfield Hospital. Does he feel Deaf professionals have a role to play within our mental health system?

Herbert Marvin very much emphasizes the importance of Deaf professionals, especially of therapists and counsellors. Yet how many are there in the UK? Both Springfield and Whittingham Hospitals employ Deaf occupational therapists. Springfield has two Deaf counsellors, whilst Whittingham employs two Deaf people as instructors/facilitators, in much the same way as does the Hayfields Rehabilitation Unit in Glasgow. The total number of full-time posts filled by Deaf professionals within the mental health system is around seventeen. This figure includes the smaller longer stay establishments such as Richardson House and Court Grange. There is no doubt that many Deaf people employed in non-therapeutic roles do perform important, albeit informal, therapeutic functions. In Section 1 we discussed the various psychiatric facilities available to Deaf people such as Hayfields and Richardson House. It might be useful at this stage to re-read that section.

In Video Three Herbert Marvin suggests that much distress could be prevented if Deaf people were able to gain access to non-statutory services much earlier on, rather than being delayed and then having to go to a psychiatric hospital. In other words, they should have the same ease of access to services such as doctors, social workers, welfare or pastoral workers, psychologists, counsellors and nursing staff, as do hearing people. Marvin also emphasizes that too many Deaf people, who could be seen in non-medical settings if these existed, end up in psychiatric care.

Sachs et al. (1972) believe that a Deaf–Deaf interaction during the therapeutic process allows for clear ‘identification’; in other words, both the Deaf client and the Deaf therapist have a shared feeling of, ‘you know what I mean, you’ve been there yourself’. Langholtz (in Elliott et al., 1987) suggests that ‘identification’ means a shared language. However, there are regional variations in BSL, and Deaf people can also choose to communicate by other methods (as Units 2 and 3 have shown). So how can one reconcile the views of Langholtz and Sachs without there being a clear uniformity of language, culture and experience?

Elliott et al. (1987) also point to a number of difficulties facing Deaf professionals working in the mental health field: a Deaf therapist may be viewed by the client or the family as less competent; the client cannot so easily claim to be misunderstood by another Deaf person, so may feel threatened; sign systems and communication methods may not be congruent and may lead to early disappointment; and there is the risk both of over-identification with the client, and of the ‘rush’ to establish a deep and meaningful relationship with the therapist because he or she is also Deaf.

40
Rampton is a high security psychiatric hospital resembling more a prison than a conventional hospital. Janet Goodwill is a Deaf person employed at Rampton as a sign language teacher. Her role within the institution is graphically described in Reader One. Her account (with Rae Than) describes the input a Deaf professional has made to the Deaf patients and the effect this has had on her hearing colleagues.

Goodwill and Than’s account seems to suggest that the appointment of a Deaf person has influenced both staff and patients—‘The impact of Janet’s arrival was instant and dramatic’—and Goodwill received ‘an astonishing sixty applications’ from staff to start sign language classes. The introduction of a Deaf professional into the system may produce unforeseen difficulties, especially considering the comparatively passive position occupied by deaf people in relation to hearing people, particularly within the medical establishment. Goodwill and Than note that some of the problem areas arise from ‘unspoken rules’ and ‘professional jargon’. In other words, Goodwill did not have access to the language of her professional colleagues and difficulties arose when she felt she needed an interpreter for staff meetings. There are parallels here with deaf teachers of the deaf, as outlined in Unit 5 and Janice Silo’s Article 19 in Reader One, which you read in conjunction with Unit 5.

Elliott et al. (1987) emphasize the need for access to an interpreter for Deaf people, especially for supervision, which is an essential ingredient to the development of professional competence. Elliott et al. and Goodwill and Than emphasize the importance of good and direct communication between Deaf and hearing colleagues, though they accept that this is sometimes difficult. Schlesinger and Meadows (in Elliott et al., 1987) describe the scenario in which hearing people avoid what they perceive as stressful interaction with Deaf colleagues, as ‘shock-withdrawal paralysis’; in other words, anxiety in the hearing person causes communication to break down completely. Elliott et al. suggest that the Deaf person ought to ‘rescue’ the situation: ‘In such circumstances, the Deaf professional must facilitate the communication process by offering reassurance and communication options’ (Elliott et al., 1987). This does, however, place the onus of responsibility upon the Deaf person rather than on a negotiated process between two individuals.

In Block 1, the diversity of the Deaf population was clearly demonstrated, yet hearing people will tend to assume that a Deaf person is an expert or authority about deafness and all aspects of Deaf culture. This may or may not be true. Elliott et al. (1987) refer to this behaviour by hearing people as the ‘instant expert’ process.

There is little or no evidence of the actual, or indeed potential, role that Deaf professionals could play with hearing patients. Their generally good communication skills may help them to be effective with a wide range of
patients both hearing and Deaf. Herbert Marvin (Video Three) felt that Deaf people do not have access to the necessary non-statutory therapeutic services within the community, and therefore find themselves in psychiatric care. Could services for Deaf people be made more available and within the community? In the next section we will look at the care-in-the-community debate and discuss its relevance to Deaf people.

13 Community care

We cannot perfect the asylum because its very existence embodies a contradiction—the central contradiction of psychiatry itself, that between care and custody. Psychiatry, both as theory and practise, has overtly the medical goal of promoting health but is compromised by its role in controlling deviance and maintaining public order.

(Basaglia, in Ingleby, 1981)

This powerful and remarkable statement characterized the mood of the anti-psychiatry movement of the 1970s. Psychiatric services until quite recently have been concentrated in large NHS hospitals; they seem set to change but we do not as yet know how the various proposals will be implemented and how these may affect Deaf consumers.

Is the anti-psychiatry movement, as epitomized by Basaglia, idealist and utopian, or can we indeed develop alternatives to hospital care based within the community? Community care will mean different things to different people. For example, it might mean something approximating a social Darwinist model; that is, where the fittest patients survive and thrive, whilst others, presumably, fail. Or perhaps it might mean the establishment of thousands of neighbourhood-based statutory services. These two models are extremes and are presented here to emphasize the vast diversity of possible forms of community care. We begin this section by looking at some theories on the development of community care and then at how current proposals might manifest themselves during the 1990s.

In *Managing Madness*, Busfield (1986) maps out the move away from the institutional care of psychiatric patients to community-based alternatives. Busfield presents two competing explanations for the post-war move to community care. First, there is the ‘standard’ account, which identifies the development of synthetic drugs in the 1950s as the main reason: this enabled some patients to be treated in the community rather than in hospital. Second, there was a recognition that institutional care was less therapeutic than the patient’s own home environment.

In contrast to this is Scull’s analysis of this shift (Scull, 1977), the basis of his argument being the economic rationale. He identifies two major weaknesses with the ‘standard’ account: (i) the number of residents in psychiatric hospitals was already in decline by the time the ‘new’ drugs started to appear in the mid 1950s; and (ii) there is little evidence to suggest that ‘anti-psychotic’ medicines have any real curative effect on mental illness. Instead, Scull maintains that the real reason for the move to community care, or ‘decarceration’ as he terms it, is that institutional,