

Information about the presenters for the SIG and their abstracts

SIG Deaf Children and Families and SIG Public Health

“Preschool children with hearing loss: social communication and parental stress”

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Abstract

Previous studies on parenting stress in families with children with hearing loss have come to mixed results and many study focus on certain groups of children (unilateral hearing loss, children with cochlear implants). There is not much research on the influence social communication skills have on parenting stress in very young children. This study therefore investigates the influence child behavior has on parenting stress, keeping in mind, that the influence is also reciprocal. Furthermore, the influence of social communication skills and the interaction is investigated. This study includes 81 preschool children with hearing loss between the age of 30 and 70 months. All of them are part of the AChild study, an epidemiological longitudinal study. The variables of interest were parental stress (measured with the parenting stress index, challenging behavior (internalizing, externalizing and hyperactivity) of the child (composite score including results of the BRIEF-P, PSI child domain, SDQ and the CBCL) and social communication skills of the child (CCC-2 and Language use Inventory). Through confirmatory factor analysis, regression analysis and mediation analysis the following research questions were answered: Is there an association between child variables, family variables and parental stress? Which type of problem behavior is most strongly associated with parental stress? The association between social communication and parental stress is mediated by problem behavior. The three problem behaviors (externalizing, internalizing, hyperactivity) account for 49.7% of the variance in parental stress, with externalizing problem behavior having the strongest effect. A significant effect of social communication on problem behavior was found (higher social communication skills were associated with lower problem behavior). Furthermore, there is a strong effect of problem behavior on parental stress. There is no direct effect of social communication on parenting stress, however, there is a moderate, significant indirect effect, with hyperactivity playing the most important role in mediating the effects of social communication on parenting stress. The importance of assessing problem behavior in children with hearing loss is shown. Also, early intervention programs should focus on behavior and emotion regulation. It is important to further investigate the directionality of parenting stress and problem behavior. There is an influence of parenting stress on parent-child interaction and vice versa.

“A 12-year old with Cochlear Implant: Technology both useful and frustrating? What advice can we provide to ensure good mental?”

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¹Clinical psychologist, ²social worker, Norwegian National Unit for Sensory Impairment and Mental Health, Division of Mental Health and Addiction, Oslo University Hospital, Norway

Abstract

We will present a case that problematizes the topic of language, identity and how we think about young people who have both some spoken language and some sign language. We would like present typical dilemmas we encounter when meeting patients and caregivers. The challenge we face in Norway is that the sign language environment for young people is centralized to about four cities. How should we think and what advice should we give based on this situation? How is this done in other countries? Has the extensive use of CI influenced how we think and should think about this? How does this in turn affect, school choice, participation in everyday life, leisure activities, etc? What access do patients like this case have to different language environments, which in turn impact identity?

“Cochlear Implant, Auditory Brain Implant and oral training in a Deaf child – how to assure a good mental health development?”

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¹Language Therapist, founder of the Sign Language and Bilingual Committee for the Deaf at the Language Therapy Brazilian Society & University Professor, Catholic University of Sao Paulo

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Abstract

Child - female - 8 years old. Referred to language therapy with 3 years old. Cochlear Implant and ABI realized when she was 3 years and 6 months. Bilingual school till 7 years old, now in mainstreaming with interpreter. The family wanted her to develop SL (LIBRAS - Brazilian Sign Language) and oral speech. When she arrived she was able to communicate in a very simple way by Libras and didn't talk. Bilingual language therapy. Auditory training and lip reading in meaningful situations. Language stimulation in Libras. Speech training in words. Auditory development: she perceives no verbal noises with accuracy and discriminate them. For language sound she perceives them but just discriminate in closed sets. Language development – good Sign Language development – she understands storytelling, can participate in dialogues, and has a good vocabulary. Uses SL appropriately. Oral language – she tries to talk, and her speech is partially understood for persons that are used to it. For strangers it is difficult to understand her. She has a big difficult to retail speech motor patters in training situations. She didn't learn to read and write – she just knows a few words – she can't retain the symbols. School performance – she understands the topics taught in Libras but can't write these contents in Portuguese. Family – she has a good family environment, and all the members know Libras to communicate with her. Social relationship - she can communicate in other ways when people don't know Libras. Make friends very easily. The family continue to demand her oral

language, but they accept and communicate everything they can in Libras. She wants to communicate orally. Challenges and concerns - Is it beneficial for her mental health to be so stimulated in oral skills as she has a big difficult to develop them? Is this methodology good for her mental health? We (the family and I) try to keep her in touch with the Deaf community and help her to develop a Deaf identity – but, is this enough for a good mental health development? How can I assure to the family that she will not have problems if she doesn't develop oral skills, and keep the family linked to the child, what is essential for good mental health development? Will the conscientization of oral abilities difficult she has, promote a damage to the relationship between the child and her parents and consequentially problems that will affect her wellbeing? Which would be the protective factors I could use to assure a good mental health development to her? How to promote oral and SL development in deaf children promoting a good mental health development? How far do we go? Till now she is developing but when is the moment to stop in order not to develop a mental issue in the child? How to work the family also in this direction: no harm for mental health and relationship with the child? How to do our work being sure that we are not harming the child and the family? The conclusion is more related to questions than to results. I think it is very important to discuss how far language therapists should go when working with oral abilities even in a bilingual approach to assure that this work will not harm the child and to put expectations on the family that can be harmful for the child mental health and even for the family.

SIG Public Health

“Access to mental health services for deaf patients-what is the problem?”

Mette Perly Uthus

Clinical psychologist, PhD-candidate, Head of unit for Mental Health Services for Deaf and hard-of-hearing adults, St. Olav's University Hospital, Trondheim, Norway

Abstract

Studies we know show lower access, higher dropout and higher prevalence of mental illness in the group DHH. Our aims is to higher the access, develop a digital patients feedbacksystem for adults and higher the quality of treatment. So far we have done 5 focusgroup interviews with interpreters, health services, adults that are deaf and hard-of-hearing. CODA is the next group. From there we plan to make a digital feedbacksystem system, and validate it in a multicenterstudy. What experiences have others with feedbacksystems? Challenges with making a goodenough digital system and validation. We have only preliminary results from the interpreters. Some of the highlights:

- *lack of information in the DHH community about mental health
- *lack of information in the society about DHH needs
- *socioeconomic reasons for dropout
- *difficult to explain their illness history
- *point at different issues that makes it hard for deaf and HH to get access to health services.
- *make the quality of treatment in psychiatry better for patients

“Communicative deficits associated with maladaptive behavior in individuals with deafness and special needs”

Johannes Fellingner

Head of Department, Psychiatrist and Neurologist, Research Institute for Developmental Medicine, Johannes Kepler University and Institute for Neurology of Senses and Language at the Hospital St. John of God, Linz, Austria

Abstract

The prevalence rate of additional disabilities in people who are deaf is between 30 and 50 % with intellectual disabilities being the most common. There is only scarce literature on challenging behavior within this population, therefore often the prevalence rate of people with intellectual disabilities is assumed, however this means that only little is known about the actual occurrence as well as contributing factors. 61 individuals who are deaf and have additional disabilities participated in the study. All of them were either living or working in one of three therapeutic living communities. Language, social communication, cognition, adaptive and maladaptive behavior were assessed with standardized measures. The mean nonverbal developmental reference age was 6.5 years, whereas the equivalent for the language measures was about 3.5 years. 41% of the participants had an elevated maladaptive behavior score and 18% reached a clinically significant score (Vineland-II). Only language and social communication were significantly associated with maladaptive behavior, while cognition and adaptive behavior did not have a significant relationship. These results highlight the importance of constant promotion of communicative skills, since people with better language and social communication skills showed less maladaptive behavior.

“The health care journey of Deaf and HoH individuals in Netherlands: Interviews and focus group discussions outlining lived experiences”

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Abstract

In the Netherlands, information about (the impact of) DHH status is often provided through psychoeducation. Psychoeducation is offered to DHH individuals in order to help them better understand and cope with their hearing loss. By teaching specific coping skills and providing recommendations, therapists strive to help clients deal with the barriers that relate to their hearing loss. To date, however, DHH individuals are not typically involved in the development of psychoeducation. As a result, important treatment decisions tend to be made without input from the those who benefit (or are harmed) the most. As a first step to better align care with clients' needs and preferences, we here examined current and former DHH clients' experience of psychoeducation

treatment during their journey of receiving sensory disability care. Interviews with current and former DHH clients revealed the following five core themes:

1. Client needs during their journey,
2. The role of the social network,
3. Support needs for dealing with hearing loss,
4. Making use of information services, and
5. Acceptance of hearing loss

These themes were then used in focus group discussions. Although DHH clients generally appreciate the care they receive, focus group discussions revealed that more effort is needed regarding the inclusion of lived experiences in DHH care. The deaf and hard of hearing community is highly diverse and so is their health care journey. When integrating client perspectives in public care, this diversity should be taken into account (e.g., variations in level of hearing, cultural identity and communication methods). In addition, there was a consensus that the journey many travelled was unnecessarily long and could have easily been shortened had general care providers had more knowledge about the referral possibilities. More can be done to increase the visibility of DHH organizations in the Netherlands. Implications for sensory disability care providers in how they present themselves will be further discussed. The potential contribution of welfare organizations to DHH care should be explored even further.

SIG Deaf Adults and Families

Enhancing Mentalization-Based Therapy for Emotional Regulation and Relationship Challenges in Deaf Adults link to early Trauma with brain development: Best Practices in the United Kingdom.

Hannah Whalley, UK

Community Psychiatrist Nurse, National Deaf Mental Health Adult Community Service, South West London and St. George's Mental Health Trust, UK

Abstract

Mentalisation, often attributed to scholars like Peter Fonagy, integrates Attachment theory, Psychodynamic concepts, and emerging evidence linking early trauma with brain development. In the case of Deaf Adults, many of their struggles stem from experiences of language deprivation and childhood trauma. Deaf children face an increased risk of abuse, as referenced by Cameron et al. (NDCS ref), and there are higher observed rates of trauma within this population. Additionally, specific traumatic experiences unique to the deaf community have been identified (Anderson et al., 2016). Moreover, Deaf individuals often experience delays in theory of mind development and encounter difficulties with acquiring incidental knowledge and expanding their fund of knowledge (Hindley, 2005). MBT involves an active process where we comprehend ourselves and others regarding our mental and emotional states. It's an imaginative process acknowledging that we can't fully understand or enter another's mind. Mentalisation involves implicitly and explicitly interpreting



actions, both our own and others', as meaningful based on intentional mental states such as desires, needs, feelings, beliefs, and reasons.

Access to therapy in the United Kingdom for people who are culturally Deaf is limited mostly as a result of communication barrier. MBT has been adapted for use in deaf people in Deaf Adult Community Team, Southwest London & St George's Mental Health NHS Trust, England as a local innovation in the context of non-existent resources that are appropriate for Deaf people. Following through an audit in 2019, an audit aimed to assess the relevance of tailoring Mentalisation-Based Therapy (MBT) to address the communication and cultural needs of Deaf adults struggling with emotional regulation and relationship challenges stemming from traumatic events. The audit involved 12 Deaf adults diagnosed with complex trauma or emotional dysregulation (also known as EUPD/BPD). These individuals underwent a 12-week MBT-I therapy that incorporated visual and Deaf-specific modifications in British Sign Language (BSL), in addition to a 15-month MBT group program. The therapy was conducted entirely in BSL by two therapists, one of whom was Deaf. The Zanarini Rating Scale by Mary C. Zanarini EdD was utilised to measure symptom changes at the beginning, middle, and end of the MBT group program. Results indicated a reduction in symptoms for most participants. The adaptation of MBT to accommodate the communication and cultural needs of Deaf BSL users in the UK proved to be an effective approach in addressing emotional regulation and relationship challenges resulting from traumatic events in Deaf Adults. The use of sign language to articulate experiences not only provided validation and value but was also recognised by participants as a support system that fostered resilience. The National Institute for Health and Care Excellence (NICE) recognizes MBT as a viable treatment option for people dealing with Emotional Regulation and Relationship Challenges stemming from Traumatic Events. However, further research and evaluation are recommended. This audit is expected to pave the way for future research in this specific area, aiming to enhance understanding and treatment effectiveness for this population.

Currently, we are in the fourth cycle of the MBT group, comprising four females diagnosed with similar issues related to relationships and emotion dysregulation. Our approach involves: MBT-I and MBT therapy that incorporated visual and Deaf-specific modifications in British Sign Language. We frequently reference examples from MBT-I Adolescence because it provides more visual information and is presented in simpler, more accessible English, which aligns well with the needs of Deaf Adults.

Challenges: The MBT group convenes once every two weeks, complemented by individual MBT sessions every alternate week when the group session isn't scheduled. However, the participants' commitment to attending sessions has been inconsistent. Selecting participants posed initial challenges, considering their connections (some knew each other from their time as students and a teacher) and aligning ages/gender to match experiences, commitment, and their ability to travel to the therapy base. Notably, one participant resides approximately three hours away but is still committed to attending. Currently, we are halfway through the MBT-I program- we are on our 15th MBT group and halfway of our 12 weeks MBT-I.

Feedback from a participant who attended a previous MBT group but did not complete it indicated difficulties in establishing relationships and trust due to the biweekly schedule and inconsistent attendance by others. Another suggestion was to involve an interpreter and a student who cannot

sign, which impacts the therapy dynamics. Additionally, considering the staff-to-participant ratio was recommended to enhance the overall experience.

“The pitfalls and challenges in the treatment of deaf forensic patients”

Jette Stam

Master in Special Psychology, therapist at the ‘Dovenlijn’, Deaf Units of Trajectum, Forensic Treatment Service in Boschoord. Netherlands

Abstract

The treatment of deaf (forensic) patients in a (closed) care setting gives many pitfalls and challenges for their therapists. We will look closely to these challenges in a few specific areas; court, diagnostics and treatment, outplacement and the lack of perspective. Therapists can experience difficulties in communication and in working with sign language interpreters. The shaping of treatment for deaf patients within a institution which mainly focuses on hearing patients can be complicated. There is a lack of perspective for most of the patients due to a shortage of appropriate accommodation, which causes a lack of motivation for patients (and possibly their therapists).

“Escaping from Hospital”

Alexander Hamilton

Clinical director, consultant forensic psychiatrist for Deaf people, St. Andrews Hospital, Northampton, UK

Abstract

In the UK there have been significant challenges in discharging Deaf patients from specialist Deaf secure psychiatric institutions due to a lack of appropriate community placements and a lack of Deaf expertise in community forensic services. St. Andrew’s Healthcare in Northampton, England, have developed a specialist service combining residential care for Deaf people with significant Deaf forensic ad mental health needs, and a specialist Deaf community forensic team. Dr Hamilton will present the service and development of this service.

Evaluation of a volunteer employment intervention for marginalized DHH people: a pilot project for work integration

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Abstract

Work is one of the most important factors for social identification. In a world shaped by a hearing society, people who are deaf and hard of hearing (DHH) usually experience themselves as members of a cultural and linguistic minority. Therefore, they are frequently confronted with challenges in their professional development that often results in unemployment. As a non-profit project, Café Gutmut, the first sign language café in Austria, and the therapeutic workshop for deaf people with multiple disabilities at the Insitute for Neurology of Senses and Language in Linz (ISSN) were rebuilt from June to October 2023. DHH volunteers were employed as part of this reconstruction project of the café and workshop. DHH people who had an established relationship with ISSN and were thought could benefit most from the project were approached, for example, people experiencing isolation, refugees, people experiencing mental and physical illnesses, unemployed people or people with occupational invalidity pensions. This resulted in a heterogeneous group working voluntarily with varying frequency. Five of these DHH volunteers were recruited and monitored for the study. They answered questionnaires (with accompanying sign language videos) about psychological well-being (GHQ-12), quality of life (WHOQOL-BREF), and self-efficacy (ASKU) before and after their participation. In addition, interviews regarding goals and developed skills were conducted. All subjects, no matter their differences, benefited from the project. The factors that contributed to the beneficial outcomes were the well-known location of the construction site next to ISSN, the specific social engagement of the architect of the project, matched technical expertise and interest of the participants, strong sense of independent creative engagement, and collaborative work in a team with secured communication through sign language. Moreover, in this environment, the performance of the participants increased significantly. For DHH people occupation can have stabilizing and integrating effects. While this was a one-off project, considerations should be given to similar future integrative projects that could improve work environments and professional opportunities for DHH people.

Exploring and Interpreting Body Language

Monica Versluis

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Abstract



Through non-verbal therapy we aim to understand the deaf client's body language in order to give their words, thoughts and values meaning. Psychomotor Therapy (PMT) chooses between boxing therapy, water therapy or pet therapy to enhance the non-verbal aspects of the therapy.

Simply sitting and talking with the client can become a pitfall for the therapist, especially if they don't know what they are supposed to think or do. The therapist can become stressed, lose sleep, become ill or unable to articulate. This leads to falling into the normal pattern of advising, offering solutions; the therapist becomes confused, angry or distracted.

Therapeutic boxing is a form of therapy not as a sport or activity, but in order to observe body signs, emotions, movements. It clearly shows body language.

The presentation is intended to illustrate how the mental and physical effects of therapeutic boxing give value to the therapeutic process.