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Special Issues in Psychotherapy with Minority Deaf Women
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Client examples used in the current manuscript were constructed according to the Ethical Principles and Code of Conduct of the American Psychological Association. The names used are fictitious, and identifying information was altered or removed to protect client confidentiality. The examples provided do not reflect individual clients, rather, a consolidation of characteristics found in the author’s work with minority Deaf women. These characteristics were combined to illustrate salient issues that impact the community.

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SUMMARY. Minority Deaf women have been traditionally underserved by mental health professionals, and specifically, therapists are unaware of issues unique to this population. It would be highly unlikely for a minority Deaf woman to have a therapist who matches her in racial background, hearing status, and communication mode. Therefore, the therapy process will be completely cross-cultural. Therapists who provide psychotherapy services to minority Deaf women need to be aware that their clients are members of a community where deafness is a culture and not a disability. Minority Deaf women are also likely to report feeling forced to choose between competing identities in order to get important needs met.

In the following article, case examples are provided which illustrate some of the major issues that are likely to arise in therapy with minority Deaf women. These issues include: access to important information; communication, support and level of involvement with biological families; competing cultural demands; health concerns; and coping with chronic mental illness.

KEYWORDS. Minority, deaf, psychotherapy, sign language

The current article will focus on some of the unique aspects of providing psychotherapy services to minority Deaf women. The author of this article is a hearing, African American psychologist who has worked for twenty years as a psychotherapist in the Deaf community. Until quite recently, published information about psychotherapy with Deaf individuals has been minimal, most often published by agencies or organizations serving the Deaf community (Brauer, 1980; Glickman & Harvey, 1996; Gough, 1990; Harvey, 1989; Leigh, 1991; Myers, 1995; Sussman & Stewart, 1971). There is only one major publication that highlights the special issues of culturally diverse Deaf persons in treatment (Leigh, 1999). In the current article, the author will provide examples of how issues of culture vs. disability, racism, sexism, and communication preference simultaneously impact the lives of minority Deaf women. Client examples will highlight how these concerns might manifest themselves during the therapy process.

Before embarking on this journey, it will be important to provide some operational definitions. For the purposes of this article, the term
minority refers to women of color. Although the term “women of color” is commonly used in the psychological literature (Comas-Díaz & Greene, 1994), it is not a phrase that is used within the Deaf community. Therefore, the author has chosen to use the term minority in order to be consistent with what is used by the clients. The word Deaf is capitalized because it is used to describe a specific population of individuals with hearing loss, who consider their deafness as a culture and not a disability (Glickman, 1993; Lane, Hoffmeister & Bahan, 1996; Maxwell & Zea, 1998; Padden, 1980; Sussman & Brauer, 1999). The women presented in this chapter are also members of the Deaf community. Members of the Deaf community most often have the following characteristics: hearing loss prior to age 17; education in a school or educational program for the deaf; self-identification as Deaf, not “hard of hearing” or “hearing-impaired”; and, fluency in American Sign Language (ASL; Higgins, 1987; Padden, 1980). As members of the minority Deaf community, these women also have variations in American Sign Language which reflect their cultural experiences (Aramburo, 1992).

Therapists who provide culturally competent psychotherapy services to minority Deaf women must make a serious commitment to learning about how competing forces impact their client’s lives. As Deaf individuals, the clients have to contend with living in a world dominated by hearing people who use speech as their primary mode of communication. Within hearing culture, major decisions are made based on the calibre of an individual’s speaking skills. Deaf people who do not use speech and/or do not understand speech face many prejudices and oppression. These issues are compounded when the Deaf person is also a member of a racial minority group. The individual is likely to encounter racism in both the hearing and Deaf communities (Anderson, 1992; Anderson & Grace, 1991; Corbett, 1999; Hairston & Smith, 1983). When the Deaf person is a woman, she is likely to experience sexism as well.

Minority Deaf women often report feeling forced to choose between identities in order to get important needs met (Younkin, 1990). Very often, the Deaf community asks the women to focus only on their Deaf identities and to deny their minority status. The minority hearing community often sees the women as belonging to the Deaf community because of their hearing loss. Both communities ask the women not to focus on gender issues, because this might take away from the focus on the “real struggles” of the larger group. As a result, many minority Deaf women who seek psychotherapy services experience isolation and marginalization from their peer reference groups.
When considering which examples to include in the current article, the author selected some client examples which highlight themes that are often raised by minority Deaf women in psychotherapy. The issues to be presented include the importance of access to information, family issues, cultural collisions, physical health, and chronic mental illness. While writing the chapter, the author realized that the headings in the following sections are not mutually exclusive. Each example could possibly fit in another category as well, due to the complexity of issues presented. However, the author chose the particular section for each example based on the client’s identification of salience of the problem in her life.

**THE IMPORTANCE OF ACCESS TO INFORMATION**

Access to information is of critical importance to minority Deaf women and being “left out” is an issue that is often expressed in psychotherapy. As a beginning therapist working with this community, the author did not realize how intensely minority Deaf women felt about “not knowing about something.” When a client would say “Oh, really? I didn’t know about that” or “Nobody ever told me that before,” the therapist responded as if she would a hearing person by thinking or saying “OK, well now you know that information.” However, time after time, the client expressed a need to process this lack of knowledge and discuss the pain associated with it.

Minority deaf women have wanted to discuss, in therapy, issues like proper procedures for cashing checks, or filling out applications for employment. One client knew that having sex would make you pregnant, but did not know that having a baby hurt. When she began having contractions, she called stating that she was in pain. Fortunately, she was able to reach someone who could tell her that she was in labor. Lack of access to information can have devastating consequences that severely impact the individual’s mental health. The following client example illustrates this problem:

Vanessa, a 23-year-old Deaf Cuban woman, came to the United States with her family, through a relief organization sponsored by the church. She was 8 years old at the time of her arrival in the United States. Spanish was spoken as the primary language in the home and Vanessa’s parents communicated with her through gestures. Shortly after her arrival in the United States, Vanessa’s par-
ents enrolled her in a residential school for the deaf. At this school, Vanessa learned American Sign Language. On weekends home, she taught her mother to sign and her mother took the initiative to enroll in sign language courses at the local community center. Vanessa’s father continued to communicate primarily in Spanish. After many years in the residential school, Vanessa’s ability to understand Spanish deteriorated and her mother began to interpret Vanessa’s conversations with her father into ASL. After completing high school, Vanessa enrolled in a residential vocational training program in another state, but continued to visit her family one weekend per month.

When Vanessa was 22 years old, her mother was diagnosed with terminal cancer. Vanessa was committed to visiting with her mother on weekends and spent many hours with her. As her mother’s condition worsened, she and Vanessa began to discuss her funeral. It was decided that there would be a short memorial service, with a closed casket, with a reception held at a neighbor’s home after the services. Several weeks later, Vanessa receives a TTY call from her father saying, “Come home. Funeral in two days.” Vanessa is grief stricken over her mother’s death. She rushes home and arrives on the morning of the funeral. They rush her to the church. She sits on the front row. People come by to shake her hand and tell her that they are sorry for her loss. Everyone is speaking in Spanish. There is no sign language interpreter for the funeral. Vanessa does not know what is going on, and feels very depressed and disappointed that she does not know what people are saying about her mother. Her father is overcome by grief. The reception is held at the neighbor’s house as planned. Vanessa is encouraged by her father to go back to her program, so she leaves the next day. Upon her arrival at her program, Vanessa receives a lot of support from her classmates and teachers.

Two weeks later, Vanessa gets another TTY call from her father. He says “Mother died yesterday. Come home funeral.” Vanessa is shocked because she thought she already attended her mother’s funeral. She asked her father whose funeral she had attended. She found out that it had been the neighbor’s funeral. Vanessa is devastated. She attempts to tell her friends what happened. They think she is lying and do not want to associate with her. Vanessa is isolated and alone, and grief stricken over missing the last two weeks of her mother’s life. She is seen for individual psychotherapy with the diagnosis of depression.
What is important about the above case is not whether Vanessa is telling the truth or lying. It is the fact that serious communication gaps often exist between Deaf individuals and people who provide significant support in their lives. This can include immediate family members primarily responsible for their care, extended family members, ministers, employers, and romantic partners. Lack of access to even simple information intensified the experience of loss for the client, which she experienced twice, unnecessarily. Within minority Deaf communities, sign language interpreters of color often donate their services to minority families during funeral services. In this way, it can be assured that the Deaf person is able to fully participate in the mourning process for her family member.

**FAMILY ISSUES: COMMUNICATION, SUPPORT, AND LEVEL OF INVOLVEMENT**

Within the Deaf community, parental hearing status plays a major role. Leadership in the community, social popularity or inclusion on the “A list” for events, and even choice of romantic partnerships often use the criterion of parental hearing status for decision-making. Parental hearing status is important because Deaf children of Deaf parents are considered keepers of the culture; they have access to the purest forms of American Sign Language and knowledge about traditions in the Deaf community. Within minority communities, deafness is a low-incidence condition that most often does not involve genetic factors (Holt & Hotto, 1994). Rubella, high fever, chronic ear infections, and meningitis are all frequent causes of deafness in minority individuals (Corbett, 1999). Therefore, minority Deaf women are more likely to come from families that have hearing parents. Deaf women who have hearing parents often struggle with issues involving communication, social support, and degree of involvement they will have with their biological families as adults.

Deaf individuals who have severe to profound hearing loss are often educated at residential schools, which takes them out of the day-to-day interaction with their families of origin. As they become more proficient in sign language use, the communication gap between child and parent widens, especially as the child matures. For minority Deaf individuals, who most often do not have Deaf parents, this places them in an odd situation where they are torn between their biological families and
their “family” that they develop with deaf peers. The author has seen several minority Deaf women in therapy who struggled with issues of being both an “insider” and an “outsider” in their own families. The following client examples will illustrate this issue. Two major issues to be highlighted are over-involvement and isolation from one’s family of origin.

Jamillah, an African American Deaf college student, always returned home to her family during school breaks. The student was from a large extended family and the home of the maternal grandfather was the central meeting place of the family. Two of the Jamillah’s adult cousins, whom she described as “irresponsible,” resided with the grandfather. Although they both worked full time, the cousins did not contribute financially to the household and did not help with the grandfather’s care. On one spring break at home, Jamillah began to notice that her grandfather was beginning to deteriorate both physically and mentally. Jamillah became concerned that her grandfather would no longer be able to take care of himself. Since his retirement, her grandfather had attended a day program for senior citizens in their community, but recently began stating that he didn’t want to go any more. He also had “Meals on Wheels” delivered to his home, but was not eating. Jamillah contacted the local adult protective services to request help.

While at home, Jamillah used her own money to pay some of her grandfather’s bills and to buy groceries for the entire household. However, upon her return to school, she often did not eat because she had spent the money on family bills. Jamillah expressed her concerns to one of her uncles, who was considered the “head” of the family, due to his financial standing. The uncle called a meeting of the family while Jamillah was at school. She received a letter from her uncle outlining the expenses related to her grandfather’s care and it contained a “bill” for her share of the expenses each month. The bill did not take into account all of the money she had already contributed to the family. Jamillah supported herself on Supplemental Security Income (SSI) in the amount of $175/month. The bill presented exceeded this amount. The student was not allowed to work because she would lose her SSI benefits and possibly her vocational rehabilitation support for school.

As therapy progressed, Jamillah became anxious because she thought that if she refused to pay the bill, she would no longer have a family. Jamillah continued to struggle in therapy about how
much involvement she should have with her family, especially when they were expecting her to take on responsibilities they were not willing to do themselves.

Marta, a 35-year-old Puerto Rican returning adult student, came into the mental health clinic at her college. She was brought in by her partner because she was experiencing severe depression. For the previous two months, she had been unable to contact any of her family of origin. She was the oldest of five siblings and the only Deaf member of her family. The family was extremely poor and her father had died approximately 16 years previously. The family agreed that they would all work together to make sure that each person got to attend college. So, Marta worked and provided major financial support for each of her siblings to go to school. The siblings were supposed to return the privilege when it was Marta’s turn.

Marta knew that the family was discussing returning to Puerto Rico because their mother wanted to retire there. However, when Marta departed for college the family was still in discussion about these plans. Marta completed her first year of college, with sporadic contact with family members, which she did not find unusual. However, when it was time for her to go home for the summer, all of the family telephone numbers were disconnected. The client’s siblings were supposed to be providing financial assistance during the summer months. After two months, and an actual visit to Chicago, she was unable to find any of her family members. The client had never been to Puerto Rico and did not know the names of extended family that lived there.

In therapy, the client discussed feelings of abandonment, rage, and helplessness. After six months of silence from the family and untold emotional agony to the client, one of her brothers called, nonchalantly, as if nothing was wrong to say that the family was still in Chicago, just in a different part of town.

Families where there are both Deaf and hearing members often struggle with how much involvement they will have with each other, what types of communication they will use, and who will be responsible for organizing things. When psychopathology already exists in the family, the deaf person is often blamed or given inappropriate amounts of responsibility for remedying the situation. Or, as presented in the second client example, the person is completely ignored for long periods of time and then blamed for protesting about being excluded.
THE STRESS OF COMPETING CULTURAL DEMANDS

Women who are Deaf and members of ethnic minority groups often report feeling pressured to choose between identities in order to get important needs met. Within the Deaf community, deafness is considered of primary importance. As stated previously, other identities (e.g., minority, religious, or sexual orientation) are given less consideration, with the idea that these issues take away from the focus of “empowering” the Deaf community first (Valentine, 1996; Younkin, 1990). In contrast, ethnic minority communities often view their deaf members as belonging to the Deaf community (Corbett, 1999). Thus, they do not have to be responsible for learning to communicate with minority Deaf people or make other accommodations. Given this exclusion from two larger groups, many minority Deaf individuals establish their own communities, separate from the white Deaf and minority hearing cultures. These minority deaf communities may range from informal social groups or sports clubs (Hairston & Smith, 1983), to formal political organizations (e.g., Intertribal Council of the Deaf), and households consisting of multi-generational minority Deaf members.

The author has provided psychotherapy services to minority Deaf women where the major concern was that expectations from Deaf culture, hearing culture, and their minority culture of origin were competing in such a way that their emotional functioning was compromised. Two examples are presented below:

Kenya, an African American Deaf woman with a major in computer information systems, sought therapy at a university counseling center due to feelings of anxiety over returning to her family home during summer break. Kenya’s parents were executives in a large technology firm, and were encouraging her to submit her resume to their company for summer employment. In an effort to “help,” Kenya’s mother requested that she be able to review her daughter’s resume before it was submitted to the personnel office. Kenya’s resume clearly stated that she was a student at the college for D/deaf students and that she used American Sign Language. After reading the resume, Kenya’s mother suggested that “just in case” the employers might think she was really deaf, she should put down on her resume that she spoke Spanish as well. This made Kenya feel extremely anxious because she knew that she had only one Spanish course in high school, and that it consisted of reading, not speaking.
In therapy, Kenya reported feeling upset that again her mother had not truly accepted her deafness. She also felt that this was just the beginning of several unrealistic expectations that would be placed on her during her summer, such as behaving like a hearing person. This was especially defeating because while at college, Kenya was just beginning to feel proud of her signing and Deaf identity.

In the example, the client comes from an African American middle class family, which places a high value on education and achievement for all of its members. At the same time, this family is illustrative of a common situation that many Deaf people face: *The parents have not accepted that their adult child truly cannot hear.* There are several circumstances that perpetuate this type of problem for minority Deaf women. Minority hearing parents are less likely to find themselves in circumstances in which they can actively participate in activities with the Deaf community or see their child interacting with Deaf peers (Kluwin & Corbett, 1998). The outcome is that sign language is something that is used at school, and “lipreading”/gestures are used at home. As a result, parents often maintain the illusion that their child can hear more than is the case, or that the child is able to comprehend during their spoken interactions. Thus, for many minority Deaf women, a common theme in therapy is loss regarding relationships with their parents. There are also feelings of sadness over lost opportunities to know more about their minority culture of origin, participate in family traditions, and/or learn family history that is generally passed down orally. For many minority Deaf women, trips home are sometimes traumatic because they begin to realize just how much interaction with family they have missed. Therapists who treat minority Deaf women can help them to become more empowered by addressing family communication issues more assertively. For example, one former client brought a sign language interpreter to a Thanksgiving dinner with her extended family network. Although at first the family was shocked, they began to realize that they learned more about their family member during this one dinner than they had during her entire life.

The second example involves a psychotherapy experience with an Asian Deaf woman, who was part of an extended network of Asian Deaf persons in the San Francisco Bay Area.

Lily, a 22-year-old Deaf woman from Japan resided in a large private home with other Asian Deaf women. There were 12 women
in the household, ranging in age from 18 to 54 years. Several blocks away, there was a similar household consisting of Asian Deaf men. Both households were very actively involved in the Asian American Union of the Deaf, and several members participated in sports teams. The client was dating a young man named Daniel from the other household for several years. Daniel, who was also Japanese, was from a family that lived in Hawaii. They both tried out for and made the team going to the World Games For the Deaf which was to be held in Japan. Both households were actively and successfully involved in fundraising activities to finance the couple’s trip to Japan for the competition. This was considered an honor, and they were to represent their organization.

Approximately six weeks prior to the trip, Daniel informed Lily that he no longer wanted to be in a relationship with her, and that he was interested in dating another member of her household. Lily became very depressed and suicidal. The couple also became physically combative with each other. The elders of the households called a meeting with the couple, and demanded that they seek counseling. The elders then proceeded to bring the couple for therapy at a local mental health center that provided mental health treatment to deaf people. The elders explained to the therapist their culture and living arrangements. Of primary concern to both households were the suicidal gestures, the domestic violence, and the financial burden of the trips. After several meetings and negotiations with the therapist, the couple, and the elders, the couple decided that they would still go to Japan in order to compete because it was expected of them in their culture. Couples counseling and individual therapy were extended to facilitate the trip and the termination of the relationship.

In individual therapy with Lily, in addition to crisis resolution and reduction of suicidal ideation, the focus was on how she would successfully negotiate the culture in order to bring this relationship to a close. Lily reported to the therapist that propriety required that she and the “ex” boyfriend stop at his parents’ home in Hawaii on their way to Japan. This stay would be one week minimum. Then during the World Games, she and Daniel would stay at her parents’ home in Japan for two weeks. Each was also required to bring “gifts” to the other’s family. The client anticipated that she would have to bring approximately $700 worth of gifts for Daniel’s family. Although she didn’t really want to have anything more to do with Daniel, she wanted to fulfill her obligation to her...
household which sponsored her competition, and she wanted to be able to live in the same community upon her return. Lily also wanted to be known within her community as a person who understood the honor associated with her selection for the team and who fulfilled her commitments.

This example is interesting because it illustrates the importance of understanding the culture of the client in order to provide quality mental health services. In this case, the leaders of the community, namely the elders, initiated contact with the service providing agency. When working with the minority Deaf community, service providers must be flexible in how they engage clients, because this population is severely underserved. If the agency had rejected the call by stating that the couple needed to initiate their own services, it is possible that no treatment would have been provided and the potential danger of the situation could have escalated. The second major issue in this example is that the client provided education to the therapist about what was required in order for her to maintain standing within her community and to maintain her own self-respect. There were places where the client’s cultural expectations did not match those of the therapist’s culture. However, the goal of treatment was not for the therapist to agree with what the client was doing, but to facilitate healthy resolution of the problems.

**MINORITY DEAF WOMEN AND HEALTH CONCERNS**

National health statistics indicate that women of color are more likely to have severe health problems than are white American women. Cancer, heart disease, hypertension, diabetes, and AIDS are all diseases that have had a major impact on minority communities (National Center for Health Statistics, 2001). Minority Deaf women share with their hearing sisters of color similar health concerns. However, communication access and literacy issues decrease the likelihood that they will receive quality health care (Corbett, 1999; Leigh, 1999; Myers, 1995).

A large number of minority Deaf women receive SSI as their primary means of income and Medicaid as their health insurance. Although sign language interpreters are supposed to be covered as part of their health insurance benefits, in practice this tends to be the exception rather than the rule. Very often, minority Deaf women seek health care at a time of a health crisis, when interpreters might not be immediately available. As a result, they often receive medical treatment in circumstances in
which they are not able to communicate their concerns effectively with their doctors, and are not able to understand what the doctor is recommending for them in terms of treatment. Literacy issues also have a major impact in the health arena. Nationally, the average reading level for Deaf adults is approximately third grade; minority Deaf individuals read at even lower levels (Traxler, 2000). Poor reading comprehension reduces the likelihood that a minority Deaf woman would be able to accurately complete her written medical history without assistance, understand the doctor’s written instructions, or actively investigate her own health issues through independent reading. When the woman is facing long-term health intervention, the potential for gaps in treatment increases exponentially. These issues are illustrated in the following client example.

The client, Ms. Wynn, is a 35 year old, single, African American woman, originally from South Carolina. Ms. Wynn became deaf at age 3, due to spinal meningitis. Although Ms. Wynn is able to use her voice for communication, she prefers American Sign Language and she is unable to understand any sounds in the speech range. Ms. Wynn has renal failure due to a long history of severe obesity and severe hypertension. Ms. Wynn received a special education diploma from a residential school for the deaf. Ms. Wynn is the mother of one daughter, Roslyn, who is currently six years old.

Ms. Wynn was referred for psychotherapeutic intervention because she was having significant difficulty following her renal dialysis program. She is scheduled for three dialysis sessions per week, which last for three hours each. She has been receiving dialysis for approximately three years. However, over the past four months, Ms. Wynn has missed at least one appointment per week. In the opinion of her physician, Ms. Wynn’s physical condition is deteriorating unnecessarily because of her failure to keep her appointments. According to the report of multidisciplinary team at the hospital she receives treatment, Ms. Wynn seemed to be pushing the limits recently, skipping appointments, rescheduling days, almost to the point where her life is in jeopardy.

The multidisciplinary team decided to refer Ms. Wynn for immediate intervention after an event which occurred the previous afternoon. Ms. Wynn came in for her dialysis appointment with her daughter, Roslyn. It is strictly against policy of the Unit for a parent to leave a child unattended when he/she is receiving dialysis. Ms. Wynn had already rescheduled her appointment, meaning
she was one day late, and when confronted by the social worker, she stated “I didn’t have a babysitter... I told you people I didn’t have a babysitter... You people keep expecting me to come in for these appointments and I don’t have anyone to take care of my child. You all just don’t understand what I’ve been going through.” According to the social worker’s report, “Ms. Wynn then turned to the child and informed her ‘Because of you, I am missing my appointments, which means I am going to die soon. It’s your fault. I will be dead before the month is over.’ At this point, Roslyn began to cry hysterically and had to be seen by an emergency child therapist.”

During the first session of therapy, as part of the history, Ms. Wynn was asked if she planned to have a kidney transplant. She states “Oh, my name isn’t even on the list for that.” When the therapist explores further, Ms. Wynn says “Oh, I never even finished the evaluation for that. They had all these papers that I couldn’t even read and no one would help me. I started it, but then my shunt collapsed and I had to go into the hospital. So that means I have to start all over again, and I just haven’t had the time to do it... (When was this? “A year ago”). But, really, think about it, I am a poor, black, Deaf woman on Medicaid. Who the hell is going to give me a kidney, anyway? What’s the point? Those medical people aren’t even thinking about me. Black people are the last people to get transplants anyway. I’ll be dead before the list ever comes to my name.” The therapist asks Ms. Wynn about her relationship with Roslyn. She says “Oh, Roslyn’s a good kid. She can take care of herself, most of the time. She can make herself a sandwich, or make Oodles of Noodles. She doesn’t need me for much. We get along OK.” When asked if she thought Roslyn had any feelings about her illness, she said, “Roslyn doesn’t need to talk about anything like that.”

Home-based individual therapy services were provided to Ms. Wynn and home-based family therapy was provided for Ms. Wynn and Roslyn. The therapist was hearing and had expertise in providing therapy to clients with chronic medical concerns. The therapist did not sign herself, but was accompanied each week by a registered interpreter for the deaf. Even though the services were brought to the client’s door, Ms. Wynn continued to be resistant. In therapy, Ms. Wynn struggled over whether she was going to actively live or plan her death (intentionally or unintentionally). Ms. Wynn was encouraged to become more actively
involved in the Deaf community in her area as a means of social support. Literacy support services and interpreting services were provided in order to assist Ms. Wynn in completing the evaluation for the kidney transplant program. The focus of family therapy was on improving parenting and communication skills, and reuniting Ms. Wynn and Roslyn with their extended family network.

MINORITY DEAF WOMEN WITH CHRONIC MENTAL ILLNESS

Anderson (1992) discussed the “triple threat” of being a member of a minority group, Deaf, and mentally ill. In the current article, the issue of gender is entered into the equation. Deaf women of color who are mentally ill face racism, sexism, discrimination because of their mental illness, and oppression by hearing individuals, at a minimum. However, they face the additional issue of being excluded from participation within the Deaf and minority Deaf communities as well. The stigma of mental illness that is common in hearing communities also filters to the Deaf community. In addition, mental illness affects thought processes and thus interrupts the flow of communication. This has a significant impact on American Sign Language production and comprehension, both of which are critical for full participation in the Deaf community.

Minority families with members who are Deaf and mentally ill face many challenges. First, mental illness interrupts the sometimes tenuous connection that the family already has to a member who cannot hear and communicates using sign language. Minority families have difficulty finding the appropriate resources to assist them in providing treatment to their Deaf mentally ill relative. Thus, they are often isolated and overwhelmed by the level of stressors involved. Families also struggle with caretaking responsibilities and the financial considerations. Rejection of the mentally ill Deaf person from the Deaf community intensifies the confusion that hearing extended families already have about the best place for their relative. The following client example provides some perspective on this problem.

The client, Ms. Pagan, is a 33-year-old Deaf single female, whose family is from the Dominican Republic. The client was born in the Dominican Republic but states she was raised by her “adoptive” parents in New Jersey. She claims that she was left on the doorstep of the Pagan family and that they knew her “real” mother. The
therapist has the occasion to meet Ms. Pagan’s father; she looks exactly like him. The therapist learned from Mr. Pagan that he and his wife raised her and that she is their biological daughter.

Ms. Pagan has enrolled as a returning adult student in college and presents herself for therapy at the Counseling Service. She is required to attend counseling in order to have the Bureau of Vocational Rehabilitation (VR) pay for her school. When asked why counseling was ordered by VR, Ms. Pagan stated, “I have a bad temper. It gets me in trouble sometimes.” When asked if she had been in counseling before, she stated that she saw a psychiatrist, Dr. M. at University Hospital. When asked if she was on any medications she stated that she was. In her purse she had Haldol, an antipsychotic, and several other psychotropic meds. When asked if she was taking her medications, Ms. Pagan stated “the doctor told me only to take it if I get in a bad mood.” The therapist asked Ms. Pagan to sign a release of information so that she could talk with Dr. M. She was more than happy to comply.

The therapist talked with Dr. M. He stated that Ms. Pagan was well known to him, having been an institutionalized patient at Forest Haven for 13 years. He described Ms. Pagan as “a tough lady who likes to have her own way.” She was known to have an explosive temper with frequent outbursts against family members. Ms. Pagan is quite bright and it was suggested to VR by University Hospital that she might be allowed to attend college. Two weeks before she was to begin college, Ms. Pagan became explosively angry and physically assaulted her mother. She was hospitalized for approximately twelve days at that time. She was released from the inpatient unit at University Hospital two days before arriving at the college.

In therapy Ms. Pagan was always on time, if not early, for every appointment. She was lively and energetic. She told many horrific stories, such as “In high school, I was chased home from school every day by boys. They called me names, beat me up, and broke my glasses. I wished someone would have helped me.” She hinted at being raped/sexually abused by several uncles during her childhood period. She stated these things matter-of-factly, often with a smile.

Ms. Pagan’s adjustment in college began to deteriorate because she stopped taking her medication. She spent hours in chat-rooms on-line; she interrupted many courses on campus that had on-line activities/discussion groups. Her computer activities
caused a significant stir on campus when she used it to “preach the gospel.” The therapist was able to read some of the postings on-line, which were open to the campus community. The therapist found Ms. Pagan’s writings to be frequently incoherent and twisted interpretations of biblical passages, with bizarre word usage. Ms. Pagan stopped attending classes and spent most of her time in the computer lab. She was in the process of failing all of her courses. Her on-line activities became even more incoherent, and she was being threatened with physical harm by other students of the campus. Ms. Pagan’s on-line privileges were revoked when she send a string of emails containing long paragraphs of profanity to the entire campus community. After a hearing with the Campus Disciplinary Board, Ms. Pagan was told that she would not be allowed to return to school the following semester.

Upon news of her dismissal and revocation of her computer privileges, Ms. Pagan became more difficult to manage. She was unable to manage on her own, requiring daily (sometimes hourly) therapy sessions. She became loud and unruly. Ms. Pagan began to believe some of the threats she had received. She called her father to ask him to pick her up.

The therapist had a chance to meet with the father, at the client’s insistence. Mr. Pagan stated that he and his wife had been attempting to manage their daughter’s mental illness for several years. However, now they were getting older and on the verge of retirement. He said that although they knew it was a long-shot, they decided to send their daughter to college so that she could get some experiences away from home. They also used her time away as a respite from the long-term treatment that they had provided.

In the current client example, the family attempted to exercise an option that was unlikely to succeed in the long run, but useful for their immediate goal of getting some respite from an emotionally intense situation. The family would benefit from receiving ongoing support services, and assistance in helping their daughter to make the transition to a community residential facility.

**CONCLUSION**

In the current article, the author has presented several issues that are likely to arise when providing psychotherapy services to minority Deaf
women. In psychotherapy, it is highly unlikely that the minority Deaf woman will have a therapist who matches her in racial background, gender, hearing status, and communication choice. At a minimum, therapy with minority Deaf women should include clear interaction/communication with the therapist, based on the client’s communication preference. If the therapist is not fluent in sign language, it is appropriate to hire a professional sign language interpreter to ensure communication effectiveness. The therapist is also responsible to do her own self-work on how her hearing status, racial background, and communication style impact the therapeutic relationship. The therapist should also educate herself about the local Deaf community, its activities, and leadership.

REFERENCES


