



Mental Health in Deaf Children

By Prof Barry Wright

The most recent study of mental health in deaf children in England showed that 26% in a sample of 144 signing deaf children and young people not currently accessing child mental health services had a probable mental health problem and 57% had a possible mental health problem (Roberts et al, 2015). This is much higher than the general population of 11-16 year olds (Sadler et al, 2018) where approximately 14% are thought to have a mental disorder. Developing an understanding or a model for why these rates are so much higher would be very helpful for two main reasons. The first is specific to developing an understanding of the needs of the deaf child population so that we can begin to think more about service planning and particularly understanding social, emotional and mental health needs. The second is that when we consider the stressors that different groups of deaf children are placed under and why it is that deaf children have higher rates of mental health problems it may give us a much richer understanding of the multiple routes to mental health problems.

What is it like to be a deaf child in a hearing community? We know from research that deaf children

are more likely to be isolated, bullied or abused (Wolters et al, 2011; Kvam, 2004), which can impact upon mental health. There is a large literature on prejudice towards deaf children and their families and experiences of feeling stigmatised.

Over 90% of deaf children are born within hearing families and most of them are not expecting a deaf child. This leads to difficulties in adjusting to the new challenges of parenting and educational choices and can be complicated by very different views and/or advice about what the best approach to take is. Parents are almost always dedicated to their children, but may also struggle with anxiety, depression, over-protection, challenges with relationship and attachment, and rarely rejection of their child. All of these have mental health consequences for the child.

We also know that the government's inclusion policy means that most deaf children are in mainstream schools and they are often the only deaf child in their class. This makes the likelihood of them having a deaf peer group in any meaningful day to day way very limited. It also means that large numbers of mainstream

teachers, often with limited training have to make sure that the curriculum is available to those children. A large proportion of deaf children have single gene causes for being deaf and no intellectual, neurological or congenital problems but these children do not do as well as hearing children at all examination test stages (Hendar & O'Neill, 2016) suggesting that the education system may struggle to meet fully the needs of many deaf children.

Another factor relates to communication. There is a tendency for the research literature to consider all deaf children together as if they are the same. In fact, they all have very different life trajectories with different causes for being deaf, occurring at different times, in different families who make different and sometimes changing educational and communication choices. Some deaf children communicate through spoken English, especially those who are mildly deaf. Some children communicate completely in British Sign Language (BSL) with no spoken English. BSL is a fully recognised UK language, but despite this it is not always readily available in our education or workplace systems. BSL has a different word order, grammar and syntax to spoken English and does not map easily on to spoken or written English. The UK system is not well prepared for this variability. This creates a number of challenges for deaf children and their families that include high levels of stress, communication problems and social and emotional challenges. Some children are being educated in bilingual ways and are being taught spoken and written English as well as BSL or sign supported English (using the English word order with adjunctive signs). Attempting to learn multiple communication modalities can be very challenging for children, especially for that subgroup of deaf children with additional complex problems or intellectual disabilities. This can create its own problems. Deaf children sometimes have less exposure to language learning and may have language deprivation and/or delay, which can in turn lead to delays in theory of mind (empathy-related) skills (Peterson et al, 2016) compounding problems in social settings.

Some deaf children may be deaf as a result of a neurological insult or a more complex genetic problem that leads to multiple difficulties including intellectual disability and/or a range of possible physical problems such as visual problems, balance problems or other organ damage (e.g. heart, kidney etc.) (Van Dijk et al, 2010). These all carry their own increased mental health risks.

This landscape helps us understand the multiple myriad pathways to mental health problems. This population of young people has much to commend it. Meeting deaf

children and young people it is clear to see their joys and enthusiasms, their hopes for the future and their numerous strengths and abilities, as well as the multiple challenges that they face. It would be instructive to understand this group better in order to be able to provide better community based services, education services, health services and mental health services for deaf children and their families, but also as a learning experience to help us as professionals to develop innovative therapeutic strategies that can engage with the multiple pathways to mental health problems.

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