

# Deafness and Intellectual Disability

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- Degrees of deafness
- Deafness and ID
- Service provision
- Working with a deaf person with ID

# Degrees of Deafness & Communication

Functional categorisation is useful:

- Can't hear very well, can speak fluently
  - deaf, some speech (oral education), no signing
  - Deaf, some speech, some signing
  - Deaf, some speech, relies on signing
  - deaf, no speech, no signing
- 
- d/Deaf identity

# Sign Language User

- Don't learn to sign fluently from parents
- Oralist education punished sign use
- Most deaf people learn to sign after school (16+)
- Regional variations add to flexibility of language
- Grammatical structure is visual (3D), parallel as well as serial

# Experience of growing up deaf

- Communication
- Linguistic and social deprivation
- Gaps in knowledge
- Theory of mind delay
- Isolation and difficulties with inclusion
  
- ToM skill development is delayed when taught orally and parents aren't deaf.

# Sign Language User

- Non-verbal communication in parallel with “verbal” – is not usually out of shift as with hearing communication.
- Non-manual: Role shift, placement,

# Deafness & ID

- Causes:
  - Congenital: rubella; infection; hypoxia/anoxia; prematurity.
  - Chromosomal: CHARGE, Waardenburg, Usher, Alport, Downs Syndromes.
  - Acquired: head injury, ototoxic medication, meningitis, encephalitis (mumps, rubella, etc.), leukemia.

# Deafness & ID

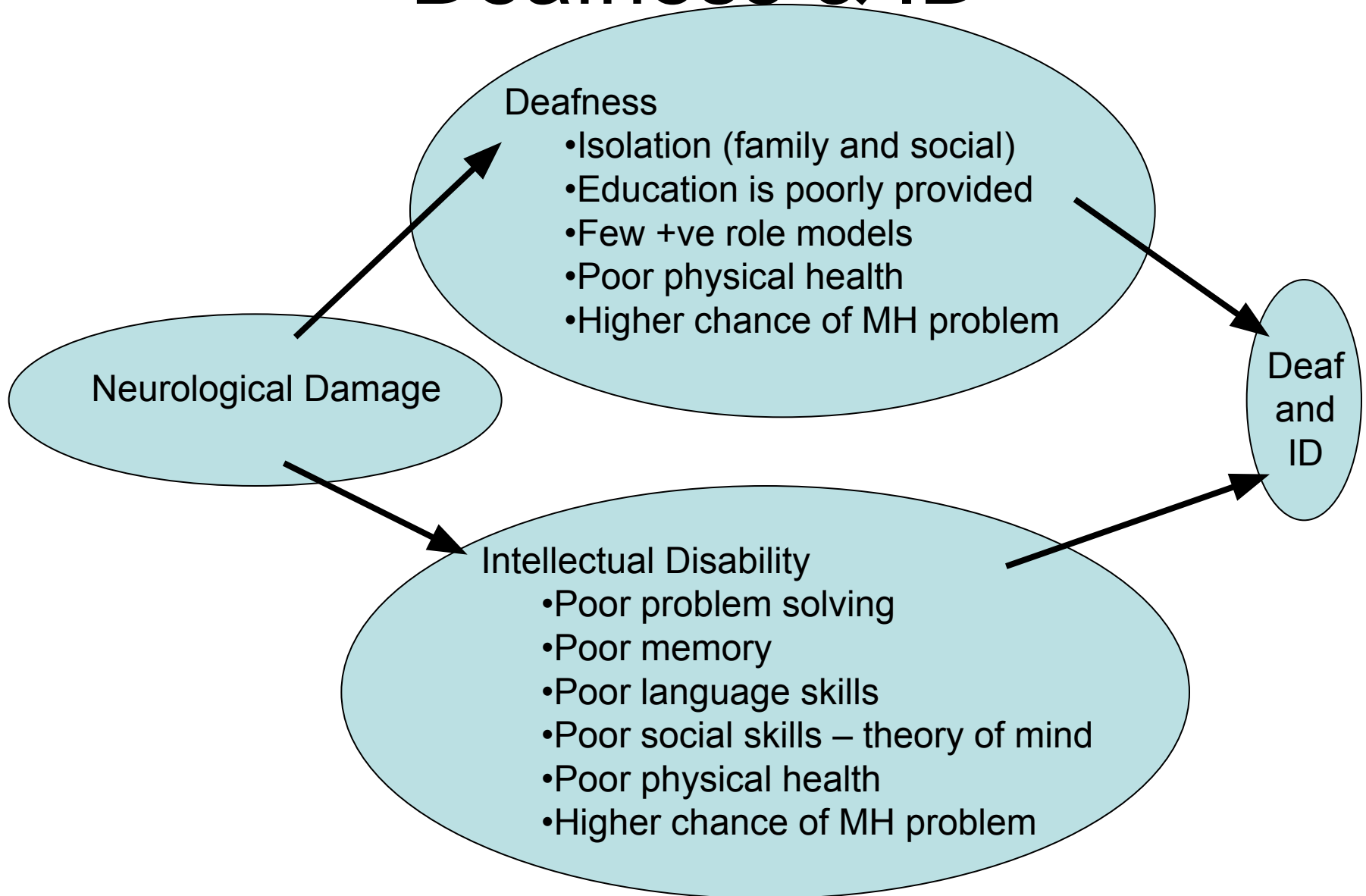
- Deafness 40% higher in ID population compared to non-ID population (Cahill, 37)
- Half of all deaf children have extra disability (Gallaudet, 38)
- Kelly et al (42) found children with a rubella or meningitis cause to deafness also experienced difficulties with attention



# Deaf & ID

- Rates of deafness in LD pop, 40-100 times higher (Yeates, 1989, 1992, 1995; Evenhuis, 1995)
- Higher Rates of additional disability in the Deaf population: 23,000 deafblind people in UK
- Double/Triple jeopardy
- Diagnostic Overshadowing

# Deafness & ID



# Service Provision

- ID services can't provide direct services to deaf patients
- Deaf services don't have the expertise that ID services do (use an AMH model)
- Worst served category are “mild to moderate” ID, with some sign language, behavioural problems, emotion-control problems, social isolation from both Deaf and hearing worlds.
- Difficult to engage, “underserved” population
- Habilitation more often than rehabilitation

# Working with a Deaf person with ID

- Sign language skills
- Communication “attitude”, visual working
- Working with Deaf support staff
  - training, gaps of knowledge, experience of being “cheated” by hearing staff
  - Deaf staff never had contact with professional ID staff (OT, physio, community nurse, etc...)
- Working with a good relay interpreter
- Working with an interpreter
- Danger of being everything because you are the only one! It’s got to be equal access not just access.