

Chapter Four

Mental Health Counseling

“I’ve seen many harsh winter storms
Icicles on my heart
Then spring with its beauty in color changing
With blooming flowers in my heart
With summer and it’s heat
I find beauty in the summer
Sunrise and Sunset
Then fall with its crispy windy days
With darkening colors....”

Marcia McDermott
(Reflections From A Recycled Heart, 2006)

Mental Health Counseling with DeafBlind Students: Recommendations for Families and Professionals

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Students who are deafblind represent a uniquely heterogeneous group of consumers. Factors such as age at onset of sensory loss, the degrees of the loss, the etiologies, and the progressive versus the static nature of hearing and visual disabilities are among the reasons for this huge variability. These are specific conditions not faced by the general population of adolescents. More importantly, these added factors can have profound effects on deafblind students' language development, opportunities for human interaction (marriage, friendships, family ties), mobility, psychological adjustment, employment, and education (Salmon, 1970).

It is common for fear to be a student's primary reaction upon hearing the diagnosis of a disorder which can potentially lead to deafblindness. Students have reported feeling completely helpless and without control. The desire to stop time and rearrange the stars leaves the student feeling as though death has come; but the heartbeat, breathing, eating, and sleeping continues as he awaits the actual death of his body (Sculthorpe, 1966). This anguish is magnified for students who have already adjusted to life with the single disability of deafness or blindness. For these students, getting through elementary school and then entering adolescence only to learn that the sense upon which they had established their connection to the world has been or soon will be purged can be quite devastating.



Christian Markovic communicating with student using tactile sign language at community art festival.

This change, coupled with the typical crises and stresses which result from living in a world that can not be seen or heard, and the lack of mental health specialists who possess the multiple counseling skills and experiences needed to effectively serve deafblind students, creates a demand for services far in excess of supply. It is the purpose of this chapter to describe some of the mental health issues raised by deafblind students and to provide practical ways and valuable resources to address these challenges.

Factors Related to the Onset of DeafBlindness Which Impact Mental Health and Overall Psychological and Educational Functioning

The conditions affecting adjustment to deafblindness vary tremendously in terms of the age at the onset of the loss of hearing and of vision, respectively. For example, was the student born deaf and then later became blind? Did the blindness precede the deafness, or did both occur together? The reason age at onset is of such profound psychological importance is that it determines in large part the coping skills and other assets, and the overall life experience the student may potentially bring to his new life as a deafblind individual (Adler, 1987; Stiefel, 1991). Age at onset determines, in part, some of the personal resources a student can call upon in coping with isolation from peers and comprehending what is involved with being deafblind. The age at onset of the preexisting blindness or deafness also impacts the amount of grief already experienced (Duncan, Prickett, Finkelstein, Vernon, & Hollingsworth, 1988). Having not dealt with severe grief and acceptance issues, the newly diagnosed deafblind student will be faced with mammoth issues related to identity, self-worth, sense of belonging, and attaining independence (Adler, 1987).

Blindness Followed by Deafness

Most students who become blind before losing their hearing have been blind from birth, or for many years. Whether blind resulting from neonatal or postnatal complications, blind students who experience deafness later in life are likely to have become accustomed to traversing through the environment relying on their four remaining senses. Thus, they are already on their way or have made the adjustment to blindness. For example, most blind students will already possess orientation and mobility and self-help skills used by the blind. Often, many of these individuals can read braille. These students also tend to have a good command of English and have retained usable speech. For these blind students, deafness symbolizes the absence of the one key sense believed to be most important, i.e., hearing.

Such a major loss involves intense grief, mourning, and possibly denial, anger, and other emotions that are understandable reactions to a major life tragedy. In terms of function, the major psychological loss faced by blind students with late onset hearing loss is related to



Student using the PacMate braille notetaker to access the Internet.

receptive communication. Although these students may still possess intelligible speech and

the ability to verbally *express* themselves to others, it may be difficult for them to understand what others say in response. Most do not know sign language. Fingerspelling is slow, and few people know it. Other means of receptive communication such as print-on-palm are also slow and laborious. In addition, the student may not have previous experience with reading and writing print letters from which to draw. Thus, these students find themselves tremendously isolated from other people, an isolation caused primarily by an inability to *receive* communication.

However, blind students who become deaf still have reasonable access to information through reading braille. They may have lost auditory input through radio and television; however, streamlined programs can still be accessed via the Internet by using a Braille display. The increase in web-based information outlets that are accessible to persons with vision loss has enabled many deafblind students to remain up-to-date with local and world events. Thus, isolation from people is primarily physical, but not necessarily in the sharing of ideas.

Among these students, those who need psychological services may find that assistive devices such as the TeleBraille (this device is no longer manufactured in the US; however, thousands of units still remain in use) or Screen Braille Communicator (SBC), can be used to communicate directly with a mental health specialist. The deafblind student can receive, via Braille output, information that the practitioner types via a qwerty keyboard attached to a Braille display. The student can then respond orally or by using the Braille keys to type out his or her response. The words typed by the student will appear in regular print on the LCD screen that faces the practitioner. Another option for deafblind students who possess knowledge and comfort with a computer keyboard or Braille keyboard is to utilize the computer screen (practitioner access) and braille display (student access) to type out and receive responses on a desktop or laptop computer. The student can then access the practitioner's typed remarks using the Braille display connected to the computer, and the practitioner can in turn read the student's responses that appear on the computer screen. This method, while neither smooth nor ideal, can enable the blind student with acquired deafness to have direct access to experienced practitioners who may have valuable strategies and input which can help the student cope with his new limitations.

Deafness Followed by Blindness

By far, one of the largest numbers of deafblind teenagers and adults are those who are born deaf or who lose their hearing early in life, and then later lose their sight. For many years, research suggested that nearly half of all identified deafblind adults had a genetic disorder called Usher Syndrome. This disorder typically involves a progressive loss of vision

due to Retinitis Pigmentosa (RP), and an early onset of hearing loss, which may or may not be progressive depending on the particular form of Usher that is present (Table).

Table: Three Types of Usher

<u>Symptom</u>	<u>Type I</u>	<u>Type II</u>	<u>Type III</u>
Hearing loss	Born deaf with profound hearing loss and have a "corner audiogram" with responses only to very loud low tones	Born hard of hearing with a sloping sensorineural loss from mild loss in low frequencies to severe-profound loss in high frequencies	Born with good hearing or mild hearing loss which gets worse over a decade or more. Sloping sensorineural pattern on audiogram
Balance	Absent inner ear balance	Normal inner ear balance	Some balance disturbance progressive
Vision loss from RP	Night blindness in infancy or early childhood. Blind spots by late childhood or teens. Legally blind by early adulthood	Night blindness in childhood or teens. Blind spots by late teens or early childhood. Legally blind in early to mid adulthood	Timing of progression may vary, but night blindness precedes daytime loss

Reprinted from: Davenport, S.L.H. (1995). Usher Syndrome Fact Sheet. National Institute on Deafness and Other Communication Disorders. Hereditary Hearing Impairment Resource Registry, Boys Town National Research Hospital, 555 N. 30th St., Omaha, NE 68131.

Usher Syndrome

Students with Usher Type I and some with Usher Type II usually learn to cope effectively with their deafness or partial hearing early in life. Most attend or have attended some type of education program for deaf youth, have primarily deaf friends, and are becoming skilled in sign language and fingerspelling. When these individuals become legally blind, they are able to communicate expressively and receptively with deaf people, hearing people who sign, and deafblind people who use tactile sign language. This means that these students have a major psychological advantage over deafblind people who grew up blind, because there are three (aforementioned) groups of people with whom they can readily communicate expressively and receptively. Thus, students with Usher Syndrome have a realistic chance to reduce the major psychological impairment of deafblindness, which is isolation from other people. However, if most deafblind



Two deafblind consumers using tactile sign language to catch up on the latest gossip.

students are to escape isolation, society has to structure environments that will make this possible. Access to residential living facilities with other deafblind and deaf people must be available. There is need for reliable transportation to helping with accessing a community center where other persons can be found with whom the deafblind student can communicate regularly. However, such arrangements can be rare. On-line chat rooms, listservs, instant messaging, and video phones are other high tech means by which deafblind students can use to remain connected to their peers and others.

Another major *advantage* students with Usher Syndrome, or other such acquired forms of deafblindness, have is that the loss of vision may be gradual, spanning a period of 20 to 60 or more years. Thus, psychological adjustments can be made gradually. When such students have matured, married and had children, or when they have been able to maintain close contact with the deaf community, this existing support system may be used to help with adjustment to deafblindness. Students who remain uncoupled, or who withdraw from the deaf community face greater barriers in coping with isolation.

Students with Usher Type I can typically receive adequate mental health services from facilities or specialists who know sign language and understand deafness. By contrast, students with Usher Type II and Type III can often hear and see adequately enough to combine residual hearing with speechreading and assistive listening devices in order to make use of regular mental health practitioners and programs. However, it is preferred that practitioners with knowledge of and experience with adolescent students and adults who are deafblind render these essential services.

Other Etiologies

Most other deafblind students are those who were first deaf, and then lost their sight from diseases such as diabetes, glaucoma, macular degeneration, cataracts, or other conditions that usually do not cause blindness until the student is well into adulthood. Certain conditions, such as diabetic retinopathy or cataracts, may involve loss of vision with partial return of vision and a lot of uncertainty about prognosis. This is extremely traumatic and, understandably, can precipitate depression, anxiety, and suicidal feelings. The relatively sudden or uncertain onset of blindness in most deafblind students who first lose their hearing *generally* makes adjustment more difficult than for those with Usher Syndrome.

Individuals in this other etiology category can generally have their mental health needs met at facilities serving deaf people, because such clinics have practitioners who know sign language. However, for students who have no sign language skills and have relied extensively on their vision for speechreading or other visual cues during

communication, sudden vision loss can be demoralizing. Feelings of complete abandonment and rejection are common for this group of adolescents. Many of these students report feeling as though they had been abducted and taken to an isolation room, which permits only a blurred semblance of their previous existence.

Sudden-Onset Post Lingual DeafBlindness

A tiny percentage of deafblind students were born with normal hearing and vision, and then lose both senses simultaneously over a brief period of time. Usher Syndrome Type III, meningitis, severe accidents, or war injuries are the usual causes. For these students, the initial psychological trauma is emotionally unsettling

However, these students bring to deafblindness a wealth of knowledge gained from their years as hearing-sighted individuals by using a technique called visualization (Alexander, 1994). This knowledge aids in mobility, in self-help, and, most importantly, in human communication. These students with acquired vision and hearing loss have the potential to overcome some of the isolation from ideas, people, and knowledge that most prelingually deafblind students face.

Generally, students with late onset deafblindness retain intelligible speech, which enables them to communicate expressively in a treatment or education setting. The mode of receptive communication that they generally rely on varies depending on the degree of vision and hearing loss. Braille, writing large print messages, and close vision or tactile sign language represents just a few of the communication modes used by this group of students. However, because onset is often later in life, these students frequently lack proficiency in using many of these modalities. This makes obtaining psychotherapy an especially tedious and difficult process. The concept of living in a world with diminished vision and hearing may be so foreign to these students that personal adjustment is often very slow and not easy.

Peer Interactions and Mental Health

One of the best actions that can be taken to help a deafblind student cope is to provide opportunities for meeting and interacting with other deafblind individuals. While not always easy to arrange, it is possible in many cases. If the student is an older teenager or an adult, several options are available.

One option is state-sponsored learning weekends or camping activities for deafblind consumers. Here, students have the opportunity to interact with peers and are given the chance to meet deafblind adults from whom they can gain a better understanding of the independent living and employment potential of persons with the same disability. The

Helen Keller National Center for Deaf Blind Youths and Adults (HKNC: 141 Middle Neck Road, Sands Point, NY 11050; PH: 516-944-8900) is another program which can provide deafblind students with an opportunity to gather together with their peers in a structured and supportive environment. The HKNC program is a federally-supported, and offers residentially based training curriculum and regional services. With its more than 50 affiliated programs across the nation, HKNC provides comprehensive rehabilitation services for eligible deafblind persons 16 years of age and older (Ferrell, Carlson, and Friend, 1995). The Center offers pre-employment and job training, education (e.g., braille, tactile sign language or adaptive technology), basic life skills such as independent living skills, mobility, use of assistive devices, and other skills needed by deafblind persons. Also, the many colleges and universities that offer quality support services for deaf and hard of hearing students are now attracting more deafblind students. Such academic and social environments are another excellent place for the deafblind student to receive peer support while adjusting to life with limited hearing and vision.

Another helpful organization is the **American Association of the DeafBlind (AADB)**, a national consumer group for deafblind people and professionals (8630 Fenton Street; Suite 121, Silver Spring, MD 20910). The AADB holds week-long conferences every two years where deafblind people and their families attend from all over the United States. It has several local chapters in some large cities; and has recently begun pairing young deafblind students with older deafblind mentors. The AADB conferences are ideal settings for acquainting deafblind individuals and their families with the deafblind community nationwide, and for establishing friendships with professional workers who are deafblind and/or involved in the deafblind field. Some other facilities are listed in the Available Services section of this chapter.

The key point to make is that for students facing life with vision and hearing loss, contact with others who share this dual disability is a major enrichment to their lives and a huge aid in their ability to cope with life. The students learn about services, assistive devices, and ways to handle situations, but most of all, students receive support and a realization that they are not alone. Parents also obtain corresponding benefits by witnessing how other families with a deafblind member interact successfully.

Because peer interaction is so critical, if a young, deafblind person is to avoid isolation, the selection of an appropriate school program is essential. Usually, a school district may have, at most, one or a very few deafblind students. If this is the case, the deafblind student is usually placed in a class with children who have different disabilities and/or vary widely in educational and age levels. Sometimes, an interpreter is provided, but not always. Often, the teacher has had little or no experience or training in the area of

deafblindness. Due to a lack of training, the support staff (psychologists, audiologists, administrators, counselors, aides, consultants, etc.) generally lacks the qualifications to meet the special needs of the deafblind student. Additionally, in these settings there are often issues related to limited or no opportunity for interaction with other students who are deafblind. This imposes upon the deafblind student severe isolation, which can have life-long, damaging impact. Funding, ego-driven needs of school administrators whose ignorance of deafblindness can lock a student into this type of educational placement indefinitely unless strong, articulate parents and advocates take a stand for students and demand the rights to which they are entitled under Section 504 of the Rehab Act, the Individuals with Disabilities Education Act (IDEA) and other related legislation.

The most effective approach for deafblind youth up to 16 or 18 years of age is to have a psychological/educational evaluation completed. Community-based adult service agencies may have more resources from which to choose than the school system. The **Helen Keller National Center** has a list of affiliated agencies from across the country that can provide information on existing mental health and peer support services for deafblind students (www.hknc.org). The **Perkins School for the Blind** (175 N. Beacon Street, Watertown, MA 02172; PH: 617-972-7220) is another excellent resource from which to obtain psychological and educational assessments for students with cognitive disabilities, in addition to vision and hearing loss. Under existing laws such as IDEA, Section 504 of the Rehabilitation Act, the 1998 Amendments to the Rehabilitation Act, No Child Left Behind and other legislation, deafblind students have a legal right to demand proper assessment services. As indicated earlier, few school districts have a multi-disciplinary team available, which is needed to conduct a comprehensive, multi-disciplinary, educational evaluation. Under IDEA the local school district is responsible for paying the full cost of a student's evaluation, including travel and meals for the deafblind student and a parent or guardian.

One value of obtaining this type of evaluation is that a part of it provides detailed educational recommendations. These recommendations can then be used as documented expert opinion regarding what is an appropriate program for the student. Such legal leverage can be critical for parents in obtaining the educational program that a deafblind student needs, and to which he or she is entitled.

Other resources for psychological and educational evaluations exist in the eleven states, which have what are called "dual schools." These institutions, which serve both deaf and blind students on a single campus, are located in Alabama, Arizona, Colorado, Florida, Hawaii, Idaho, Montana, Nevada, South Carolina, Virginia, and West Virginia. These schools usually have programs and evaluation services for children and youth who are deafblind. Other states have facilities for deafblind youth at either the state residential school for deaf

students, or for blind students. A listing of additional programs for deafblind youth can be found in the annual April edition of the American Annals of the Deaf. This publication is available in many large libraries or can be purchased for \$27 from the American Annals of the Deaf (KDES PAS-6, 800 Florida Avenue, NE, Washington, DC, 20002-3695).

Psychological Aspects of the Diagnosis of Progressive Visual Disorders

As indicated earlier, a great majority of the population of deafblind adults have Usher Syndrome. This disorder poses some unique psychological issues. Even though the condition of Retinitis Pigmentosa (RP) in Usher Syndrome can be diagnosed at or near birth, it is usually not discovered until between the early teens and mid-to-late twenties (Minor, 1996). By this time, most students with Usher Syndrome and their families have adjusted to their deafness or hard of hearing status. To most deaf people, including those with Usher, blindness is perceived as the worst possible additional disability that could occur. Thus, for a student to be told that blindness is a possibility in addition to their existing deafness presents a severe psychological trauma, the full emotional impact of which few can understand.

The question ophthalmologists, parents, psychologists, and other mental health workers face is how to communicate the diagnosis of RP. How best to provide emotional and psychological support to the student who must ultimately cope with the reality of facing the future as a deafblind person, should be approached with compassion and patience.

In order to understand how to be helpful to persons in this situation, it is important to understand the individual's psychological status at the time of diagnosis. Usually, the student is in his teens or twenties, which means he has already started to cope with the loss of night vision; which is an early manifestation of the disorder. Forms of coping usually involve not going out at night, especially to dark places such as the settings for many social events, nighttime sports competitions, and other similar activities. This type of coping can be self isolating, and the beginning of withdrawal and loneliness, which frequently accompanies deafblindness. The individual has also begun to experience narrowing visual fields due to the RP. Thus, the student may have stopped playing some sports, yet another factor that leads to reduced human contact and a sense of belonging.

As already noted, by the time these young people learn that they have RP, adjustment to deafness or partial hearing has already been made. For example, most will have learned sign language. Those students who have not should begin classes immediately; as such skills can become a major asset. As the RP progresses, the use of sign language will enable these students to communicate with other deaf people, thus providing social outlets. As vision loss increases, a switch to a tactile form of sign language will occur.

During this critical time, it is also important that students learning sign language, who are still of school age, consider entering an academic program with other deaf students who also use sign language. Another option would be for the student to connect with other sign language users in both academic and social settings if they have not already done so. This can provide the student with awareness of the Deaf community, which is of great value because as his vision loss progresses. Signing deaf people or hearing individuals who learn sign language can help the student to establish a relatively easy two-way communication system and to avoid feelings of isolation. Increasingly more students are undergoing cochlear implant surgery at earlier ages so the urgent need to acquire sign language skills for a select group of deafblind students may not be as great.

With these considerations in mind, what is the best way to handle the actual communication of the diagnosis of vision loss to the student whose condition has just been identified? A lot depends on such factors as the age of the student, the type of disorder he or she may have, the degree of the hearing loss, and the resources available. However, some general suggestions can be made.

First, the student needs to be told that he has condition that affects his vision in specific ways. For most deaf students who have just been diagnosed with a condition that can lead to potential blindness, this can be helpful information. For years, the deafblind student may have questioned the reason he was bumping into things, especially at night, or in crowded situations. He may wonder why he felt awkward playing certain games or did not see a ball when thrown to him. Also, curiosity for why people said he was ignoring them when he passed by. To realize these behaviors have been due to poor visual acuity, reduced peripheral vision and night blindness can be a relief. If the particular condition is accompanied by a balance problem, loss of sensation in the extremities or other physical disabilities, these additional limitations need to be explained as well.

Once the student has been told he has an eye disorder and its symptoms have been explained, it is important to let him know whether the vision loss is progressive and if he will need to be re-evaluated every year.

Some doctors, parents, or mental health professionals stop at this point and do not explain any further, until the student asks, "Will I be blind?" If or when this or other questions are asked each should be answered honestly. The reality of most disorders is that, even if the condition is progressive, total deafblindness is not necessarily the ultimate outcome. Many people with progressive disorders such as Usher Syndrome retain some useful vision well into their 50's or 60's. It is important not to flatly state, "You will become blind," because to most people, especially young people, the word "blindness" denotes a total loss of vision. Scientifically, blindness is defined legally and medically as a visual loss

of 20/200 or greater in the better eye with correction, or else a visual field of 20 degrees or less. Furthermore, no one can predict with specific accuracy how rapidly vision will be lost in a student with a progressive disorder because there is such great variability. However, as many have discovered, most persons diagnosed with conditions such as Glaucoma, Diabetic Retinopathy or Usher Syndrome wish their condition had been fully explained to them early on, so as to enable them to properly plan for the future as it related to careers, marriage, family planning, and choice of where to live (Minor, 1995; Vernon, Boughman, & Annala, 1982).

Becoming a of a support group or other group with individuals who are also coping with vision loss is one of the best possible therapeutic activities for students who have just learned of their diagnosis (Vernon & Hicks, 1983). This same kind of interaction with other deafblind people can be equally valuable to students experiencing a sudden onset of deafblindness, or blind people who later lose their hearing. However, depending on the severity of the loss, these latter students must first master sign language or use an interpreter. As stated earlier, this is a problem not faced by most students who have grown up deaf and already know sign language by the time vision loss begins.

It bears repeating that the Helen Keller National Center for Deaf-Blind Youths and Adults and the American Association of the Deaf-Blind Conferences are ideal settings for a student who is becoming, or has become deafblind, where supportive interactions with others sharing the same disability can occur.

Issues in the Assessment of Students who are DeafBlind

Psychological assessment of students who are both deaf and blind is a challenging task for three major reasons: 1) the problem of communication, 2) a lack of adequate psychological tests designed specifically for these individuals, and 3) a lack of psychologists qualified to work with the population. A few tests have been developed for persons who are blind or deaf, and for deafblind children (Mar, 1996; Vernon & Hammer, 1996). Also, certain tests for non-disabled people are sometimes modified for use with students who are either deaf or blind. However, no comprehensive psychological or personality tests have been developed for and standardized on older deafblind persons. At best, testing involves the adaptation of existing instruments used with the general population, which is far less than satisfactory.

Because tests for blind people usually emphasize sound or language, they are obviously inappropriate for deaf people (Vernon & Green, 1980). Similarly, tests for deaf clients inevitably require vision and are unsuitable for blind clients. In a test such as the Wechsler Intelligence Scale for Children (WISC), the verbal scales are applicable to blind

persons, and the performance scales to deaf persons who have sufficient vision (Vernon & Green, 1980). Thus, students who are both deaf and blind are inadequately tested. In addition to the absence of appropriate tests, there is a lack of qualified psychologists. To work effectively with deaf students, a psychologist should know sign language and have experience socializing and working with deaf people (Vernon & Hammer, 1996). To be effective with blind students, a psychologist should be able to administer the appropriate tests for persons with vision loss, have some understanding of Braille, and be familiar with blindness (Vernon, Bair, & Lotz, 1979). Professionals with either background are extremely rare, and only a handful of psychologists in the United States are familiar with both deafness and blindness.

As a result of these limitations, extreme injustices are inevitably imposed upon deafblind students in the form of gross misdiagnoses and hospitalization for mental illness, or a diagnosis of intellectual disability, when students experience neither (Vernon & Green, 1980; Miles & Riggio, 1999). Such errors are commonplace. Many practitioners who have worked with deafblind students and adults have encountered individuals who spent decades in mental institutions because of incorrect diagnoses.

One important way of avoiding injustices is to obtain an extensive case history. Whenever possible, the case history should include information about the student's early development and complete school records. If available, family members should be asked to describe, in operational terms, important details of the student's behavior. Finally, it is vitally important to obtain a complete medical history that includes the etiology and time of onset of both the auditory and visual losses.

To locate a psychologist or psychiatrist capable of evaluating deafblind students, refer to the "Available Services" section of this chapter.

Available Services for Students Who Are DeafBlind

It is impossible, within the scope of a monograph chapter, to address fully the many complex issues involved in mental health for deafblind students. For this reason, a section on available services and resources is provided below:

- **Locating Psychologists**

The American Psychological Association has a special interest section on deafness, which is part of its Division 22, Rehabilitation Psychology. By contacting the American Psychological Association, one may obtain the names and addresses of psychologists in the United States who are members of this special section and knowledgeable about deafness and deafblindness. Most of these individuals know sign language and have

experience working with deaf people and, in some cases, deafblind students. (750 First Street, Washington, DC 20002-4242)

- Locating Psychiatrists

The American Psychiatric Association has a special caucus of psychiatrists working with deaf and deafblind people in the United States. A list with addresses of its members can be requested. Most caucus members know sign language. (1400 K Street, NW, Washington, DC 20005)

- Vocational Rehabilitation

Every state provides vocational rehabilitation for disabled individuals, including those who are deafblind. This includes job training, medical services related to job training, independent living, psychological evaluations, and a multitude of other services that are available to eligible applicants (Ingraham et al, 1994). Vocational Rehabilitation is a state agency that is sometimes listed as a "Division" or a "Department," but is always available in the phone book in the "State Government" section. Vocational Rehabilitation usually has trained counselors who work with deafblind students and who would know of local mental health services that are available and can accommodate deafblind students. These specialists can also provide access to vocational rehabilitation services for deafblind clients.

- Helen Keller National Center for Deaf-Blind Youths and Adults

This agency should be contacted by every deafblind student age 16 or older (141 Middle Neck Road, Sands Point, NY 11050; PH: 516-944-8900). The Center offers a number of evaluation and training programs for students, professionals and family members. Resource information on available mental health professionals trained to work with deafblind students can be obtained by contacting the HKNC Regional Representatives or Affiliates. (www.hknc.org)

- American Association of the Deafblind

Also described earlier in this paper, with address and phone number, this organization can provide some socialization options for deafblind students (8630 Fenton Street, Suite 121, Silver Spring, MD 20910).

- Hilton/Perkins Program Perkins School for the Blind

Also described earlier in this paper with address and phone number, this school should be contacted by every parent of a deafblind youth aged three to 18, to discuss the possibility of having their child evaluated there (175 N. Beacon Street, Watertown, MA 02172; PH: 617-972-7220).

- Boys Town Research Hospital

This hospital provides comprehensive educational, psychological, medical, and communication evaluations for deafblind youth, and has special services for sexually abused children and their families, including those who are deafblind. The Boys Town Research Hospital is also conducting extensive research on genetics related to Usher Syndrome. (Institute for Communication Disorders, 555 N. 30th St., Omaha, NE 68131)

- **DB-LINK: National Information Clearinghouse on Children Who are Deafblind**
DB-LINK is a federally funded information clearinghouse that identifies, coordinates, and disseminates information related to children (0-21) who are deafblind. DB-LINK provides free, individualized information and referral services across many topics, including effective early intervention, special education and general education practices, medical, health, social, recreational services, legal issues, employment and independent living, post-secondary educational services, and information on the nature of deafblindness. In addition, fact sheets are developed on selected topics. These, too, are available at no cost. Parents, professionals, employers, and other members of the public are encouraged to contact DB-LINK (Jacobs, 1999-2000). (Teaching Research, 345 N. Monmouth Ave., Monmouth, OR 97361 [PH: 800-854-9376; TTY: 800-854-8150; FAX: 503-838-8150; www.dblink.org])
- **National Family Association for Deafblind (NFADB)**
NFADB is a national network of families who focus on issues surrounding deafblindness. As a national organization, NFADB advocates for all persons who are deafblind, supports national policies to benefit people who are deafblind, encourages the founding and strengthening of family organizations in each state, provides information and referrals, and collaborates with professionals who work with persons who are deafblind. The organization has representatives in each of its 10 regional districts throughout the country. It also publishes a quarterly newsletter (Jacobs, 1999-2000). (141 Middle Neck Road, Sands Point, NY 11050 [PH: 800-255-0411 ext. 275])
- **The Directory of Mental Health Programs and Resources for Hearing Impaired Persons**
This book lists mental health programs for deaf people, which means the agencies presented have professionals on their staff who can use sign language, understand deafness, and will probably have some experience with deafblind clients. It also lists available inpatient services for severely mentally ill deaf and deafblind individuals. (Available for \$15.00 from the Gallaudet University Bookstore, Washington, DC 20002 [PH: 202-651-5380]).
- **Foundation Fighting Blindness**
This is primarily a research foundation studying RP and other retinal disorders and causes of blindness. It has a human services division which will provide up-to-date

literature on Usher Syndrome and general information on services and current research on this disorder. (Executive Plaza I, Suite 800, 11350 McCormick Road, Hunt Valley, MD 21031 [PH: 800-683-5555]).

Summary

The major psychological problem faced by students who are deafblind is isolation. By learning sign language or some other reliable mode of communication, appropriately using available public services, and by maximizing peer interactions with other deafblind students, deaf signers, and hearing signers, the isolation of deafblindness can be significantly reduced. Developing computer literacy skills which afford access to chat rooms, listservs, instant messaging, and video phone technologies are also critical skills to acquire.

Although psychologists, social workers, and psychiatrists able to provide competent, helpful evaluations or treatment of students who are deafblind and need these services are in short supply, methods and places to locate such individuals are suggested for both deafblind youths and adults. Any appropriate or available resources should be thoroughly explored and contacted to improve the mental health outlook for deafblind students.