

Important Implications for Psychologists of the Americans With Disabilities Act: Case in Point, the Patient Who Is Deaf

Lawrence J. Raifman and McCay Vernon
Springfield Hospital Center

Increased implementation of the Americans With Disabilities Act of 1990 (ADA), which empowered persons who have disabilities, has begun in earnest with recent federal court action. Three legal opinions have far-reaching implications for psychologists whose practices include disabled clients. These implications are especially true for those psychologists who are most likely to work at least occasionally with deaf, hard-of-hearing, or otherwise disabled individuals. However, ADA court decisions also apply to psychologists in group practices and managed care corporations. In this article, these legal opinions are reviewed. The authors consider the implications of the decisions on psychologist practitioners, with special emphasis on their legal responsibilities to deaf clients and on liability and related malpractice concerns. The authors also consider the profound impact of these decisions on deaf and hard-of-hearing individuals in need of psychological services.

The Americans With Disabilities Act of 1990 (ADA) guaranteed access to psychological services to those for whom such services were previously unavailable. Because 14% of the general U.S. population is disabled (Pollard, 1993), the ramifications of the ADA are of major consequence to psychologists and other mental health professionals. The ADA extended its jurisdiction deeper into the practice of psychology; consequently, it created a new standard of care and legal liability that may likely increase the service costs and responsibilities of psychologists, mental health professionals, and agencies that deliver services to those with disabilities.¹

In a throwback to the era of school desegregation, judges are grappling with problems of implementation of the legal right to equal access. With the ADA, as with desegregation, translating the law on the books into practice is far from clear and straightforward. Implementing the newly accorded equal access rights to persons with disabilities, especially deaf persons, poses many of the same pitfalls as does racial minority access, including problems of cultural identity, stigma, ideological versus pragmatic strategies, limited resources, and political resistance. The present decade's political agitation over civil rights of persons with disabilities has consequences for how psychologists prac-

tice in schools, hospitals, and private and public mental health clinics. In this article, we examine recent judicial decisions that address one illustrative aspect of the ADA's impact, that is, the issue of a deaf client's right to receive equal access to psychotherapy and psychological assessment. The same issue exists with respect to the rights of other people with disabilities and to the duty and obligation the ADA places on all psychologists. What follows is a discussion of three recent cases and a consent decree. It is our view that these decisions directly affect psychologists who provide psychotherapeutic and psychodiagnostic services to deaf patients. We are concerned that, without specialized attention to these implications, psychologists' professional practice duty to these persons will serve as a financial disincentive for them to undertake interventions with patients with disabilities. The initial consequence for persons with disabilities may be that the benefits of the ADA will evaporate because of problems in its implementation. We provide recommendations that we hope will avert that outcome, such as the acceleration of training programs' efforts to graduate therapists who are fluent in American Sign Language (ASL).

Deafness, the Deaf Therapy Patient, and the Deaf Community

There are 400,000 to 500,000 people in the United States who cannot hear speech well enough to understand it and who experienced their hearing loss prior to the age of 17; 95% of them were deafened before they were 3 years old (Schein & Delk, 1974, p. 25). The overwhelming majority of these individuals use ASL, have their primary social contacts with other

LAWRENCE J. RAIFMAN received his PhD in clinical psychology in 1981 and his JD degree in law in 1982 from the University of Arizona. He currently serves as director of forensic services at Springfield Hospital Center in Sykesville, MD. He is also an adjunct assistant professor of psychology at The Johns Hopkins University. He maintains an independent practice specializing in forensic psychology and deaf mental health services.

MCCAY VERNON received his PhD from the Claremont Graduate School and University Center in 1966. He is currently professor emeritus at Western Maryland College and is in independent practice. His career has focused on deafness, a field in which he has authored or co-authored seven books and over 250 journal articles and book chapters. CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Lawrence J. Raifman, Springfield Hospital Center, Nurse's Building, Sykesville, Maryland 21784.

¹ Various terminologies are used to describe individuals with disabilities, including the following: *persons with disabilities*, *disabled individuals*, and *disabled patients*. We presume to use these terms interchangeably in this article. Likewise, we presume that the terms *deaf*, *hard-of-hearing*, and *hearing impaired* are interchangeable for purposes of this article.

deaf people, and form a distinct minority cultural group within this country. Sullivan and Vernon (1979) generalized that, for these persons, psychotherapy and psychodiagnostics would be likely to occur in ASL or not at all.

Of the 1 to 1½ and half million persons who experience deafness in later life, there is a relatively small segment of the population (some 15,000) of hearing-impaired persons who experienced a sudden profound loss of hearing in adulthood (Byl, 1975). These persons' hearing losses are psychologically traumatic, often creating career disruptions, family discord, and so forth. Only a few of these persons learn ASL; they retain speech and do not see themselves as members of the Deaf Community but as part of the majority culture. In therapy sessions, these persons can benefit from a special teletype device (TDD).

A third segment of the hearing-impaired population, estimated to have 20 to 24 million persons, is the group who can hear speech with or without a hearing aid or cochlear implant well enough to understand some words in a quiet, one-to-one setting. These persons vary in their capacity to hear, and they tend to have hearing impairments that occurred after they acquired English through hearing it. A minority are congenitally or prelingually hard of hearing, and they often rely on ASL and other forms of manual communication.

It is the first group, those persons who are deaf at birth or early life, that is the primary focus of this article. These persons are members of the Deaf Community and often rely on ASL. Their language is primarily visual, and because of their relative isolation from the majority culture, they form strong in-group interaction patterns. Their interactions are characterized by a different sense of humor, less emphasis on reading, a tendency to work with their hands rather than with words, and so forth. Higgins (1983) documented these cultural differences as did researchers Padden and Humphries (1988), Lane (1992), and Vernon and Andrews (1990).

Deaf persons who are members of the Deaf Community pose special challenges for psychologists. To increase the chance for success therapy, practitioners should be sensitive to the Deaf Community, its culture, and its visual language. The passage of the ADA has revitalized the debate concerning what provision of services is required in order to provide equal access for disabled persons. Following a systematic review of 6 months (January 1995 to June 1995) of *Silent News*, a leading publication within the Deaf Community that tracks judicial decisions relating to deaf persons' rights, we chose three categories of opinions for review. The first is exemplified by a recent case, *Concerned Parents to Save Dreher Park Ctr. v. City of W. Palm Beach* (1995), that recognized that, following passage of the ADA, persons with disabilities are entitled under the law to the provision of separate, additional services to ensure their equal access. The second, a potentially precedent-setting case, *Tugg v. Towe* (1994), required psychotherapists to be fluent in ASL in order to treat deaf clients; the third, *People v. Mid-Hudson Medical Group* (1995), permitted somatic physicians to rely on auxiliary services in treating deaf patients.

The Right of People With Disabilities to Separate but Equal Services

The court ruled that although there was no deliberate exclusion of disabled persons from general recreational programs

offered by West Palm Beach, still the ADA had been violated by the city when it attempted to cut funding to special recreational programs the city had provided to persons with disabilities. The court rejected the city's position that it was not in violation because all existing recreational programs would remain open to persons with disabilities. *Concerned Parents to Save Dreher Park Ctr. v. City of W. Palm Beach* (1995) held that in certain situations, namely the provision of recreational services, separate programs were required in order to provide equal access for disabled people. The court ruled that if people with disabilities cannot participate in or benefit in an equal way from a generally provided benefit or service, then an injustice has occurred (see 28 C.F.R. § 35). The decision stated that if the city provided recreational services to its nondisabled citizens, then disabled persons were entitled to equal access to whatever benefits the city offered to nondisabled persons. Furthermore, the court ruled that, in this case, "equal access" meant separate recreational programs for persons with disabilities in order to put them "on equal footing with the general population" (p. 1002). This opinion is consistent with efforts in many states to establish a separate inpatient ward with signing staff and sign language interpreters in the state mental hospital for deaf mentally ill patients (Raifman & Vernon, in press).

The application of this ruling and others like it to psychologists engaged in psychotherapy and assessment interventions with persons with disabilities became evident in a 1995 issue brought about by Hurricane Andrew's impact on South Florida.

Psychotherapists Who Work With Deaf Patients Must Be ASL Fluent

In 1994, the U.S. Federal District Court in the Southern District of Florida ruled that the state of Florida violated the ADA by providing interpreters at mental health counseling sessions rather than psychotherapists who could themselves use sign language and who were knowledgeable about deaf culture (see *Tugg v. Towe*, 1994). The court held that the use of interpreters denied a deaf patient the benefits of mental health services that were equal to those provided to the general public.

The court issue arose as the result of a dispute between Neil Tugg, a 40-year-old deaf man, who sought and received counseling from the Deaf Services Bureau (DSB), an agency contracted by the Florida Department of Health and Rehabilitative Services (HRS) in the aftermath of Hurricane Andrew. Tugg had suffered mental and emotional trauma as a result of his experiences during the hurricane. The DSB had been funded by grants from both the Federal Emergency Management Agency and Florida's special trust fund to provide crisis counseling to hurricane victims. The DSB employed two mental health counselors who were deaf or hearing impaired, both of whom were proficient in ASL. Following termination of the contract, HRS arranged to continue providing counseling services to Tugg through a contract with another mental health provider whose therapists were not proficient in ASL. Instead, an ASL interpreter was provided for the counseling sessions at no additional cost to the client. Tugg objected to receiving counseling services from the HRS-contracted therapists. He and two hearing relatives of deaf people sued under the ADA,

contending that "the presence of an interpreter in a therapeutic setting deprives them of an equal opportunity to achieve the same results as a hearing individual" (*Tugg v. Towey*, 1994, p. 1001).

In support of their arguments, the plaintiffs introduced the following evidence:

1. ASL is a visual language that does not translate word for word into English. Therefore, the chance of miscommunication between therapist and client is greater when an interpreter is used.

2. A therapist could use different interpreters during the course of counseling, with potential for confusion to the patient because each interpreter might differ in the choice of signs.

3. The number of interpreters in Miami is limited, creating the possibility that a deaf person might come across his or her interpreter in a different setting. The deaf patient's awareness that he or she might encounter an interpreter with whom he or she divulged intimate personal information in the counseling session would inhibit the patient in therapy.

4. Deaf patients would benefit most from the direct communication that occurs with a deaf or hearing-impaired counselor who signs, as contrasted with having a sign language interpreter involved as a third person in the process.

The defendant's primary argument was that the plaintiffs had sought relief on the basis of the inability of hearing counselors to understand deaf culture and that culture was not a disability. The defendants maintained that a physical or mental impairment "does not include simple physical characteristics, nor does it include environmental, cultural, economic, or other disadvantages, such as having a prison record or being poor" (*Tugg v. Towey*, 1994, p. 1002). Furthermore, the defendants noted that there was no evidence of deliberate exclusion of disabled persons from services. The defendants asserted that the plaintiffs had failed to demonstrate a "substantial likelihood" that they were denied benefits in order to qualify for court relief under the ADA.

The federal court in the Southern District of Florida held the plaintiffs were denied equal access to psychotherapy services, although the defendants did not deliberately seek to discriminate against them. In support of its position, the court cited *Concerned Parents to Save Dreher Park Ctr. v. City of W. Palm Beach* (1995) for the proposition that additional separate services were appropriate to assure equal access. The court held that direct communication with a signing therapist was required to afford Tugg an equal opportunity to participate in and benefit from the mental health counseling.

The *Tugg v. Towey* court confronted a debate that has at times raged within the Deaf Community. The issue is framed by those who oppose the imposition of the medical model on deafness—those who prefer to regard deafness as being cultural identity, not a medical disability. To others, the issue is a matter of discrimination; that is, deaf persons shall not unjustly face discrimination because they are physically impaired by their deafness. The court skirted the issue and preferred to focus on the plaintiffs' deafness as being a disability (analogous to other disabilities, such as paralysis) rather than a cultural variable. As far as the court was concerned, the plaintiffs' desire to achieve equal access to services under the ADA was co-related to their assertion that Tugg alleged he was denied equal access exclu-

sively because of a medical disability. The claim that the plaintiff was a member of a culturally distinct group invoked neither the ADA's protection nor any constitutional protection, such as the First Amendment. The court was not interested in recognizing the Deaf Community as a specialized minority community, similar to the African American Community, that was politically discriminated against or stigmatized illegally. The court was more comfortable regarding the issue as a medical disability matter in which equal access to services was raised. The position of deafness as culture, not disability, was adopted by the defendants in this case and was rejected by the courts. The defendants asserted that the ADA provision defining physical or mental impairment does not include environmental, cultural, economic, or other disadvantages. Their point was that culture is not a disability according to the ADA regulations. The court sided with the plaintiffs, who emphasized the unique nature of the deaf culture, though the court noted, "To the extent that this obstacle is heightened by a therapist's lack of education, training or experience regarding the specific psychological conditions common to the deaf, the Court finds this issue is rooted in the Plaintiff's condition, not their culture" (p. 1002).

The practical implications of providing services to deaf counselees were not lost on the court. It noted that, although no cost-benefit analysis had been conducted, logically "it would cost less to employ one individual to perform two tasks (signing and counseling) than two individuals to perform those same tasks" (*Tugg v. Towey*, 1994, p. 1004). Furthermore, the court rejected the contention that using specialists would be either a fundamental alteration in the government service or that, because of the scarcity of persons meeting the qualifications, their fees would amount to a higher cost than those resulting from use of a nonsigning therapist and a sign language interpreter.

ASL Interpreters, Communication Aids, and the Medical Doctor-Deaf Patient Relationship

The federal courts have differentiated between the psychotherapeutic relationship and the medical doctor-patient relationship in the implementation of the equal access provisions of the ADA. Specifically, the courts have not adopted the requirement that the physician be fluent in ASL in order to directly communicate with the patient, as was the case for the psychotherapist in *Tugg v. Towey* (1994). Instead, in one decision, the court permitted flexibility in achieving communication and, in another, rejected the need for specialized accommodation and permitted simple written notes to be sufficient between physician and patient.

On March 15, 1995, in the U.S. District Court for the Southern District of New York, a medical practice group and Assistant Attorney General Michael A. Schwartz reached an agreement. The attorney general's office had alleged that the medical practice group had violated the ADA by failing to provide "appropriate auxiliary aids and services to patients with a hearing impairment" (*People v. Mid-Hudson Medical Group*, 1995, p. 1). The state further alleged that patients with a hearing impairment did not have effective communication with the health provider and did not "enjoy equal benefits and services of the Defendant as those provided to other patients who were not hearing impaired" (p. 2). Although they did not admit to

any violation, the Mid-Hudson Medical Group agreed to provide (a) qualified interpreters in ASL, oral, or cued speech; (b) computer-aided transcription services; (c) assistive listening devices; and (d) note takers and so forth as needed. The agreement also stipulated that the Medical Group was obligated to consult with the deaf or hearing-impaired patients before the medical appointment regarding the type or form of aid to be used during the appointments to ensure effective communication. "The Medical Group shall regard the patient's preference 'as a significant factor' in its determination of what constitutes effective communication" (p. 7). The court agreement also authorized a specialized procedure that would be followed by the Medical Group to "document its manner of selecting and ensuring its communication with its deaf patients" (p. 7). The cost and expense (including the initial visit to assess the appropriate means of communication) was to be borne by the Medical Group, not the patient.

In a separate and contrary opinion, the U.S. District Court in Washington, D.C., concluded that the physician-patient relationship met the requirements of the ADA provisions without special accommodation (*Banks v. District of Columbia*, 1994). Chrysta Banks, a hearing-impaired patient, was eligible to receive health care services under Medicaid at the time this case was brought to court. She is of average intelligence and was deafened before she was 3 years old. She read the English language at a second grade, third month level on the basis of a standardized reading test. Her primary mode of communication was ASL.

Banks obtained health care services through the Medicaid program. She alleged that the District of Columbia (D.C.), distributor of the federal funds, refused to provide her with a sign language interpreter during visits to her private physician. This, she maintained, prevented her from participating (i.e., receiving equal access) in D.C. medical assistance programs. The Medicaid plan did not compensate for sign language interpreters. The basic issue was whether or not Banks had sufficient "ability to communicate in a medical environment without the aid of a sign language interpreter." The city objected to assuming the cost of hiring an interpreter.

The case was heard by the U.S. District Court for the District of Columbia on March 24, 1994. The court opinion acknowledged that in "important matters" of medical care, Banks' receipt of information from her doctor was more accurate and effective with the use of a sign language interpreter and that it was her preferred mode of communication with medical providers. Her physician maintained that he had provided her with satisfactory treatment over the course of more than a decade without the use of a sign language interpreter. The court determined that her limited comprehension of her health condition and treatment was caused by her lack of sophistication regarding technical medical terminology, not by the absence of a sign language interpreter. The court noted Banks had access to medical care with the assistance of sign language interpreters at the emergency room of several local hospitals. The court decreed that the D.C. Medicaid program was not required to provide reimbursement for sign language interpreter services because to do so would cause it to spend money presently earmarked for health care benefits "to the blind, the poor, the aged, and other equally deserving beneficiaries" (*Banks v. District of Columbia*, 1994, p. 5). The judge held that Banks needed to demonstrate

that she was unable to communicate to the doctor by other means. Her successful treatment by her physician for more than a decade before the case was seen as evidence that she could communicate adequately by written notes.

These illustrative examples reflect the determination of courts to hold the doctor-patient relationship relating to somatic medicine to a separate, less strict intervention than treating psychologists. In the *Banks v. District of Columbia* (1994) case, the court decision emphasized the previous medical treatment and the implied successful communication between doctor and patient (e.g., passing notes back and forth), rather than concerning itself with assessing the patient's inherent disability: her innate disability to understand and read.

In the *People v. Mid-Hudson Medical Group* (1995) case, the court decision was noteworthy because, although the court rejected the use of passing notes between doctor and patient, it permitted the use of auxiliary aids and services under the ADA and did not obligate medical providers to employ interpreters or use ASL-fluent physicians. Instead, physicians "are the ultimate arbiter of what auxiliary aid or services he or she will provide" (Schwartz, 1995a, p. 6). In contrast, in *Tugg v. Towey* (1994), the court specifically held that "provision of mental health services for the deaf . . . shall include, to the extent available in the community, mental health counselors, deaf or hearing, with sign language ability, who possess by training, education, or experience, an understanding of the mental health needs of the deaf community" (p. 1004).

Implications for Psychologists and Other Mental Health Professionals

"In this post-ADA era, psychologists now have a legal as well as an ethical duty to provide complete access for persons with disabilities to our profession, our places of work, and our communities" (Pollard, 1993, p. 1). Pollard also noted that "it would be most desirable if these changes could come about in a proactive and enthusiastic manner, through ADA education, enhanced disability awareness, and commitments to the civil rights ethic, rather than begrudgingly and protractedly through litigation" (p. 1). Unfortunately, as with the implementation of most civil rights, litigation is apparently going to dictate the implementation of ADA. What does this mean to psychologists?

First, it means that psychologists who are not fluent in ASL and who are employed in HMOs, group practices, or other businesses of 15 or more employees face new critical demands if they are to be in compliance with the provisions of *Tugg v. Towey* (1994). Is it sufficient for the practice group to employ a sign language or oral interpreter for deaf and hard-of-hearing patients needing them, or must the practice group engage a therapist who is competent in sign language to do the counseling? The additional costs associated with hiring interpreters is likely to pose a financial disincentive for psychologists; for example, in Maryland, interpreters' fees begin at \$35 an hour and have a minimum charge of \$70, although this may vary elsewhere. Given present contractual relationships for mental health services offered by HMOs, this interpreter fee may well constitute the entire fee for a therapy session. For others, it will still be a significant expense that cannot be passed on to the client. Likewise, school psychologists who work within school systems and

evaluate deaf and hard-of-hearing students may not be able to rely on sign language interpreters as the preferred mode of communication; rather, they may be required to be fluent in ASL themselves.

If requirements to employ an ASL-fluent provider of services are ignored or opposed, potential legal liability malpractice problems arise. This liability may occur because court opinion, rather than the practice in the community, is defining the standard of care required in treatment activity. Such action by the court increases the likelihood of legal actions (e.g., malpractice suits) that assert the provider has failed to offer care according to the court-defined standard. Specifically, may a therapy practice group, HMO, or PPO whose staff are not fluent in ASL enter into a contract to provide services to a population that contains deaf persons? What is the duty of care owed to a deaf client seeking therapy who does not use ASL or who prefers to rely on an interpreter? Is there a professional obligation to enter into therapy services with deaf clients who represent a financial loss rather than profitability? What is the consequence of not providing an ASL-fluent therapist if, after a good faith effort, the provider group is unable to find a qualified applicant? Finally, how are damages defined under the ADA for a deaf client who believes that he or she has failed to achieve equal access to psychotherapy treatment because the therapist is not fluent in ASL? There are also questions regarding the appropriateness of using standardized psychological test measures that are not translated into sign language. In fact, the Minnesota Multiphasic Personality Inventory now has a sign language version on videotape developed by Barbara Brauer (1993), a psychologist who is deaf.

One outcome of the *Tugg v. Towe* (1994) decision may well be a revisitation of the debate as to whether the ASL format should be used as the standard form of communication. In fact, among deaf people, ASL is but one format of several. The legal opinions reviewed in this article assumed that deaf persons use ASL exclusively, which is not always the case. Are requirements of these decisions met if a practice group employs the use of an ASL-fluent therapist to serve the needs of a deaf client who is not fluent in ASL? What are the alternatives for the practice group?

It is clearly important for both the patient who is deaf and the psychologist to clarify these issues before entering a therapeutic relationship. We recommend that the provider adhere to the legal requirements of informed consent before undertaking a therapeutic intervention with a deaf client. However, these matters may not be easily resolved if the client and provider are speaking two different languages to each other. Yet how issues of informed consent are resolved has major legal implications in terms of meeting the standard of care.

Implications for Deaf People

There is a shortage of psychologists and other mental health professionals who are fluent in ASL. For example, the American Psychological Association (APA) lists only 150 members of their Special Interest Section on Deafness, a subgroup of APA's Division 22 (Rehabilitation Psychology). Many of these individuals do not provide clinical services but, rather, work in administration, research, college teaching, and so forth (APA,

1994). Only 51 persons are listed by the American Psychiatric Association as being members of the Caucus of Psychiatrists Working with Deaf and Hard of Hearing Persons (American Psychiatric Association, 1994). A number of these individuals are not psychiatrists. There are no available statistics concerning psychologist or psychiatrist practitioners who are fluent in ASL. Likewise, organizations that are sensitive to deaf clients exist (e.g., American Deafness and Rehabilitation Association), but there are no available statistics documenting the number of ASL-fluent therapists. For example, a recent review of mental health services for deaf people concluded the following: Most programs are nonaccredited; many have no psychologist, psychiatrist, or licensed social worker; some offer services only to parents; and most depend on interpreters (see Willigan & King, 1992).

Although these membership lists do not specify numbers of providers who work with deaf clients, they are sufficiently inclusive to give a stark picture of the gross lack of mental health professionals able to provide counseling and psychotherapy services to deaf people in ASL. In terms of the *Tugg v. Towe* decision, this would mean only a bare minimum of deaf people could get treatment for mental illness. With the new clinical psychology program and the recently accredited master's degree program in social work at Gallaudet University, the situation will be somewhat alleviated but not to a significant degree (Vernon, 1995).

No one doubts that the ideal situation is one in which the therapist or counselor serving the deaf patient is fluent in ASL if that is how the patient communicates. However, it will be years before there are enough qualified mental health professionals capable of doing psychodiagnostics and therapy in ASL. On the basis of the small number of ASL-fluent psychologists and psychiatrists (who belong to special deaf interest groups) when compared to the total number of professionals in each respective association, we estimate that fewer than 3% of all providers serve deaf people in counseling or psychotherapy.

In the educational system, the situation is even more impossible. Previously, frequent psychological evaluations of all deaf and hard-of-hearing students in special education or the mainstream were required. Yet only a minimal number of school psychologists know even rudimentary sign language. Thus, these requirements could never be met.

In the *People v. Mid-Hudson Medical Group* (1995) case, a consent decree was negotiated that stated that a sign language or oral interpreter should be provided for a deaf or hard-of-hearing person who needs one if the physician concludes that effective communication between doctor and patient requires it (Schwartz, 1995b). In addition to the financial disincentive to the provider, the *Mid-Hudson* opinion places the physician in a situation in which he or she must choose whether or not to provide interpreting services and must face the liability consequences. It is likely that a decision-making environment will be fostered in which physicians "take their chances" rather than offer more translation services to deaf people. The opinion will perhaps fail to increase equal access to physicians by deaf persons. Furthermore, the *Mid-Hudson* opinion is not the result of a court litigation but, rather, is a consent decree; therefore, it does not set a legal precedent. Its application to similar practice groups is questionable.

The *Tugg v. Towey* (1994) intervention effort, which presumptively requires an ASL-fluent therapist, may foster an atmosphere in which psychotherapists avoid treatment efforts with deaf clients because of the requirement that the therapist be fluent in ASL. This opinion will not only fail to foster increased equal access to therapists, it may well reduce access by deaf persons to therapy, having the opposite of its intended effect. In achieving the idealistic sentiment of recognizing the sanctity and integrity of the therapeutic environment's private domain status, the opinion could, in practice, pose a further obstacle to deaf client access. It may not be improper to compare the idealism created by the *Tugg* decision as analogous to the famous *Brown v. Board of Education* decision.

Conclusion

It is our view that these legal decisions represent a potentially troubling round of legal case law that defines a new standard of care for mental health professionals who serve persons with disabilities. Specifically, in the case of a deaf client, recent ADA court activity appears to have the consequence of requiring psychologists to become fluent in ASL before offering psychotherapy and psychodiagnostic services to deaf clients. Given the unique and special nature of the therapeutic environment as well as the privacy considerations it fosters, court opinions that permit more flexibility in modes of communication between somatic doctor and patient are not applicable to psychotherapy situations in which most psychologists practice. Thus, inpatient psychiatric facilities and HMOs or PPOs may be required to provide treatment services to deaf patients by exclusively employing those mental health professionals who are fluent in ASL.

As Pollard (1993) indicated, it would be far better for the APA to take a proactive, well-developed position on the responsibilities of psychologists who work with patients with disabilities than to wait for the courts to make the decisions associated with appropriate standard of care under the ADA's provisions. The APA should establish a subspecialty in service training and provide in-service training so that psychologists can recognize the special culture of deafness and its psychological implications. We wholeheartedly support the APA's commitment to establishing a process to recognize specialities and proficiencies in the APA.

Finally, it is evident that much research is recommended. It is our view that a research effort that undertakes a cost-benefit analysis of employing ASL-fluent therapists versus interpreter-supported psychotherapy should be undertaken. Deaf consumers of psychotherapy treatment should be consulted and their needs identified through approach research analysis, rather than through well-intentioned ideological viewpoints adopted by courts as law. In the meantime, efforts to teach ASL to psychologists should be presumed, without benefit of research study, to benefit deaf persons seeking psychological services and should be supported by the APA. We anticipate that over the next decade a stream of court cases will further identify the

practice care standards psychologists need be aware of in their interventions with deaf persons. The APA can track these developments and apprise its membership of current opinions and the effect these opinions have on psychologists in private practice, schools, hospitals, and for-profit groups.

References

- American Psychiatric Association. (1994). *Caucus of psychiatrists working with deaf and hard of hearing persons membership list*. Washington, DC: Author.
- American Psychological Association. (1994). *Special interest section on deafness membership list*. Washington, DC: Author.
- Americans With Disabilities Act of 1990, 42 U.S.C.A. § 12101 et seq. (West 1993).
- Banks v. District of Columbia, Civil Action No. 92-0515, 1994. (Available from the National Center for Law and Deafness, 800 Florida Avenue, Washington, DC 20002)
- Brauer, B. A. (1993). Adequacy of a translation of the MMPI into American Sign Language for use with deaf individuals: Linguistic equivalency issues. *Rehabilitation Psychology, 38*(4), 247-259.
- Byl, F. (1975). Thirty-two cases of sudden profound hearing loss occurring in 1973: Incidence and prognostic findings. *Transactions of the American Academy of Ophthalmology and Otolaryngology, 80*, 298-305.
- Concerned Parents to Save Dreher Park Center v. City of West Palm Beach, 846 F. Supp. 986 (S.D. Fla. 1995).
- Higgins, P. C. (1983). *Outsiders in a hearing world*. Beverly Hills, CA: Sage.
- Lane, H. (1992). *The mask of benevolence: Disabling the deaf community*. New York: Vintage Books.
- Padden, C., & Humphries, T. (1988). *Deaf in America: Voices from a culture*. Cambridge, MA: Harvard University Press.
- People of the State of New York v. The Mid-Hudson Medical Group, Consent Judgment 94 Civ 4688 (HB), U.S. District Court, Southern District of New York, March 13, 1995.
- Pollard, R. (1993). Preface. *Consulting Psychology Journal, 45*(2), 1.
- Raifman, L. J., & Vernon, M. (in press). Impact of the ADA upon mental hospitals: New rights for patients with hearing loss: New responsibilities for hospital administrators. *Psychiatric Quarterly*.
- Schein, J. D., & Delk, M. T., Jr. (1974). *The deaf population in the United States*. Silver Spring, MD: National Association of the Deaf.
- Schwartz, M. A. (1995a). Good news on the doctor-interpreter-patient front. *Silent News, 27*(5), 6.
- Schwartz, M. A. (1995b). Providing interpreter is not enough, federal judge says. *Silent News, 27*(7), 6.
- Sullivan, P. M., & Vernon, M. (1979). Psychological assessment of hearing impaired children. *School Psychology Digest, 8*, 271-290.
- Tugg v. Towey*, No 94-1063, 5 Nat'l Disability Law Rep. 999-1005 (July 19, 1994).
- Vernon, M. (1995, spring). Psychology and deafness: Past and prologue. *Gallaudet Today, 25*(3), 12-17i.
- Vernon, M., & Andrews, J. E., Jr. (1990). *Psychology of deafness: Understanding deaf and hard of hearing people*. New York: Longman.
- Willigan, B., & King, S. J. (1992). *Mental health services for deaf people*. Washington, DC: Gallaudet University Press.

Received October 11, 1995

Revision received February 1, 1996

Accepted March 5, 1996 ■