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Lessons Learned from 23 Years of a Deaf Psychiatric Inpatient Unit: Part 2

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Abstract
The author was the director or co-director of a specialty Deaf psychiatric inpatient unit for 17 of its 23 years. In Part 1 of this article, the author reflected on the lessons learned about deaf psychiatric patients from this experience. These lessons include recognition of the wide continuum of communication skills and deficits of the deaf persons served and the significant numbers of deaf patients who have poor communication skills in any language. The author also supported the hypothesis that many deaf psychiatric patients have a particular disorder involving language dysfluency, related mainly to language deprivation and an array of psychosocial skill deficits present from childhood and continuing into adulthood. This disorder may be mistaken for more familiar forms of mental disorders or it may accompany them. In Part 2 of this article, the author reflects on lessons learned about adapting mental health treatment and about staff and program development.

Keywords: deaf, psychiatric inpatient treatment, culturally affirmative

What Did We Learn About Adapting Mental Health Treatment For This Population?

The language, learning and behavioral problems of so many of our patients forced us to adapt our treatment approaches. The majority of our patients were not people who made good use of verbal, insight-oriented psychotherapies even if they were carried out in fluent American Sign Language (ASL). Their sign language impairments, very limited fund of information about the world, developmental deficits, lack of experience with the idea of using language to solve problems, along with their cultural differences, meant we had a huge chasm of understanding to overcome before we could treat them effectively. Facing this chasm eventually led to embracing a concept we called "pre-treatment."

By "treatment" we refer to a process that occurs when clients and counselor(s) share an understanding of a problem, a set of relevant goals, and the procedure for achieving those goals, and the client says, "Yes, I want that." Mental health treatment is collaborative. It is done with clients, and it assumes some informed understanding and commitment from clients. Many of the problems counselors working with such clients face when treatment does not work are due to the fact that the client does not understand, value, or know
how to use mental health treatment. When clinicians try to influence persons who do not understand and have not agreed to mental health treatment, they are not doing mental health treatment. They are instead doing social control. The subjects of their social control efforts can be said to be pre-treatment.

Pre-treatment work refers to the process of trying to educate and motivate clients for mental health and rehabilitation interventions. It is the process of trying to bridge the gap between the thoughts worlds of the client and the provider(s), and fashion a form of treatment that is meaningful and useful. Because our clients may lack a schema or map for the treatment process, a central pre-treatment task is to give them one. That is, we need to find a way to conceptualize treatment so that it makes sense to them and elicits their engagement. For most patients, the most useful map we could give them was found in a focus upon skills. We explained that treatment, in a nutshell, boiled down to the process of developing skills. We stopped inviting clients to join “therapy.” Instead, we invited them to “practice skills.”

We talked to patients about skills; those they already had and those they needed to acquire; and this became the treatment language of the milieu. We found it is much easier to build a treatment program around the notion of skills than it was, for instance, around the idea of insight, and it was certainly preferable to any notion of treatment as helping with mental illnesses. “Practicing skill” is a more user-friendly concept. There is no stigma associated with it, and it is also easier to explain. Our most common discussions focused on skills for managing internal experiences like emotions. We called these coping skills. We also discussed with clients skills for dealing with other people. This included; social, conflict resolution, problem solving, communication, assertiveness and other skills. With some patients, we focused on basic activities of daily living (ADL) skills such as taking a bath, making a bed and doing laundry.

This emphasis on skills brought us right into the world of psychiatric rehabilitation and cognitive behavioral therapy (especially the form developed by Donald Meichenbaum (Meichenbaum, 1977a, 1977b, 1985, 1994, 1996, 2001, 2007; Meichenbaum & Biemiller, 1998; Meichenbaum & Goodman, 1971; Meichenbaum & Turk, 1987) We also drew heavily upon Marsha Linehan’s Dialectical Behavior Therapy (Linehan, 1993a, 1993b) and Ross Greene’s Collaborative Problem Solving (Greene, 1998; Greene & Ablon, 2006). These approaches recognize skill deficits as the principal reason for client problems, and they present different ways of helping clients develop
psychosocial skills. Working within this skill-building model, we could be confident we were doing best practice as currently understood. However, these models would need to be adapted considerably to fit the language and conceptual world of our clients (Glickman, 2009).

The principal way we adapted these skill-building treatments was by approaching them developmentally. Dialectical behavior therapy (DBT), for instance, with its highly didactic treatment approach, formal curriculum, heavy reliance upon abstract concepts and written materials, was developmentally inappropriate for most of our clients, yet we could borrow many ideas from it. For instance, the DBT notion of “distress tolerance” could be simplified to the idea of “coping.” The DBT emphasis on “mindfulness” could be incorporated into a skill we called “red, yellow, green” (from the traffic light), with the red light signifying “stop and notice.” Rather than expecting clients to sit through lectures on skills, we would use treatment approaches more developmentally appropriate such as role-playing and therapy games.

We also conceptualized each skill using a picture. Our communication specialist Michael Krajnak drew hundreds of these pictures and produced two CD-ROMS on which they are available (Glickman, 2009; Glickman & Gulati, 2003). These pictures were posted everywhere in the milieu. They were in the day hall and referred to each morning during community meetings when each client was asked to look at the pictures and select a skill for the day. They were reproduced into sets of laminated “skill cards,” which were incorporated into therapy games (e.g., “Pick a card and act it out.” Then others guess the skill, and the winner gets a prize.) Patients drew their own skill cards in art therapy. They built traffic lights (“red, yellow, green” skills) to bring home. Many patients asked for sets of the skill cards to take home with them on discharge and brought these to their group and family homes. These pictures became so popular that the hearing adolescent and adult units in the hospital started using them. Other staff told us that many hearing patients had severe language and learning challenges, (Gaines, Meltzer, & Glickman, 2009) and these simple, clear pictures provided them a clear, practical, and appealing map for the treatment process. Since the publications of the CD-ROMs, Michael’s skill cards have been reproduced in treatment programs around the world.

One other developmental adaptation was noteworthy. This was the heavy reliance upon sensory movement interventions to develop coping skills. Sensory movement interventions were pioneered by occupational
therapists originally for use with children with developmental disorders like autism, but more recently have been brought into the mental health field (Ayres, 1979; Champagne, 2006; Champagne & Stromberg, 2004; Moore, 2005). Sensory interventions that we used on the Deaf Unit included heavy blankets, vests, and wrist bracelets, and toy animals stuffed with rice so they became very heavy. We also used a variety of mechanical massagers (which patients would self administer) and rocking chairs. Patients at all ability levels would draw upon these tools as their “coping skills,” but for patients with severe language impairments, sensory-based interventions were sometimes the only coping skills accessible. We had many patients identify “rocking in a chair” or “using the heavy blanket” as their favorite coping skill. Not only did these interventions often work, but they became the occasion for success stories being built about how patients were able to calm themselves down. Nursing staff came to embrace these tools because they were practical, minimally dependent upon language, and effective (Trikakis, Curci, & Strom, 2003). Sensory strategies are included in sophisticated treatment approaches like DBT but they are not emphasized there. With our concern with developmental adaptations and language impairments, sensory strategies took center stage.

When patients were able to calm themselves down, for instance, by recognizing they were agitated (the red light skill), going to their room or our “comfort room” to wrap themselves in a heavy blanket and lie on a soft mattress (the yellow light skill), or tell themselves to calm down (the green light skill), then staff would converse with them about their successful use of such skills. (i.e., “Look what you just did! You were angry and upset. You used the red light skill. You stopped and noticed and then you went to the comfort room. Then you used the heavy blanket skill and the lying on the mattress skill. Wow. What success!”) After our staff was trained to see such developmentally simple activities as skills, they were able to see skills everywhere. They could see skills when patients went for a walk, played with...
a dog, used a videogame, or tossed around a basketball. When they could see these skills everywhere, they could talk about what they saw. This created a strength-based program. This framework opened up for us treatment possibilities with clients that were otherwise very difficult to reach.

Over time, the main discourse with clients in our milieu became, “Look what skill you used.” This kind of shared discourse served many functions. It served the pre-treatment function of bringing patients into dialogue regarding a practical treatment strategy. With so much of a focus upon what patients did well, it became easier to introduce discussions of what they could do better; what new skills they could learn. These discussions of skills set the foundation for many skill-building techniques that are available in the world of cognitive behavioral therapy (Glickman, 2009). They also serve a function consistent with cognitive therapy of changing a client’s self-talk and beliefs about his or her own abilities. In other words, they change clients’ “stories” about themselves. For instance, we had one patient, a deaf male with schizophrenia, who would say to his treatment providers: “When I’m upset, I go to my room and rock on my bed. Don’t worry. That’s my coping skill.” This patient had a skill and a story about his successful use of skills. Both the skill and the story were important parts of his recovery.

While patients are still pre-treatment, particular strategies for developing skills are most effective. The easiest way to begin is to simply notice and label the skills that patients already use. We paid attention to any time a patient did not show a particular problem and attributed their success in that instance to particular skills. We engaged patients in discussions on how well they did. What enabled them to use this particular skill in this stressful situation? When patients are referred for behavioral problems, and they have not acknowledged their behaviors as problems, or haven’t accepted responsibility for changing their behaviors, we focused on times they did something to stay in control. How did they do that? What does this say about their skills?

David was an adolescent patient referred from a residential school after a particularly bad episode in which he pushed a teacher down a flight of stairs. On admission, he blamed everyone but himself. It was the teacher’s fault because she was mean to him. It was the other students’ fault because they provoked him. It was the doctor in the emergency room’s fault for sending him to the hospital. If people were nicer to him, he would have behaved fine. They should be in the hospital, not him.
David was pre-treatment. He would not go into anything called “therapy” to work on changing his behaviors. However, in the hospital, David had to deal with a number of new stressors. He was on a locked unit. His freedom was more curtailed than it was at school. He had to eat food he did not like according to a schedule he did not like. He could not use the videophone whenever he wanted. He was expected to attend certain activities and keep his behavior under control.

As expected, David had difficulty with these new stressors, but not all the time. Even patients with the most severe behavioral problems do not show these problems all the time. Sometimes they accept a rule, limit or structure. They also do things that help them cope with these stressors. In David’s case, as with many other adolescents we have served, he coped with these new stressors by using videogames.

Earlier in our history, we would have called his preoccupation with videogames a problem that limited his access. This usually provoked escalation in the behavior problems. We came to learn that there was much more therapeutic payoff by seeing his use of videogames as a skill, and talking to him about how he used this skill to manage the stressors of this environment. Did he notice, for instance, how he was feeling? (angry, frustrated, sad, etc,) and then how he felt when he was using the videogames? Did he notice that this helped him to keep from blowing up? Could he show us what he could do on the videogame? Could he teach us?

Our goal, of course, was not to reinforce videogame playing, but rather to get him engaged in a conversation about coping skills. We learned that this was done best by recognizing the realities of the skills he already had. Hopefully, this got our foot in the therapeutic door. Our next steps would be to engage him in a problem solving conversation related to use of skills. We would ask questions such as:

“What other skills do you have? What else do you do that helps you cope when you are stressed? Do you use these skills all the time? What happens when you don’t use these skills? Is that what you want? Did you use your videogame skills when the teacher at school told you that you couldn’t join the trip? If you had used that skill, instead of pushing the teacher down the stairway, what would have happened? Would you be stuck in this hospital then? If you used your videogame skills and stayed in control, didn’t hurt anybody, would your life be better now? What if you learned other skills?
What if you had a lot of skills for staying in control when you are stressed? Would your life be better then? Would you be able to do more of what you want, like go on trips to the mall?”

Naturally, the questions we could ask depended on the language skills of the client. It was much easier to do this work with clients who had better language skills. When their language skills were poor, we would need to draw upon communication experts. Often, we could not ask hypothetical questions (i.e., “What would happen if...”) Sometimes clients could not understand or use conditional phrasing (i.e., “If this, then that.”) This made the work harder, and makes collaboration with communication experts essential.

Implicit in this style of work is a second means of developing skills in pre-treatment individuals. That is doing what psychologist Ross Greene calls “collaborative problem solving” (Greene & Ablon, 2006). If we can present a client with a problem and help them think it through, we will be developing their problem solving skills and affirming their abilities. In David’s case, as with so many others, we were aiming to help him to think through the consequences of his behavior. If he continued to behave aggressively, what would happen? If he used these and other skills, what would happen? Which outcome was better?

In our strength-based treatment mode, we interpreted many outcomes as successes. When David was merely able to have the conversation without blowing up, that showed use of skills (e.g., listening, turn-taking, respectful communication, and managing feelings), and was evidence of what he was capable of. Of course, this conversation is the treatment. It is the therapy. The fact that it occurred outside a designated therapy hour, sitting in the day hall alongside the videogame, was irrelevant. We were working in that conversation on the development of an array of psychosocial skills. This would be reflected on our treatment plan and documentation to insurance providers. As we engaged David, we could move these sessions into formal, designated, treatment venues like a counselor’s office.

Through this process of engaging David and other clients, we learned something else. We learned to work from a “one down” stance. In essence, we recognized his abilities, asked him questions, which put him in the position of being the authority, and then invited him to work with us to learn more skills. This was different than our previous “one up” stance in which staff told clients what was right and wrong, setting and enforcing
rules, imposing limits and consequences. The one down stance, though not appropriate for every occasion, was more effective at soliciting engagement.

Learning to work one-down was also a key element of culture change on the unit, resulting in a far less triggering environment for patients, and a dramatic sustained reduction in our decisions to restrain patients. Early in the unit's history, we restrained patients an average of about forty times a year. Some deaf persons have complained of being traumatized by the use of restraint in our program. We had a signing environment, but they still had a bad experience because they were restrained. In our last year and a half, we had one restraint. We had stepped out of the older psychiatric culture in which restraints were a default response to dangerous behaviors (National Association of State Mental Health Program Directors Medical Directors Council, 2002). Staff learning to work one down was a key element of this culture change.

The key lesson here is that we could treat many patients who would normally be considered “poor candidates for therapy” but whom we saw as “pre-treatment.” We found a number of best practices from cognitive behavioral therapy, especially those concerned with developing psychosocial skills, which were applicable. We created a strength-based model by beginning conversations with patients on our recognition of skills they already showed, even such basic skills as rocking in a chair or drawing pictures. The Deaf Unit moved from a program that was reasonably culturally affirmative (which it strove to be from the beginning) to one that was also clinically effective, when it learned these lessons.

What Did We Learn About Staff and Program Development?

We started our program with a commitment to cultural affirmation of Deaf people, but it took about fifteen years before our clinical approach solidified. Eventually, I came to appreciate that cultural competence is necessary, but not a sufficient condition for Deaf treatment programs. In the first book that emerged from the Unit’s work, we were able to operationalize what we meant by “culturally affirmative” treatment for Deaf people (Glickman, 2003). These definitions are:

a. Culturally affirmative programs serve only deaf people, usually from a large geographic area.
b. Culturally affirmative programs strive to hire large numbers of
competent Deaf staff at all levels of the organization.

c. Culturally affirmative programs need genuine communication excellence. They strive to create signing environments and have some staffs who are communication experts.

d. Culturally affirmative programs create an affirmative physical environment for deaf persons with vision and mobility limitations.

e. In culturally affirmative programs, Deaf people manage the communication dynamics. Deaf people must judge whether or not effective communication is occurring.

f. A culturally affirmative program works mindfully with Deaf/hearing cross-cultural transference, counter transference, as well as cultural biases.

g. A culturally affirmative program adapts treatment methods to fit the skills and needs of clients.

When the Deaf Unit was created in 1987, we began with a political commitment to culturally affirmative services, but the lesson we learned subsequently was that we could not be clinically effective unless we provided a treatment environment grounded in the Deaf experience. Without a culturally affirmative approach, we would not have the communication resources that are needed. We would not have the talented Deaf staff and their unique abilities to join and communicate with very impaired deaf people, and model more healthy psychosocial skills. We would also have been far more vulnerable to the over-pathologizing of deaf people that occurs when clinicians work exclusively within the medical pathological framework.

Fortunately, the administration of Westborough State Hospital promoted a culture of psychiatric rehabilitation. A psychiatric rehabilitation model, focused on skill development, sets the stage for the creation of a program in which there can be skill-based strategies for most problems. By contrast, the medical model locates all client problems in some presumed illness or disorder that patients have; and assumes that staff are experts with the ability to fix them. This easily replicate patterns of domination and oppression between Deaf and hearing people. Because for most people trained in the medical disciplines, deafness is “storied” within a medical framework, it can be dangerous when Deaf treatment programs are administered by people working only from a medical model. It is dangerous because the disempowerment of deaf people emerges out of the medical model of deafness. It is dangerous because most of the work of deaf treatment programs is rehabilitative or habilitative, involving teaching psychosocial skills, rather than fixing a
medical problem even when clients do have major mental illnesses. This is dangerous because the medical model reinforces a hierarchical culture, with everyone reporting through their discipline heads and a physician in charge. It will be rare for deaf people to have leadership roles in this hierarchy. This hierarchical structure is less likely to be attuned to the skills and strengths of deaf people.

While we were fortunate on the Deaf Unit to work with many physicians and nurses who could see beyond their medical training to embrace Deaf culture, we also struggled with others who could not do so. Programs that serve deaf people have been far more likely to have deaf staff in lower paid, paraprofessional roles (though this is changing as deaf people gain access to the professions). When culturally insensitive, domineering doctors and nurses run such programs, Deaf people will not want to work there. Communication will be poor, and management of the communication dynamics is probably the core skill Deaf programs need to master. This power imbalance is still, I believe, the rule, not the exception in mental health programs that serve deaf people. This means that many Deaf treatment programs are still places of profound disrespect for deaf people. The hearing people who work there do not usually perceive the injustices. They may well imagine themselves to be providing culturally affirmative treatment services simply because an interpreter or Deaf staff member is present. The Deaf staff in their midst, if there are any members at all, often consider these claims to be nonsense. They commonly feel very disempowered and disrespected. I have heard this many times from Deaf staff in various programs, including the program I ran. Generally speaking, the Deaf staff in our program would say that we were not as culturally affirmative as we liked to believe we were.

There is another lesson that is not evident until a reasonably culturally affirmative treatment program is attained. That lesson is that cultural affirmation is not a sufficient condition for good clinical care. Until you have it, you may always imagine that if we just got the communication right, everything would be fine. Once you have a reasonably culturally affirmative milieu, it becomes possible to see that Deaf role models and good communication do not solve all patients' problems. If that were the case, deaf children raised in Deaf settings like residential schools would never have emotional or behavioral problems.

It should also be noted that Deaf treatment programs serve some extraordinarily challenging clients, some of whom are very violent, and that
very commonly the police and courts refuse to set limits on these clients. No hearing program serving challenging hearing clients is successful one hundred percent of the time. However, because there are so few Deaf programs, they are expected to serve well, every deaf person who is referred. They are expected to do this even in the face of severe language and behavioral challenges, with non-collaboration from clients, and in the absence of community resources readily available to hearing persons.

Deaf people, like hearing people, need to be trained in mental health care. Individual Deaf clinicians may or may not be competent, and sometimes the Deaf candidate is not the best choice for a job. As the Deaf Unit matured, we found that we struggled to get both the cultural and the clinical dynamics right, and that sometimes (such as with many personnel decisions,) we might meet one goal at the expense of the other. This was one reason we never escaped cross-cultural conflicts.

Depending so heavily upon paraprofessional staff to manage a treatment milieu also presented challenges. When people are raised in family and school environments where authoritarian rule setting is the norm (an unfortunate reality for many deaf people), they will tend to copy what they know, and they will need supervision and training to work with clients in the collaborative decision making style so essential to psychiatric rehabilitation. Both deaf and hearing people can be authoritarian. Both can show poor work attitudes and skills, as well as a lack of work ethic and commitment to patient care. However, when offered proper supervision and training, many staff members learned to behave differently. I remember talking to one Deaf male staff member who behaved in a very bossy manner with patients. I asked him how he was raised, and he told me about his bossy, abusive father. I asked him if he liked how he was raised and if he wanted to raise his own children in the same way. He answered without hesitation, “No! No! I don’t want to be like my father.” It was not hard to help him see the parallels to how we relate with our patients. However, not all staff, deaf or hearing, can make good use of supervision to overcome an authoritarian style of relating that they learned as children.

Over time, we found that the concept of skills gave us a framework equally effective for both patient treatment and staff development. This was one shared concept that every discipline could use and that was equally applicable to staff as well as patients. With patients, even when we are treating significant mental illnesses such as Schizophrenia, the treatment could be
conceptualized as developing a variety of skills (understanding and managing symptoms, coping with unpleasant emotions and dealing with other people.) Staff conflicts with patients, with each other, and with administration require coping and conflict resolution skills. This skill language is relatively easy to understand, can be conceptualized in pictures, and is compatible with the world views of most of our deaf patients and staff. Skills can also be taught through stories, and when patients are helped to use skills, this in itself becomes a story of their developing abilities. Therefore, I would argue that the adoption of a skill-based treatment approach is an example of culturally affirmative treatment for Deaf people. It is through helping patients develop skills, that we create with patients a culturally affirmative story. The theme of this story is “I can do this. We can do this.”

The most advanced social skill that I asked Deaf unit staff to practice was cross-cultural conflict resolution. In multicultural settings, such as programs employing Deaf and hearing people (and many other culturally different people,) cross-cultural misunderstandings and conflicts are common. The conflicts take many forms. When hearing people think about personnel matters, for instance, they usually value clinical competence most. They value clinical training and credentials. When Deaf people think about personnel matters, they usually prioritize good communication in sign. This is because they understand in a far more profound way the crippling experience of having poor communication throughout one’s life. They also know, much more clearly than hearing people do, what effective communication in sign actually looks like.

These respective biases were behind many of the cross-cultural conflicts between Deaf and hearing people that occurred in our setting. They commonly played out in staffing decisions. Who should be hired and promoted? How do we weigh the relative importance of communication and clinical skills? How important is it that large numbers of deaf people are employed by this organization? Who is qualified to work here? Who decides this? The social context for these biases is usually one in which hearing people hold more institutional power so that when Deaf people advocate for their point of view, especially if they do so unskillfully, it can look to hearing people like insubordination or incompetence. I believe this dynamic sometimes occurred at Westborough State Hospital.

Consider how these respective biases played out in some Deaf/hearing cross-cultural conflicts that I know of:
1. A hearing nurse, new to deafness, approaches a deaf mentally retarded patient and speaks to him as she would a hearing person. She does not sign. She also approaches a deaf-blind client and, to the astonishment of deaf staff, speaks to him as if he could see and hear. One of the deaf staff interrupts her and tells her, in sign, gesture, and with unclear speech that she cannot do that. He is visibly annoyed and impatient with her. He gets an interpreter and tells her very bluntly that she is not communicating respectfully with deaf people. She takes this as a scolding from someone who she considers professionally “inferior,” and she complains about his rudeness. She writes him up for disciplinary action. This triggers a rage response from the deaf person who sees multiple forms of oppression occurring. He also complains that this nurse is culturally insensitive and unsuitable for work with deaf people. When the nurse hears about the complaint against her, this triggers her own rage response. She is also in the middle of a difficult divorce and custody battle with a “bossy” husband and the behavior of the deaf male staff person triggers her feelings of anger with her husband.

2. In a Deaf treatment program, a board meeting that was run by a hearing administrator and psychiatrist was held. Several Deaf staff members were present, including the staff person who recently created a Deaf awareness program for the agency. The subject of the Deaf awareness program came up, and Board members asked the program staff to describe it. The hearing psychiatrist immediately jumped in to do so. Because of the five-second time lag for those watching the interpreter, the psychiatrist had the opportunity to comment before the Deaf staff person who actually created this program had the chance. The Deaf staff member raised his hand to speak after the psychiatrist had started talking, and a Board member asked that the Deaf staff be able to address this issue. The psychiatrist then stopped talking and the Deaf staff person described the program. Later, it became clear, however, that the hearing psychiatrist felt that the Deaf staff person had rudely interrupted him. The Deaf staff person was counseled for his “unprofessional” behavior. However, the issue of who interrupted whom is open to interpretation. Because the hearing psychiatrist did not consider the interpreter time lag, it could just as easily be argued that he interrupted the Deaf staff person. Secondly, it was the Deaf staff person who was more qualified to talk on that topic so arguably it was the psychiatrist whose behavior was, if not unprofessional, at least non-collegial. However, because the Deaf staff person had less power, it was he who was disciplined.

3. In a residential treatment setting, one of the Deaf staff members
who is loudest in his criticism of the “oppression” coming from the administration is widely known to have a poor work attitude, abusing sick time, spending much work time on the internet or his mobile pager, and being negligent and disrespectful of patients. A promotional opportunity comes up, but he is not considered for the position. To add fuel to the fire, a hearing staff person, who has much poorer signing skills, but is seen by administration to be more dedicated to good patient care, receives the promotion. For the Deaf employee, this is further proof of hearing biases of this “audist” organization. For the hearing administrators, the attitude of the Deaf employee is infuriating. They believe they are also dedicated to cultural affirmation for Deaf people, but not if it means promoting Deaf staff who are not doing good work. The bottom line for them is who is providing the best care and treatment of patients. They do not see this as a Deaf or hearing matter, but rather a matter of individual competence and dedication which either a Deaf or hearing person may show. Many of the Deaf staff, and their hearing allies, grumble amongst themselves that this hearing person, with marginal signing skills, was promoted over a Deaf person with native signing abilities. Some could see that the Deaf staff person had poor work attitudes and behaviors but they still perceive that, when push comes to shove, the communication abilities that Deaf staff usually have, are not valued by hearing administrators on par with other qualities that applicants for hire and promotion possess. They suspect that the hearing administrators think all signing is “good enough” and do not appreciate what truly excellent signing communication contributes to patient care.

The important lesson we learned about administering Deaf mental health programs is that these cross-cultural conflicts are built in. They are bound to happen; indeed, how skillfully they are handled can make or break a program.

**Conclusion**

The challenge of Deaf mental health care is to achieve both cultural affirmation of Deaf people and clinical competence. When creating such programs, we need to move dialectically between these two themes and we need to find the synthesis; the creation of culturally and clinically competent programs, which are unique constructions in their own right. That is to say, successful mental health and rehabilitation programs for deaf people not only provide appropriate communication environments, and not only...
affirm Deaf people individually and culturally, but also adapt best treatment practices so that they match the skills, strengths and sensibilities of Deaf people. Indeed, in the process of doing all of this, they may even create something entirely new, something that might be called “Deaf mental health care.”

When Westborough State Hospital closed in the spring of 2010, the unit moved with most of its staff to another state psychiatric hospital. By this time, the Deaf Unit was well-rooted in the culture of Westborough State Hospital, and its future prospects starting again in a new hospital culture were uncertain. Would the new facility provide the same nurturing soil for the development of a culturally and clinically competent program? To make the challenge even more difficult, the number of referrals to the Deaf Unit had been in decline for several years. Some of this could be attributed to Massachusetts succeeding in creating more community-based services. At the time Westborough closed, there were more than a dozen Deaf group homes in Massachusetts serving many of the long term mentally ill and mentally/behaviorally challenged deaf people that previously had been on the Deaf Unit. This certainly represented progress. Ultimately, of course, our goal was not to have a successful inpatient facility, but rather to have successful community programs that enable people to live and thrive outside institutional settings. However, in the case of Massachusetts, I think such community programs would not have been developed were there not first a Deaf inpatient program, which brought deaf people in need of services “out of the closet.” I also think the community programs would not have the same level of commitment to cultural affirmation were it not first modeled by the inpatient program.

Twenty-three years after the Deaf Unit was created, there is a far greater degree of understanding and commitment in Massachusetts to culturally affirmative mental health care of Deaf people. There are also a greater number of culturally and clinically competent providers, both Deaf and hearing. In 2010, Massachusetts, like most of the United States, is struggling to emerge from recession. Can we apply the lessons we have learned in the face of new budget constraints? Will we be able to hold on to the culturally affirmative treatment resources we have and still be able to create new ones? When money is not available, people argue that such specialized programs are not needed. They argue, “We can’t afford Cadillac programs on the public’s dime.” Our 23-year experiment in Deaf inpatient care taught us what it takes to do this work. The usual compromises, such as placing an isolated
deaf person in a hearing program with a few hours of interpreting time, do not buy the public a Ford. They buy the public an Edsel, an obsolete model which doesn’t run. They buy the public, and subject the deaf consumer, to treatment that is neither culturally nor clinically competent. Over twenty-three years, we learned how to effectively conduct psychiatric inpatient treatment for deaf people, and the lessons we learned are applicable to community based rehabilitation efforts. The knowledge and skill base to create such programs is available. Financial resources and political will are less certain.

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References


