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Lessons Learned from 23 Years of a Deaf Psychiatric Inpatient Unit: Part 1

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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. This program was established as a culturally affirmative mental health program. The author reflects back on what this has meant and how the unit staff struggled to create a program that was both culturally and clinically competent. In Part 1 of this two part article, the lessons learned about some unique clinical challenges are discussed. These involved the challenges of working with ASL competent deaf persons and with deaf persons with severe language dysfluency in their best language, sign. The question of whether some of the deaf clients have a unique clinical syndrome involving severe language deprivation and an array of psychosocial deficits and behavioral problems is also discussed.

Part II of the article discusses lessons learned about adaption of best practices in psychiatric rehabilitation for language and learning challenged deaf persons. In Part II, the author also reviews the lessons learned about staff and program development including the need to balance cultural and clinical competence and respond skillfully to Deaf/hearing cross-cultural conflicts.

Keywords: deaf, psychiatric inpatient treatment, culturally affirmative

The Deaf Unit at Westborough State Hospital was a specialty psychiatric inpatient unit for deaf persons established in a state mental hospital in Massachusetts. It opened in January 1987, and I was hired as co-director, along with Sherry Zitter. I worked there for three years until I left to pursue a doctorate in psychology. I returned in 1996 as the unit director and psychologist and worked there for another 14 years until Westborough State Hospital closed in the spring of 2010.

The vision that guided the creation of this unit was that of a "culturally affirmative" treatment program for deaf persons (Glickman & Zitter, 1989). This meant creating, as much as we could, a Deaf space, with American Sign Language (ASL) used as the language of treatment, large numbers of Deaf staff at all levels of the organization, and a Deaf sensitivity brought to everything we did. These efforts at creating culturally affirmative treatment were documented in the first book that emerged from the unit's work (Glickman & Gulati, 2003). The unit never relinquished this vision of cultural affirmation though in practice achieving it was easier said than done. I think most of the staff would agree that, at our best, we were a well-...
functioning bicultural, bilingual program, where cross-cultural conflicts were often handled skillfully.

In the 23 years of its existence, the Westborough Deaf Unit provided psychiatric care for an estimated 200 deaf people, many of whom were hospitalized numerous times. In the spring of 2010, as Westborough State Hospital closed, the Deaf Unit was moved with most of its staff to Worcester State Hospital, about a half hour further west. I chose at that time to retire from the unit. At that time, I also decided to reflect on our 23-year history. We learned a number of important lessons about the problems of deaf psychiatric patients, about how to adapt assessment and treatment for them, and about the creation of culturally affirmative and clinically competent treatment environments.

This article, in two parts, presents my summary of these lessons. This first part addresses what we learned about deaf psychiatric patients. I'd like to begin by describing three of our patients. I've changed names and some details to protect confidentiality.

Ed was a 30-year-old man transferred to the Deaf Unit from a hearing hospital where he had been brought by the police, in restraints, after threatening his parents. He grew up in a third-world country where he received no formal education. He had never been exposed to a sign language and used only home signs with family. Initially, he appeared to lack the concept of language. When first admitted, he didn't attend when people signed and he made no efforts to learn sign. He was a large man, and would gesture dramatically, vocalize loudly and raise his fists. His parents managed him by giving him whatever he wanted.

Sometime in the past, a doctor prescribed the older, powerful anti-psychotic drug Haldol for him, possibly believing him to be psychotic. His family dutifully gave it to him for years, and when the family arrived in this country, the prescription was renewed. Ed experienced painful muscle cramps as a side effect of Haldol and started to refuse it. His mother responded by crushing it up and hiding it in his food. He caught on and would hover over her while she cooked. The report we got was that he was "paranoid." One day he became angry with his parents and threatened them. They called the police. Eight policemen arrived and, faced with a large, agitated man with whom they could not communicate, restrained him. This required a terrible battle, and one can imagine how terrified Ed
must have been. The police brought him to an emergency room where he was restrained for three more days because no one could communicate with him to assess his safety for release. While in restraints, he was given Haldol. Then they called our Deaf unit.

Omar was a 35-year-old deaf male living in a hearing group residence at the time of his referral. He was friendly and pleasant most of the time and was not usually physically aggressive. He had Bipolar Disorder, and as long as he took his medicine and avoided alcohol and marijuana, he was usually safe. However, he didn't think he needed the medicine and liked to drink and get high. When he stopped taking his medicine, he became manic. He stayed awake all night, his language became more confused, and he went out and did things that got him into trouble. He borrowed money and got into debts he couldn't pay off. He became very defiant with staff. He went cruising for young women and, even more concerning, for young teenage girls.

Omar didn't have the social skills to get romantic partners, and he tended to push himself on women. He had grabbed the breasts and buttocks of several female counselors and staff. He expressed an interest in young girls but as far as staff knew, he had not actually sexually assaulted one. Staff in the programs that served him worried about what this apparent interest in young girls meant and how they should respond. They asked us whether his inappropriate sexual behavior was due to poor language and social skills, to him being off his medication and on drugs, or it reflected problems of pedophilia and criminal sex offending. He was brought to the hospital after a period of being off his medication when he sexually assaulted a staff person. Omar's account of the event was that 1) it didn't happen, 2) she grabbed him and 3) he wouldn't do it again.

Joe was a 16-year-old student in a nearby deaf residential program at the time of his hospitalization in the Deaf Unit. The police arrested him and brought him to the emergency room after he threatened a teacher with a knife and threw rocks at her car. The reason he gave was that he was mad because the teacher postponed a trip to the mall.

Joe, at age 12, started at this school after being kicked out of three other less restrictive placements. “Less restrictive” meant hearing mainstreamed programs where most people couldn't communicate with him. He was kicked out because of severe behavior problems: fights with peers, threatening and sometimes punching staff. Due to late exposure to sign, Joe had very basic
sign skills. He only read simple words. His intelligence tested around 75, in the borderline mentally retarded range. Joe was removed from his biological family at age four following confirmation of physical abuse and neglect. His stepfather may have also sexually abused him. He lived in two foster placements before an adoptive family was found for him at age eight. The adoptive parents were kind, patient people who knew some sign but Joe was so difficult to manage that they placed him in a residential school. They were supportive and involved and took Joe home whenever they could. Joe could be quite friendly and funny at times, and he was especially good at taking care of animals. He wanted to be a vet, but at this time he had difficulty attending to any academic class and was frequently disruptive. He carried diagnoses of ADHD, Oppositional Defiant Disorder and PTSD. The school did not want to take him back until we evaluated his medication and stabilized his behavior.

Ed was an unusual patient for us in that when he was first admitted, he had no functional language skills at all. Omar and Joe were more representative in that they had some signing skills, though they were not fluent signers. However, over time we came to realize something vitally important about our patients. More than half of them were not effective language users in any language. They were language-dysfluent, some quite severely, in their best language, which was almost always ASL. This meant they were often not able to provide us with clear, coherent stories about what had happened to them. This made us very dependent upon other people to gather basic history, and sometimes these people were also poorly informed. They also had poor ability to communicate with our patients. Records were sometimes available, but their quality was uneven.

Reports of sexual and physical abuse were common, but they were often not detailed or substantiated and may have reflected little more than the suspicions of the person writing the report. In a seven-year review of all 94 deaf patients served in the Deaf Unit at that time, we were reasonably confident that some kind of physical abuse occurred in 15% of patients, some kind of sexual abuse occurred in 21%, and a combination of physical and sexual abuse occurred in another 16%. That means that we were reasonably certain that just over half of our patients (52%) had experienced some kind of abuse. We suspected abuse in another 11% of patients. For 19% of patients, we didn't know and couldn't find out (Glickman, 2009, p. 30). This meant that it was extremely likely that a large majority of our patients had experienced physical, sexual abuse or both, but it was also very common.
that we could not obtain a clear, reliable account of what actually happened. Our patients’ poor language skills prevented them from developing coherent narratives about their lives. Of course, it also interfered with the treatment and recovery process.

From its beginning, the Deaf Unit staff included a Deaf communication specialist. Initially, that person’s job was primarily concerned with providing sign language training when needed and helping to assure a treatment environment that was culturally affirmative for Deaf people. Over time, as we paid more attention to the problem of language dysfluency in our patients, the communication specialist came to function more as a Deaf relay interpreter, assisting with interviews and treatment sessions with our many language disordered patients. Many of our hearing staff, especially new signers, had difficulty understanding the patients’ language deficits. It was common for new signers to grossly overestimate their own communication abilities and their ability to communicate well with all deaf persons. We needed a communication specialist to set communication standards.

For example, we had one deaf patient who was particularly difficult to understand, and one day the interpreters, Deaf staff and others were discussing this problem. We were trying to figure out how to communicate to him some important issues. At that moment, a counselor who had just completed his first sign language class came over and announced confidently that he had no difficulty communicating with the patient. In the domain of communication with deaf people, it is certainly true that a little knowledge is a dangerous thing.

Communication problems are the bread and butter of Deaf treatment programs. They provide daily challenges and opportunities. For instance, it sometimes happened that one deaf patient would accuse another of sexual assault. These situations almost always called for formal investigations including, sometimes, medically oriented rape assessments. One time, such an incident occurred when our interpreters, communication specialist, and Deaf social worker were not present. A nurse with beginner-level signing skills, working alongside a hearing mental health worker with slightly better signing skills, and a doctor who knew little about deaf people, misunderstood the patient, jumped to conclusions, and sent the patient for a rape evaluation. The next day, we had to call in the appropriate communication and clinical resources, and painstakingly go through the whole interview process again. We concluded that no such assault had occurred, and the patient had gone
through this invasive, and potentially traumatizing, medical procedure unnecessarily.

The problems of working with language-dysfluent deaf clients brings new meaning to a phrase attributed to the English playwright George Bernard Shaw: “The single biggest problem in communication is the illusion that it has taken place.”

In the Westborough Deaf Unit’s last few years, spurred on at first by the dissertation research of psychologist Patricia Black, we spent a lot of time analyzing the particular language errors our Deaf patients made (Black, 2005; Black & Glickman, 2005; Black & Glickman, 2006). Our Deaf communication specialist Michael Krajnak would interview them and videotape the interview, and then he and the interpreters would evaluate the language samples. This led us to notice that certain kinds of language problems were common. These included:

1. Very limited (impoverished) vocabulary, with many signs used incorrectly.
2. Poor ability to communicate time and sequencing. This includes an absence of grammatical indicators for tense (e.g., LAST-YEAR, THREE-MONTHS-FUTURE), inaccurate use of the FINISH sign to indicate tense, an absence of references to time, a lack of sequential reasoning (first this happened, then this, then this) and a tendency to mix up past, present and future events. Sometimes a person was not clear as to whether something actually happened or whether this was something they wanted to happen. Asking questions like WHEN? would not work, and when we introduced specifics (YESTERDAY, MONDAY, ONE-WEEK-AGO), we couldn’t be confident we were not suggesting the response.
3. Absence or inaccurate use of key grammatical features such as subject, verb and object. Patients would say something happened but leave out the subject. They were not clear as to who did what to whom. One patient would sign TEACH repeatedly when she meant LEARN. We’ve often found ourselves asking repeatedly, WHO?, and not getting a clear answer. Related to this would be the inability to inflect verbs correctly (to move verbs to show actor and receiver and qualities of action) or to use the spatial properties of ASL to indicate subjects and objects. ASL syntax would be absent or confused.
4. Mixture of established signs, home signs, sometimes signs from foreign sign languages, gestures, English words and sometimes words from
Spanish. In some cases, where patients had grown up outside the United States, we weren’t sure if they were using a local sign variant or a home sign.

In the deafness mental health literature, sign language dysfluency has been discussed primarily in four contexts. First, sign language disorders, like spoken language disorders, are assumed to have neurological causes related to the etiology of deafness (Vernon & Andrews, 1990; *White paper on addressing the trauma treatment needs of children who are deaf or hard of hearing and the hearing children of deaf parents*, 2006). Secondly, Howard Poizner, Edward Klima and Ursula Bellugi were probably the first researchers to take sign language errors seriously as clinical problems (Poizner, Klima, & Bellugi, 1987). They studied the sign language abilities of deaf fluent ASL users who lost some communication abilities due to strokes. Through this analysis, the researchers were able to show that acquired aphasias in deaf fluent signers resemble those in hearing users of spoken English. Thirdly, in Great Britain, Alice Thacker studied the sign language production of deaf persons with schizophrenia and found that thought disorders can influence sign production just as they can influence spoken language production (Thacker, 1994, 1998). Fourthly, sign language dysfluency is related to inadequate exposure to ASL-rich environments in childhood. Our own work built on Thacker’s but placed greater emphasis on this sign language dysfluency related to language deprivation (Black, 2005; Black & Glickman, 2005; Black & Glickman, 2006; Glickman, 2007, 2009).

Very few of our patients were fluent ASL users who suffered language loss due to a severe mental illness. Much more commonly, they were persons who had dysfluent language all their lives. Through careful review of numerous videotaped language samples from patients, we tried to pare out the kinds of language problems most likely to be related to language deprivation as distinct from those most likely related to thought disorder. This differential diagnosis is very difficult and as a field we have barely begun to articulate how this task can be accomplished (Glickman, 2007).

The key lesson learned here is about the prevalence and clinical significance of the problem of language dysfluency in deaf mental health and rehabilitation clients. Serving deaf persons who are fluent signers presents one kind of challenge. Many deaf clients are dysfluent or poor signers, and serving them presents a much greater kind of challenge. Programs that serve deaf people need to staff with this understanding that they will
serve deaf people with greatly varying degrees of language competency in both sign and spoken language. The appropriate standard has been set by the Office of Deaf Services in the Alabama Department of Mental Health. The expectation set there is that all clinicians sign fluently and that they work alongside a qualified communication specialist when evaluating and treating deaf persons with severe language disorders. Even deaf clinicians are expected to work with the communication specialist.

The high numbers of language-dysfluent deaf clients was one way in which our clientele differed from the hearing clientele in the hospital. Returning to the three patients cited above, Omar had a bona fide severe mental illness: Bipolar Disorder. Joe carried working diagnoses of ADHD, Oppositional Defiant Disorder and PTSD but no psychotic disorder. Joe had severe attention and behavioral problems, compounded by a history of multiple forms of trauma and poor language skills. Omar had a similar history of trauma, poor language development and other developmental deficits, but he also had a serious mental illness. Ed had Obsessive Compulsive Disorder but this was not the reason for his hospitalization. What made these clients different from hearing psychiatric clients was that, in addition to their mental illnesses, they had emotional and behavioral problems related to language deprivation, beginning in childhood and continuing to this day.

We had higher-functioning deaf people on the unit; deaf persons who were fluent in ASL and/or English, some of whom had bachelor's and master's degrees. But they were not typical patients. For a variety of reasons, higher functioning deaf people often chose not to be hospitalized in our program. They had concerns about confidentiality. They knew many of the staff socially. Some higher functioning deaf people had worked as counselors to some of the lower functioning persons on the unit and they didn't want to now be treated as those persons' peers. Many higher functioning deaf persons actually would select a non-deaf setting, with all its communication problems, because they are more likely to have intellectual peers and because they had to worry much less about confidentiality. When in crisis, they faced an unfair dilemma: a Deaf unit would provide good communication access and sensitivity to Deaf culture but also likely a lack of intellectual peers and real concerns regarding confidentiality. For some, accessing hearing programs through an interpreter was the better option.

The hearing patients at Westborough State Hospital, a state psychiatric hospital, were primarily adults who developed a severe mental illness like
schizophrenia. Many had trauma histories, problems with alcohol and drugs, and personality disorders. However, by and large, they were not people who had the kinds of language and developmental disorders that many deaf patients had. Many of our deaf patients had shown emotional, behavioral and learning difficulties their entire lives. About a quarter had mild levels of mental retardation, and we could have increased the size of this cohort if we changed our admission policies. Hearing patients admitted to the hospital had to be persons in the public mental health system, primarily persons with severe mental illnesses who could not be served adequately in private, acute care hospitals. By contrast, any deaf person needing inpatient care could be referred to us so we had patients with a much greater range of clinical problems.

On the milder end were relatively well functioning deaf people who suffered an acute psychiatric crisis and needed a brief hospitalization, the kind of patient that is usually served in private mental health hospitals. Some of our clientele were deaf persons with severe addiction problems who became suicidal or dangerous to others in the context of substance abuse. Some were deaf people with major mental illnesses like schizophrenia, but these constituted only about a third of our patients whereas they were nearly 90% of the hearing patients in the hospital.

Whether they had a severe mental illness or not, the largest cohort of our patients were deaf people with emotional and behavioral disorders associated with language deprivation and sometimes with neurological problems related to the cause of their deafness. This group had a low baseline level of functioning and were not easily made safe to return to community living. For some of these patients, medication would play a relatively small role in their recovery. Much more important would be the proper rehabilitative focus of treatment.

The challenges of serving deaf persons on our specialty Deaf unit were, first, that we served clientele with a huge range of functional and language abilities while, second, the population was unquestionably skewed towards "lower-functioning" persons, with severe learning and language challenges, like Ed, Omar and Joe. This diversity meant that on any particular day, we would have to provide programming for intelligent, linguistically competent deaf persons who, could, for instance, explore in cognitive therapy how their thoughts contributed to their emotions, while having other deaf, mentally retarded, language-disordered clients with whom the goal was that they use...
rocking chairs to calm themselves down. This meant that the content of any particular treatment group, such as coping skills, was constantly being shifted "up or down." It meant struggling to meet the needs of more competent deaf persons who complained, rightly, that they had no peer group. It meant great difficulty getting a meaningful quorum for any particular treatment group as the functional abilities, language skills, intellectual sophistication as well as treatment problems of the group members differed so dramatically.

Many of our clients fit the profile of those described in the literature as "low functioning," "high risk" or "traditionally underserved deaf." I have used the terms "psychologically unsophisticated" and "language and learning challenged" to describe the same group (Glickman, 2003, 2009). Poor language abilities in their best language are the first and most significant characteristic of persons from this group. Other commonly cited characteristics are difficulties in school and work life; behavioral, social and emotional adjustment problems; health, mental and physical limitations, and inabilities to live independently (Dew, 1999; Long, Long, & Ouellette, 1993).

This cohort of deaf clients is also discussed in the literature on mental health care of deaf people, especially the few studies of inpatient treatment. In fact, it's in this literature that one finds speculation as to whether these deaf people have a unique clinical syndrome. Possibly the earliest speculation on this matter was from a Norwegian psychiatrist, Terje Basilier (Basilier, 1964). He postulated that some deaf patients might have a "certain personality structure" he called surdophrenia. A similar argument was made by American pioneering psychiatrists John Rainer and Kenneth Altshuler. They noted that a subgroup of the deaf patients they treated did not appear to fit any of the established diagnostic categories. They talked about deaf people having "primitive personalities" and "impulsive disorders" (Rainer & Altshuler, 1967), and they were not always careful in distinguishing this subgroup of the clinical population from deaf people as a whole.

These two notions, of surdophrenia and primitive personality disorder, have been roundly criticized, especially when they are misapplied to deaf people as a whole (Lane, 1992). However, psychologist McCay Vernon, whose work has done much to legitimize the importance of sign language use with deaf children, has embraced the diagnosis of primitive personality disorder, while being very clear about the subgroup of deaf persons to whom it applies (Vernon & Andrews, 1990). He has written extensively and
eloquently on the problems involved when such persons commit crimes and interact with police and courts (Vernon & Miller, 2001, 2005; Vernon & Raifman, 1997).

These clinicians are not alone. Another pioneering psychiatrist with Deaf persons, Roy Grinker (Grinker et al., 1969), with whom McCay Vernon worked early in his career, discussed how common it was for deaf patients to have no adequate means of communication, including sign language. They noted that two-thirds of the deaf patients they studied displayed patterns of "inadequate and marginal functioning" (p. 42). They described these persons as suffering essentially from developmental delays and noted the treatment was better characterized as developing basic psychosocial skills than as treatment of psychiatric disorders per se. Grinker and colleagues used the term "borderline syndrome" to describe this group. They were not thinking of "borderline personality disorder" as it is understood today but rather of persons with very marginal communication and psychosocial development.

In Great Britain, the pioneering work on mental health care with deaf persons was done by psychiatrist John Denmark. He also pointed out that most of the deaf patients seen were referred due to communication and behavioral difficulties. He called such problems "developmental disorders of communication" and also "problems related to deafness (Denmark, 1985, 1994).

More recently, Haskins presented a study of 43 deaf patients treated in a specialty Deaf psychiatric unit. Among her findings was the higher percentage of patients diagnosed with Pervasive Developmental Disorder Not Otherwise Specified. Patients with this disorder have difficulty befriending fellow patients who are deaf, have a history of job failure because of an inability to grasp the implicit social demands that are present on most job sites, and often end up in altercations because of their rigid cognitive styles and inability to appreciate another's point of view (Haskins, 2004). This is one diagnosis that can be used to describe this group although this gives the impression that neurologically we are seeing a variant of autism, and this may not be the case.

Another recent study of deaf psychiatric inpatients found compatible results. Landsberger and Diaz (Landsberger & Diaz, 2010) reviewed archival data comparing 30 deaf and hard of hearing inpatient adults with 60 hearing inpatient adults. "Significant differences were found between deaf
and hearing inpatient groups in the frequency of impulse control disorders (23% versus 2%), pervasive developmental disorders (10% versus 2%), substance use disorders (20% versus 45%), mild mental retardation (33% versus 3%) and personality disorders (17% versus 43%). The deaf group had a larger proportion of diagnoses of psychotic disorders not otherwise specified (17% versus 2%).” (p. 196).

In this author’s experience, the difficulty clinicians have in diagnosing deaf patients is evident in the heavy reliance upon the tag of “not otherwise specified,” or NOS. One sees this in developmental disorder NOS, psychotic disorder NOS, impulse control disorder NOS, pervasive developmental disorder NOS and personality disorder NOS. Another recent study of schizophrenia in deaf inpatients found that the largest number of deaf persons diagnosed with schizophrenia were categorized as having undifferentiated schizophrenia (Mompremier, 2009). The qualifier undifferentiated is similar to the qualifier not otherwise specified. It means that the person doesn’t fit into established categories. It’s an acceptable way of admitting, “I’m not really sure about this.”

The consistency in findings of every major study of deaf psychiatric inpatients, with regard to a large subgroup of “low-functioning,” language-impaired, developmentally delayed and behaviorally disordered patients, cannot simply be attributed to the prejudice and ignorance referred to as audism (Humphries, 1977; Lane, 1992). The audist conclusion is that this group represents deaf people as a whole or that there is something like a deaf personality with these attributes. This is obviously not true. However, the persons discussed here are a significant cohort of the deaf persons served in clinical settings. They do not represent deaf people as a whole, but they are a significant percentage of deaf people referred for mental health and rehabilitation treatment. Indeed, I believe the strongest argument we have for the need for specialized Deaf-friendly treatment programs is that it is only such programs that have a chance of serving these persons well.

Is there a unique psychiatric disorder at play here? Having treated so many of these clients in the Deaf Unit, and seeing how often other deafness clinicians have described and struggled to diagnose persons with these characteristics, I believe all of us are describing a clinical reality, a specific disorder. However, I don’t like any of the diagnostic labels, such as primitive personality disorder, that have been proposed so far. I read into all the discussions of diagnostic challenges found in the deafness mental health
literature as well as the literature on traditionally underserved deaf persons
the attempt to define this disorder. Essentially, these are deaf people who
experienced severe language deprivation and never developed mastery of
any language. Some of them have neurological compromises. Some have
attachment problems related to poor communication between child and
parents. They have experienced education deprivation. Primarily because
of severe language deprivation, they develop an array of psychosocial
deficits and display problem behaviors in every setting. These problems are
developmental. They do not suddenly appear in adulthood (as major mental
illnesses usually do) but have been present all their lives. By the time they
reach adulthood, they have “failed” in school, work, home and independent
living settings, and pose major treatment challenges. In essence, these
programs are asked to make up for the disastrously poor environments they
were raised in, including the foolishness, short-sightedness and arrogance
involved in not exposing them sufficiently to ASL.

My own attempt at a name for this disorder was language deprivation
with deficiencies in behavioral, social and emotional adjustment (Glickman,
2009). The criteria I proposed were:

a. The person is born with a hearing loss severe enough so as to preclude
the ability to comprehend oral language or the child loses that ability
before the acquisition of oral language.

b. The hearing loss cannot be remediated, or is not remediated,
sufficiently for the person to be able to acquire and comprehend oral
language effectively.

c. The child is not exposed to ASL (or other sign languages) sufficiently
so as to acquire it as a native user.

d. The person is severely dysfluent in his/her best language or
communication modality, either receptively, expressively or both, as
measured by objective tests or determined by expert evaluators of
that language. The person is functionally illiterate in the spoken/
written language of the larger community.

e. From early childhood, the child displays a pattern of behavioral, social
and emotional disturbances such as aggression, self-harm, a gross lack
of social skills and poor school performance. These problems usually
occur in every setting.

f. The person demonstrates an enormous deficit in fund of information
about the world (e.g., social norms, knowledge of history, government,
current events, rights and responsibilities of being a citizen.)
g. As an adult, the person experiences great difficulties developing work skills, particularly in the interpersonal and attitudinal aspects of work, and learning to live independently.

h. The person is at least 14 years of age.

i. The person does not have mental retardation, schizophrenia or another psychotic disorder. If adolescent, they do not have a conduct disorder; and if adult, they do not have anti-social personality disorder (Glickman, 2009).

When formulating these proposed diagnostic criteria, the most difficult part was being clear about criterion “i,” the rule-outs. The heart of the disorder, and the key issue which distinguishes this group of deaf patients from hearing psychiatric patients, are the language problems and associated developmental deficits and behavioral problems. However, these problems often accompany more recognized clinical disorders, and pure cases, where there is no co-morbid problem, are less common. Criterion “i,” therefore, may be more useful for research purposes than in clinical settings where co-morbidity is the rule.

Deaf people with these language and developmental deficits are easy to misdiagnose. The language and behavioral problems make them appear more ill than they really are. Clinicians working exclusively from a medical model can easily decide that these patients are primarily in need of psychiatric medication as opposed to language and skill development. When clinicians do not sign and do not know deafness, and when culturally affirmative treatment resources to develop language and psychosocial skills are not available, all the pressures on clinicians are towards diagnosing and treating these problems as if they resulted primarily from brain pathology. This is not to say that such medications don’t sometimes help, especially when there is co-morbidity, but the primary need is usually for treatment resources that are scarce. Over 50 years ago, Grinker, one of the pioneers of deafness mental health treatment in the United States, got it right when he noted that the most important treatment paradigm is the development of psychosocial skills (Grinker et al., 1969).

The key lessons learned about our patients were the pervasiveness and significance of language deprivation and the likelihood that we were working with many patients who had a unique clinical disorder. The disorder combined language and other developmental deficits, as described above, and sometimes occurred along side more recognized clinical disorders. In
essence, we saw more patients with language and developmentally based behavioral problems and fewer patients with major mental illnesses than would normally be expected in a psychiatric inpatient setting. To serve these patients adequately, we had to have staff with exceptional communication abilities, not just “signers,” and we had to adapt considerably our approach to psychiatric rehabilitation.

In Part II of this article, to be published in the next issue of JADARA, I will describe what we learned about adapting best practices in psychiatric inpatient treatment for this population. I will also describe what we learned about staff and program development, in particular how we struggled with the politics of Deaf and hearing people working together and with the cross cultural conflicts that I came to see as unavoidable in Deaf treatment programs.

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