ON ESTABLISHING A CULTURALLY AFFIRMATIVE PSYCHIATRIC INPATIENT PROGRAM FOR DEAF PEOPLE

Neil S. Glickman, M.A., C.R.C.
and
Sherry M. Zitter, M.S.W., L.I.C.S.W.
Mental Health Unit for Deaf People
Westborough State Hospital
Westborough, Massachusetts

Abstract

The authors describe their effort to create a Deaf culturally affirmative psychiatric inpatient unit at a state psychiatric hospital in Massachusetts. A culturally affirmative program is defined as one based on Deaf cultural values. Four values are discussed in the context of how they could be translated into programmatic realities. These values are (1) that the least restrictive environment for serving deaf people is a Deaf environment; (2) that communication needs to be appropriate as well as affirming of the Deaf community; (3) that staff have to be recruited, hired and developed with the necessary cultural and clinical skills; and (4) that therapeutic approaches have to be specifically designed for deaf psychiatric patients.

The barriers to developing such a culturally affirmative psychiatric inpatient unit are presented along with some necessary compromises made as these ideas were implemented. Administrative issues pertinent to psychiatric inpatient work with deaf people include finding the balance between program autonomy and integration within the larger institution as well as working with unions, civil service, established hiring policies and affirmative action in order to hire deaf and hearing staff with the needed skills. Clinical issues include developing verbal and non-verbal therapeutic evaluations and interventions, balancing clinical and communication dynamics in grouping patients for treatment, using themes relevant to deaf people's experiences and understanding cross-cultural psychological dynamics between deaf and hearing people.

Introduction

In June, 1986, the task of setting up the first inpatient unit in Massachusetts for deaf people with severe mental illness began. Established at a state psychiatric hospital (Note 1), this unit was one of many programs for which an increasingly vocal and politically astute Deaf Community (Note 2) had long lobbied. Though both hearing, the authors shared a vision of creating a "culturally affirmative" therapeutic environment for deaf patients. This paper is about the establishment and implementation of such a program, about the obstacles faced, the compromises made, and the way the vision was shaped by practical, political and administrative realities.

Some basic beliefs about American society informed our work. Both of us saw our task as analogous to white people treating African Americans, English speaking treating non-English speaking, middle class treating poor, men treating women, and heterosexuals treating gay/lesbian clients. We recognized and considered significant the social fact that in American society wealth and power are distributed unequally, and more powerful groups have a long history of dominating or oppressing less powerful groups. This domination takes many forms:

1) unequal access to material wealth, education and high status employment;
2) unequal access to physical and mental health care, since these are influenced by material factors like money, housing, diet, and recreation;
3) whether prejudice and discrimination work for you or against you;
4) whether the kind of language you use is considered correct and standard;
5) whether people approach you with an attitude of respect or an attitude of fear, pity or loathing;
6) whether you are expected to achieve or fail, and in which arenas you are validated for achievement;
7) whether your way of life is considered healthy, normal or good;
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8) whether you grew up with a sense of self worth and pride or self hatred and shame;
9) whether you were taught to see yourself as someone who helps or someone who receives help and what helping means to you.

The work of Frantz Fanon, a West Indian psychiatrist who pioneered the study of the psychological effects of oppression, informed our thinking that oppressed or colonized people experience low self esteem, feelings of powerlessness, contempt or ambivalence towards their own group, and a tendency to identify with and emulate the dominant group (Fanon, 1963, 1967; Gendzier, 1973). Fanon and later Thomas Szasz (1974; Vatz and Weinberg, 1983) indicted the field of psychiatry for colluding with the forces of domination while pretending to either a scientific neutrality or benevolent humanism. Such criticism has become standard among feminist therapists (Miller, 1976; Walters et al., 1988), therapists counseling gay people (Bayer, 1981; Woodman and Lenna, 1980) and therapists working cross-culturally (Pedersen, et al., 1976; Sue, 1981). Consequently, a unit that purports to serve a cultural and linguistic minority such as Deaf people, and that hopes to affirm its patients' identities and mental health, needs to develop a therapeutic milieu and treatment strategies informed by an awareness of cross-cultural counseling principles and by the particular needs of the community being served.

Culturally affirmative meant basing the unit on Deaf cultural values. Practically speaking, we sought to translate four values or principles into programmatic realities. These values, each of which will be discussed in depth, were as follows: (1) that the least restrictive environment for serving deaf people is a Deaf environment; (2) that communication needs to be appropriate as well as affirming of the Deaf Community; (3) that we had to recruit, hire and develop staff with the necessary cultural and clinical skills; and (4) that our therapeutic approaches had to be specifically designed for deaf psychiatric patients.

Our goal was to create a humane, therapeutically effective and culturally affirmative treatment milieu, but the obstacles were many. Some of our patients would not be culturally Deaf. We were working with limited resources in money, personnel and expertise. We were working within a state agency that had well established policies and procedures, none of which had been designed with deaf people in mind. We would be influenced by the differing agendas of our own administration, other departments within the agency, other agencies, service providers and constituency groups, families, and our own staff. We were working with people of different opinions who had different priorities and needs. Most of all, we were working with very demanding patients who needed appropriate psychiatric care. What happened when our lofty goals met with these real world obstacles?

The Least Restrictive Environment is a Deaf Environment

The creation of a deaf inpatient unit is itself a recognition that “mainstreaming” deaf psychiatric patients on hearing units produces neither valid evaluations nor effective treatment. Proceeding from this principle, we have sought to create a largely separate deaf psychiatric program. Although administratively the Deaf Unit is completely dependent upon the larger hospital, our clinical services are provided, as much as possible, on the Deaf Unit by deafness mental health specialists.

The idea that deaf people should be served in a separate program is controversial, reminding people of segregation. The Supreme Court noted in its landmark 1954 decision in Brown vs. Topeka that separate facilities for minority communities were inherently unequal. Integration, notes the historian Godfrey Hodgson (1976, p. 474) was the “key idea behind the civil rights movement of the early 1960's.” Although bitter battles are still fought in America over integration, equality of opportunity, if not of condition, appears to be a well established American value. Specialized treatment of minority communities, whether used to perpetuate inequality or to overcome it, touches a sensitive nerve in the American psyche. Congress attempted to establish the principle of equal opportunity in education for handicapped children in the Education for All Handicapped Children Act of 1975. This act mandated that handicapped children receive educational services in the “least restrictive environment.” In America, consistent with the ideology of integration, the least restrictive environment is generally assumed to be the environment of the larger community.

In arguing for specialized deaf services, one needs to recognize that segregation of ethnic and racial communities in America, as in other societies such as South Africa, has generally been
the foundation for gross inequality and oppres-
sion. At the same time, integration as a value
becomes problematic when it demands of minority
communities that they yield up cultural differen-
tes that are a source of collective identity and
pride and forces them to communicate in a lan-
guage that is not their own. One theme in the
literature on cross-cultural counseling is that
individual minority persons striving to integrate
themselves may do so at the cost of disparaging
their cultural heritage. This may show itself
through feelings of shame, self-hatred, helpless-
ness and depression (Sue, 1981). Glickman
(1986) argues that deaf people can best resolve
identity crises by going through a period of closely
identifying with the Deaf Community, rather
than by distancing themselves from the Deaf
Community. Thus integration and separation
have powerful psychological meaning to margin-
alized or oppressed people.

The Deaf Community appears to be increas-
ingly questioning the idea that mainstreaming
deaf children into hearing educational settings is
providing them with the least restrictive environ-
ment (Stewart, 1989). Lane (1987) argues that
not only has mainstreaming been an educational
disaster but it has provided “poor conditions . . .
for social and emotional growth.” He says,

In a school with a signing com-
unity, the deaf student is able not
only to understand and respond to the
instruction, but also to get help after
class with course work, to discuss local,
national and international events, to
participate in student activities, to
develop friendships with other deaf
students, . . . to emulate older students
and deaf teachers, to acquire self-
respect as a deaf person.

We have applied this criticism from educa-
tional settings to mental health settings by saying
that here too, services need to be specifically
designed for deaf people.

Skeptics might question the necessity of doing
more to access psychiatric services than provid-
ing a qualified sign language interpreter. We
have two full time interpreters on the Deaf Unit,
and our experience has been that even with
incredible attention paid to the communication
process, the provision of interpreters only estab-
lishes for hearing people the illusion of access
and equality. Between deaf and hearing people,
there can be not only language and communica-
tion style differences, but profound differences in
world view and experience. Certainly inter-
preters are most effective with skilled users of
different languages who understand and care
about the interpreting process. Our attempts to
mainstream deaf patients into substance abuse
groups offered by the hospital day program have
met with limited success. Sophisticated deaf
communicators will at least understand the ideas
being discussed, but because communication in
the group is rapid and confused and the inter-
preter is always lagging behind the speaker, the
deaf patient is rarely able to participate meaning-
fully. Deaf patients who lack a complete language
system or skill in using an interpreter would be
completely lost and overwhelmed by such an
experience.

In addition, there is a psychological value to
treatment among “one’s own.” There is the
experience, “this is where I am understood. This
is where I belong. This is where I can lower my
guard.” In psychotherapy with a deaf patient
who is, for instance, defensive about substance
abuse or the troubled nature of his/her interper-
sonal relationships, this feeling of basic safety
among one’s own may be an essential ingredient
to successful work. Even the most skilled inter-
preter will not enable a client to join with a
therapist or group of people perceived as funda-
mentally different or even hostile. The clinician’s
and group members’ lack of awareness of signifi-
cant cultural differences between them and the
deaf patient, which may take the form of labeling
these differences as the deaf patient’s “resis-
tance to treatment,” will certainly only worsen
the likelihood of a helpful therapeutic inter-
vention.

A separate deaf environment means for us a
distinct physical space, specially trained clini-
cians from a variety of disciplines assigned
primarily or exclusively to this unit, appropri-
ate communication, and therapeutic activities
designed for deaf psychiatric patients. We draw
a distinction between clinical separateness, which
is a goal, and administrative separateness, which
is neither possible nor desirable.

Administratively, every unit or department of
the hospital is interdependent upon all the others.
We could not possibly expect to find specialized
defarness expertise in departments such as Busi-
ness, Treasurer’s, Dietary, Infection Control,
Medical Records, Maintenance, Housekeeping,
Staff Development, and so on. Nor could we
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expect the hospital administration to have already established, before the unit opened, expertise in the psychiatric treatment of deaf people in crisis. Although we originally intended only to utilize nursing staff with signing abilities, the reality of inpatient life is that nursing staff are often “floated” between wards. This has meant deaf staff being temporarily assigned to hearing units and hearing, non-signing staff to our unit. This is far from ideal, but psychiatric hospitals frequently deal with crises such as staffing shortages and patient management problems when “culturally inappropriate” decisions need to be made.

The fact that we are a deaf unit within a hearing hospital means that we are constantly called upon to advocate with other systems. This might mean convincing the business office to provide a separate TDD phone line or the maintenance department to install a visual door alarm. It means painstaking efforts to teach the department that arranges outside medical appointments the procedure for obtaining and cancelling interpreters. It may mean diplomatic efforts to decline the services of a well meaning music therapist who claims to have used music therapy effectively with deaf children and can’t understand why our staff has such an “issue” with this. It means training Staff Development not only to consider interpreters in workshops but to obtain services relevant to inpatient work with deaf people. It means advocating to obtain the services of expensive consultants in, for instance, neuropsychology and deafness, when the hospital has competent neuropsychologists on staff who are open to learning about deafness and may even know a few signs. Depending upon the receptivity of different individuals and departments, this advocacy work can be rewarding or frustrating. Inevitably, compromises are made.

At the same time, our unit could not survive without the support of the full hospital system. A delicate balance is maintained between autonomy and integration. Clinically we try to be separate; administratively we need to be integrated. This balancing act is prey to external pressures. A round of budget cuts, a new administrator with priorities different from ours, a new clinical problem which our unit lacks the expertise to handle, can easily tilt the balance away from cultural affirmation. Within the larger hospital system, the boundaries around the Deaf Unit keep shifting. This is inevitable, but without a clear goal of cultural affirmation, as manifested in part by a physically separate Deaf environment, the pressure to integrate services will inevitably whittle away at the specialized services that make such a unit effective.

Insuring communication that is appropriate and affirming

To create a culturally affirmative treatment milieu, we believed our most basic task was to affirm and utilize the language of the Deaf Community, American Sign Language (ASL). At the same time, we had to realize that a significant percentage of our patients would not be proficient users of ASL. As the only deaf inpatient facility in Massachusetts, we certainly do not wish to turn down deaf people in psychiatric crisis because they are not competent signers. We need to communicate with each individual patient in the manner he or she prefers, whether that means ASL, Pidgin Sign English, Sign English, gesture, drawing, or even written and spoken English. Just as therapists begin treatment by entering and accepting the client’s world, we had to affirm whatever communication abilities our patients would present. Thus there were two communication goals: to affirm the Deaf Community via use of ASL and to affirm the individual patient via affirming his/her communication strengths. With ASL-using patients, these goals coincided. At other times, they existed in a creative tension. Our ability to implement both goals is tempered also by the limits of our staff’s abilities and commitment.

For the most part, we want staff to utilize ASL. Often the best hearing staff can produce is Pidgin Sign English. We are also clear that we want to discourage the simultaneous use of speech and sign (Simultaneous Communication or Sim. Com.). Linguistic researchers have documented that neither ASL nor English is presented clearly when the attempt is made to perform them simultaneously (Cokely and Gawlik, 1973; Charrow, 1975; Stokoe, 1975; Baker, 1978). We have also heard many articulate deaf people make clear that they regard Sim. Com. not only to be difficult to understand but also to be an insensitive distortion of their language. We want our staff to make complex evaluations of our patients’ communication abilities and to adjust their signing and other forms of communication as needed. Many of our patients’ communication abilities are also compromised by psychiatric crises. With all these considerations, the obstacles to ensur-
ing appropriate communication can indeed feel humbling.

We face the impossibility of finding professionals from many disciplines with these linguistic abilities. There is the constant stream of emergencies that goes along with helping people in crisis when instant communication is needed and everyone utilizes her or his own easiest method. There is the painful process of acculturating new hearing staff. It seems they often pass through the stage of arguing that deaf people learn to speak, that signing and speaking simultaneously is a fair compromise, and that (this comes out sooner or later), “it is, after all, a hearing world.” There are the day to day incidents where anything but speaking and signing simultaneously leaves out someone and even speaking and signing simultaneously leaves out someone. There is the enthusiastic new signer who decides to sign an idea without speech, only to have a two minute suggestion drag out for five minutes and no one understands. There is the enthusiastic intermediate who volunteers to “interpret” for the doctor – only to have the patient become aggressive because he couldn’t tolerate the stress of the ensuing communication breakdown. There is the enthusiastic advanced signer who has mastered PSE and appears fluent to non-signing people, all of whom collude with her in the mistaken belief that she can communicate effectively with any patient. There is the low level of linguistic understanding among deaf and hearing people alike as to what distinguishes ASL and PSE, the constant mislabeling of any sign or gesture as ASL. There is the difficulty of consistently maintaining these linguistic goals day after day, through all the highs and lows of one’s life, the times when one just wants to “kibbitz” without linguistic constraints with another staff person with whom one shares a language. And there is staff turnover, the continuing need to begin again with a new non-signer and to persuade a new hearing administrator of the importance of this linguistic project.

Before the unit opened, the staff developed a communication philosophy and guidelines that were both idealistic and realistic. The negotiation of these guidelines took months and felt like the arbitration of a major war. As directors, we lobbied to obtain two full time interpreters in addition to a communication specialist. We labored with staff to clarify the interpreter’s role when the interpreter is a full time, regular staff member in an inpatient setting. Most importantly, we do everything in our power to maintain a core group of deaf staff without whom a culturally affirmative and linguistically appropriate environment would be impossible.

Were we creating a bilingual, bicultural environment or a Deaf environment? Our goal was to create a Deaf therapeutic environment which would involve the phasing out of speech. We think, most of our staff would agree that what has developed is a bicultural environment with speech firmly entrenched alongside ASL (but not usually at the same time). We can say proudly that Deaf culture exists on our unit, and that cultural considerations are institutionalized as part of our psychiatric care. For the most part, staff generally sign without voicing, except with patients who need both. Cultural expectations have been established so that within a few weeks new staff are signing basic ASL sentences. Whether or not an interpreter is available, staff meetings sometimes occur without voice, with new signers asking for help when needed. Yet hearing culture is tenaciously present. Hearing staff vary in their sensitivity, skill and commitment, and linguistically inappropriate communication constantly occurs. Our original dream whereby English would be eliminated from the environment completely does not appear to be realistic with our current resources. We’ve come only part way, but how much less effective would we have been had we not begun with a clear commitment to cultural affirmation of the Deaf community.

Recruiting, Hiring and Developing Culturally Sensitive Staff
A program can be culturally affirmative only to the extent that its staff is committed to this goal and possesses the necessary skills. A significant percentage of the staff must themselves belong to the minority community. Those who do not belong to this community, in our case the hearing staff, must develop cross-cultural skills. They need to demonstrate attitudes supportive of the Deaf Community. On our small ten bed unit, we had 37 positions to fill. We needed staff with the proper credentials in their respective disciplines. We needed to get these people hired by the State, which meant dealing with unions, Civil Service, internal hiring lists, and affirmative action. The personnel system had no prior experience evaluating signing skills, hearing status or sensitivity
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to Deaf culture. Finally, we had to get staff sharing different languages and cultures to work together effectively to create a Deaf environment while simultaneously providing effective psychiatric treatment for our patients.

One point can not be emphasized enough: a significant percentage of the staff must themselves be culturally Deaf. Hiring deaf people who themselves are members of the Deaf Community is not a luxury, nor is it a reflection that we are progressive-minded people. It is a necessity for a program which wishes to have any glimmer of effectiveness and credibility.

Why is hiring culturally Deaf staff important? Some of the reasons are as follows:
1. They provide effective language and role models for patients, families and hearing staff.
2. They insure effective communication will happen at least some of the time.
3. They decrease the likelihood that deafness per se is pathologized.
4. They lessen patients' ability to use their deafness as a defense ("If you were deaf, you'd understand.") and help patients feel safe enough to open themselves for treatment.
5. They enable a program to have credibility in the Deaf Community, which increases referrals and promotes recruitment of new staff.
6. They have a dramatic ability to sensitize the hospital community to the needs and abilities of deaf patients.
7. They provide immediate, direct and powerful training to new hearing staff.
8. They enable staff to feel their work environment is exciting and special, thus decreasing staff turnover.
9. They insure that a culturally Deaf viewpoint is at least factored into every decision. This said, let's look realistically at some of the obstacles to hiring the staff one desires.

Psychiatric inpatient units are staffed predominantly by nurses and attendants. The attendants, on our unit called Mental Health Workers (M.H.W.'s), can have a role that varies from managing behavior to being counselors, group therapy leaders and case coordinators. Other staff generally required are a psychologist, social worker and occupational therapist. Staff on our unit also includes an expressive therapist, communication specialist, rehabilitation counselor, two interpreters, a secretary, a ward clerk and a housekeeper.

We struggled to find deaf people for most of these positions. We discovered quickly how closed the field of nursing has been to deaf people, and we also discovered the general nursing shortage which made attracting any nurses to a state psychiatric hospital a challenge, not to mention psychiatric nurses who also sign and are willing to work second and third shift. In Massachusetts, there is a small but developing pool of deaf social workers, but these people are very much in demand. It was necessary to find a deaf communication specialist and possible to find a deaf housekeeper, but the positions of ward clerk and secretary required phone skills. In Massachusetts at the time of this writing, there are five doctoral level psychologists who sign, none of whom are deaf, and no psychiatrists who sign well enough to work without an interpreter. We advertised and recruited through Deaf Community media and used our contacts and networking skills, including use of our Advisory Board composed largely of Deaf Community leaders. Despite these efforts, we found ourselves up against the simple unavailability of professionals from the needed disciplines who sign competently and understand the implications of deafness, much less who are culturally Deaf themselves.

The easiest single place to hire a group of deaf people was as M.H.W.'s. The vast majority of M.H.W.'s in state facilities are entry level, and promotional opportunities are rare. In order to be competitive and attract bilingual people, we lobbied for and obtained many positions at the advanced and considerably higher paying levels. There were two obstacles. The first was that these higher level state positions were classified with the civil service and hiring needed to come from an approved civil service list. The second was that all promotional opportunities had to be posted and offered to candidates within the hospital first. Needless to say, the people we wished to hire, both deaf and hearing, were not on the civil service list nor were they, for the most part, internal candidates who could be promoted.

The civil service obstacle is a formidable one. Candidates from this list will generally be looking for promotional opportunities and will have no particular interest or skill in working with deaf people. Fortunately, Massachusetts has recognized the concept that foreign language skills require special treatment. Arguing that ASL was equivalent to a foreign language, we were allowed to consider only those applicants on the lists who
claimed to possess sign language skills. As we expected, there were no applicants from these lists who made this claim, and had there been, we would have been the people evaluating whether their skills were sufficient.

Next we had to post the promotional opportunities for in-house employees. Our hospital is unionized, and the unions are very powerful advocates for their constituents, many of whom had worked for the hospital many years and believed they had earned any possible promotion. There were no deaf employees in the hospital who could benefit from this system.

We met with union representatives and carefully and respectfully laid out our dilemma. We stressed that we were not anti-union. Indeed, we wished to help them integrate deaf employees into the union, thus enabling them to demonstrate affirmative action policies. We found them to be reasonable people who agreed to let us attach “fluency across the sign language continuum” to our job postings. The Union also agreed to explain to any union member who asked why we needed these specialized skills.

This support from the unions is always dependent upon our continuing good will towards them and our employees. We were circumventing a major factor in promoting, seniority, so it was incumbent upon us to demonstrate in all other ways that we were protective of our employees’ rights. Once we established the precedent of hiring deaf people and in the process were able to tout the affirmative action practices of the hospital, future hires became easier. The general perception was created that of course deaf people would work on a deaf unit. There was an instance when someone who gave a tour of the unit explained that “all the staff are deaf,” something not at all true. We find it ironic that our hospital community, knowing only our deaf program, assumes deaf people always staff deaf units. We know, sadly, that the truth is otherwise.

We used affirmative action policies to build our case for hiring deaf people. We encouraged the hospital to tout its excellent record of hiring disabled people. This contradicted, of course, our view that deaf people are not disabled, but we swallowed this contradiction in order to get deaf people hired. Then we had “anti-Deaf culture” deaf people apply. For a program trying to be culturally affirmative, deaf applicants who don’t possess the needed language abilities and positive attitude towards deafness present a particularly awkward problem. On paper, some of these applicants had the right academic credentials. They were deaf. A state run program serving deaf people was refusing to hire them. We have had legal action filed against us for not hiring deaf people who, in our opinion, lacked the ability to do the job.

We feel strongly that any person, deaf or hearing, without signing skills, who believes that deaf people should measure their success in life by their knowledge of English, their skill in lipreading, their speech abilities and their degree of integration into the hearing world is not qualified to perform mental health services for deaf people. This is true even if the person has impeccable academic credentials.

One could criticize us for having the arrogance, as hearing people, to decide who is and isn’t culturally Deaf. Aren’t we just establishing a new kind of tyranny where only the right kind of deaf person need apply? Aren’t we, as hearing people, completely without credibility in making such determinations?

All of our hiring interviews include a culturally Deaf staff person, usually the communication specialist, who is the final judge of cultural sensitivity and signing skills. The interview includes culturally relevant questions such as: “What experiences have you had working with other minority groups? What experiences do you have with other languages and cultures? What attitude do you think hearing people need to have to work well with deaf people (and vice versa)? What attitude towards deafness would help a deaf patient improve self-esteem?” We don’t have a rigid formula of what it means to be culturally deaf, and we agree that hearing people shouldn’t be making such assessments. In practice, hiring decisions are made on the basis of accepting the most skilled applicant from the pool who applies. Attitude and awareness are factors balanced with skills and prior training. Cultural inappropriateness has only ruled people out in extreme situations.

Needless to say, it wasn’t sufficient to be deaf or to sign. We needed staff with inpatient experience or at least human service experience, and we needed staff trained and certified in a variety of disciplines. Our desire for a culturally affirmative environment and our lack of prior inpatient experience was such that, faced with a difficult choice, we tended to select competent signers.
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over non-signing applicants who had inpatient experience. This may have been a mistake. Some of our first few patients were people with severe neurological deficits resulting in a variety of disabilities. They presented with significant behavioral disorders. For our first fourteen months, our staff were, on an almost daily basis, kicked, punched, scratched, bitten, spit at and otherwise abused. No medical or behavioral intervention we could devise had much impact. This was our introduction to one kind of patient who presents at deaf inpatient units, and we were in no way prepared for them. We found we had grossly overjudged the therapeutic power of a signing environment on these particular patients. We were astounded to discover that expertise in behavior management and behavior modification was more important with these patients than expertise in deafness per se.

One incident symbolized this dilemma for us. A culturally Deaf staff person was eating her dinner in a common area when a patient knocked her tray of food off the table and lunged at her. After recovering, she commented, "The problem is communication." Alas, we came to realize, in many situations the problem is not communication.

After several months of working with these behaviorally disordered people, we gained a healthy respect for the staff who can last in inpatient settings. Some of our signing staff realized that inpatient work, deaf or otherwise, was not for them. Their image of the client population was far different from the reality. By the end of our first year, though we persisted in seeking out deaf people with relevant experience, we painfully accepted the need to hire non-signing staff who were good psychiatric hospital employees. Our goal of cultural affirmation became tempered by the reality of inpatient work. In the absence of applicants who have all the skills we need, we make compromises and seek an overall balance.

Getting nearly 40 staff to work together well in the high stress environment of a psychiatric hospital is difficult enough without the added complication of at least two languages and cultures. We say "at least" two, because we are aware of other differences among staff stemming out of our different positions in society. Our staff is composed of different races, different religious and ethnic backgrounds, different classes, different sexual orientations and both sexes, and all of these differences shape our attitudes and points of view towards our work.

In psychiatric hospitals, there are normally conflicts among shifts, between administrators and line staff, among disciplines, between staff and patients. These conflicts are compounded by the impossibility, because of the need to supervise patients 24 hours a day, of getting everyone together to discuss an issue. We have found this impossibility of holding a staff meeting where everyone attends or arranging a weekend retreat where everyone can go to be the single greatest obstacle to working through problems. Nevertheless, in addition to traditional conflicts, we have the conflicts that must happen when two cultures collide.

To help overcome Deaf/Hearing cultural conflicts, we've sought to institutionalize training in Deaf culture and ongoing evaluation and monitoring of the communication process. It is here that the position of the communication specialist becomes crucial. The communication specialist was a position we invented for which we wanted a deaf person with native signing skills, at least a Bachelor's Degree and prior experience in Human Services. The job of this staff person is not only to teach ASL and Deaf culture but to monitor all the communication interactions occurring on the unit. We have our communication specialist issue bimonthly communication evaluations to the unit and conduct regular communication workshops. The communication specialist is responsible for evaluating how patients communicate and helping staff match their communication strengths. This can be sensitive, since staff commonly imagine they have better communication skills than they do and commonly do not appreciate the complexities of communicating with this population. Ironically, we often find that our best communicators are often the most likely to feel inadequate in communicating with patients with idiosyncratic language skills while beginners who don't appreciate the complexity of the communication issues often imagine they are achieving full communication. The communication specialist and the interpreters are responsible for always raising the communication issues. Without someone whose designated job is to train staff in cultural sensitivity, a large part of which is effective communication, this issue will become submerged under the deluge of other daily pressures.
Designing culturally affirmative therapeutic programming

In many ways, therapeutic programming on a unit designed to serve deaf psychiatric patients is identical to that of hearing units. The basic strategies of clinical management of people in severe distress are similar. These include providing patients with a clear schedule and set of expectations, behavioral programs, use of various levels of supervision, and, when necessary for safety, seclusion and restraint. We are constantly thinking about how our work is different, about what makes a deaf unit Deaf. Some of the distinctions are obvious, others more subtle. Differences exist in areas of language and communication, therapeutic content, dynamics of staff/patient interaction and patient population.

A. Language and Communication Issues

Certainly the most dramatic difference is in the need to utilize a variety of visual communication methods. Communication on a deaf unit will consistently be complex and multifaceted. Patients will have varying degrees of skill in visual/gestural modalities, in variants of sign language and in English. Some will be able to code-switch between modalities and others will have a limited repertoire of communication abilities.

Grouping patients for therapy involves matching their clinical issues, conceptual abilities and language styles. A group for high functioning, verbal (signing) patients might involve a discussion of the events that led to their hospitalization. A group for low functioning patients might involve matching emotions with facial expressions and role playing what makes them happy, sad and angry. Sometimes oral and signing patients can be grouped together through use of an interpreter, but just as often their differences in world experience and outlook make such a grouping unproductive. Often the group leaders target the language and conceptual level for the “least common denominator,” with the inevitable result that some patient is bored because the group is too simple while another is lost because the group is too difficult. We find ourselves constantly moving patients in and out of groups according to the particular mix of patients we have at the time. This can make our treatment appear chaotic.

We almost certainly see a higher proportion of deaf people with language deficits than is representative of deaf people in general. We believe this reflects the fact that language deficits are often accompanied by emotional/behavioral problems and a low level of psychosocial functioning. Bill Huston of Northern Essex Community College in Massachusetts has coined the term “highly visually skilled” (Note 3) for people who used to be termed “low verbal” or as having “minimal language skills.” He suggested we use the term “visual/gestural” (Note 4) rather than “non-verbal” communication to highlight their communication strengths. This perspective has helped us orient our therapeutic approaches for these patients to their communication abilities. About half of our groups now occur using a non-linguistic modality, be that art, drawing, movement, gesture or activity.

An example is a group developed with our communication specialist called Communication Therapy. These groups do not teach sign language. Rather, they use a non-verbal task to accomplish a psychosocial goal. For example, using visual/gestural communication, the communication specialist presents an individual or group with a communication task. This might be describing a picture, a group member or the room. No formal language, sign or English, is allowed. In relation to this task, all staff and patients, regardless of their language abilities, are on an equal linguistic footing. Patients who have a thought disorder as well as language limitations will generally reveal their thought disorder by the manner in which they attempt to carry out the visual/gestural task. In the same way that an occupational therapist might use a crafts activity to advance psychosocial goals, so here does the communication therapist use the visual/gestural task to improve eye contact, lengthen attention span, build frustration tolerance, increase ability to stay on task, refine social skills and develop self esteem. In these groups, patients who experience communication breakdowns in most of their life interactions suddenly find themselves to be communication experts. The result can be quite dramatic.

The need to develop a variety of visual/gestural therapies for patients without strong communication abilities in sign or English has made our expressive therapist a key clinical staff member. The expressive therapist’s primary media of intervention are non-linguistic. These include art, movement, relaxation and psychodrama. Even our higher functioning verbal groups have been influenced by our expressive therapist and now employ many of these non-linguistic tools.
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These non-linguistic interventions of communication therapy and expressive therapy are not a luxury. They are a necessity for accurate diagnosis. It is commonly said that the English language skills of mentally healthy deaf people can resemble those of hearing people with major mental illness (Heller, 1987). Even the most skilled deafness clinician can have a difficult time diagnosing a thought disorder in a highly visually skilled deaf person, especially when the clinician depends on a linguistically based assessment tool such as a traditional diagnostic interview. It is only by removing language as an assessment vehicle that we observe accurately a thought disorder in a language impaired person. A patient, for instance, with loose or tangential associations will reveal them most clearly by the manner in which he or she performs art, movement or a visual/gestural task.

Jane was a 23-year-old patient who was reported by her non-signing family to be wandering in the streets all night, threatening her brothers for no reason and saying her mother was “looking at the food inside her stomach.” Jane had significant neurological impairments including in her ability to process language. Even our most skilled deaf communicators, using visual/gestures, role plays and pictures, were not completely sure communication was occurring with her. Jane’s mother was extremely intrusive and had been closely monitoring what she ate. Was Jane’s statement a delusion or a perceptive metaphor for her relationship with her mother?

In communication therapy, Jane could focus on a visual task but evidenced extremely bizarre associations. When the therapist mimed an island in the ocean with a spreading palm tree, Jane thought the tree was a bomb and the ocean was a rug. In art therapy, her drawings lacked solidness, with the center of the page tending to be empty. In group drawings, she continuously drew over other people’s portions of the picture. Her art work suggested a fragile ego with diffuse boundaries. Through these media, we were gradually able to form a clear diagnosis of a profoundly disturbed individual.

While in Jane’s case, visual/gestural evaluations enabled us to diagnose a thought disorder, in another case these same media enabled us to conclude that a language impaired patient was not psychotic.

Larry was a 35-year-old patient who was neurologically impaired and had not been exposed to any formal language system until age 24. He was easily aroused to anger, would yell and shake his fist threateningly in the face of a family member or neighbor and had been arrested for becoming assaultive. Neighborhood teenagers taunted him, and some of his outbursts were clearly provoked. Others seemingly came out of nowhere. On the unit, Larry would often accuse someone of teasing him when the other person had apparently done nothing. His language deficits and extreme anger and agitation made it difficult for him to develop insight into his behavior. Was Larry clinically paranoid?

In art therapy, the people Larry drew did not have the staring, lidless eyes often drawn by paranoid individuals. In movement therapy, he was able to tolerate and enjoy having other people follow and support his movements, indicating ego strength and non-defensiveness not consistent with paranoia. In the visual/gestural activities of communication therapy, he appeared to perceive social situations accurately.

Our conclusion was that Larry was not clinically paranoid and had no formal thought disorder. His behavior grew out of years of inadequate and inaccurate information about the social world. Our treatment did not include psychotropic medication. It focused on intensive social skills training with the goal of helping him read body language and social situations more accurately.

B. Therapeutic Content Areas

Therapeutic groups with deaf patients often revolve around a set of themes relevant to deaf people. Independent living skills (ILS) are emphasized more than is typical on an acute hearing unit due to common information gaps. Educational topics related to ILS, such as skill building in using a TTY, relay service or interpreter can
be taught in the context of an occupational therapy group. Even such seemingly benign subjects, however, can elicit strong emotional responses from deaf people who have had to suffer without interpreters, whose family members have not bought a TTY or who have been frustrated by constant busy signals on the relay service. Other patients are hampered by lack of reading and writing skills and are unable to use the TTY effectively. Issues of competence and self esteem are aroused easily by a beginning TTY lesson.

Our occupational therapist, working alongside a deaf mental health worker, has come to emphasize ILS training, and to work with an understanding of the particular psychological meaning attributed by deaf people to such training.

Patients in therapy groups often discuss themes typical of Deaf culture: for example, where they went to school, the kind of communication used there, their first exposure to ASL, discrimination against deaf people, and struggles with hearing family members. Patients’ self esteem as deaf people can be fostered in a group by discussions comparing how deaf and hearing people behave, for instance, how they make introductions or give directions. Such discussions make explicit to patients our awareness that deaf and hearing people behave in ways that are equally valid, but correspond to different cultural norms. This can be a dramatic realization for someone who has been taught to believe that deaf people’s ways are inferior.

Perhaps most importantly, the frustration of real life discrimination, or patronizing attitudes from hearing people who assume deaf people are not capable, and of hearing families who never learn sign are live therapeutic issues. They need to be validated as the genuine experiences of deaf people, but this is not to suggest that these real experiences of oppression can’t become the basis for dysfunctional patterns of relationships. A common “deaf world view,” that hearing people have it easier in life and deaf people are put down and denied opportunities, can be distorted into the belief that “I may as well not try because hearing people won’t let me succeed,” or “hearing people pick on deaf people all the time, so if I get made at a hearing person and hit him it’s alright.” The reality of discrimination and prejudice can be validated at the same time that self-defeating beliefs and actions can be challenged. It can be tricky for clinicians to find the balance between acknowledging the oppression their deaf clients have faced and helping the client move to accept responsibility for change. Having clinicians on staff who are themselves deaf, and ensuring that all clinicians can demonstrate through their language abilities, attitudes and behavior an intimacy with Deaf culture is essential for having any credibility in this process.

Family members of the deaf patient also have similar areas of concern which are explored in a family support group not open to patients. Discussions there often revolve around frustration at communication barriers as well as the effects of mental illness, guilt at not learning sign language, overprotecting or not protecting their children enough, feeling responsible for the patient’s deafness or mental illness and anger at professionals who advised them not to learn sign language and left them with impoverished emotional relationships with their deaf child. Families also find enormous relief in the fact that they are not alone with their feelings and experiences. The fact that one of the group leaders herself has a deaf child has helped families feel particularly understood.

C. Dynamics of Staff/Patient Interaction

Simply having deaf staff demonstrates to patients that deaf people can have power and responsibility and are competent, capable and valued professionals. At both a conscious and a symbolic level, this has powerful implications for patients who have poor self esteem and who disparage their own deafness.

In a culturally affirmative environment, deaf patients find it more difficult to use deafness as an excuse for not assuming responsibility for their behavior. Suddenly, staff are not excusing bizarre or rude behavior, pitying them or granting them special privileges because they are deaf. Indeed, deaf staff can sometimes have the highest expectations of patients and be the most unforgiving of attempts to maneuver out of responsibility.

Deaf patients’ psychological responses to staff take the form not only of traditional projection of personal emotional material but also the mechanism of transference, whereby hearing or deaf staff come to represent important hearing or deaf people in their lives. Trying to communicate with the new hearing staff member who is a beginning signer easily evokes experiences with non-signing family members. The fluent, culturally aware and supportive staff member may contrast with the mother/father they wished they
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had had. Patients may seek out deaf staff, because “only a deaf person can understand me” or seek out hearing staff because “hearing people are skilled, deaf people are not competent.” Patients with borderline pathology often split staff along deaf/hearing lines. Staff must be aware of the psychological defense of splitting as well as be a cohesive deaf/hearing team in order for such splitting not to lead to polarization.

While deaf staff have an insider’s ability to understand patients’ experiences, they may also overidentify with them. This tendency for a staff person to see patients as representative of people or themes in his/her own life is termed countertransference. Deaf staff have also experienced discrimination and prejudice from hearing people, and it can be tempting for them to join with patients who attribute all their problems to the harsh, cruel, hearing world. It is easy for deaf staff to consider patients as less mentally ill than they are, or to feel that hearing staff just don’t understand the patients’ needs as they do.

Hearing staff must also guard against several common psychological patterns. Hearing staff may, out of countertransference, unconsciously need to maintain deaf patients in a helpless position in order to validate their own worth as helpers. The beginner to deafness whose valiant efforts to sign are not appreciated by some deaf patients may experience the frustration of being invalidated as a helper. Enthusiastic neophytes who fall in love with everything deaf and see nothing to criticize in any deaf person may be responding to past experiences where they felt criticized and misunderstood. The advanced signer (not a certified interpreter) who is annoyed at not being allowed to interpret for a “simple medical procedure” may be remembering experiences where parental figures refused to validate their accomplishments.

Hearing staff in such settings are working cross-culturally. They will have culturally determined attitudes about how much “segregation” is appropriate for minorities about how much minority persons should want to fit into the larger world. In this context, this means they bring attitudes about speech, hearing aids, and lipreading. They will be reluctant to believe they are part of a class of people, hearing people, who as a group have been oppressive to the Deaf community. Without an awareness of the cross-cultural dynamics between deaf and hearing people, they will tend to personalize all their experiences with deaf people as if they were working without a context. Thus it may be very difficult for them to appreciate a deaf patient’s anger, to validate the real oppression he/she has faced, and to go from that foundation to the expectation that the patient ultimately take responsibility for himself or herself.

To provide a forum for the exploration of these issues, we have made clinical supervision mandatory for all staff. Each staff person is expected to sit down with his/her supervisor on a regular basis to discuss not only job performance but personal responses to patients. The idea that clinical supervision is both essential for effective work and a norm in the environment has helped create an atmosphere where people work with psychological dynamics, where many staff understand how their “issues” may parallel those of patients. Supervision has been less successful, however, where the supervisors don’t themselves have the training or motivation to perform supervision well.

D. Patient population

The cluster of psychiatric problems typically presented by deaf patients appears to be different from that presented by hearing patients in an acute care psychiatric ward in a state psychiatric hospital. We have no hard data comparing deaf and hearing inpatient settings, but in our acute care setting, the range of patient problems is striking. Eighteen of our first fifty patients (36%) were diagnosed as having a major mental illness (schizophrenia, other psychotic disorders, major mood disorders). One would expect this percentage to be much higher on the admission ward of a state psychiatric hospital. Twenty one of our first fifty patients (42%) were diagnosed as having an adjustment disorder, a less severe psychiatric problem. Had they been hearing, most of these patients would probably have been served in a private psychiatric facility.

We also appear to receive a higher percentage of patients who either test out as or are functionally mentally retarded. Ten of our first fifty patients (20%) were so diagnosed. Twenty two of these fifty patients (44%) had some clear indication of neurological dysfunction, be that mental retardation, a learning disability, a seizure disorder, or an organically based behavior disorder.

We serve, then, high functioning deaf people who experience a crisis and need a brief inpatient stay, ideally on an unlocked unit, as well as mul-
tiply handicapped, neurologically impaired and often behaviorally disordered patients who need long term habilitative or rehabilitative care. Even without considering the communication differences, we must somehow program for the high functioning patients who need to talk about their problems as well as the low functioning patients who need strict behavioral plans. While the communication environment is appropriate, the unit’s policies and rules may in fact be either too restrictive or not restrictive enough for individual patients.

The common denominator for our patients is that they are deaf and in need of some kind of psychiatric care. Their clinical problems are so diverse that our staff can easily feel pulled helplessly in all directions, trying to be all things to all deaf people. One day we’re struggling to improve our treatment of substance abuse. The next day we’re trying to develop a comprehensive evaluation of sexual abuse and victimization. The next day, we’re trying to pull together an educational program for a deaf adolescent who, if hearing, would be on an adolescent unit with educational services well established. The next day, we’re trying to implement two distinct behavioral plans for explosive, multiply handicapped patients. Always we face the challenge of communicating appropriately.

This is the turf covered by deaf psychiatric inpatient units.

Conclusion

In some ways, we pass our two year anniversary with more questions than when we began. We marvel at the simplicity of those who suggest that providing a deaf program means providing interpreters or one deafness expert. We are convinced of the importance of providing a culturally affirmative environment as part of promoting sound mental health, have a reasonable picture of what that means, are fully committed to the concept, and yet are stymied by the obstacles to doing it correctly. In the real world, resources are limited, human conflict is omnipresent, political and economic pressures apply and one has many therapeutic goals which need to be balanced. Despite these obstacles, we have daily evidence of a certain magic in culturally affirmative programming, in particular the magic of skilled deaf staff. Sincere effort and meaningful goals do carry great weight. Perhaps one indication of this is the number of patients who have left us saying that they hoped someday to become mental health staff. They have seen, many for the first time, that deaf people can be the givers of help, can do so with exceptional skill, and can be the experts about helping other deaf people. The therapeutic environment must affirm deafness and the Deaf community. This is not tangential to mental health treatment. It is the essence of it.

NOTES

1. The authors want to emphasize that the Massachusetts Department of Mental Health and, in particular, Westborough State Hospital have put a great deal of effort and resources into establishing this new program and developing it to the point that it became certified by the state and federal government in July of 1988.

2. Following Padden (1980), we will use the capitalized “Deaf” when referring to the Deaf Community or Deaf Culture and the lower case “deaf” when referring to the audiological condition of deafness.

3. According to Huston (1989), highly visually skilled (HVS) communicators have not been exposed to an appropriate, consistent educational/linguistic methodology but have highly developed internal thought systems which order visual concepts in a logical way. HVS individuals are extremely attuned to visual environments and should be communicated with in visual-gestures, the “basic language of the eyes.”

4. Again according to Huston (1989), visual-gestural (V-G) communication is the developmental base of ASL, encompassing pointing, visual sculpting, facial expressions, body shifting and posturing, visual logic and visual processing. Although not a formal language, V-G communication can convey effectively feelings, thoughts, ideas and concepts. V-G is the purest form for the visual processing of information.
REFERENCES


