The development of psychosocial and problem solving skills in deaf students: Insights from the Deaf mental health field

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Part I

- A bit about my work in Deaf mental health
  - Culturally affirmative mental health care
  - Adapting therapy for persons with language and learning problems
  - Language deprivation syndrome (LDS)

- Common challenges in education of deaf children today

- Similarities between Deaf education and Deaf mental health
Part II

• Collaborative Problem Solving, Ross Greene

• Deaf friendly embellishments to CPS, based on my work on adapting CBT for deaf people with language and learning challenges
Part III

- Other evidenced based curricula for teaching psychosocial skills
- Deaf friendly teaching and counseling
Key vocabulary: Language deprivation

• Inadequate exposure to sign language plus inability to hear spoken language

• LANGUAGE WITHHOLD
Key vocabulary: Language “dysfluency”

• Not referring to stuttering
• Language that native users would easily recognize to be unclear, poorly developed, and substandard for everyday conversational purposes.
• LANGUAGE NOT-CLEAR, NOT-FLUENT, SKEWED
Who are you and how did you get involved with Deaf people?

• I am hearing
“How did you learn sign language?”
“How did you get involved with Deaf people?”

• ASL was the hook that caught me
To learn ASL, I went to the “country” where it was used, Gallaudet College, in 1980. Later I went to graduate school there. My 3 years there were crucial to my identity development.
I worked as a counselor and later a psychologist with D/deaf people in many places

- Vocational rehabilitation counselor
- Community mental health center
- HMO counseling center
- Private practice
- Westborough State Hospital Deaf inpatient unit (17 years)
- Community settings (outreach and group homes) • 6 years
- Deaf mental health respite program • Hospital diversion and step down
- Psychiatric emergency services
The USA Deaf world in 1980

• Sign language returned to Deaf schools in the 1970’s
• People were discovering ASL, Deaf Culture and the Deaf Community. ASL found a new legitimacy.
• There was no university based mental health training program on working with Deaf people
• VR counselors, teachers and interpreters did informal counseling
• Counseling deaf people was a brand new topic
• Beginnings of thinking about qualifications of the professionals doing the work
• The medical-pathological model of deafness was dominant, but the cultural model was catching on.

• The cultural model of Deaf people had not yet been applied to mental health work with Deaf people.
What would a “culturally affirmative” approach to psychotherapy with deaf people look like?
How do we create “culturally affirmative” mental health programs for Deaf people?

• Westborough State Hospital Deaf Unit was my attempt (with colleague Sherry Zitter) to create a culturally affirmative program
What does “culturally affirmative” mental health care or education for deaf people mean?
• Deaf people staffing to the extent possible
• Hearing signers
• Striving for signing environment
• Interpreters and Communication Specialist
• Affirmative view of Deaf community and culture throughout program
• Staff with requisite training and cultural sensitivity
• Skillful handling of cross-cultural conflicts
Growing attention to language and learning issues in clinical population

- Deaf Unit research, initiated by Patricia Black, 1999-2006, Westborough State Hospital.
- 94 Deaf Unit deaf patients served over 7 years
- Compared to all the hearing patients in the hospital at one moment in time.
- Most complete form of this study is in Chapter 1 of *Cognitive behavioral therapy for deaf and hearing persons with language and learning challenges*, Routledge 2019
Allen Cognitive Level (ACL)

• Mean = 4.6
  • Needs helps with transportation
  • Supervise medication administration
  • Needs help meal planning, shopping, cooking
  • Needs help recognizing dangers in environment
  • May need reminders to wash and dress appropriately; assistance with laundry
  • May need supervision with money
94 deaf patients, 1999-2006

<table>
<thead>
<tr>
<th></th>
<th>Deaf (N= 94)</th>
<th>Hearing (N = 180)</th>
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<tbody>
<tr>
<td>Psychotic</td>
<td>33%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Mood</td>
<td>32%</td>
<td>21%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>28%</td>
<td>9%</td>
</tr>
<tr>
<td>Personality</td>
<td>37%</td>
<td>22%</td>
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<tr>
<td>Developmental</td>
<td>34%</td>
<td>7%</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>25%</td>
<td>42%</td>
</tr>
</tbody>
</table>
Communication skills

- Visual-gestural: 0%
- Grossly impaired: 3%
- Functional skills, non-fluent: 43%
- Fluent foreign language: 1%
- Fluent English (sign, writing, speech): 23%
- ASL fluent: 3%
- Bilingual ASL-English: 6%
- Total language dysfluent: 66%
Language problems due to language deprivation we have observed

• Vocabulary: impoverished, incorrect
• Absence or poor use of time indicators
• Absence of topic-comment structure
  • Missing pronouns, verbs, objects
• Spatial disorganization
• Incorrect or absent facial grammar
More than half of the deaf patients

• Have difficulty telling a clear, linear story
• Have difficulty establishing who did what to whom and when
• Have difficulty seeing patterns (verbal reasoning)
  • Cause and effect
  • If this, then that
  • This relates to that
  • This means that
Are poor language skills at the heart of a unique clinical disorder?

• Studies of deaf psychiatric inpatients also struggle to diagnose something atypical in deaf patients
Studies of deaf psychiatric inpatients

- Rockland State Hospital, 1960’s
  - Ken Altshuler and John Rainer
    - “Primitive personalities” and “psychosis with mental deficiency.”
- Terje Basilier, Norway, 1960’s
  - Surdophrenia (personality structure associated with early acquired deafness)
- Michael Reese Hospital, 1960’s
  - Roy Grinker,
    - “inadequate personality,” “borderline syndrome”
• St. Elizabeth Hospital, D.C., 1970’s
  • Luther Robinson
  • Voluntary admissions; screened out major behavioral problems and persons with M.R.
  • Lower percentage of psychotic patients

• Springfield Hospital, Maryland. 1990’s
  • Beth Daigle
  • Half the patients had violent or self-destructive behaviors
  • Lower percentage of persons with schizophrenia; higher with personality disorders;
  • More undiagnosed or diagnosis deferred
• Whittingham Hospital, Great Britain,
  • John Denmark
  • “Problems related to deafness”
  • Behavioral and adjustment problems; poor maturational delay
  • “Developmental disorders of communication”
Haskins, 2004

• 43 deaf patients on a specialty Deaf psychiatric unit
• Higher percentage of clients diagnosed with *Pervasive Developmental Disorder Not Otherwise Specified*
• “Clients with this disorder have difficulty befriending fellow clients 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”
Landsberger & Diaz, 2010

• “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).
Mompremier, 2009

- Largest number of deaf persons diagnosed with schizophrenia were categorized as having *undifferentiated schizophrenia*
- *Undifferentiated* is a residual category like *not otherwise specified*
All studies find the same group

- Severe language problems
- Severe behavioral problems
- Evident from early life in all domains
- Developmental deficits
- Fund of information deficits
- Not psychotic (though easily misdiagnosed as such)
Traditionally underserved deaf” (Dew et al, 1999)

- Inadequate language skills
- Vocational problems
- Behavioral, emotional and social adjustment problems
- Independent living skill problems
- Educational and transitional problems
- Mental and physical health problems
Language dysfluency with deficiencies in behavioral, social and emotional adjustment, Glickman 2009

- Deaf (unable to acquire spoken language through hearing)
- Language deprivation in spoken and sign languages
- Severe language problems (dysfluency)
- Severe fund of information deficits
- Disruption in thinking, mood and behavior evident in all settings since early childhood
- In adulthood, problems developing independent living and vocational skills
Is there a “language deprivation syndrome” (LDS)

• Sanjay Gulati’: Language deprivation syndrome
• https://youtu.be/8yy_K6VtHJw
Gulati: Language deprivation syndrome

- Common language deficits
- Struggling with time and linear organization
- Struggling with cause and effect
- Struggling with empathy and theory of mind
- Struggling with abstract thinking
- Difficulty learning
- Difficulty with emotion regulation (coping)
- Struggling in relationships
- Reduced “fund of information”
- “Acting out” of feelings

- How often do you see deaf people with these challenges?
CALI: Atypical Sign language

- [https://www.northeastern.edu/cssh/asl/research/center-for-atypical-language-interpreting/](https://www.northeastern.edu/cssh/asl/research/center-for-atypical-language-interpreting/)
- Persons with physical differences or limitations that impact signing (CP, deaf blindness, missing or malformed limbs, etc)
- Persons who have exposure to different sign or spoken languages
- Deaf immigrants
- Senior Citizens
- Language and social deprivation
CALI Preliminary Report on “Atypical language” of sample

- Limited or skewed use of space
- Limited or no non-manual markers
- Lack of referents/pronouns
- Limited, incorrect or no use of classifiers
- Limited or no use of temporal referents
- Shorter, less complex sentences
- Omission of verb inflections
Inadequate (sign and spoken) language exposure

• Unable to hear spoken language sufficient to acquire it as a native speaker

• Insufficiently exposed to sign language from native signers sufficient to acquire it as a native signer
Poor language development means poor cognitive development.

- Time and tense
- Cause and effect
- If this, then that
- Problem solving
- Abstract thinking: Ability to see patterns
Delays and impairment in “theory of mind”

• Deaf children of deaf parents have age appropriate ToM
• Deaf children of hearing parents lag significantly behind in ToM; some not obtaining it until adolescence or adulthood

• “The evidence suggests that any delays in establishing and taking part in communication or access to social interaction via an accessible language code have consequences for theory of mind that can be both problematic and long-lasting.” (Morgan, Meristo & Hjelmquist, 2016.)
• Lack of theory of mind probably related to poor abilities at empathy
Poor “fund of information” (FOI) (Robert Pollard)

• Fund of information
  • Physical health
  • Mental health
  • Sex and relationship information; often including how to prevent pregnancy or STD
  • How does the government work
  • Healthy diet and habits
  • Independent living: budgeting, cooking,
  • Family information

• Learning how to learn
Poor language development is highly correlated with behavioral problems

- Sanjay’s research (Gulati, 2019), 99 consecutive referrals to Deaf Services at Cambridge Hospital
- Difficulty with emotional self-regulation (coping) and interpersonal skills

“Both dangerousness to oneself and dangerousness to others correlated strongly with language dysfluency”

“Indeed, nearly half of the variance in these deaf psychiatric patients’ aggressive behaviors seemed attributable to problems with language”
Age of Language Acquisition and Prevalence of Suicidal Behavior in a Deaf Population with Co-occurring Substance Use Disorder

• Among deaf persons in substance abuse treatment, those with significant language deprivation (language exposure after age 10), more likely to show past suicidal behavior and thinking

• Study shows the importance of assessing language skills more closely

Language dysfluency in Deaf and hearing people

**Hearing people**

Medical/neurological/psychiatric causes
- Intoxication
- Developmental neurological problems: autism, severe developmental delays, learning disabilities
- Brain injury, trauma, aphasia
- Mental illness

**Deaf people**

Medical/neurological/psychiatric causes
- Intoxication
- Developmental neurological problems: autism, severe developmental delays, learning disabilities
- Brain injury, trauma, aphasia
- Mental illness
- Some medical causes of deafness

**Social causes**
- Language deprivation
Language dysfluency in deaf people may also have medical causes

• Some of the causes of deafness also cause other medical or neurological conditions which impact language development.

• Difficult to identify one primary cause of dysfluent language; causes reinforce each other

Cytomegalovirus (CMV)

• Cerebral Palsy
• Vision loss
• Hearing loss, often progressive
• Microcephaly
• Motor difficulties
• Developmental delays
• Learning problems
• Autism
• Attention deficit disorder

• Obsessive compulsive disorder
• Language learning disabilities
• Balance problems
• Poor impulse control
• Poor ability to delay gratification
• Language processing problems
Language problems associated with Cytomegalovirus (CRS)

• Periods of incoherent language
• **Asymmetrical language skills** (receptive and expressive). May receive sign differently than they express it.
• Sign produced at slower rate
• Difficulty learning new vocabulary
• Difficult with word finding
• Difficulty with expressive and receptive fingerspelling
• May copy signs used by others before responding
Language deprivation and dysfluency...

• Poor language skills contribute to or cause every other problem
• Make learning very difficult
• Easily misdiagnosed as psychotic or mentally retarded
• Make behavioral problems very likely
• Make rehabilitation and counseling very difficult
Psychological co-morbidity. Language deprivation plus....

- Trauma
- Developmental delays, including autism spectrum (hard to tease out)
- ADHD with learning disabilities
- Oppositional Defiant Disorder and Conduct Disorder
- Poor life skills set one up for depression, anxiety, anger, self-esteem problems
- Poor life skills set one up for maladaptive coping approaches like substance abuse, violence
Trends in Deaf Education

- Beginning in the 1970’s, signing was re-introduced into most Deaf residential programs through variations of “Total Communication”
- The Individuals with Disabilities Education Act (IDEA), first passed in 1976, introduced the concept of “least restrictive environment,” (LEA) which has generally been interpreted to mean a mainstream environment.
- Over 75% of deaf children in U.S. are mainstreamed
- The IDEA also introduced the idea of “individualized educational programs” (IEP’s) to meet “the unique needs of each child with a disability.”
• The move away from specialized residential treatment and large Deaf programs has been accelerated by the rise of cochlear implant technology, especially when accompanied by an Oral only philosophy.
• While there are still residential schools, the students in these schools are different than students in mainstreamed settings.
  • More likely to be profoundly deaf
  • More likely to have multiple disabilities
  • More likely to be socially disadvantaged
  • More likely to have behavioral challenges
• This makes comparison of outcomes between programs unfair.
Enduring truths about educating Deaf children

• Language development remains the fundamental challenge in Deaf education.

• Language development is intimately connected to everything else.

• Early interventions, including CI’s, can help, but deaf/hearing impaired children remain at a considerable disadvantage for language development.

• Deaf children of signing deaf parents have a clear advantage over other deaf children in language and cognitive development, especially in early years, but their spoken language skills, and especially literacy skills, also lag behind hearing peers.

• These early advantages may decrease as the deaf child enters high school and post-secondary education (Marschark and Knoors, 2019)
• Most deaf children with CI’s do not hear spoken language the way hearing children do.
• Most deaf children in “signing school environments” are not receiving natural sign language exposure the way native users of a language do.
• If deaf children are not provided rich visual language environments or are unable to process spoken language with the help of CI’s and other adaptations, they can begin school with severely impoverished language abilities.
• Regardless of educational method or provision of CI’s, the majority of deaf children lag substantially behind hearing children in spoken language skills and especially in literacy.
• There is no good evidence sign language exposure hurts acquisition of spoken language skills, and considerable evidence that it helps with language, cognitive and psychosocial development.

• There is no good reason to deny a deaf child sign language exposure.

• Cochlear implants can help some deaf children develop spoken language skills, but the results are highly variable.

• The oral only philosophy that usually accompanies implantation is destructive much, if not most, of the time.

• There is no one approach that works for all deaf children.
Additional disabilities and learning

• At least 35%, and probably over 50% of deaf/hh students have an educationally significant additional disability (2006, Annual Survey)
• Largest additional disability is intellectual or cognitive delay (“mental retardation”), over 8% (2005 Annual Survey)
• Attention, learning and behavior problems (differential diagnosis is difficult) are more common than with hearing children.
• Deaf-blindness obviously imposes even more challenges to language and cognitive development
• Cochlear implants are generally less effective with multiply handicapped deaf children
Implications of poor language development

• Learning problems; Poor thinking and problem solving skills
• Behavioral problems
• Teachers and counselors don’t have many tools

• “Pull” to work in a highly directive (“one-up”), and sometimes punitive manner
• Main tools are medication and simple behavioral plans (consequences)
Deaf education and Deaf mental health (DMH)

• Language deprivation and delays are a major issue in DMH (e.g., “language deprivation syndrome.”

• DMH providers often need to work with a “developmental” framework, considering language, cognitive and psychosocial delays

• DMH providers often must focus on language and cognitive development

• The development of cognitive and psychosocial skills is a foci in both.

• Eliciting informed engagement in learning/counseling is a challenge

• In both cases, the work must be adapted to be “Deaf friendly.”
Discussion
Part II

- Collaborative Problem Solving
  - Philosophy: Kids do well if they can
  - Skills and skill deficits
- 3 Steps
  - Empathy
  - Define the problem
  - Invitation to problem solving
- Some reframing and modifying for work with deaf people (children through adults)
Collaborative Problem Solving with adaptations for deaf persons
“Students do well if they can.”

• [https://www.youtube.com/watch?v=jvzQQDfAL-Q](https://www.youtube.com/watch?v=jvzQQDfAL-Q)

• When students (or clients) have problems, what is your “go-to” explanation?
  • They are not motivated
  • They lack skills

• It’s much more useful, in teaching and counseling, to assume the problem is due to lack of skills

• In both contexts, the key question becomes, “how do I engage this person and then teach him/her the relevant skills?”
• We understand most problems as due to skill deficits

• We attend to the skills and skill deficits of staff and family members.

• This idea will change your work and personal life forever.

• Treatment consists of engaging people in the process of developing relevant psychosocial skills, including problem solving

• We draw upon evidenced based practices for relationship development and skill building
Language processing skills

- Difficulty expressing thoughts, needs or concerns in words
- Often does not appear to have understood what was said
- Long delays before responding to questions
- Difficulty knowing or saying how he/she feels
From Greene: Executive skill deficits

- Difficulty handling transitions, shifting from one mindset to another or adapting to new circumstances
- Poor sense of time/difficulty doing things in a logical or prescribed order
- Disorganized/difficulty staying on topic
- Difficulty anticipating outcomes, consequences
- Difficulty considering a range of solutions to a problem
Cognitive flexibility skills

Concrete, black-and-white, often takes things literally

Insistence on sticking with rules, routine, original plan

Does poorly in circumstances of unpredictability, ambiguity, uncertainty

Difficulty shifting from one original idea or solution

Difficulty appreciating perspective of others

Inflexible, inaccurate interpretations

Add language deprivation and all these skill deficits worsen dramatically
Emotion regulation skills

- Difficulty staying calm enough to think rationally
- Cranky, grouchy, grumpy, irritable
- Sad, fatigued, tired, low energy
- Anxious, nervous, worried, fearful
<table>
<thead>
<tr>
<th>Social skills</th>
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</thead>
<tbody>
<tr>
<td>Difficulty attending to or misreading social cues</td>
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<tr>
<td>Starting, entering, maintaining, ending conversations</td>
</tr>
<tr>
<td>Seeks attention of others inappropriately</td>
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<tr>
<td>Seems unaware of how behavior effects others</td>
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<tr>
<td>Lacks empathy</td>
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<tr>
<td>Poor sense of how one’s attitude, behavior, comes across to others</td>
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<tr>
<td>Inaccurate self perception</td>
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<tr>
<td>Conflict resolution and management skills</td>
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Domains of skill training

- Skills for dealing with your “inner world.”
  - Coping, Distress Tolerance, Emotional Self-Regulation
  - You could put thinking skills here
• Skills for dealing with your “outer world.”
  • Social skills, interpersonal effectiveness, assertiveness training,
  • Conflict resolution, Communication skills
• Cognitive and problem solving skills

• Educators and mental health professionals all need to focus on these skills
Core strategy of CPS

- 3 Steps, Each needs to be unpacked and adapted
  - Empathy
  - Define the problem
  - Invitation to problem solve

- Note: Other approaches emphasize more the specific psychosocial skills and curricula for teaching them
Key vocabulary:
“Sympathy”
“Pity”
“I feel bad for you.”
Key vocabulary: “Empathy” = Heart
Understand
Validation

• “Oh, you feel ..... Oh, I see. That makes sense to me.”

• Empathy and validation usually must happen before you can proceed to problem solving
Empathy

• [https://www.youtube.com/watch?v=cDDWvj_q-o8](https://www.youtube.com/watch?v=cDDWvj_q-o8)

• Note: DNR means “do not resuscitate”. Means let the person die.
I think you'll find I'm one of the most empathetic doctors around.
Who shows empathy?
We teach empathy in part by demonstrating it.

"I know exactly how you feel."
Needed vocabulary:
Words/signs for feelings

“You seem to feel ....?”
Empathy also involves the ability to perceive and communicate back what another person *thinks* and to distinguish *thoughts from feelings*.
What is a thought and what is a feeling?

- Sad
- Embarrassed
- Nobody loves me
- Irritable
- Joe is ignoring me because he thinks he is better than me
- Men can’t be trusted
• Nervous
• Hate
• Everyone drinks on New Years Eve so I can too
• Just one drink won’t cause any problems
• Sexual lust
• My life is a complete mess
• I am a failure
• Jealous
• Someone is going to hurt me
• People will always take advantage of you if they can
• Grouchy
• Deaf Services is a terrible agency
• Deaf Services is a great agency
• Tomorrow will be an awful day
• I’m lucky. It could have been worse.
• Curious
• Resentful
• I’m a worthless person
• Love
• I feel like you are a jerk.
• I feel like a jerk.
Much coping depends on what you say to yourself

I’m dying!

Shit happens!

Remember to breathe slowly, from the belly.
Teaching children to recognize thoughts

It’s not fair!

What should I do?
3 ways to develop empathy in students

• Use of empathic communication skills, including reflective listening. Modeling of empathy
• Notice and label examples of students showing empathy
• The “reverse role play.” “Put yourself in my shoes.”

• Note: Language development appears fundamental to development of theory of mind and empathy
1. Teach by noticing what is already there

How is empathy taught in the following clip:

https://www.youtube.com/watch?v=9_1Rt1R4xbM
Catch and label evidence of empathy already present

• Staff and students/persons receiving services showing empathy
  Person says: “I didn’t want to hurt you.”
  Person is helpful and caring.
  Person shows empathy on their face.
  Person shows empathy for animals.
• What examples are already there?
  “THAT!”
THAT!

- Notice people using a specific skill
- Elicit specific skills from people
- Name the skills

THAT! CARING SKILL. EMPATHY SKILL. OTHER PERSON FEEL WHAT? YOU UNDERSTAND, CARE SKILL

- Invite more practice.
2. “Put yourself in my shoes.” The reverse role play.

How would you like it if the mouse did that to you?
How would you teach this?

- The idea of personal spatial boundaries
How would you teach the idea: “You glaring at me and standing too close makes me afraid.”
3: Use of empathic communication skills

- Paraphrase
- Reflection of feeling
- Reflection of thought/meaning
- Checking out if you are right
Paraphrasing

“COPY. CHANGE-A-LITTLE”
Reflection of feelings; “You seem to be feeling....”
Must include feeling words
Check it out

• Did I get that right?
First step in problem solving is empathy
“Always leading (begin) with empathy”

• Student/client/any human being is upset about something.
• You resist the “righting reflex” to fix it
  • “You should use your coping skills/ just ignore him/ forget about it/ etc.”
Reflective listening

• Clips from Everyone loves Raymond
  
  https://www.youtube.com/watch?v=aP55nA8fQ9I
  
  https://www.youtube.com/watch?v=4VOubVB4CTU
Good life lesson, not just teaching/counseling

Lead with Empathy!
• “I know how you feel” is NOT empathic communication. It is fake empathy.

• Empathic communication must be demonstrated, not claimed.
Practice Paraphrase plus reflection of feeling

Describe something that happened to you which was annoying or stressful

Other person: 1. Paraphrase
2. Say back what you think the person felt.

Check accuracy: Is that right?
2. Define the problem (promoting metacognition)

- Promoting the “stop and notice” moment
- Addressing the “fund of information” deficit

- “What’s happening?”
- “What are you doing?”
- “What are you feeling?”
- “What are you thinking?”
Developing the ability to self-observe (meta-cognitive skills)
Give students names for what is occurring

• Names of situations: So you both want to sit here but there is only room for one person. Is that right? You have a conflict.

• Names of feelings: “You seem to be feeling..... Is that true?”

• Names of thoughts (more advanced). “You are thinking that this isn’t fair. Is that right?”
Sesame St teaching conflict. Notice the teaching method.

• https://www.youtube.com/watch?v=Gl3e-OUnavQ
Notice and label the conflict
Examples
3. **Invitation to problem solve**

- **Basics:** “What can we do about this? How can we solve this?”

- Teaching staff and parents to engage students/children/staff through a “one-up” style, that includes more reliance on questions than directives.
“Frame” the conversation as an opportunity to use skills

• “Can we discuss this problem?”
• “Can we show respect for each other?”
• “How?”
Guide students in steps of problem solving

• What’s the problem?
• What do you want?
• What does the other person want?
• What does each person think?
• What are possible consequences?
• What are options?
• How do we decide?
The problem of "bossiness"
Key vocabulary: “One-up”
“One-up”; Using power to influence people

1. Telling people what to do
2. Telling people what is good and what is bad
3. Using rewards and consequences as one’s primary strategy
The problem of the “blow up”

How do staff tend to respond?
Staff think: Where are the consequences?

We need a larger toolbox of responses.
Directives and judgments

“Your should use your coping skills.”

“You need to control your behavior.”

“When you are angry, just count to 10.”

“That behavior is inappropriate.”
It’s easy and natural for staff to work in a “one-up” way

• Client lack of problem solving skills means dialogue is not immediately effective
• Staff don’t always have strong problem solving skills either
• Behaviors often very serious; people can be hurt; programs worry about bad outcomes
“One-up” style often provokes resistance
“One-up” directives teach obedience, following rules, **not thinking and problem solving skills**
Key vocabulary: “One-down”
One-down

Inviting
Curiosity/wondering
Worrying
Asking for help
One-down: Inviting

• "Would you be willing to discuss this now?"
• “Can we practice that skill?”
• “Is this a good time for you to meet?”
One-down: Curiosity

• "I am curious what you think about this?"
• “What happened?”
• “How were you feeling?”
• “What were you thinking?”
One-down: Wondering

- "I am wondering what you think is the best plan right now?"
- “I am wondering how this happened?”
- “I am wondering how I can help.”

- What are good questions to show you are wondering about why someone did something?
One-down: Worrying

- "I am worried what will happen to you if you continue to drink?"
- "I am worried about you getting in trouble."
- "I am worried that you will lose friends."
- "I am worried that staff will not want to work with you."
One-down: Asking for help

• “We really need to figure out a better plan. I need your help on this.”
• “I’m stuck. I don’t know what to do. Can you help me figure this out?”
• “I can’t solve this problem without you.”
Practice: Core strategy of CPS

• 3 Steps, Each needs to be unpacked and adapted
  • Empathy
  • Define the problem
  • Invitation to problem solve
Use of authority

• Of course, we use authority
• Of course, children need to learn about consequences
• Immediate safety is always a priority
• But focus on rules and consequences alone creates people unable to problem solve independently

• We over-use it, often because we don’t know other methods. We need a bigger tool box.
Part III

Other evidenced based curricula for teaching psychosocial skills
Teaching negotiation and other skills
Deaf friendly teaching and counseling
Formal social skills curricula give you skills vocabulary

- Boystown training curricula
- [http://www.boystowntraining.org/lesson-plans.html](http://www.boystowntraining.org/lesson-plans.html)
- Note: It’s very helpful to be able to **identify the specific skills taught** even if you don’t use this program
- There are lots of books and other materials on social skill development in children
183 Basic to complex life skills

- Basic skills group
  - Following instructions
  - Accepting “no” for an answer
  - Talking with others
  - Introducing yourself
  - Disagreeing appropriately
• Intermediate skills group
  • Accepting apologies
  • Accepting compliments
  • Accepting consequences
  • Asking for clarification
  • Being on time
  • Completing Tasks
• Advanced skills group
  • Accepting defeat or loss
  • Accepting help
  • Advocating
  • Analyzing social situations
  • Dealing with embarrassing situations
  • Dealing with failure
  • Delaying gratification
• Complex Skills group
  • Accepting self
  • Assessing one’s own abilities
  • Being assertive
  • Clarifying values
  • Maintaining relationships
  • Resolving conflicts
Skill names example: friendship making skills

- Introducing yourself
- Beginning a conversation
- Ending a conversation
- Joining in
- Playing a game
- Asking a favor
- Offering help
- Giving a complement
- Suggesting an activity
- Sharing
- Apologizing
PATHS

• Example: PATHS (Promoting Alternative Thinking Strategies)
• Advantage: a year by year curriculum
• Has been researched with deaf children

• As you listen to this, think about your students/clients. How relevant are the skills? Even to adults?
  • “Do turtle”
  • Feelings charts and pictures
Paths has been used successfully with deaf children


CONTROL SIGNALS

STOP
Take one long, deep breath.
Say the problem and how you feel.

MAKE A PLAN
Think—what could I do?
Think—would it work?

GO
Try your best idea.
How did it work?
“Do turtle”

- Step 1: Recognize your feeling(s)
- Step 2: Think “stop”
- Step 3: Go inside your “shell” and take 3 deep breaths
- Step 4: Come out when calm and think of a “solution”
Skills are taught:

• **Informally:** Praise and reinforce when a youth uses a skill
  • Notice, label and praise the skill being used
  • Example: youths plan an even

• **Guided, Socratic teaching**
  • Ex: Help youth anticipate consequences; consider point of view of others

• **Proactively:** Formally instruct in skill use
  • How to make an apology

• **Corrective teaching:** When a youth does not use a skill, issue a consequence and demonstrate appropriate skill
  • Modeling a better apology: Practice teaching a good apology
  • Practice this with some socially unskilled behaviors like interrupting
Skills are taught

Individually and in groups

According to identified skill deficits

In a developmentally attuned way, from simple to complex

By different people, in different settings, to promote skill generalization

In the context of caring relationships, by the people closest to the youth
Discussion

• How do you develop problem solving and other skills in the classroom?
Deaf friendly teaching

• Close, expert attention to communication and language
• The “elephant in the room:” Is the communication environment optimal?
• Is every means of communication and language development used?
Language Equality and Education for Deaf Kids (LEAD-K)

- http://www.lead-k.org/about/
- http://www.lead-k.org/leadkfaq/
- The Campaign aims to end language deprivation through information to families about language milestones and assessments that measure language milestone achievements, and data collection that holds our current education system accountable.
• “There must be language benchmarks and systemic accountability for outcomes. Deaf children must be tested for language development when they are first identified, as infants and every three months afterwards, from age 0 to 5. Waiting until early elementary grades will cause irrevocable developmental harm to the child. The parents should be informed about the benefits of ASL and provided with opportunities and resources to learn ASL.”
  • [http://www.lead-k.org/leadkfaq/](http://www.lead-k.org/leadkfaq/)
Language/communication learning takes a village

• Signing environments, not a signing teacher, aid or interpreter, have to be available as options

• Developing language skills in language delayed persons requires an exceptional level of language expertise

• A competent language/communication evaluation, assessing spoken and sign language, is essential.
Adapting “evidenced-based” CBT practices for deaf (and hearing) persons with language and learning challenges
Adapted CBT

• Focus on decreasing behavior problems
• Focus on eliciting informed engagement in counseling
• Drawing on “evidenced-based” practices with hearing people but drawing upon and developing further strategies for “Deaf friendly” adaptations
• Attention to language, communication and cognitive barriers to mental health care
• Psychosocial skill building as a focus of treatment
Visual and hands on learning

• Visual aids
  • Pictures of skills
• Toys and other manipulatives
Pay Attention

Eye Contact

Lean Forward
TRY TO UNDERSTAND
WHAT OTHER PERSON FEELS
PAY ATTENTION.
LISTEN.
DON'T INTERRUPT.
EXPRESS FEELINGS SAFELY
Cooling down: what’s the method?
• Don’t forget that sensory strategies are likely to be most helpful and available
Rock, Paper, Scissors
Naming skills

- WE HAVE DIFFERENT OPINIONS
- WE NEED TO DECIDE WHICH
- COMPROMISING
Free pictures by Michael Krajnak (CD from the 2009 book)

Are you willing or stubborn?
Are you respecting each other?
Humble or Big Head?
Open or Closed Mind?
Active learning, especially role playing
Use props and visual aids
Teaching stories in ASL
Adopting a “one down” style to pull for thinking skills
Take Home Points

• Language delays and deficits creates cognitive, emotional and behavioral problems
• Language and psychosocial skill development are inseparable
• Evidenced based teaching and mental health practices are concerned with cognitive (problem solving) and psychosocial skill development
• Collaborative problem solving
  • Empathy
  • Identify the conflict
  • Invitation to problem solve
  • Elaborate on skill training: there are many ways to do this
  • Questions are usually better than directives
• Skills are taught formally and informally
• Naming skills, and helping students recognize when they use them
• Use pictorial aids to name skills
• Inviting, not compelling participation
• Guided problem solving
• Role playing

• Constant and expert attention to language in all modalities