

Engaging Deaf Persons with Language and Learning Challenges and Sexual Offending Behaviors in Sex Offender-Oriented Mental Health Treatment

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Abstract

The authors present a framework and practical strategies for engaging deaf persons who have language and learning challenges as well as sexual offending behaviors in sex offender oriented mental health treatment. Current treatment approaches for persons who commit sexual offenses are reviewed along with modifications that have been made for persons with intellectual impairments. The additional challenges when the persons referred are deaf and poor language users are explored. The treatment resources for helping this subgroup of deaf persons with highly specialized needs are limited, and the common fallacy that a “signing clinician” with some knowledge of sexual offending treatment can make up for this absence of resources is contrasted with what it actually takes to do this work effectively. Finally, practical suggestions for treatment providers and programs without such highly specialized expertise, but with clients who have these problems, are presented.

Keywords: deaf, sexual offender, treatment

“We have in our treatment program a deaf client who needs therapy for sexual offending problems. This person has sexually assaulted both peers and staff and needs specialized treatment for this problem. Nobody in our program has this expertise. Can you assist or refer us to the right therapist who also signs?”

If you are a signing mental health clinician or work in a Deaf mental health program, you have probably received this kind of inquiry. The first two authors worked together in a Deaf inpatient program which was forced to develop some expertise in this area because we served a number of deaf persons who were sexually aggressive. The third author works in a mental health “service” (hospital) in Great Britain which regularly treats deaf persons with sexual offending problems. Some of the patients we have all worked with committed crimes like rape or child molestation. Others grabbed and groped the private parts of other people against their will or pressured and intimidated people into having sexual relations with them. The people we saw victimized adults, adolescents and children. They are a small percentage

of the deaf persons seen in mental health inpatient programs, but they raise unusually difficult treatment and risk management concerns. They often endure long hospitalizations because of staff fear of discharging them into the community (and the fears of community programs about accepting them.)

Staff worries about their reoffending to be related to the scarcity of appropriate treatment resources and the fact that even if we had such resources, many of these persons are not ready or willing to use them. Strictly speaking, sexual offending problems are criminal matters, but when persons with mental illness, developmental disabilities, addictions or other challenges are in treatment programs, and they engage in these kind of criminal behaviors, the programs typically try to “treat” these problems, or at least manage the risk, when they can. Indeed, sexually dangerous behaviors may by necessity become the dominant concern *to staff* no matter what other problems the person served may have.

The first two authors work outpatient now, so when we get these referrals, it is often from someone looking for an outpatient therapist. The first author has developed a set of questions which he uses to evaluate whether individual psychotherapy is likely to be a useful intervention. These questions attempt to get at the person’s readiness for the very specialized kind of work involved in sexual offender treatment. They attempt to understand how great the chasm is between this persons’ “thought world” and the thought world needed to do such treatment. These questions are:

- a. Does the client believe that he or she has a problem with sexually aggressive behaviors?
- b. Does he or she have language and learning challenges associated with developmental disabilities, language deprivation, low educational achievement, possibly neurological impairments, or other factors?
- c. Does he or she have a history of other kinds of behavioral problems, most likely including non-sexual physical aggression and self harm?
- d. Has the person been able to make good use of use of conventional “talk” oriented counseling/therapy up until this point, whether the clinician signs well or not?
- e. Has the person ever been arrested for any of his or her behavior? If he or she was arrested, did he or she go to court? Were the charges dropped? Is there court oversight or probation? Is the legal system deferring to the mental health system to address the person’s problem behaviors?

Usually, the answers are that the person referred doesn't think he has a problem (and isn't aware of the referral); does have language, cognitive and other learning challenges; has many kinds of behavioral problems; has never used therapy productively; and that no legal action has been pursued. In cases where legal action was pursued, courts were often reluctant or unwilling to hold the person accountable, and instead the person was referred to some treatment or rehabilitation program, even when that program had no real expertise in treating this kind of client or problem. If none of these conditions were true and the person had "just" a sexual offending problem, the task of finding a signing therapist who could help him would be still be very daunting. What basis, then, do we have for thinking that finding the right therapist for this subset of deaf persons with all these extra challenges is going to be an effective intervention? The language differences and deficits, the impaired cognitive abilities, the unwillingness of legal systems to hold people accountable, the lack of accessible, culturally and clinically appropriate treatment programs, all mean that we ask a great deal of the therapists, whether they sign or not, who agree to work with these persons. We are asking these therapists to overcome enormous therapeutic barriers and to make up in individual therapy for the absence of group and residential treatment resources. We are asking the therapists to take on this enormous challenge with high risk individuals who often have neither understanding of nor motivation for the kind of therapy that is needed.

There is a saying that "no good deed goes unpunished," which therapists who naively take on this challenge may come to appreciate.

The deaf persons we are discussing here have significant "language and learning challenges" (Glickman, 2009). *They are not representative of deaf people in any way*, but they exist and they need help. Many are not good signers and will not necessarily understand signing therapists who cannot match their particular communication abilities. Therefore, finding a "therapist who signs" is no guarantee of good communication, much less good therapy. Similarly, finding someone with expertise in sexual offending problems is no guarantee they can work with intellectually disabled offenders, much less deaf intellectually disabled offenders. The clinician who has some of the needed expertise but not all of it is likely the best resource available, but it's very easy in this work to get in over your head.

In this article, we address what it takes to serve deaf persons with language and learning challenges who are referred for specialized sexual

offender treatment. We de-mystify the treatment process and goals and offer suggestions about practical steps that can be taken by Deaf treatment programs which do not have this additional specialty. We summarize the main strategies used in sexual offender treatment, consider adaptations made to this treatment for sexual offenders with intellectual disabilities, consider the further challenges of serving deaf persons with language and learning challenges and problem sexual behaviors, and offer practical strategies for Deaf treatment programs which do not also specialize in sexual offending treatment but do serve persons who need this kind of help. To our knowledge, the United States does not have any facilities which have all the kinds of expertise needed. We look briefly at work in the United Kingdom where 5 designated “services” (psychiatric hospitals) are attempting to do this work.

The History and Current Framework for Sex Offender Treatment in the United States

According to the Center for Sex Offender Management (www.csom.org), sex offender treatment as it is generally practiced in the United States today refers to one or a combination of the following three interventions:

1. Cognitive-behavioral therapy (CBT), a language-based therapy in which clients are taught to recognize how their thoughts and feelings interact and are helped to modify these toward a desired goal,
2. Psychoeducation, which involves components of both teaching and therapy and is geared toward helping clients learn about sex offending from multiple standpoints (psychological, behavioral, legal, systemic). The assumption is that by teaching about sex offending and offering an opportunity for exploration and discussion, clients will increase their motivation to refrain from sexually abusive behaviors, thus reducing their risk of harm to others, and
3. Pharmacological approaches, in which medications are used to reduce sex drive and/or treat any medical conditions which might cause or contribute to risk factors, such as conditions which cause poor impulse control.

In addition, assessing and promoting motivation is often a key component of such work. Treatment success is very related to clients' ability to understand, accept, and engage meaningfully in the work toward the attainment of agreed-upon goals. The most widely known and utilized approach to assessing and fostering motivation is motivational interviewing

(Miller & Rollnick, 2002). This is a style of interviewing which helps people identify and think through consequences of their behaviors and then articulate for themselves the reasons for changing. It is premised upon the clinician demonstrating a strong empathic connection with the offender, which includes demonstrating understanding of why the person may be reluctant to change problem behaviors.

We are not physicians, and therefore, we will not discuss pharmacological approaches except to raise two concerns. First, when working with any person who has high-risk behaviors, including sexually abusive behaviors, a psychiatric evaluation should be an early if not the very first intervention. This is because when a client has an untreated psychiatric condition which is fuelling the behavior (for instance, untreated bipolar disorder in which manic episodes are marked by hypersexuality and poor impulse control), talk therapy and education are unlikely to yield much result. Sometimes, if the mania or other medical problem is treated, the problem may be resolved.

A second concern regarding psychopharmacology is this: the fewer appropriate treatment resources, and the less capable the person is to engage meaningfully in existing treatment resources, the more likely psychopharmacology will be the only treatment intervention attempted.

Pharmacological treatments can have very significant unwanted side effects, and the persons we are discussing here may not be competent to make informed decisions (or only competent if extraordinary attempts at communication accommodation are made). Indeed, it is always important to ask whether the prescribing physicians attempted to provide information regarding the risks and benefits of the medications; what accommodations to communication, if any, were made; and whether the patient had the capacity and opportunity to make an informed decision regarding medication.

There is another saying that, “if the only tool you have is a hammer, every problem will look like a nail.” If medication is the only available tool, then it is much more likely to be perceived as what is needed (that is, as a “nail”), regardless of whether or not the patient can or does make an informed decision.

Prior to the 1980s, people (generally prisoners) identified as having shown sexually abusive behaviors were treated with the same kind of therapies that were used for the general public, especially psychodynamic and

client-centered therapies. But in 1983, an important article by Pithers and colleagues described a treatment approach, borrowed from the addictions treatment field, which has become the most widely used approach in the United States today (Pithers, Marquez, Gibat, & Marlatt, 1983). Relapse prevention, a kind of cognitive behavior therapy (CBT), was touted in the article as offering “a self-control model of treatment and maintenance of change” for treating incarcerated sex offenders (p. 261). Adopted by the National Academy of Corrections in 1984, relapse prevention was taught to treatment providers in most of the 50 states and has become the uniform treatment of approach in prisons across the country, and it remains so today.

The relapse prevention model was originally developed by Marlatt for treatment of alcoholics and is based on the belief that there is an “offense cycle”, a predictable course of thoughts, situations, and behaviors which interact and which lead to problem behaviors such as alcohol abuse or sexual offending problems (Marlatt & Gordon, 1985; Yates, Prescott, & Ward, 2010). Marlatt and colleagues showed that people can learn to understand these connections and develop skills to avoid relapses.

The relapse prevention model was embraced in the field of sexual offender treatment because of its many advantages. It is easy for clinicians to learn, can be imparted in many formats (workbooks, individual and group sessions, audio-visual materials), and theoretically, it empowers clients because it teaches that each individual has the power to recognize his or her pattern(s) of behavior and, therefore, to deliberately modify them.

Relapse prevention work, while the main standard of care, has significant limitations, especially for the deaf language and learning challenged population. First, it presumes that everyone who is in treatment has already made a decision that they want and are ready to change their behavior. That is, it presumes motivation. Second, it presumes that the model is easily understandable and accessible to the person in treatment. Commonly, neither condition is in place when deaf persons with language and learning challenges are referred.

More recently, clinicians doing this work have moved beyond risk prevention, offering other models. These include the following:

1. The Risk-Needs-Responsivity Model. This is the term used to describe the importance of individualizing treatment. The level of

intensity of an intervention should be matched to the level of risk posed by the individual. All interventions must be specifically tailored (responsive) to the individual characteristics of the client. This last principal is especially important when working with deaf language and learning challenged offenders who vary enormously in their language and cognitive abilities (Yates, et al., 2010).

2. The Stages of Change Model. Often used alongside of motivational interviewing, this model addresses stages in the readiness of persons to change and how to promote greater readiness (Prochaska & DiClemente, 1992; Prochaska, Norcross & DiClemente, 1994.)
3. The Good Lives model adds to sexual offending treatment recognition that individuals need to develop feelings of positive self-worth and self-esteem and lives that they feel are worth living (Yates, et al., 2010). Some group treatment foci that promote good lives and relapse prevention are social skills training (e.g., communication, self esteem, relationship skills, appropriate touch, hygiene). Promoting healthy sexuality is also a part of developing good lives. The Good Lives model includes recognition that clients need real-life opportunities to practice the skills they learn in treatment. The goal is to develop relationship skills and this has to be done in practice, not just in theory.

Psychoeducation with Sex Offenders

With some sex offenders, it is clear that lack of information is at least one factor fuelling their sexually abusive behavior. For example, if a client engages in sexual behavior with a 20-year-old who has severe developmental delays, and the client cannot comprehend that such an individual cannot legally and meaningfully give consent, he is not likely to see his sexual behavior as abusive. In theory, if you teach this client how the legal system looks at the issue of consent, for instance, and about the psychological impact of being subject to sexual behavior when you are not capable of meaningful consent, the client should ultimately regret their action and increase their motivation to change.

This psychoeducational approach to treatment is widely utilized to try to help clients better understand factors underlying their sexually abusive behaviors. Topics addressed includes victim impact, legal and public safety issues, non-abusive sexual behavior norms (arguably a wide continuum), and the influence of factors such as alcohol abuse, mental illness, and social

influences on a person's likelihood to engage in sexually abusive behaviors. Often persons who are very concrete thinkers have trouble understanding why some kind of sexual behaviors are all right while others are not. They may mistakenly believe that they are being told that all sexual contact is wrong.

Information and skill deficits are presumed to be highly significant factors when working with deaf persons with language and learning challenges who sexually offend. Psychoeducation should, therefore, always be attempted. But appropriate sex education resources for deaf persons with language and learning challenges are also scarce. In this area also, we have few clinicians and educators with the communication skills (matching the communication abilities of clients) and specialized knowledge in sexuality education, and we also have a scarcity of educational materials that do not depend upon the ability to read the English, Spanish, etc., of the larger community.

Promoting Motivation to Do Sexual Offender Treatment Work

Probably the greatest challenge in sexual offender treatment, as with addictions treatment with which it has much in common, is helping persons become motivated to do the work. It is common for offenders to deny they have a problem and to hold "cognitive distortions" (e.g., "women want to be raped") that promote offending behaviors. These behaviors may also be pleasurable and gratify desires to dominate, control, or even hurt other people. Often people are not motivated to do this work until they are arrested or face some other very negative consequence, like having a spouse or partner leave them or losing a job.

In our experience, motivational interviewing, the most common way in which motivational deficits are addressed, is not a sufficient strategy for bringing deaf persons with significant language and learning challenges into sex offender treatment. To begin with, motivational interviewing is easier to do when the person has faced real world negative consequences like arrest or loss of a job or partner. Counselors help clients articulate and elaborate upon such real world negative consequences as a way of motivating themselves to change. If the person has been protected from facing these real world consequences, as we sometimes see in the deaf persons with language and learning challenges who are referred, then they will not have had the benefit of this consequential learning. They are referred to programs or counselors who must hold out as motivators

abstract, theoretical possibilities (i.e., you might be arrested) which in fact have never happened to them.

In addition, it is far easier to do motivational interviewing when the person has strong reasoning abilities such as the ability to weigh pros and cons, consider alternatives, and articulate their thoughts and feelings in clear language. Sometimes discussions of the use of motivational interviewing seem to assume that all persons have such strong reasoning abilities. The presumption is also sometimes made that “resistance to change” is the only or main barrier to enhanced motivation. The barriers to treatment that some of the persons we are describing face are not merely a lack of readiness to change but a lack of understanding of why they are in trouble, the nature of their problem, and how and why to get better. It can be especially difficult for them to understand very abstract notions such as that offenders have cycles and that internal processes (e.g. thoughts, fantasies, feelings) may set them up for offending behaviors.

The “fund of information” gaps that such persons usually have along with poorly developed reasoning abilities mean there must be much more attention given to foundational problem solving skills. Sometimes the first task has to be language development. Other times, very simple problem solving abilities, like the ability to compare pros and cons or the ability to recognize consequences, must be developed. There must always be a great deal of psychoeducation, and it always has to be finely attuned to the language and communication abilities that the person already has. Thus, the “pre-treatment” (Glickman, 2009) work is going to be much more extensive and complicated than with persons who have well developed language and reasoning abilities.

Language and Learning Challenged Deaf Persons

Scholarship regarding deaf people with language and learning challenges has gone by different names. Sometimes, this group of deaf persons is referred to informally as “low functioning,” but this label has been avoided in the recent professional literature due to perceptions it is derogatory and stigmatizing. For many years this group was referred to, especially in vocational rehabilitation literature, as “traditionally underserved deaf (Bowe, 2004; Dew, 1999; Harmon, Carr, & Johnson, 1998; Mathay & LaFayette, 1990) Glickman (2009) documented the discussion from the mental health

literature, especially where deaf inpatients units were found, of the cohort of deaf patients who fit a profile of language, developmental and behavioral deficits. Not all deaf persons with language and learning challenges also have severe behavioral problems, but when they do they frequently find themselves involved, usually involuntarily, with the mental health system. He noted that diagnoses used with this group have included surdophrenia (Basilier, 1964), primitive personality disorder (Altshuler & Rainer, 1968; Vernon & Andrews, 1990; Vernon & Miller, 2001) borderline syndrome (Grinker, et al., 1969), developmental disorders of communication (Denmark, 1985), and include the ubiquitous use of the diagnostic tag *not otherwise specified* (e.g., psychotic disorder not otherwise specified or pervasive developmental disorder not otherwise specified) (Haskins, 2004). Glickman proposed a new name for this set of problems, *language deprivation with deficiencies in behavioral, social and emotional adjustment*, and also proposed specific diagnostic criteria (Glickman, 2009/2013).

The key issue distinguishing this group of deaf clients from hearing psychiatric clients, are severe language limitations and associated developmental deficits and behavioral problems (Glickman, 2009). These language and developmental issues profoundly confound diagnosis and treatment. Glickman noted that the day-to-day life problems of most of these deaf patients served in the Westborough State Hospital deaf inpatient setting, as well as the reasons for their hospitalization, were more often more related to these language, developmental and behavioral problems, as well as to traumatic experiences, than to more familiar thought or mood disorders for which they were presumed to need hospitalization. Once these patients are ensconced in a medical setting, however, they are subject to a medical understanding of their problems. Clinicians can experience institutional pressure to frame this complex set of problems as a medical condition, a mental illness. Such persons would typically be medicated while the underlying environmental and developmental factors are ignored. Glickman argues that the more appropriate treatment interventions are psychosocial skill training in a sign language rich environment (Glickman, 2011a/2011b). Unfortunately, treatment resources for the latter are scarce while medication is very easy to provide.

Common Examples of Sign Language Dysfluency

Research done at the Westborough State Hospital Deaf Unit focused on both diagnoses and patient communication patterns (Pat & Black, 2005;

Pat, Black & Glickman, 2005/2006). A closer examination of the kind of (sign) language errors commonly observed in Westborough State Hospital Deaf unit patients found the following:

1. Very limited (impoverished) vocabulary, with many signs used incorrectly.
2. Poor ability to communicate time and sequencing. This includes an absence of grammatical indicators for tense (e.g., LAST-YEAR, THRE-MONTHS-FUTURE), inaccurate use of the FINISH sign to indicate tense, an absence of references to time, a lack of sequential reasoning (first this happened, then this, then this) and a tendency to mix up past, present and future events.
3. Absence or inaccurate use of key grammatical features such as subject, verb and object. Clients would say something happened but leave out the subject. They were not clear as to who did what to whom. Related to this would be the inability to inflect verbs correctly (to move verbs to show actor and receiver and qualities of action) or to use the spatial properties of ASL to indicate subjects and objects. ASL syntax would be absent or confused.
4. Mixture of established signs, home signs, sometimes signs from foreign sign languages, gestures, English words and sometimes words from Spanish. In some cases, where clients had grown up outside the United States, it wasn't clear whether they were using a local sign variant or a home sign. (Pat & Black, 2005; Pat, Black & Glickman, 2005/2006).

When people have these kinds of language problems, they also have trouble with rational problem solving, and they lack many of the thinking skills necessary for sexual offender treatment. These skills include: recognizing who did what to whom; establishing cause and effect; parsing events in time; identifying how other people think and feel (theory of mind); understanding and applying abstract ideas such as relapse, risk, trigger, warning signs, seemingly unimportant decisions and cycles; identifying feelings; and distinguishing feelings from thoughts and reflecting on thoughts (Glickman, 2009). Severe language dysfluency of this kind may also make it more difficult for persons to accept responsibility for their behavior, as it appears to be the case that such persons tend to externalize causality, to see other people as responsible for their own behaviors. This might be because they literally lack the vocabulary to describe their inner life. Language dysfluency can therefore make cognitive distortions (e.g.,

“you made me do it.”) worse and more difficult to change. This externalizing might also be related to the life experiences of such persons, being raised in over-protective environments where they are given few opportunities to use thinking, language and dialogue for problem solving.

Engaging Deaf Persons with Language and Learning Challenges and Sexual Offending Behaviors in Sex Offender-Oriented Mental Health Treatment

There is a small research literature on deaf persons with sexual offending problems. It has been difficult to study this group of persons because deaf individuals with this problem are usually not found in one place long enough, and with enough consistent staff, for the program to advance the expertise of the field. The exceptions represented in the peer reviewed literature are forensic psychiatry programs in Great Britain and correctional programs in Texas, which brought deaf prisoners together.

In a study of deaf sex offenders in the Texas prison population, Miller and Vernon found that the rate of sexual offending by deaf offenders was 4 times the rate of sexual offending by hearing prisoners (Miller & Vernon, 2003; Miller, Vernon & Capella, 2005.)

Sixty-two percent of deaf sex offenders in this group were functionally illiterate while their performance IQs were comparable to those of the overall prison population. Twenty four per cent of the deaf sexual offender population possessed minimal language skills, characterized by impoverished social skills and markedly restricted sign language and English vocabularies. Their performance IQs suggest they function similarly to the hearing prisoners but the poor language skills set them apart, and very likely mean substantial cognitive and functional impairment.

In another study, Vernon and Rich (1997) reviewed the demographic data from 22 deaf persons with pedophilia Vernon had assessed over the course of his career. Eight of the 22 persons met criteria he presented for primitive personality disorder. Vernon and Rich wrote, “Results indicate a number of factors that distinguish deaf pedophiles from hearing pedophiles. First is the prevalence of primitive personality disorder...Other significant differences include a high rate of brain damage, illiteracy, poor communication skills, and other psychiatric illnesses (Vernon & Rich, p. 300.)

Sex Offender Treatment Resources for Deaf Persons in Great Britain

Sex offender treatment is offered to deaf people in Great Britain in several forensic services. All these services aim to provide self-contained Deaf programs, serving only or primarily Deaf people. All aim to provide fully communication accessible environments and all work on adapting established treatment protocols for Deaf persons who have widely varying communication and functional abilities. Services are offered at the services listed below, the first four of which are forensic hospitals with varying levels of security:

- a. The National Centre for Mental Health and Deafness, Rampton Hospital, Nottingham
- b. All Saints Hospital Oldham. (The third author works here.)
- c. Alpha Hospital Bury
- d. St Andrews, South Hampton
- e. National Centre for Mental Health and Deafness, Manchester.

The most recent research from Great Britain on deaf persons with sexual offending problems was done at the National Centre for Mental Health and Deafness. Iqbal, Dolann, and Monteiro (2004) presented data on 137 deaf sexual offenders served there between 1969 and 2002. Their findings suggested that deaf sex offenders are primarily male, single, target child victims and have low rates of major mental disorders. They did have high rates of cognitive impairment, poor communication abilities, little sex education and a history of sexual offences in public places. They describe a cohort of persons who were deaf, intellectual disabled, educationally deprived and socially unskilled. They do not comment on language abilities per se (Iqbal, Dolan, & Monteiro, 2004) . Bramley (2007) described the highly specialized program at the NCMHD for deaf persons with sexual offending problems. This program took clients 170 hours over a course of 2-3 years to complete.

Great Britain seems to be ahead of the United States in providing forensic mental health services, including sexual offender treatment, to deaf persons in designated Deaf treatment settings. Because they bring deaf people who have these behavioral challenges together, they have the opportunity to gather better communication resources and work collectively on the challenges of adapting established treatment protocols.

As in the United States, the deaf people they serve have highly varying communication and cognitive abilities. Persons with greater language and learning challenges are far more difficult to serve. Many have real limitations in their capacity to develop insight into their motivations, risk factors, and offending cycles. Many had difficulties developing empathic understandings for their victims that are partly due to limited capacities in “theory of mind,” or appreciation that other people have other points of view.

Services in Great Britain draw upon a cognitive neuro-rehabilitation model developed for persons with brain injury and criminal behaviors (Stuss, Winokur, & Robertson, 1999). This approach aims to support specific brain functions like perception, memory, thinking and problem solving.

Treatment providers in these programs have found that some of their patients do not seem capable of developing skills at self-regulation. Their language and cognitive impairments, including very limited insight and poor problem solving abilities, mean that they remain dependent upon external controls (i.e., locked forensic settings or mandated community supervision.) If they have not been mandated into treatment or supervision by a court, it is usually impossible (and, we would argue, undesirable) for mental health providers to assert that level of control, especially in open community settings.

These few studies refer to deaf persons whose behaviors have brought them to the attention of the criminal justice system. We presume that, as with hearing people, a much larger cohort of deaf sexual offenders are never arrested or adjudicated (O’Rourke, Glickman, & Austen, 2013). There is also reason to believe that deaf people who commit minor crimes are diverted from the criminal justice system until their crimes become more serious (Hindley, Kitson, & Leach, 2000; K. R. Miller & Vernon, 2001; Mitchell & Graham, 2011). Elsewhere in the world, there are no specialized treatment programs like the NCMHD and few, if any, clinicians with the kinds of expertise required to work with this group of persons. The scarcity of clinicians and programs that are capable of serving expertly this cohort of persons is no doubt why there is also so little research describing their characteristics and treatment needs.

Sexual Offender Treatment with Persons with Intellectual Disabilities

Recent research with a large cohort of (presumably hearing) sexual offenders found significantly lower education and higher incidences of

school drop outs than community controls. Neurodevelopmental factors such as birth complications and defects, motor and language developmental abnormalities, ADHD, neurological disease and injury, mental retardation, and learning disorders all contributed to the educational deficits, but learning disorders diagnosed in childhood contributed the most (Langevin & Curnoe, 2007). The authors indicate that histories of educational failure can produce poor attitudes towards any new learning environment and that these poor attitudes become yet another formidable barrier to the work.

There is a developing literature and practice focused on sexual offender treatment for persons with intellectual disabilities (Blasingame, 2005; Horton & Frugoli, 2001; Wilson & Burns, 2011). "Intellectual disability" is the contemporary label for a complex of cognitive/emotional factors previously referred to as "mental retardation," though this work is relevant to less severe forms of learning disability. The authors/proponents argue that the same treatment goals can be met by modifying and adapting CBT with simpler materials and procedures

Three important books that address this topic are *Developmentally Disabled Persons with Sexual Behavior Problems* (Blasingame, 2005), *Healthy Choices: Creative Ideas for Working with Sex Offenders with Developmental Disabilities* (Horton and Frugoli, 2001), and *Intellectual Disability and Problems in Sexual Behavior* (Wilson and Burns, 2011). We will summarize briefly the first book.

Blasingame's *Developmentally Disabled Persons with Sexual Behavior Problems* describes structured sexual offender treatment programs for persons with developmental disabilities. Such programs include an array of treatment modalities such as individual and group treatments, sex education, various skill training opportunities, and adjunctive family and caretaker support groups. There is a heavy reliance upon group treatment for such core tasks as using group processes to elicit ownership and responsibility taking.

Blasingame describes one treatment program which maintains the cognitive behavioral focus upon relapse prevention skills and incorporates behavior modification strategies. The basic therapeutic tasks are: identification and ownership of problematic behaviors; learning about high risk factors, warning signs, triggers; developing victim empathy; recognizing and changing thinking patterns that reinforce offending; learning new

social behaviors; resocialization; development of related psychosocial skills such as anger management, communication, coping and problem solving; and practicing new skills in a variety of situations. He cites research that supports the efficacy of such treatment approaches with (hearing) persons with developmental disabilities.

The basic treatment focus is the same as with non-developmentally disabled persons, but the treatment is adapted so that it matches the vocabulary and learning capabilities of each person. Learning and skill acquisition are understood to be developmental processes, and the clinician and team aim their teaching at what developmental psychologist Vygotsky called the “zone of proximal development,” which is the zone of learning just ahead of what the person already knows (Vygotsky, 1978).

This concept of “zone of proximal development” is very useful when working with deaf language and learning challenged persons. It is crucial that clinicians understand what these persons already know and how they already think so they can match interventions to their learning capacity. Clinicians working through interpreters will not understand the clients’ zone of proximal development and will usually talk “over their heads.” This is a key reason why working through interpreters is often ineffective. Skilled interpreters may “unpack” the clinicians’ ideas, breaking them down, providing examples, filling in fund of information gaps, in a way that may be completely opaque to the non-signing clinician. The likelihood of misunderstanding and of treatment failure is high because the communication challenges are not sufficiently understood by the clinicians who, therefore, cannot tailor their interventions to their clients’ learning capacities.

Blasingame describes treatment adaptations such as simplifying the language levels of written materials (but rarely the elimination of written materials) and using a variety of creative and active treatment modalities such as expressive therapies (art, music, drama), games and role playing. Blasingame recommends a commitment to make treatment playful and fun. He pays close attention to whether or not clients are actually learning and not just pretending to learn. There is a need for more repetition, slower steps, and more action than talk. Clients demonstrate and cement learning by helping and teaching each other. Behavior modification principles such as active reinforcement of positive behaviors, modelling and shaping of new behaviors, practicing behaviors in new settings, with decreased staff prompts, to ensure generalization, are included.

An example of a pictorial aid used by Blasingame is a picture called “my ladder to trouble,” which has seven rungs. The rungs, representing steps in the path toward sexual offending, are:

1. Feeling bad
2. Keeping things to myself
3. Wrong way of thinking
4. (Bad) nasty thoughts
5. Danger zones
6. Set up/opportunity, and
7. Act out/bad behavior.

This pictorial aid is used in group discussions to help clients identify their own paths toward offending. Pictures which are created by the patients themselves can also be very useful.

Despite the authors’ claim that the (hearing) persons they work with do well with these simplified pictorial tools, our experience is that the cognitive restructuring part of this work is particularly challenging for many deaf persons with language and learning challenges. It may be that the intact language skills of their intellectually disabled group makes the crucial difference. Simplified English and pictorial materials may help but current scholarship and practice regarding adaptations of psychotherapy approaches for deaf persons place much more emphasis upon the development of sign language based materials, such as DVD’s with deaf actors who illustrate key teaching points through engaging and culturally relevant stories (Glickman, 2013; O’Hearn & Pollard, 2008; O’Hearn, Pollard, & Haynes, 2010) These materials are not, strictly speaking, interpreted from spoken to sign language. Rather, they are redesigned and recreated in a way that fits the fund of information, thought world and language capacities of deaf persons who are likely to be clients in these programs.

The Unique Challenges of Work with Deaf Persons with Language and Learning Challenges and Sexual Offending Behaviors

While there are many similarities between the treatment of hearing persons with intellectual disabilities and deaf and hearing persons with language and learning challenges, there are some very significant differences.

First, the language and communication challenges, while not unique to deaf people, are often far more severe; and in extreme cases, we see deaf people who are virtually alingual (Schaller, 1991). While non-verbal cognitive abilities will vary enormously, the psychosocial implications of language deprivation (often confounded further by neurologically based learning difficulties) are so profound that such persons usually function well below their intellectual potential, sometimes making them more “disabled” than hearing persons with mild to moderate levels of mental retardation. Many deaf persons with language and learning challenges are not merely poor readers who can work with simplified English texts. They are functional non-readers who cannot use even these simple English texts. Overall, the combined language and cognitive challenges can render materials and approaches designed for hearing persons with intellectual disabilities inaccessible. The simplified approaches to teaching hearing persons about cognitive distortions may still be extremely difficult for deaf people who struggle to express even basic concepts clearly. Their “zone of proximal development,” may not include understanding what a thought is, much less recognizing their own thoughts, much less adopting some strategy to change how they think.

Secondly, coincident with language deprivation are common psychosocial developmental and cognitive deficits. Fund of information deficits are often severe. Cognitive functioning may be weak in very basic thinking skills (i.e., identifying patterns, placing events in time, understanding “if, then” constructions, recognizing and labeling emotions in oneself and others; even the ability to tell a story with a beginning, middle and end; as well as even more abstract notions such as how one’s behavior may impact others.) This means that basic language and cognitive development must often come first, that much of the work is habilitative (teaching skills for the first time), not rehabilitative (restoring lost skills). The skills must then be taught in a way that works for visual and experiential learners.

The need for a developmental approach is often what is missing when deaf people are placed in with hearing groups with an interpreter. The group leader assumes that access is provided by the interpreter, but this is only true when the person has strong language skills and a roughly comparable fund of information and thought world. Deaf mental health programs are needed not merely because of the possible language and cultural differences but because large percentages of the clinical population have these other deficits; and all of this requires very significant treatment adaptations (Glickman, 2008/2013). Unfortunately, the accumulated weight of all these

challenges can mean that some deaf persons treated in these facilities are not prepared for the treatment and that their prognosis is poorer. At the very least, the treatment is likely to take much longer as all the “pre-therapy” remedial work must be done first.

Thirdly, the standard of care for most sexual offender treatment is group therapy. If deaf offenders are in specially designed deaf mental health or rehabilitation programs, they are very likely in a tiny minority of persons with sex offending problems. If they are being served a program for hearing sexual offenders, intellectually disabled or not, they are very likely the only deaf person or one of very few. In either case, these deaf clients have no real peer group of persons struggling with the same set of behaviors and challenges. This is one reason that such programs may put more weight on individual therapy, hoping that a talented signing therapist will make the difference, but there is no reason to believe that individual therapy alone is any more effective with deaf persons with such behaviors than it is with hearing persons.

Fourthly, there are very few treatment materials developed for deaf persons with language and learning challenges, and even less for those with sexual offending behaviors. What’s needed are a set of DVDs, in very clear and simple ASL, which teach core concepts through engaging stories, performed by deaf actors. We need such materials to teach such core concepts as relapse, cycles, risks and warning signs; and to demonstrate people using skills to avoid or escape high risk situations. Ideally, these signed stories would be available as part of a manualized treatment approach designed for language and learning challenged deaf persons. Work done at the Deaf Wellness Center in Rochester has established procedures for adapting educational and treatment materials for deaf people (O’Hearn, et al., 2010; O’Hearn & Pollard, 2008; Pollard, Dean, O’Hearn, & Hayes, 2009). A framework for adapting CBT for language and learning challenged deaf people was developed on the Westborough State Hospital Deaf Unit (Glickman, 2009), and a recent volume on “Deaf mental health care” describes examples of adaptations for deaf people of inpatient, residential, trauma focused, and substance abuse therapies (Glickman, 2013). Beyond this, of course, what is needed is to develop larger capacity treatment programs and milieu for such persons and overcome the administrative and fiscal barriers so that referrals could be made from large geographic areas.

Recommendations for Programs Serving Deaf Persons with Language and Learning Challenges and Sexual Offending Behaviors

It is an illusion to imagine that all these challenges are overcome by finding one “therapist who signs,” even one with training in sexual offending work. If the state of the art for persons with much stronger language and intellectual abilities consists of treatment programs with many components, why would we imagine that a “therapist who signs,” no matter how talented, can make up for the lack of these treatment resources? Even more rare than the “therapist who signs” is the therapist who signs well enough to work with sign language dysfluent persons. The combination of the needs for specialization in sexual offender treatment, then such treatment with intellectually disabled offenders, and then such treatment with deaf, language and learning challenged offenders, is almost impossible to find in one person. Therefore we need to conceive of this work as being done by a team. While the challenges are significant, there are a number of practical, achievable steps that treatment programs that involve deaf persons with language, learning, and sexual behavior problems can undertake.

a. Get the communication right

The first challenge for any program serving deaf people is to get the communication right. Deaf clients who sign range from multi-lingual to a-lingual. Signing staff (that is, people who sign but are not necessarily sign communication experts) also vary enormously in their communication abilities. As the field of Deaf mental health care pays increasing attention to the issue of sign language dysfluency and its implications for mental health treatment, there is increasing realization that we need to raise our standards for communication. It is one thing to be fluent in American or British Sign Language. It is another to be skillful in communicating with very sign language dysfluent persons. Many people who communicate well with fluent signers are not that skillful in communicating with sign dysfluent communicators, and many people who claim to be fluent signers are misinformed about their own abilities. In programs that are knowledgeable enough to recognize these realities, there is the growing practice of work with certified Deaf interpreters or other Deaf “communication specialists” who have the ability to bridge that gap between skilled signers and very dysfluent signers.

One hallmark of the clinical specialty of Deaf mental health care is the recognition that addressing the communication challenges well is every

bit as important as addressing the clinical challenges; indeed, it is difficult to separate them (Glickman, 2013). Programs that serve deaf persons, therefore, need to have at least one genuine communication expert who can assess objectively the language abilities of deaf clients and staff, and set the standard for effective communication, especially with deaf clients who have very significant dysfluency. This person, who should have a certified deaf interpreter's level of signing skills, meaning they can communicate expertly with deaf persons with widely varying communication abilities, might be called a "communication specialist" though other titles could apply. This person would be responsible for quality control when it comes to communication, not just assessing the abilities of clients and staff but working to provide the communication bridge when necessary. *Having a communication specialist is not a substitute for signing staff or interpreters but an addition to them.* This staff person should be considered just as essential as a psychologist, social worker, occupational therapist, psychiatrist or other recognized member of the treatment team.

The Westborough State Hospital Deaf Unit in Massachusetts had a communication specialist working as part of the team for its entire 23 year history. When the program moved to the Worcester Recovery Center and Hospital, the communication specialist moved with it as the key communication expert in the program. The Alabama Bailey psychiatric unit copied this practice, and it was the policy and practice there that all staff, deaf and hearing, work with the communication specialist when needed.

Bramley (2007) described the sex offender treatment program (SOTP) set up at the National Center for Mental Health and Deafness, referenced above. Her comments included a discussion of the huge variation in communication abilities, and the crucial role that "deaf facilitators" play in making treatment accessible:

- i. Clients within the SOTP have varying communication abilities, with specific language disorders (where narratives, question words and comparatives are difficult to understand), sign-supported English (SSE), BSL, limited vocabulary or difficulties in comprehension or expression. In such a diverse group, difficulties for the group members and facilitators arise due to these differing levels of sign language abilities and the group tends not to move on as a whole "unit" at the same pace.

ii. The group requires a great deal of clarification and repetition in terms of communication, awareness of concepts and awareness of terminology that deaf people may not have encountered before. However, where deaf facilitators are involved they enhance clarification, meaning that the group members understand more and are less likely to be nervous when asking for clarification. Deaf facilitators can also present information in different ways. The group itself is held in a room away from the inpatient service to maintain confidentiality and a sense of “safety” (p. 66).

Bramley’s discussion of “deaf facilitators” is very akin to our discussion of the role of communication specialists. She recognized that the “signing clinicians” in her program did not have the sign language skills to communicate well with many of the deaf patients.

Communication specialists or deaf facilitators rarely have advanced clinical training and skills. They should not be expected to have such expertise any more than clinical staff should be expected to have their level of communication skills. This work takes a team, but the communication specialist, working with interpreters and signing staff, is there to help clinical interventions actually reach the targeted persons.

b. Provide accessible sexuality education

One question that should always be asked when working with persons who have intellectual and developmental disabilities is how much their problem sexual behaviors are a result of never being given the knowledge, skills and opportunities to develop appropriate sexual behaviors. Studies of the characteristics of deaf persons incarcerated and treated for sexual offending in the United Kingdom have found that very few have had formal sex education and that ignorance regarding sexuality and sexual relationships was widespread (Iqbal, et al., 2004; Young, Monteiro, & Ridgeway, 2000). Studies of intellectually disabled sexual offenders in the United States also found significant educational deprivation along with an aversion to formal, school like, learning situations (Langevin & Curnoe, 2007). Appropriate sex education is almost always a good place to start. Sex education can be offered to all program participants so that the offender is not singled out. Sex education can include information about appropriate and safe versus

inappropriate and dangerous sexual behaviors so that follow up discussions of the latter are more possible.

However, providing appropriate sexuality education is also easier said than done. It is difficult to find materials with little or no written content, and as with every other intervention with deaf persons, programs have to get the communication right. This is another place where a talented deaf communication specialist can be a great help. It is best for this person to be involved in the lesson planning and materials development, not merely brought in at the end to interpret or help with communication. Information needs to be presented in a way that maximizes visual and active learning, with important concepts “unpacked.” Here, as in all areas, the lack of specialized materials makes our work so much more difficult.

c. Strive to create accountability and motivation

A main reason that many people with sexual offending problems enter treatment is because they get into legal trouble. They are either court ordered into treatment or given a choice between mental health treatment and jail. In other cases, they are in treatment because they face a harsh social sanction (e.g., loss of a job) or someone important in their lives (a spouse, for instance) gives them an ultimatum. These persons enter therapy because they do not want to face the consequences they otherwise would face. The therapist or program can therefore be a resource for them, allying with them in their effort to achieve goals they set for themselves. It is far easier (indeed, it may well be essential) to work as a therapist from this stance of therapeutic ally than it is when the therapist or team is expected to simultaneously hold the person accountable and apply negative social sanctions for continued offending behaviors.

Therapeutic programs that strive to assist children, adolescents, mentally ill or disabled persons who sexually offend are often expected to act in roles of both agent of social control and therapist. The social control role comes in when programs are expected to supervise persons and prevent them from offending again. In community settings like group homes, continuous supervision is difficult to achieve without the clients acquiescence. Total supervision can also be anti-therapeutic because people in treatment need opportunities for normal social experiences which can include having safe and consensual sexual relationships with appropriate peers (Wilson & Burns, 2011). When programs set limits on the independence their clients

can take, the clients frequently resist and rebel, and this can create struggles which are contrary to the therapeutic mission the program wants to assume.

Wilson and Burns discuss how essential it is for all persons, regardless of disability, to experience consequential learning:

Consequential learning can be very important for people who have poor problem-solving skills, or who are less able to develop appropriate means of assessing and responding to situations. Clearly, unless the consequences of engaging in certain behaviours are not tolerable, the behaviours will not stop. Persons with intellectual disabilities have often received a “free pass” from the criminal justice system; police officers have been reluctant to lay charges against, and courts have been reluctant to convict, persons who may not understand the nature of their offenses. Consequently, many persons with intellectual disabilities who sexually offend never truly learn that their behavior is unacceptable. Regardless of the reason for the behavior, we need to stress that our clients have a right to comprehensive assessment and sensitive and effective treatment. They also have the right to be held accountable for their actions, just as their non-disabled compatriots would be. (p. 75)

Deaf people who commit crimes are sometimes not held accountable for their behaviors until the crimes become so serious that they can no longer be ignored (Hindley, et al., 2000; Miller & Vernon, 2001; ; Mitchell & Graham, 2011; O’Rourke, et al., 2013). This is even more likely when deaf people have language and learning challenges which raise questions of competence to stand trial and which require extensive and costly modifications to the adjudication process (Vernon & Miller, 2001). It is simply easier for police and courts, often responding to well meaning parents, advocates and program staff, to refer the problem back to a deaf service program or, in some instances, to the individual therapists who are somehow suppose to create motivation in people who are continuously protected from experiencing the consequences of their behavior. This is especially problematic because the low cognitive development of these persons often means that they are far more likely to be motivated by fear of punishment than by “higher”

considerations like empathy and appreciation of the needs and rights of other people.

Therapists and programs need to resist these efforts. The authors have seen repeatedly the therapeutic benefits of having the persons we serve report regularly to a probation officer who, appropriately, plays the “bad cop” role. Wherever we can, we need to advocate that our clients face real world social sanctions, including arrest, adjudication and incarceration if necessary, so that they have reasons to participate in treatment and so we can work from a therapeutic and not a punitive stance. Of course, we also need to work for the creation of appropriate treatment resources.

We acknowledge that prisons are not likely to be therapeutic places for deaf persons, if indeed they are for anyone. Recently, Vernon wrote about to the “horror” of being deaf in prison (Vernon, 2010). In practice, the outcome we hope for when someone commits lower levels of crimes is usually that they go to trial and that if found guilty they be assigned probation. The court can set the terms of probation, such as that the person attend therapy or accept supervision, which enables the therapist and program to take an “ally” stance, helping the person avoid unwanted consequences. Because Great Britain has some treatment programs, they have an alternative to jail at least for persons convicted of crimes or found “unfit to plead” (i.e., incompetent to participate in their own defense). The United States needs to have this alternative also.

The authors believe that if our clients faced reasonable consequences early in their “criminal careers,” therapeutic interventions would have a much greater chance of working, and more serious consequences, such as jail, would more likely be avoided.

e. Think and act developmentally

There is a cliché in the mental health field that counselors must meet clients where they are at, not where we want them to be. This is well worth remembering when working with deaf language and learning challenged with problem sexual behaviors. We may want badly to believe that providing treatment for them requires nothing more of us than using a sign language interpreter. That belief is naive. We might also to believe that “readiness for change” problems are just a matter of using motivational interviewing. That belief is also naive. The obstacles to treatment engagement are much

more formidable, and in extreme cases, there is no alternative but to begin with basic (sign) language development. More commonly, at least in the United States, clients will have some signing skill, but poorly developed language skills mean poorly developed thinking skills. A distinguishing feature of Deaf mental health care, as in Deaf education, is the prominent role language (and cognitive) development must play much of the time, no matter what the clinical problem.

Counselors must, therefore, bring a developmental framework alongside of the frameworks of Deaf cultural affirmation and sexual offender treatment. They must pay attention to the state of the persons language and cognitive development and strive to match interventions appropriately (Glickman, 2009). Programs need to devote time to adapting treatment interventions which are designed for visual and experiential learners, suitably adapted for a person's fund of information base and learning capacities.

f. Create developmentally attuned skill oriented treatment cultures

Many of the core tasks in sexual offender work are core tasks in all therapeutic modalities, and there is no need for a program to wait for a specialized therapist to work on goals that should be part of any sound therapeutic milieu. For instance, therapeutic tasks like helping clients identify and label feelings and then cope with unpleasant feelings are part of most treatment approaches. Before a person can notice and manage the feelings (much less the thoughts) that precede a sexual offense, they must be able to notice and manage more routine feelings such as anger and sadness. Similarly, programs need to help the people they serve manage interpersonal conflicts. Before one can negotiate with a potential sexual partner around sexual and affectional needs and desires, one should be able to negotiate more simple tasks like what movie to go see, what television show to watch, or other shared activities. Basic conflict resolution skills should be built into any treatment program because the need to resolve conflicts is as fundamental to healthy living as the need to cope with a variety of emotions.

The development of a suitable map or schema for "getting better" is a core "pre-treatment" task when working with deaf language and learning challenged clients (Glickman 2009). The most suitable schema pertains to skills, namely, "I use skills to get better." One of the most important strategies to establish this schema is to help people notice and label skills they already use. For instance, when a person with aggressive behavior walks

away from a provocation, the staff can notice and label whatever skills the person might have used (for instance, the “red, yellow, green,” or “shield” or distraction or just “walking away” skills) (Glickman, 2009). By doing this repeatedly, a schema becomes established around the language of skills.

Another part of the schema that needs to be established is that communication is a crucial skill for problem solving. “We talk about problems. We listen to each other. We respect each other in the communication process. We try to solve problems together.” These are all key skills that are best taught in groups and in a treatment milieu, and which lay the groundwork for offender specific treatment.

Once this skill-oriented schema becomes established, it is a much easier step for staff and therapists to ask questions such as “what other skills could you use?” or to specifically offer to teach skills that are relevant to a goal like “staying out of jail.” In this case, the program has done the pre-treatment work to prepare the client for the work of psychotherapy, and then referring the person to a “therapist who signs” is more reasonable for the therapist and for the client.

Therapists trained in cognitive behavioral therapy already have the foundations of much sexual offender treatment work. Clinicians who have basic CBT training, for instance, can learn the basics of relapse prevention without much difficulty. It is not a huge step from learning relapse prevention for psychiatric symptoms or addictions to learning relapse prevention for sexual offending. In most cases, the core treatment challenge is much less about obtaining expertise in sexual offending work than about the pre-treatment task of getting informed client buy-in to the reality that he or she has a problem that needs managing. In practice, this pre-treatment work may well occupy most of a program or counselors time.

When the client isn’t ready for the more advanced work, the non-specialist clinical staff can and should do the foundational work. If an expert in sexual offender treatment is brought in, that person might be most profitably used to help orient the treatment milieu to where it would like to go, to the work it ultimately wants to get done. That expert in sexual offender treatment will most likely not know how to match and advance the language and cognitive abilities of the deaf clients, and the team will need to fashion and implement this work first. The sex offender treatment expert will become more of a treatment resource after the client is more ready for such specialized treatment.

g. Consider moving from discussions of client risk to those of staff worries

At the time of this writing, Advocates, the agency where the first author works, is moving away from discussions of “risk” towards discussion of “worry.” The distinction is profound. Risk factors lie in the person served. Clients have risk factors. Worries lie with the staff, though it is a positive sign when staff are able to get the client to worry also. It is often very hard to explain to some persons why we believe they are showing risky behaviors, feelings or thoughts. It does not help that risk is an abstract concept. Clients very commonly insist that they “won’t do it again,” and find discussions about risk factors mystifying. We’ve worked with clients who never seem able to understand this, and with these persons it is much easier to talk about our worries than their risks. We explain to clients what they do that makes us worry and how we will behave when we are worried. For example: “When you drink, stop following program rules, and show an angry attitude, we worry more that you are getting ready to touch someone again. When we worry more, we supervise you more closely. When you are staying sober, attending AA, filling out your check list, and talking about your feelings and thoughts, we worry about you less. We feel you are developing skills to stay safe. We feel more comfortable then setting up times of much less supervision.” While the work remains difficult, discussing how and why we behave as we do is clearer and more respectful.

This line of reasoning involves “I statements” (i.e., “when you do this, I feel x and I do y”), which are a well-known aspect of effective communication (Heitler, 1990).

Conclusions

As with addictions, the single most important therapeutic goal in offender treatment is obtaining client recognition and acknowledgment that: 1. They have a sexual offending problem, 2. It’s in their interests to work hard on overcoming this problem, and 3. This can be done if they work in treatment to learn new skills.

We have seen that there are many obstacles to helping deaf persons with language and learning challenges and sexual offending problems achieve this foundational goal. One set of obstacles have to do with the abstract nature of much of the treatment process and the cognitive and language

problems which make fully informed participation difficult. Another set of obstacles has to do with systemic forces (police, courts, well intended family and community advocates) which may not hold the person accountable until more serious crimes are committed. Yet another set of obstacles has to do with the scarcity, in most places non-existence, of qualified professionals and programs designed for these persons.

The scarcity of treatment resources often means that professionals who do not usually work with deaf people, and have no knowledge of Deaf mental health care often do not know what kinds of assistance they need. They do not, for instance, understand the huge differences in how deaf signing people communicate, how significant a problem language dysfluency can be for some deaf persons, nor do they understand about the huge fund of information deficits that usually accompany deafness and language dysfluency. Therefore, even when they recognize the need for an interpreter, they do not understand how much work they still must do to bridge the chasm in “thought world” between themselves and their client. Without an appreciation of the clients’ “thought world”, they cannot tailor their interventions to the clients’ “zone of proximal development.” They are very likely to assume clients have a knowledge base they do not have and talk over their heads. This problem is not solved by introducing an interpreter.

Bridging this chasm will take a team of mental health and communication experts. Seeking to serve these persons well by finding a “therapist who signs” and knows sexual offender treatment, in the absence of other services, is naïve. There are few, if any, clinicians in the world who have all the skills sets necessary to do this very specialized work. No matter the skill set of the therapist, the client still has to develop an informed and willing attitude for the treatment to work.

Therapeutic buy in and understanding is promoted in different ways:

- a. It is promoted when the person is held accountable and there are unwanted consequences for offending behaviors.
- b. It is promoted when the person is provided with good information about sexuality, healthy and unhealthy relationships.
- c. It is promoted when genuine communication experts work to ensure that the sign communication skills of the person are matched and then developed. This often requires, we argue, much more than the presence of an interpreter or “signing clinician.”

- d. It is promoted when the person is served within culturally affirmative Deaf treatment settings where there are Deaf role models and a generally positive perspective on deaf people. Deaf staff can work to help clients not blame deafness, Deaf culture or hearing people for their problems. It is much harder for hearing persons, especially non- or poor signers, to do this.
- e. It is promoted when the person is offered a map or schema for the treatment/recovery process that they can understand. We argue that “learning skills” can often provide such a schema especially when the skills themselves are “unpacked” and simplified and presented clearly in sign, often with additional visual aids (Glickman 2008). Programs that help clients develop skills usually already work from a cognitive behavioral therapy paradigm. Programs that work from a CBT orientation generally incorporate or can develop relapse prevention programs. From there one has to think about the challenges of adapting treatment, first or deaf persons, then for intellectually challenged persons, then for deaf intellectually challenged persons. Beginning with CBT though, the building blocks of sexual offender treatment are often already there.
- f. It may be promoted through motivational interviewing, but this counseling strategy works best when there are real world motivators and also when persons have developed rational problem solving and reasoning abilities. Promoting accountability fosters the former, but developing language and reasoning abilities (e.g., identifying pros and cons, weighing alternatives, developing a coherent narrative of what did happen and what might happen, thinking ahead and planning accordingly) will likely have to be a core aspect of the treatment plan. Sex offender treatment experts do not normally focus on these foundational thinking skills. Mental health and rehabilitation programs for deaf persons, because of the large numbers of language and learning challenged clients, must do so.
- g. It is promoted through strong efforts by therapists and teams to establish empathic and collaborative relationships with the persons served and to make the decision making process as transparent as possible. This is much easier to do when the therapist and team do not simultaneously have to be limit setters, acting as surrogate agents of social control because police, courts and others will not hold people accountable. Shifting the discussion from “you have these risk factors” to “we have these worries, and we behave in these ways when we are worried,” is easier to understand, more transparent, honest and

respectful. This can minimize common struggles when clients lack insight and appear unmotivated.

Finally, because this work requires such a high degree of specialization and so few, if any, people have all the skills necessary, this work is best taken on by teams of people who can address different aspects of treatment and recovery. One of the specialists, we have argued, should be an expert in sign communication. This is not the same thing as a “clinician who signs” or an interpreter. This is more possible when the person is already in a Deaf mental health or rehabilitation program where, ideally, there is already a critical mass of competent signers, including Deaf persons. It goes without saying that we need more such programs, and we need in the United States some treatment facilities (or even one) that can develop this important specialization.

When the lone clinician receives the request to provide therapy because “we need someone who signs and knows about offender treatment,” humility is called for. The clinician might begin her response, “let me ask you a few questions...”

The authors wish to thank Robert Q. Pollard and Marc Marschark for their helpful reviews of an earlier version of this article.

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