Challenges in Using Evidence-Based Treatments with Deaf, Hard of Hearing & Deaf-Blind Clients

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Vancouver Coastal Health

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WBP: Past, Present and Future

- Greater Vancouver Mental Health Services began providing services in 1987 to survivors of the JHS and their families
- WBP formally established in 1993
- Psychotherapy services largely contracted out to therapists in the community

WBP: Past, Present and Future: Kane Report

- Dr. Diana Kane's 2006 recommendations on developing WBP:
  - Provide fuller spectrum of mental health and addictions services to all Deaf, Hard of hearing, and Deaf-Blind clients in BC (i.e., not just to JHS survivors)
  - Transition from primarily contracting therapists in the community to a "strong Centre of Excellence"
  - Provide services that are accessible and culturally sensitive

WBP: Past, Present and Future: Kane Report (Therapy Recomendations)

- Focus on the particular mental health and addiction needs of WBP clients
- Focus on outcome-based, time-limited treatments rather than open-ended therapy
- Establish centralized regular supervision of therapy staff
- Whenever possible therapy should be provided by signing, in house staff

WBP: Past, Present and Future

- WBP acted on many of Kane's recommendations
- Developing services in-house helped to make services more culturally sensitive
- But *which* treatments to provide?

Which Therapy Services?

- Client needs
- What does the research say is the best treatment
- Program goals and resources
- Staff interest and motivation

WBP: Past, Present and Future

- Key Areas of Need:
  - Suicidal/Dysregulated Clients
  - Anger
  - Depression
  - Addictions

Empirically Supported Treatments

- Standards for evidence have been established to minimize bias inherent in evaluation of treatments
- Randomized Control Trial is the standard for supporting the efficacy of any therapy
- Multiple trials from different groups before the APA gives the stamp of approval

Randomized Control Findings of DBT for borderline personality disorder/ dysregulated behaviors

- ↑ treatment engagement[1], treatment completion [1,2,3]
- ↓ parasuicide repeats at 1-year follow-up [1]
- ↓ suicide attempts [2] and suicidal ideation [4]
- ↓ hospitalization inpatient days[1]/less psychiatric hospitalizations[1]/ER visits[2]
- ↓ substance use [3]
- ↓ anger [4]

1. Linehan et al., 1991; 2. Linehan et al., 2006;
3. Linehan et al., 1999; 4. Koons et al., 2001

Criticisms of EBP

- Outcomes do not always reflect the goals of clients
- Long-term effects of short term psychotherapy are not well studied
- Some outcomes are difficult to measure (self actualization)
- Populations studied (initially) homogeneous and did not reflect clinical populations

Considering the Evidence

- Limited evidence in Deaf and Hard of Hearing populations
- Issues specific to communication and issues of culture need to be considered
  - Treatments often rely on written materials
  - The duration may not be sufficient
- Adaptation vs Adherence
- Awareness of core treatment principles

Randomized Control Findings of Specialized Treatment for Anger and Addictions Problems

- Anger problems and addictions problems[1]
  - ↑ treatment engagement
  - ↓ anger
  - ↓ substance use
  - ↓ gambling

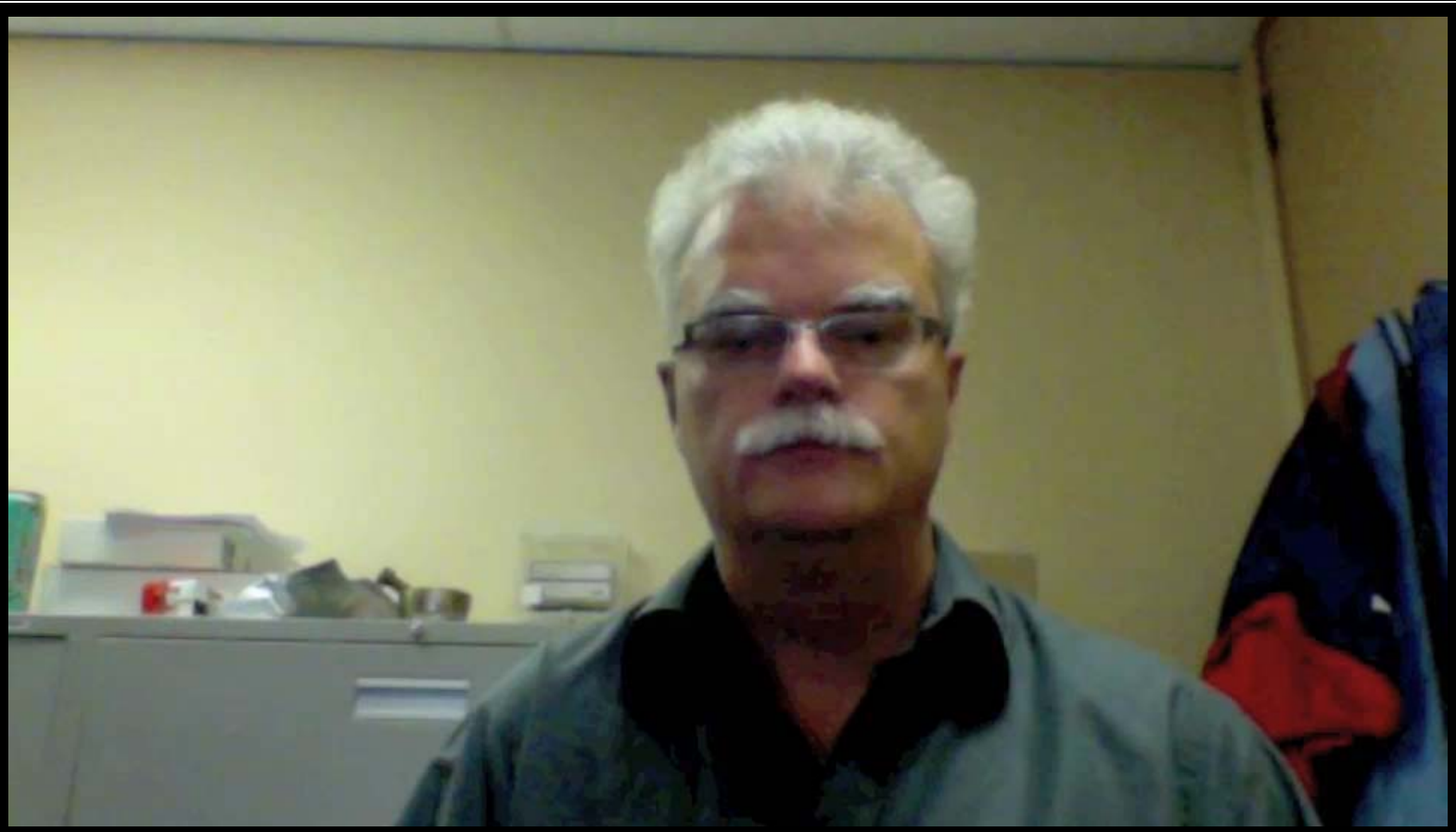
1. Korman et al., 2009

CBT for Depression

- > 100 Randomized Control Trials
  - Greater remission rates than placebo
  - Equivalent to medications
  - Lower relapse rates at 1 year and 2 year compared to medications
- Effective when delivered as group or individual
- Effective across a broad range of populations and individuals
- Effective for people who have not responded to medications

Evidence-Based Treatments: Challenges in Implementation

Clip 1



Implementation Challenges with Trainers and Staff

- Some staff put off by “expertise” being “brought in” by outside, hearing contractors
- Hearing contractors largely naïve to Deaf culture
  - Hearing trainers unable to sign/limited efforts made to learn
  - Ignorant about Deaf Culture

Implementation Challenges with Trainers and Staff (continued)

On the one hand…

- Limited awareness by trainers of:
  - Frequent histories of oppression among Deaf
  - Common experiences of invalidation
- Some unfair, culturally oppressive expectations made by trainers of Deaf staff:
  - e.g., complete readings in English

Implementation Challenges with Trainers and Staff (continued)

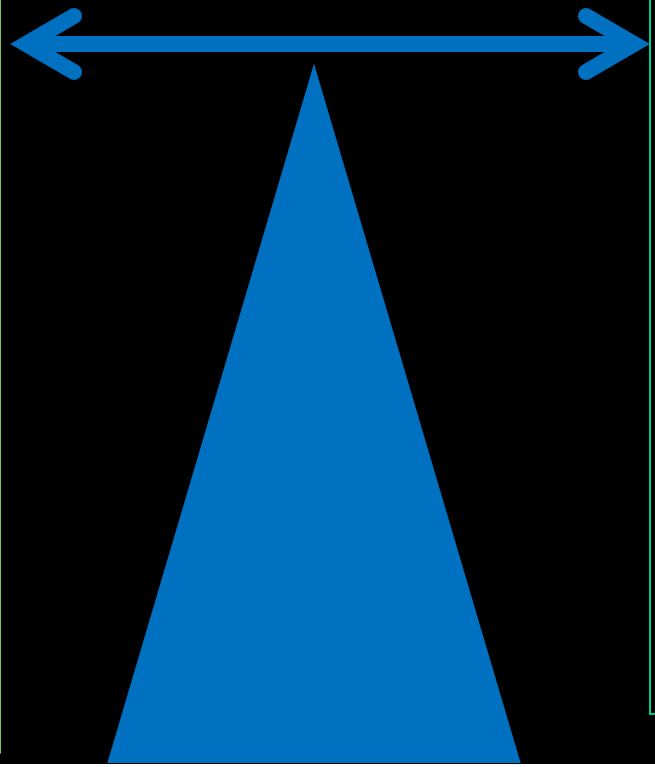
On the other hand…

- At times, more extreme sensitivity by staff to training and supervision
  - Sensitivity to blunt supervisory feedback
  - Sensitivity to being held accountable:
    - To standard of care/ethical issues
      - "Oppressive"
      - "Why now?
    - To learning and delivering treatments

Clip 3

Dialectical Implementation Challenges with Trainers and Staff

- Demanding too little of staff
- Treating staff as incapable
- Limiting professional growth opportunities
- Not optimizing treatment for clients



- Making unfair, unreasonable, audio-centric or "audistic" demands of staff
- Being culturally insensitive to Deaf colleagues
- Not seeking Deaf staff input, expertise

Implementation Challenges with Trainers and Staff: Attempted Solutions

- More focus on direct training of staff
- Live supervision and Deaf-accessible supervisory technology
- More opportunities for Deaf staff to supervise and provide feedback to one another
- Applying Deaf staff expertise in adapting treatment skills (e.g., anger skills) and making treatments more accessible to WBP clients

Implementation Challenges in Making Evidence Based Treatments Accessible and Sensitive to WBP Clients

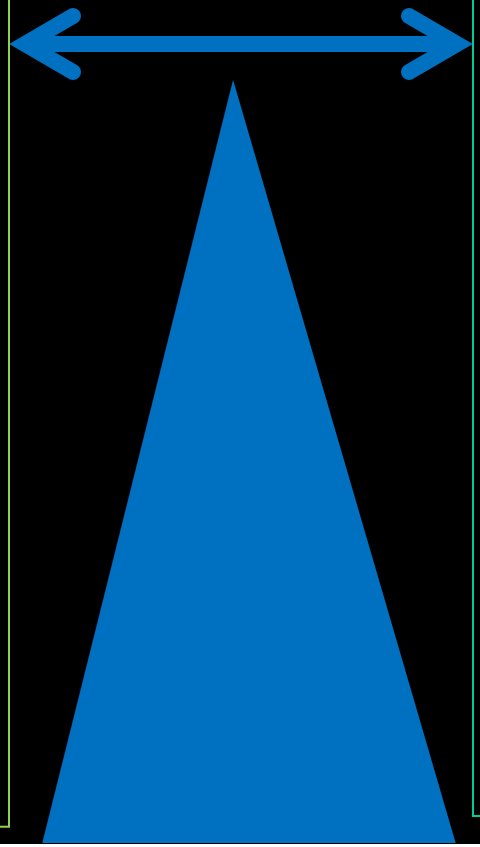
- Psychotherapy presented from hearing/Anglocentric perspectives to many clients whose first language was ASL
  - E.g., use of English metaphors
  - E.g., written homework
- Challenges in making some concepts accessible to those clients with limited cognitive abilities

Implementation Challenges in Making Evidence Based Treatments Sensitive to WBP Clients (continued)

- Failures to acknowledge histories of invalidation, abuse experienced by WBP clients
- Expectations for clients to try to follow through on their commitments to work on their goals sometimes experienced by clients as oppression
- Radical genuineness sometimes experienced as oppressive

Dialectical Implementation Challenges in Making Evidence Based Treatments Accessible & Sensitive to WBP Clients

- Treating WBP clients as fragile
- Viewing clients uniquely as victims
- Treating clients as incapable of making existential decisions
- Treating clients as incapable of change, progress
- Withholding demands, feedback



- Ignorance of clients' histories of invalidation, impact of treatment demands
- Inadequate orientation
- Material inaccessible
- Moving through skills too quickly
- Ignorance of cognitive limitations

Making Treatments Sensitive & More Accessible to WBP Clients: Attempted Solutions

- More focus devoted early in therapy to increasing clients' motivation to work, particularly on anger and addictions problems
- More explanations of how invalidating environments have contributed to problems like regulating emotions
- Greater focus on issues like healthy relationships, conflict, and self-care to address gaps in incidental learning

Making Treatments Sensitive & More Accessible to WBP Clients: Attempted Solutions (continued)

- Slower pace in skills groups, elaboration and repetition of key constructs:
  - What are emotions? Primary & secondary emotions
  - Recognition of emotions- bodily referents, prompting events, generic appraisals associated with each basic emotion
- More time in group sessions devoted to:
  - Skills practice/rehearsal
  - Role playing

Making Treatments Sensitive & More Accessible to WBP Clients: Attempted Solutions (continued)

- More participation by clients in groups
- More time for clients in groups to share their experiences
- Modeling by Deaf clients in groups has been enormously important
- Insight has played a greater role in skills groups
- Greater group cohesion

CLIP 2

Implementation Challenges with Interpreters

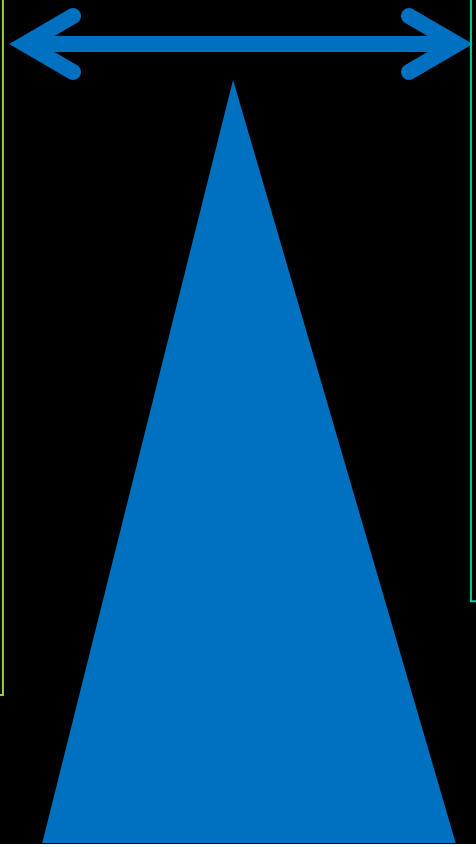
- Minimal (if any) training provided to interpreters as therapies were implemented
- Interpreters initially unfamiliar with concepts, meanings, signs, goals of new treatments
- Minimal clarification sought by some interpreters
- Confusion by trainers regarding roles

Implementation Challenges with Interpreters (continued)

- Minimal (if any) input and feedback requested from the interpreters
- Minimal attention to morale issues among interpreters
- Trainers wondered if radically genuine communications to clients and critical feedback to staff were at times "softened" by interpreters

Dialectical Implementation Challenges with Interpreters

- Maintaining interpretive role of interpreters
- Maintaining neutral roles
- Let therapists conduct treatments, including ensuring clients understand therapeutic concepts



- Ignoring expertise of interpreters in facilitating communication of tx
- Neglecting training of interpreters in basic treatment concepts
- Ignoring morale issues among interpreters

Implementation Challenges with Interpreters: Attempted Solutions

- Skills adaptation implementation team with interpreters, Deaf staff, trainers
- Discussions regarding establishing scheduled times for interpreters, trainers, therapists, and to debrief after group
- Discussions regarding establishing formal training opportunities for interpreters about therapy concepts, goals
- Discussions regarding establishing formal consultation meetings among interpreters: standardized signs, morale issues, etc.

Thank You

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