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Deaf 101: How to Navigate Clinical Interactions with Deaf Sign Language Users

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DEAF 101:
HOW TO NAVIGATE CLINICAL INTERACTIONS
WITH DEAF SIGN LANGUAGE USERS

MELISSA L. ANDERSON
TIM RIKER
MYTH: Deaf people are disabled.

FACT: Deaf people are members of a sociolinguistic minority group.
LABELS AND DIRTY WORDS

Deaf - distinct values, traditions, and language (American Sign Language)

deaf - physical condition of hearing loss

hard-of-hearing - matter of self-identification

hearing impaired - more likely to be used as a "politically correct" term by hearing people
Deaf – distinct values, traditions, and language (American Sign Language)

deaf – physical condition of hearing loss

hard-of-hearing – matter of self-identification

hearing impaired – more likely to be used as a “politically correct” term by hearing people
HISTORY OF OPPRESSION
PRIDE AND IDENTITY
MYTH: An ASL interpreter is a sufficient accommodation.

FACT: An ASL interpreter is necessary, but not sufficient.

COMMUNICATION
First step in what is the client’s preferred language use and forming of follow client performances.

Practicing of deaf education systems using many different communication methods may be used:
- American Sign Language
- Signed English
- Cued Speech
- Oral Expression
- Cued Speech
- Lip Reading
- Written English
- English
- Spoken English
- American Sign Language
- Signed English
- Cued Speech
- Oral Expression
- Cued Speech
- Lip Reading
- Written English
- English

WORKING WITH AN INTERPRETER
Certified ASL interpreter with extensive training in specific needs of client.

- They have extensive knowledge of the nuances of sign language, deaf culture, and sign language protocol.
- May need assist, time, and adaptability to user
- Client has control of language expression, as an interpreter, may be required.

- ASL interpreter’s skills and expertise
- Knowledge of cultural sensitivity
- Relationship with mental health professional
COMMUNICATION

First step: What is the client’s preferred language use and fluency? Follow client’s preference.

Fracturing of deaf education system means many different communication methods may be used:
- American Sign Language
- Pidgin Signed English (mix of ASL and English)
- Manually Coded English
- Cued Speech
- Simultaneous-Communication
- Home signs
- English (via lip-reading, via written English)
- ”A subgroup of deaf people, who had inadequate exposure to fluent signers, may have no formal language...simple signs, gestures, mime...”
WORKING WITH AN INTERPRETER

Certified ASL interpreter with specialized training in mental health is needed. If not:

• May have limited understanding of the nuances of psychiatric assessment, mental health symptoms, and jargon ("psychobabble")
• May cause bias, error, and suggestibility to occur

If client has experienced language deprivation, a Certified Deaf Interpreter may be required.

Use the interpreter’s skills and expertise!

• Bicultural mediation/cultural brokering
• Assistance with mental status examination
MYTH: Deaf people experience unique psychiatric disorders.

FACT: Deaf people experience the same disorders as hearing people.

**Psychiatric Diagnoses**

- Despite evidence that psychiatric disorders differ significantly between deaf and hearing populations,
- The primary challenge in the accurate assessment of psychiatric disorders is the linguistic and cultural factors (Conley and others, 2003, p. 92).

**Rates**

- Estimates vary widely by culture, with some studies reporting higher rates in deaf populations, especially in communities with a greater prevalence of mental health issues.

**MOS, PERCEIVED, MISSED**

- Mental disorders often undiagnosed or underdiagnosed.
- Key obstacles include language barriers and cultural factors (Conley and others, 2003).

- Translating medical information and clinical terms can be challenging.

- Early intervention is crucial for effective treatment.

- Late diagnosis can lead to more severe outcomes and reduced quality of life.
PSYCHIATRIC DIAGNOSES

Overall, no evidence that psychiatric disorders differ significantly between Deaf and hearing populations.

"...the primary challenge in the accurate assessment of psychiatric disorders stems from linguistic and cultural factors" (Landsberger et al., 2013, p. 92).
NOS, DEFERRED, MISSING

Deaf clients often misdiagnosed or given NOS diagnoses.

Key confounding factors in accurate assessment:
1. Clinician knowledge of Deaf culture and ASL
2. Client language deprivation and dysfluency

Differential diagnosis:
Untangling communication deficits related to
language deprivation vs. deficits due to general
medical brain disorders vs. symptoms of psychiatric
disorders
RATES

Literature is generally in its infancy - many older publications are not helpful due to inappropriate methodology/bias.

Change in rates over time:
- Diagnoses becoming more specific and wider in range as result of increased clinician expertise

"There is sufficient evidence of a greater prevalence of mental health issues in the Deaf population than in the hearing population" (Fellinger et al., 2012).
MYTH: Deaf people don’t experience auditory hallucinations.

FACT: Deaf people can “hear voices.”

CONSIDERATIONS FOR ASSESSMENT OF AUDITORY HALLUCINATIONS

- Look for multiple indicators of psychosis process and multiple sources of information when diagnosing a client with a psychotic disorder.

CONSIDERATIONS FOR ASSESSMENT OF COMMUNICATION

- Language comprehension
  - Asking single yes-no questions (e.g., "Can you hear voices?"
  - Using simple language and gestures
- Non-verbal communication and comprehension checks
  - Other cues in patient’s history (e.g., hearing loss, past trauma)

CONSIDERATIONS FOR ASSESSMENT OF COGNITIVE FUNCTION

- Memory issues
  - Recent cognitive decline or fluctuation
- Attention deficits
  - Inability to focus on specific tasks
- Executive function impairments
  - Difficulties with planning, organizing, and sequencing

CONSIDERATIONS FOR ASSESSMENT OF PSYCHOTHERAPY

- Trauma symptoms
  - History of abuse or neglect
- Mood swings
  -Significant mood lability
- Cognitive distortions
  - Perseverative thoughts and beliefs
Look for multiple indicators of psychotic process and multiple sources of information before diagnosing a Deaf client with a psychotic disorder.

**AUDITORY HALLUCINATIONS**
- “Talking voices” heard in isolation or in public
- May influence significant actions, based on the caregiver’s understanding of the content
- Caregivers need to arrive at a diagnosis of psychosis and be taught to report auditory hallucinations
- They may express a desire to engage in phantasmagorical behavior (e.g., “Do you hear voices?”)

**THOUGHT DISORGANIZATION**
- Language issues can be language disorganization, only to misplace real or symptoms of thought disorganization
- Paraphasias (language-related slurs)
- Verbal inaccuracies and perseveration
- Echolalia (parrot-like behavior)
- Disorganized behavior
- The “split” of their communication will be verbally and emotionally disconnected

**PSYCHOSIS**
AUDITORY HALLUCINATIONS

- "Hearing voices" hard to interpret in ASL and may introduce significant subjectivity based on the interpreter's understanding of the concept.

- Some evidence that those with experience of sound prior to becoming deaf more likely to report auditory features of hallucinations.

- Key = Open-ended discussion and exploration of perceptual phenomena (NOT "Do you hear voices?")
THOUGHT DISORGANIZATION

- Language deficits (due to language deprivation) easy to misconstrue as symptoms of thought disorganization

- Non-psychotic language-deprived clients generally:
  - Demonstrate emotional connectedness,
  - Display appropriate affect,
  - Lack disorganized behavior,
  - The “gist” of their communications will be non-bizarre and centered around a main theme
CONSIDERATIONS FOR ASSESSMENT OF MOOD DISORDERS

BIPOLAR DISORDER
- Mania - changes in mood, speech, and activity
- Serious and uncontrollable
- Rapidly changing emotions
- Suicide risk
- Hallucinations and delusions
- Diagnosis criteria: Diagnostic and Statistical Manual of Mental Disorders (DSM-5)

DEPRESSION
- Normal, some changes in physical, emotional, and cognitive symptoms as normal aging
- Elders may not realize their emotional or cognitive changes
- Depression can significantly affect one's mental health
- Risk factors: genetics, family history, physical health, stress, and life events
- Treatment options: medication, psychotherapy, and support groups
- Suicide risk
- Hallucinations and delusions (rare)
BIPOLAR DISORDER

"Rate of speech could not be assessed. Client is Deaf and mute." WRONG!

- Monitor and document speed, intensity, and size of signing and watch for changes over time.

- BUT, common pitfall = pathologizing normative expressive signing of ASL

- Key = background information and people who have personal knowledge of client’s language use, and the interpreter’s linguistic expertise!
DEPRESSION

- Overall, same cluster of physical, emotional, and cognitive symptoms as hearing people.

- Clients may not realize, or be able to describe, depressive symptoms if they have low mental health literacy.

- Key = Ask about each symptom directly and individually, use concrete examples; Check for comprehension
- Overall cognitive changes

- Clients with depression often feel

- Key = Assess individual comprehension
CONSIDERATIONS FOR ASSESSMENT OF TRAUMA/PTSD

• Trauma exposure at least double compared to hearing population.

• Yet, PTSD significantly underdiagnosed.

• Trauma-related symptoms reflect greater degrees of intensity and more symptoms of dissociation.
CONSIDERATIONS FOR ASSESSMENT OF SUBSTANCE USE DISORDER

Language considerations:
- Addiction vocabulary/idioms (e.g., cut down, hangover, eye opener)
- Need for additional explanation and comprehension checks; Don’t assume interpreter trained in addiction language

Stigma:
- Small, closeknit community with Deaf grapevine (e.g., AA/NA meetings)
MYTH: Deaf clients have different medication needs than hearing clients.

FACT: Deaf clients have the same medication needs as hearing clients.
PHARMACOTHERAPY

“No studies have evaluated psychopharmacologic treatments in patients who are deaf, and no literature suggests the use of particular psychotropic agents to treat mental disorders in this population” (Landsberger et al., 2013, p.94).

What we often see in practice?
- Laundry list of diagnoses
- Matching laundry list of medications
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