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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
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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 stage before the client's preferred language is used and where the client is proficient.

Practiceing of ASL/auditory system means many different communication methods may be used:
- American Sign Language
- English (oral and written)
- Voice Output
- Text
- Letter Board
- Slate/Quill
- Oral
- Visual/Nonverbal
- Signed English
- Signed English

WORKING WITH AN INTERPRETER
Certified ASL interpreters will accommodate cutomers.
- They have extensive training in various aspects of the American Sign Language system, including appropriate use of deaf culture.
- They understand the challenges faced by deaf individuals and are trained to adapt their methods to ensure effective communication.
- They are certified professionals who must meet certain standards of proficiency and ethics.
- They adapt their communication style to the specific needs of the client, including cultural sensitivities.
- They are skilled in adapting their sign language techniques to assist the client in understanding the information being conveyed.
- They are knowledgeable about the needs and preferences of deaf individuals, and are able to adjust their methods to ensure effective communication.
- They have a high level of professionalism and are committed to providing quality service.
- They are trained in interpreting medical terminology, legal language, and technical language.
- They are trained in interpreting specialized language, including medical, legal, and technical terminology.
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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.

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**Psychiatric Diagnoses**

Despite the evidence that psychiatric disorders do not significantly differ between deaf and hearing populations,

*...the primary challenge is the accurate assessment of psychiatric disorders across deaf and hearing cultures.*

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**Rate**

Lithium is generally safe in the elderly, but data is not available for its efficacy.

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**Not, Deferred, Misused**

Deaf people often misinterpret or generalize diagnoses.

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**Conclusion**

Understanding communication deficits related to language differences can affect the accurate assessment of psychiatric disorders.
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 PSYCHOSIS

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 Deafness as well as any other significant subject heard by the individual's understanding of the concept
- Some patients have a strong experience of connectedness to hearing and may deny the existence of hallucinations.
- Yes "supernatural ideas and repetition of preverbal expressions (e.g. "Do you hear voices?")

THOUGHT DISORGANIZATION
- Language and thought to language distortion may reveal that all symptoms of thought disorganization
- Neologistic language-related clients generally
- Simple and unclear sentence,
- Impaired concentration
- Socially disconnected behavior
- "Lack" of their communication will be characteristics of abnormal auditory voicing
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
- Sleep disturbance
- Psychomotor defeat
- Severe anxiety
- Inability to function
- Intermittent periods of depression
- Impaired functioning

DEPRESSION
- Restlessness, overt display of prolonged, and irritability
- Suicide may not manifest as attempts to commit suicide, but as negative interest in suicidal ideation,
- Self-destructive
- Depression can also involve impaired concentration, low mood, and suicidal ideation.
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 cognition

- Clients struggling with depression

- Key = Ask individuals to comprehend
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.
"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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