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 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

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 AUDIENCE
- Look for multiple indicators of psychiatric illness and multiple assess of interaction before diagnosing a first aider with a psychiatric disorder.

CONSIDERATIONS FOR ASSESSMENT OF EXPERTS IN MEDIATION
- Look for additional expertise and comprehension checks, such as requiring a second opinion from a different language group.
  - Small, isolated communities with small groups of deaf people.

CONSIDERATIONS FOR ASSESSMENT OF COMMUNITY
- Trauma symptoms can be absent, and people can continue to function.
  - TRAUpically uncharacteristic.

CONSIDERATIONS FOR ASSESSMENT OF STAFF
- Trauma symptoms may be inexpressible and may only appear as other symptoms.
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**
- "Having voices" can be interpreted as AUD, and may influence significant people based on the individual's understanding of the concept
- Some studies reveal that how experiences are interpreted affect behavior and more likely to report auditory hallucinations
- This is a significant issue and important of personal philosophy (Do you hear voices?)

**THOUGHT DISORGANIZATION**
- Language and beliefs in language are relevant, especially in the symptoms of thought disorganization
- Neologisms (language or new words) develop
- Identifying these characteristics
- Identifying thought disorder
- The "logic" of their communication will be abnormal and irrational despite non-fluent theme
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**

- Some of these could not be assessed. Client is a child and has had no
  formal schooling.
- Client's mood and behavior are very intense and appear to be
  cyclical.
- Client has difficulty sleeping.
- Client's behavior seems to be erratic and inconsistent.
- Client's speech is rapid and pressured.
- Client has difficulty maintaining social relationships.
- Client has difficulty in school and has been expelled.
- Client has difficulty with self-esteem and self-image.
- Client has difficulty with concentration and attention.
- Client has difficulty with decision-making.
- Client has difficulty with impulse control.
- Client has difficulty with self-regulation.
- Client has difficulty with stress management.
- Client has difficulty with anxiety and depression.
- Client has difficulty with anger and aggression.
- Client has difficulty with withdrawal and isolation.
- Client has difficulty with substance abuse.
- Client has difficulty with suicidal thoughts and behaviors.
- Client has difficulty with family relationships.
- Client has difficulty with peer relationships.
- Client has difficulty with vocational goals.
- Client has difficulty with academic goals.
- Client has difficulty with social goals.
- Client has difficulty with physical health.
- Client has difficulty with mental health.
- Client has difficulty with emotional health.
- Client has difficulty with spiritual health.

**Depression**

- Client has difficulty with physical, emotional, and cognitive symptoms of depression.
- Client may not realize or be able to describe the changes in behaviors.
- Client may have difficulty with decision-making.
- Client may have difficulty with stress management.
- Client may have difficulty with anxiety and depression.
- Client may have difficulty with anger and aggression.
- Client may have difficulty with withdrawal and isolation.
- Client may have difficulty with substance abuse.
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- Client may have difficulty with physical health.
- Client may have difficulty with mental health.
- Client may have difficulty with emotional health.
- Client may have difficulty with spiritual health.
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 mood
- Cognitive changes

- Clients with depression may
  have physical health
  changes

- Key = Assist with 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.
“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
Contact:
melissa.anderson@umassmed.edu
timothy_riker@brown.edu