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

PRIDE AND IDENTITY

HISTORY OF OPPRESSION

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


DUMMY
LIPREADER
DEAF-&-DUMB
HEARING-IMPAIRED
HANDICAPPED
ORALIST
DEAF-MUTE
FREAK
THE ORIGINAL
DEAF IDENTITY
crayons.
1899
CODA
SEEING
DEAF-BLIND
LATE-DEAFENED
DEAF-AMERICAN
HARD-OF-HEARING
SIGNER
DEAF
DEAF
IDENTITY
crayons
1999

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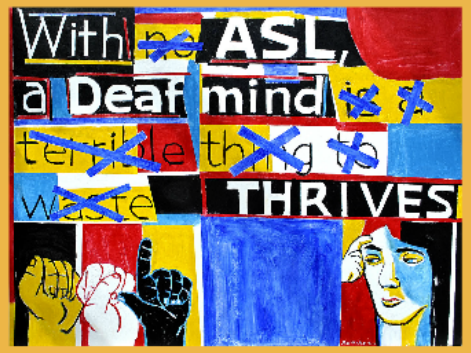
HISTORY OF OPPRESSION



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

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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).

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).

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

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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.

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)

CONSIDERATIONS FOR ASSESSMENT OF MOOD DISORDERS

CONSIDERATIONS FOR ASSESSMENT OF TRAUMA/PTSD

- Trauma exposure at least double compared to hearing population.
- Yet, PTSD significantly underdiagnosed.
- Trauma-related symptoms reflect greater degree of intensity and more symptoms of dissociation.

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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

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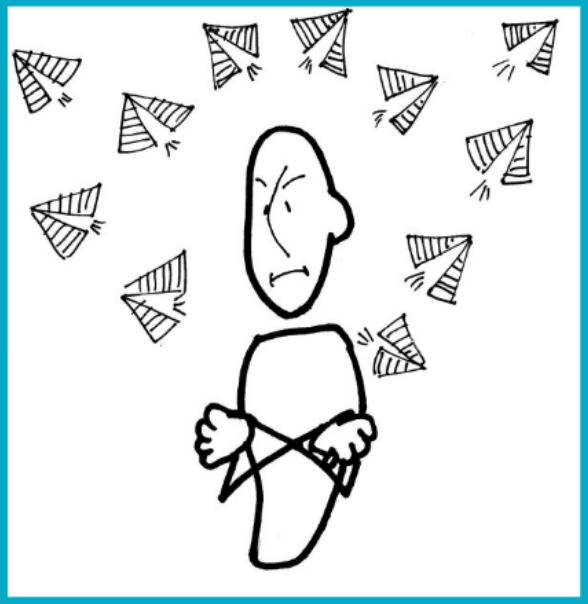

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CONSIDERATIONS FOR ASSESSMENT OF MOOD DISORDERS

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

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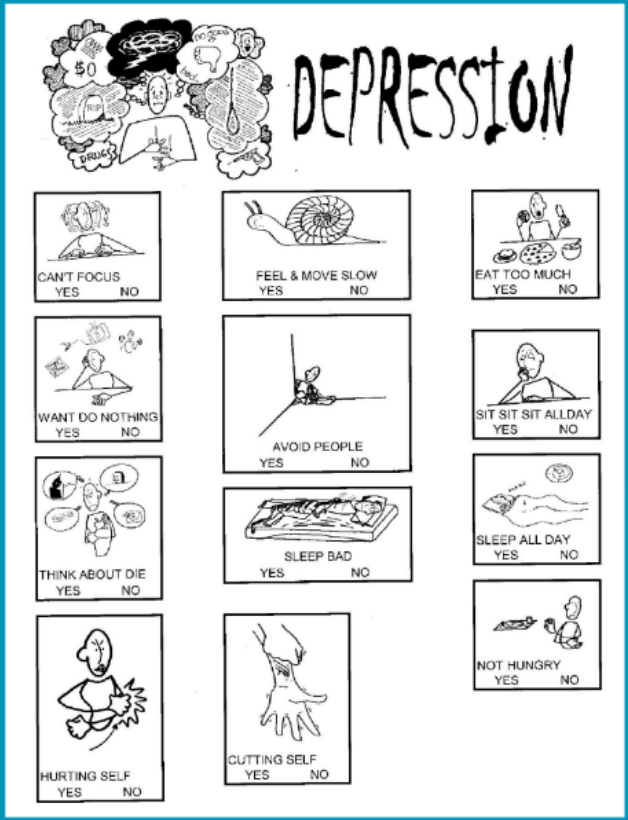

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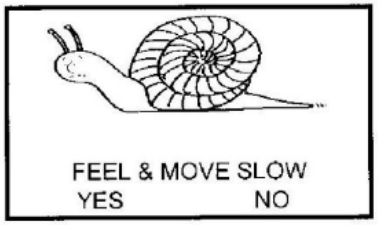
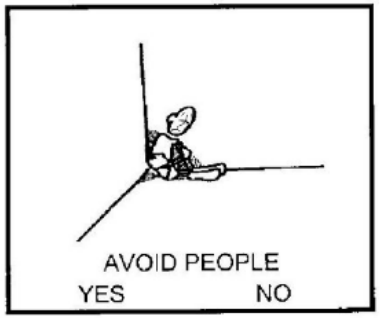
DEPRESSION


CAN'T FOCUS
YES NO


FEEL & MOVE SLOW
YES NO

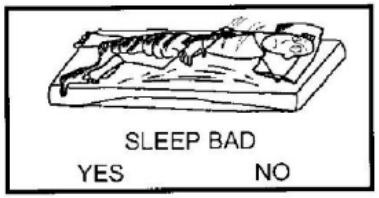

EAT TOO MUCH
YES NO


WANT DO NOTHING
YES NO


AVOID PEOPLE
YES NO


SIT SIT SIT ALLDAY
YES NO


THINK ABOUT DIE
YES NO


SLEEP BAD
YES NO


SLEEP ALL DAY
YES NO


HURTING SELF
YES NO


CUTTING SELF
YES NO


NOT HUNGRY
YES NO

- Overall
  cogniti
- Clients
  depress
  health
- Key = A
  individ
  compre

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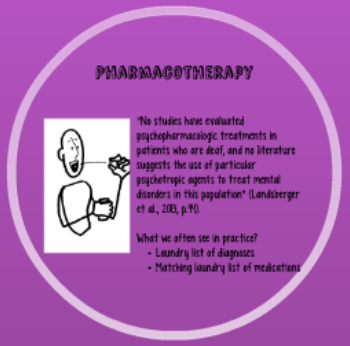
MYTH:
Deaf clients have different medication needs than hearing clients.

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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