

PSYCHIATRIC TIMES

SERVING AND ASSESSING DEAF PATIENTS: IMPLICATIONS FOR PSYCHIATRY

Generally speaking, the hearing world has a very naïve and view of deaf people. Physicians are not immune to these misconceptions. This article will attempt to add nuance and complexity to the average psychiatrist's thinking about deaf individuals.

BACKGROUND

There are large differences between persons who grew up deaf vs. those raised as hearing who then experienced hearing loss later in life. The latter group is fluent in English and can utilize English communication such as note writing, and computer keyboard. The rest of this article will focus largely on individuals raised from birth or infancy as deaf.

American Sign Language (ASL) is a complete manual language used by many, but not all, deaf people. Other manual languages are Cued Speech and Signed Exact English (SEE). Not all deaf people have a "full" language system. Because 90% of deaf children are born to hearing parents, some are at risk to not receive any usable language input during critical language acquisition periods in the brain. There is a window during brain development for language acquisition. Although there is controversy about exactly when this window is "open", most would agree that the ages of 3-7 are critical. Lacking language input then can result in an adult without fluency and competence in any language, including ASL¹.

COMMUNICATION

There are many myths about how to communicate with deaf individuals. These myths apply especially to those deaf persons for whom English may or may not be a usable language. One common misconception is that deaf people are very good at lip reading. This would be true for persons known as *oral Deaf* in that their education has focused largely on speaking and comprehending spoken English. Generally, to be an adept speech reader requires fluency in the language as speech reading requires knowledge of idioms and predicting what phrases would be most likely to occur in any given context. Moreover, only twenty-five percent of English is visible on the lips and many phonemes look the same. For example, “f” and “v” have an identical appearance on the lips. Some deaf persons appreciate *total communication* in which both sign and speech are used. In this case, the subject uses cues on the lips to help follow what is being signed.

Another common misconception concerns using written communication. To understand writing requires knowledge of English grammar and syntax. The average deaf individual reads English at a fourth grade level. Psychiatrists should never assume that a written note will be understood by a deaf person unless that individual has demonstrated a facility with English.

It is not uncommon for health care staff to try to use family members to interpret. This should be avoided for a variety of reasons. The family member often lacks fluency in sign language and can not well express complicated medical terms. When hearing parents are seeking medical care for a deaf child, they are often very stressed or, in psychiatry, are potentially part of a pathological situation. It is unfair and inappropriate

to ask parents to wear two hats in the child psychiatry situation. Also, privacy can not be maintained if family or friends are interpreting.

The ADA has, of course, indicated that reasonable accommodations must be made for individuals with a disability and for the purposes of ADA, deafness is considered a disability. The AMA has indicated that the physician should decide what is the most appropriate method of communication. This is a ludicrous suggestion as physicians generally have no knowledge of deafness or Deaf Culture, and no ability to accurately assess an individual's best communication system. Thus, best practice is for a deaf patient to pick select his preferred communication system. Many times this will require use of an interpreter and the physician is obligated to pay. This can make physicians in small practices loathe to take on deaf patients as they can end up losing money once they have billed insurance and paid for an interpreter. In some states, Medicaid has billing codes to cover the cost of interpreting. CPT has *interactive therapy codes* which can be used when working with an interpreter(90810-90815).

Unfortunately, their reimbursement rate is not significantly higher than for regular codes. These codes do not address the reality that the psychiatrist may lose money while seeing a deaf patient. Pragmatically speaking, the practical solution is often to seek care at a large institution, which can absorb the costs of interpreting with less financial hardship. Now such facilities will have to grapple with a 1994 Federal court ruling in Florida that mental health services utilizing interpreters rather than signing therapists violated ADA².

USE OF INTERPRETERS

Psychiatrists have many misunderstandings and misgivings about working with interpreters. It is crucial when using an interpreter to understand the basics of their role.

Interpreters are bound by a very strict code of ethics to maintain confidentiality. In my experience, they do a better job of this than physicians do. Thus, it is completely appropriate to disclose some confidential information to an interpreter. Interpreters prefer to have a preconference with the person who will be meeting with a deaf individual. Interpreters regularly complain that physicians refuse their requests for preconferencing and do not view them as a member of the treatment teams. In mental health situations, this is especially crucial, as it is useful for the interpreter to understand what broad differential diagnosis or what broad issues are on the psychiatrist's mind. For example, if the physician is considering the possibility of a psychotic illness, it is very useful to convey this to the interpreter, as she may never have met the individual for whom she is interpreting, and will be struggling to master that individual's unique communication style. If that individual may have a thought disorder, knowing this will help the interpreter distinguish what is pathological communication and what is idiosyncratic style. Please allocate at least five minutes to speak with an interpreter before beginning a session with a new deaf patient.

Once the session has begun, the interpreter is not allowed to give opinions and is simply there to convey communication from one language to another. Hearing people typically turn to the interpreter and ask for an opinion, or refer to the deaf individual in the third person, rather than the second person. Interpreters may not give opinions and will interpret every word that is said in the session, including questions directed at the interpreter.

COMMUNICATION TECHNIQUES

Many of our standard psychiatric questions are very abstract and

if a deaf person has experienced developmental deprivation secondary to deafness, such questions may lead to a deteriorating interview situation. Such deprivation can affect an individual's ability to think abstractly and to acquire concepts and constructs. When this has occurred, the typical psychiatric open-ended questions such as "What brings you here today?" and "How do you feel about that?" can be incomprehensible. In addition, ASL often uses "listing" as a grammatical feature. That is, rather than just saying, "With whom do you live?" which might be met with blank stares in a developmentally deprived deaf person, the interviewer will have more success asking, "With whom do you live: Mother? Father? Brother?", i.e., listing a few of the possible answers. This, of course, becomes very delicate in a forensic evaluation, as one does not want to lead the subject or suggest responses, but one must also at times use listing to cue the kind of answer one is looking for.

DIAGNOSTIC ISSUES

In the middle of this century, there were a variety of psychiatric myths about deaf persons. For example, at one point it was said that deaf people could not suffer depression, as they didn't have enough of a superego to rise to the level of obsessional defenses. There is a common misconception that deaf people are paranoid. Such paranoia may occur in the elderly who are late deafened adults. Sensory deprivation of any kind can lead to an increased prevalence of paranoia. This is a very different situation from those persons who grew up deaf, who do not have an excess of paranoia. Deaf persons do not exhibit any greater frequency of the major mental illnesses (i.e., schizophrenia, bipolar disorders). Deaf children and adolescents do exhibit some higher

levels of behavioral and ADHD disorders, especially those who become deaf secondary to rubella or spinal meningitis.

PSYCHOSIS IN DEAF ADULTS

Psychotic deaf persons can display disorders of thought form and/or thought content. Disorders of thought content can be diagnosed in a straightforward way, e.g. does the patient feel that the Devil is persecuting him, that people are following him, that someone is stealing his thoughts, etc, etc. Disorders of thought form are more difficult to diagnose without being expert in sign language. Such disorders can include clang associations (rhyming to handshapes in ASL), loose associations, flight of ideas, incoherence, tangentiality, and fragmentation. The latter is particularly difficult to sort out in a patient who presents without fluency in sign language.

Hearing people commonly believe that deaf patients can not complain of auditory hallucinations. This is not the case. Deaf patients can complain of hearing voices, even if they have been deaf from birth and have never heard sound^{3,4}. There is debate about the neural mechanisms for this, and hopefully new neuroimaging studies will clarify exactly what is going on in the brain during such events. Our inpatient unit for deaf people serves the entire Commonwealth of Virginia. Recently we reviewed psychotic phenomenon noted in our patients over a ten year period. Please refer to Tables 1 and 2 for examples of hallucinations in schizophrenic deaf persons. Some psychotic deaf persons complain that they are seeing signing such as Jesus signing to them, a face on the wall signing to them, etc. This is a unique additional psychotic feature that seems to fall between a typical auditory hallucination of communicative input and a typical visual hallucination, which is often more of forms than communicative content. Please refer to

Table 3 for a breakdown of hallucination subtypes seen in inpatients at the Mental Health Center for the Deaf.

Multiple lines of research suggest that intrauterine insult experienced during specific gestational periods is associated with a higher prevalence of schizophrenia. Most deaf people do not have hereditary deafness; thus, deafness is due to either a perinatal insult or is idiopathic. Therefore, it is not surprising that insults at particular gestational ages may produce both deafness and schizophrenia. Rubella is a classic insult that can produce both conditions⁵.

PSYCHOTHERAPY ISSUES

Deaf adults with adequate ego strengths and communication capabilities have many of the same psychotherapy issues as hearing adults: relationship, self-esteem, and vocational concerns. In some communities, the Deaf Club is a preferred social resource for deaf persons, and some Deaf Clubs feature regular use of alcohol. This can be a risk factor for a deaf person prone to substance abuse, as he or she may have a more limited repertoire of choices for socializing than a hearing individual does. Some deaf people grow up without adequate access to information available in mainstream culture and can be at risk for not having basic knowledge about AIDS and sexually transmitted diseases, how feelings effect behavior, how stress effects personal functioning, etc. At such times, psychoeducation can be extremely valuable, but therapists may need to begin at a more basic level than they would ordinarily.

Frequently deaf persons need support from their therapist in affirming their deafness as not merely a sensory deficit. The therapist affirming and encouraging the effective use of sign language by family members and the deaf person's active

participation in Deaf Culture activities can enhance self-esteem and responsible self-care.

Deaf Culture offers positive identifications and group identity to many deaf adults.

Reference:

Haskins, B., Serving and Assessing Deaf Patients: Implications for Psychiatry. Psychiatric Times. December 2000, Vol. XVII, Issue 12).

TABLE 1

HALLUCINATIONS IN DEAF SCHIZOPHRENIC PEOPLE

AUDITORY

**HEAR SINGING
SOUNDS OF SOMEONE BREAKING INTO HOUSE
GOD TALKING
VOICES COMMENT ON BEHAVIOR
TALK WITH GOD
HEAR VOICES SAYING PT SHOULD BE A SACRIFICIAL LAMB
VOICES SAY PT WILL DIE**

TABLE 2

VISUAL

**SEE THOUGHTS
SEE A "MEAN MAN"
SEE GOD
TRY TO PET INVISIBLE ANIMALS**

TABLE 3

HALLUCINATION SUBTYPES IIN PSYCHOTIC DEAF PERSONS

DIAGNOSIS	HALLUCINATION SUBTYPE			
	<u>Auditory</u>	<u>Visual</u>	<u>Tactile</u>	<u>Olfactory</u>
Schizophrenia (12)	7	4	3	2
Schizoaffective (5)	1	4		
Bipolar (2)	1	1		
MDD (3)	1	2	1	