

Communicating in the Silence: Mental Health and Cultural Considerations in the Deaf and Hard of Hearing Population

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ABSTRACT

Spoken language provides a powerful means of storytelling and describing the human experience. Serving as a cornerstone in the art and science of medical assessments, the verbal narrative is a frequently used communication modality for patients to efficiently describe their medical concerns, historical context, and relevant life experiences. The delivery of the verbal narrative itself may also provide diagnostic clues to a patient's underlying condition. For example, speech that is rapid and difficult to interrupt, speech that is loud or slurred, speech including confabulations, or other speech patterns provide valuable information in better understanding a patient's presentation—honing a diagnostic framework, and charting a treatment course. This article includes the vignette of a man identifying as Deaf and Hard of Hearing (DHH) who was initially assessed to be in a major depressive episode but, through careful screening, cultural considerations, and analysis of American Sign Language (ASL), was noted to be acutely manic. This crucial diagnostic clarification allowed proper management and subsequent remission. Deaf and

Hard of Hearing (DHH) individuals present with a unique communication modality and human experience that can be challenging or unknown for many providers. Encounters with DHH patients bring to light multiple aspects of humanism in medicine, including underlying cultural considerations notable for a clinician to consider.

INTRODUCTION

Approximately six hundred million people worldwide¹ and 14.4% of adults in America² identify as Deaf or Hard of Hearing (DHH). Individuals who experience deafness have increased rates of mental health problems³ and notable differences in the rates of diagnosed adult psychiatric disorders compared to hearing adults. For example, in a chart review of individuals admitted to a state psychiatric hospital from 1998 to 2008, impulse control disorders occurred in 23% of the DHH adults compared to 2% in a random sample of hearing adults, while pervasive developmental disorders occurred in 10% of the DHH adults compared to 0% of the hearing adults.⁴

The population of adolescent and pediatric hearing-impaired persons has a rate of psychiatric disorders from 15% to 60%.⁵ The overall DHH population is also noted to have mood, substance use, and posttraumatic stress disorder being diagnosed at increasing rates.⁴ However, in mental healthcare there are gaps in psychiatric services or training resources to help mediate interactions with these individuals.¹ Existing literature on this topic is limited, and there is a scarcity of specialized staff, clinicians, and treatment teams familiar with deaf culture.

Despite the imperative to implement resources to care for this population, Deaf and Hard of Hearing (DHH) individuals face multiple barriers. Cultural differences may impact communication and trust with hearing healthcare providers. These interactions are also molded by the specific ways that questions are phrased directly or indirectly, differing connotations or exact meaning between spoken English words versus ASL translation, interpretation of social norms including facial expressions and body language, perception of body position or gestures as dominant or passive, the content and amount of detail that one chooses to relay about an event or their life history, and assumptions around cultural background. A Certified Deaf Interpreter (CDI) can offer a role in understanding the experiences of the DHH population, navigating these nuances in communication, and helping to bridge these cultural divides.

To explore these elements of mental health care and cultural considerations in the Deaf and Hard of Hearing population, we present a vignette of a man identifying as deaf and presenting for psychiatric care.

VIGNETTE

A 23-year-old man arrived at the Emergency Department via ambulance, which was called by his

sister after he expressed suicidal and homicidal ideation. He noted a history of congenital deafness and utilization of American Sign Language (ASL) since childhood.

He was initially found to be in a great level of distress and having difficulty providing history, although he identified that he communicated fluently via ASL and an in-person ASL interpreter was obtained and utilized. However, the in-person ASL interpreter found him difficult to understand, noting that he was signing incoherently. On a subsequent encounter, the patient was calmer and could better engage in an interview. He attributed his symptoms to chronic and frustrating communication issues.

He expressed that earlier in the day he became very upset when he attempted to utilize ASL to communicate with his mother and uncle and perceived that they ignored him. He reported this is a long-standing problem for him as he is the only deaf person in his family and his family members do not know ASL well. This discrepancy had created lifelong difficulties in communication and interpersonal connections with his family, and in addition had contributed to a great sense of isolation in his human experience.

Furthermore, he also cited communication difficulties as an important contributor to his current presentation. In addition to the frustration with his family, he described additional challenges in communicating with the police when they arrived at his home. He was unclear about the reason why the police were called to interact with him, and their communication barriers with him escalated his level of distress in this experience. He explained that he had historically perceived similar issues as microaggressions, and that over his life experience these types of interactions had caused him significant frustration.

When communicating via ASL interpreters with medical providers in initial encounters, he reported depressed mood, low energy, feelings of helplessness and worthlessness, impaired concentration, and suicidal contemplation. This narrative led to a diagnosis of major depressive disorder. During subsequent encounters with medical staff on the psychiatric inpatient unit, his narrative was relayed by ASL interpreters, who described that he was challenging to redirect or interrupt in their exchange of communication via ASL. The ASL interpreters also observed that he was rapid in his speed and sequence of hand movements.

Both the interpreters and the interviewers also noted the number of words and vastness of topics communicated between each question. Multiple different ASL translators on different days consistently commented on these findings. On several occasions, the interpreters had to ask the patient to slow down his signing because the speed of his ASL hand movements was difficult for the interpreters to understand.

Based on that presentation, a more detailed screening for mania was performed, more extensive collateral information was obtained, and it was discovered that the patient had experienced prior manic episodes. This observation of rapid signing, along with a more detailed exploration of the patient's frustration tolerance and premorbid emotional dysregulation, was crucial for diagnostic clarity and more appropriate therapeutic management

For this man, his medical diagnosis and treatment path were substantially changed by a more careful assessment that considered the unique aspects of the DHH population. During hospitalization, his care benefited from timely access to ASL interpreters who were obtained for interviews, and psychiatrists strove

to utilize extra time and care to build rapport and connection with the patient. However, he voiced frustration with daily tasks while in the hospital, such as requesting items and struggling to communicate without an ASL interpreter in those spontaneous interactions with mental health staff. The team did not have access to a Certified Deaf Interpreter (CDI) to further assist him.

BACKGROUND

Only an estimated six percent of DHH Americans know American Sign Language (ASL), while approximately half of DHH individuals have not been taught any formal language, falling under the classification term “language dysfluent” or “prelingual.”¹ Even for those individuals able to utilize ASL, it is important to note that ASL is not a direct translation of English into a visual form.⁴ ASL relays the concepts being communicated but does not transmit the exact words or nuances of English language; conversely, ASL also has its own vocabulary, grammar and nuances.⁶ This adds additional complexity to interviews beyond simply providing an ASL interpreter. Because the assessment of psychiatric symptoms typically relies on verbal language, this limitation may impact adequate assessment in the DHH population.⁵

The ability to communicate effectively via ASL translation is also impacted by the age when the patient learned ASL, and the fluency of ASL obtained in childhood, as well as their overall language acquisition trajectory and its impact on that ability to communicate effectively.⁴ A full 90% of children who are Deaf at birth are born to hearing parents—placing these children at risk for language deprivation, especially during the critical developmental period of early life.⁷ Because of this difference in parental verbal

communication, children who are deaf may not gain exposure to a usable language system, and risk becoming delayed despite having normal intelligence.⁷

In addition to communication differences, the Deaf and Hard of Hearing (DHH) population may have developmental considerations that impact their interactions with others, their ability to navigate social dynamics and emotions, and their perception of medical settings and the world at large. These formative experiences include the ability to bridge attachment as children to hearing parents and family members, to develop trust for their families or for others, to form social relationships, to learn social norms, to express feelings via communication, and to communicate ideas in detail and depth via translation with hearing individuals.⁸

Moreover, the development of a language system fosters abstract thinking and a consequent developmental gap may also lead to difficulties with the ability to generalize, to understand abstract concepts, or to manipulate ideas around time or money.⁷ Due to suboptimal communication between DHH persons and their early caregivers and peers, affected individuals may face difficulties in attaining functional skills, including socialization and emotional regulation.⁹ These factors appear to contribute to the high rates of socially inappropriate behaviors, impulsivity, and aggression.⁹ Conversely, children with disabilities are overall 3.4 times more likely to have suffered maltreatment than their peers.¹⁰

Furthermore, the life experiences of Deaf and Hard of Hearing individuals may include an array of cumulative microaggressions that shape a current narrative and how the individual interacts with hearing individuals. These experiences can include a personal history of feeling left out or oppressed in families of hearing

individuals, encountering exclusive environments within family structures or institutions or society, having one's intellect questioned due to hearing status, facing barriers in socially connecting via spontaneous interactions, feeling frustrated when attempting to communicate in locations with poor lighting or physical barriers that are detrimental for ASL, or needing to rely on interpretation rather than feeling empowered to communicate directly with one's exact words.¹¹ If unaware of their own hearing privilege, hearing individuals and healthcare providers can perpetuate exclusive behavior or negative experiences for this population.

Barriers in communication may also contribute to more fundamental issues in access to healthcare, discrepancies in healthcare, and marginalization. When matched for diagnosis, age, race, and presenting problem, DHH hospitalized patients are restrained up to four times more than patients who can hear.¹² In addition, recent literature in *The Lancet* regarding the mental health of deaf people noted that the length of hospitalization for DHH patients is cited to be twice that of hearing patients.³ Moreover, in the inpatient psychiatric setting, there are documented service inequalities for the Deaf population.¹³ These include more psychiatric medication intervention and less psychotherapy offered to these patients versus their hearing peers, with the hypothesis that this imbalance is due to differences in communication and the bias of communication demands.¹³ In the context of overall communication difficulties, DHH patients can experience prominent levels of fear, mistrust, and frustration in their relationship with healthcare professionals.¹⁴

DISCUSSION

The vignette presented here highlights the difficulties that persons who utilize ASL may experience in communicating effectively with their own families, with police or other Emergency Medical Services (EMS) personnel, and with clinicians and staff involved in the assessment of psychiatric or safety concerns. This case highlights the fear or mistrust of the medical establishment that may have resulted from a DHH person's life experiences, including perceptions of marginalization or microaggressions.

Despite increased rates of mental health concerns reported in deaf individuals,³ they have been historically underserved and underrepresented in healthcare.⁴ The perspective of the vignette highlights the challenges that may be faced by individuals who identify as Deaf and Hard of Hearing. Due to communication differences, these individuals may have experienced an overall trauma exposure that shapes their perceptions of marginalization, access to healthcare, or mistrust or frustration with medical providers who utilize spoken language. Conversely, physicians may experience anxiety when attempting to overcome linguistic barriers, to obtain narratives and history, and to communicate with members of this population.¹

This highlights the importance of clinician sensitivity, empathy, and cultural competency to better understand the whole person who has presented for medical care and treatment.

The vignette also emphasizes the challenges in effectively navigating communication barriers. For example, the addition of an ASL interpreter to the clinician-patient dyad of communication creates another layer in subjectivity and clarifying communication and meaning.¹⁵ Barriers including

clinicians' lack of familiarity with ASL or with Deaf cultural norms impact the ability to assess this patient population and to rule out other psychiatric conditions.¹⁵

Cases of diagnostic ambiguity may benefit from the contributions of a psychiatric provider specializing in patients with hearing difficulties.¹⁶ However, few specialized psychiatric services or training resources exist for this population.¹ An interpreter may translate ASL into spoken English, but this still may be sub-optimal without a broader understanding of the cultural context and holistic social impact that a deaf person faces when interacting within a hearing environment.¹⁷

RECOMMENDATIONS

To reduce these communication difficulties and to optimize medical treatment, a report by the Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) outlined recommendations that included: increasing cultural competency among staff, and taking extra time and care to establish a dialogue about personalized distress reduction strategies and the impact of an environment that is potentially over-stimulating for the Deaf and Hard of Hearing.¹⁸

In addition, this population would benefit from clinical collaboration and resources that improve access to care for these individuals. Literature, particularly in the school-age population of DHH individuals, points to the benefits of interdisciplinary efforts and collaboration in connecting mental health providers, advocacy groups, ASL-fluent staff, and community agencies in order to build partnerships to best meet the patient's needs.¹⁹

The access to proper services is thankfully—but

slowly—improving after the Americans With Disabilities Act, which requires equal access to services for people with disabilities, as well as the National Association for the Deaf advocacy that individuals identifying as Deaf receive accessible mental health care in their language. However, only a few states offer these services; continued progress is still needed to adequately assist this underserved population.²⁰

Furthermore, the case presented here highlights the benefits of Certified Deaf Interpreters (CDIs) and their role in bridging these cultural divides. In addition to having native or near-native fluency in American Sign Language (ASL) and experience in the use of gesture and other tools to foster communication, Certified Deaf Interpreters (CDI) have a broader understanding of the Deaf community and culture.²¹

CONCLUSION

Spoken language is a traditional means employed by clinicians and patients to communicate efficiently and effectively. However, Deaf and Hard of Hearing (DHH) individuals present with communication barriers that may contribute to difficulty in telling their medical concerns, life narrative, or overall human experience.

Interactions with individuals may be shaped by a complex cultural construct of their humanity. This includes their developmental history, language acquisition, and life course sculpted by the ability—or inability—to communicate with medical providers, emergency assistance personnel, family members, support systems, and the world at large.

This article underscores the importance of cultural competency in improving access to healthcare of the Deaf and Hard of Hearing. It highlights the value of healthcare delivery via clinicians who are sensitive to

the unique considerations of a population, to each individual human experience, and to the underlying humanism in providing sensitive medical care.

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Dr. Katherine Kosman holds an undergraduate degree in electrical engineering, an MD from Geisel School of Medicine at Dartmouth, and a Master of Business Administration (MBA) degree from the Tuck School of Business at Dartmouth. Dr. Kosman began her post-graduate medical training with an internship year in surgery and residency training in anesthesiology before ultimately transitioning to the specialty of psychiatry, a career progression driven by her increasing interest in humanistic narratives, psychosocial factors, and longitudinal care. A graduate of the Harvard Longwood Psychiatry Residency program, Dr. Kosman has proudly served a diverse patient population and strives to leverage writing to explore broader issues. Dr. Kosman has published academic work on the importance of trauma-informed care, the need for transgender education in psychiatry, the use of stress management workshops to foster self-awareness and reduce burnout among medical students, and the implications for mothers and infants in maternal hospitalization for postpartum depression, in addition to Dartmouth Medicine Magazine essays reflecting on humanitarian medical work in the Himalayas and in Vietnam. An avid reader, Dr. Kosman founded the Harvard Psychiatry Book Club. In addition to clinical care, Dr. Kosman's current endeavors include research at the intersections of trauma, PTSD, and women's mental health.



Dr. Marcela Almeida studied as an undergraduate in Rome, Italy, and graduated from medical school in her native Brazil in 2002. Shortly after receiving her medical degree, Dr. Almeida chose to practice in a remote area of Northeastern Brazil, the poorest region of the country. She regards that experience, and the lessons learned there, as the most crucial for her medical career. She completed her post-graduate studies and her residency at the University of Chicago, where she became an avid advocate for minorities and underserved populations—especially women of color. Dr. Almeida then served as Director of the Women's Mental Health and Reproductive Psychiatry at the University of Illinois, the largest specialized program in the US, where she treated women with psychiatric manifestations related to their reproductive cycle, including pregnancy, postpartum, infertility, and menopause. In addition to patient care, she directed the women's mental health fellowship program and conducted research that focused primarily on burnout and de-stigmatization of mental illness among Latinas. In 2017, she joined Harvard Medical School's Department of Psychiatry at Brigham and Women's Hospital, where she has mentored trainees from underrepresented minorities, and provided care for women with chronic mental illness while striving to reintegrate them into society. She also sits on the board of the Salt and Light Coalition, an organization that works with victims of domestic violence and sex trafficking.