Psychosomatics 2015:56:1–11

Review Articles

Psychiatric Care of Deaf Patients in the General Hospital: An Overview

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Background: *While the number of Deaf and hard-of-hearing patients worldwide is estimated at six hundred million, few specialized psychiatric services or training resources exist to support the provision of mental health care to this population. This presents a particularly acute problem in the general hospital, where the consultant psychiatrist is likely to be confronted with the challenges of providing comprehensive psychiatric evaluation, diagnosis and treatment to patients with whom he or she may have limited experience or confidence.* **Method:** *We review critical considerations in the work-up, differential diagnosis, and management of commonly-presenting psychiatric disorders among Deaf patients in the general hospital setting.*

(Psychosomatics 2015; 56:1–11)

INTRODUCTION

Deaf and hard-of-hearing patients (a term that has replaced "hearing-impaired" by the strong preference of most Deaf communities) are often admitted to general hospitals and are seen by psychiatric consultants in collaboration with medicine and neurology teams. Although textbooks exist for the Deaf mental health specialist,[1] few articles serve as guides for consultants who are faced with the challenges of caring for Deaf patients. (N.B.: Deaf advocates use the distinction "big D" for culturally Deaf persons vs "little d" for deafness as a clinical condition.[2,3]) Psychiatric consultants may be called to assist with the differential diagnosis, management, and capacity evaluations, bearing in mind that Deaf persons' trauma exposure, mood and anxiety disorders, and psychosis may present distinctively and occur at higher rates than found in the general population and that certain etiologies and histories of deafness (such as total language dysfluency, the absence of any signed- or spoken-language learning) may correlate with cognitive deficits.[4] The global number of Deaf and hard-of-hearing persons is estimated at 600 million.[5] Yet owing to the paucity of Deaf-accessible mental health services in many parts of the world, including the United States, utilization of psychiatric services by Deaf patients is often limited; thus gaining experience and confidence in the care of Deaf patients poses a challenge for psychiatrists in training as well as their supervisors.

This article seeks to enhance the care of Deaf individuals by providing a medical definition of deafness, discussing how to gather history using effective communication strategies, and highlighting common comorbid medical and neurologic illnesses. We also describe psychiatric disorders among Deaf patients as

Received April 1, 2014; revised May 31, 2014; accepted June 2, 2014.
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well as coping differences between congenital and acquired hard-of-hearing patients, recommend medical and neurologic work-ups, and provide treatment recommendations. As enhancement of psychiatric and medical care for Deaf individuals rests on improving both available interpreter resources and education among health care providers, we also examine some of the psychodynamic issues possibly involved in many physicians' anxiety about attempting to communicate with, evaluate and effectively treat patients who are Deaf.

SETTING UP THE ESSENTIAL CONDITION FOR AN ACCURATE EVALUATION: COMMUNICATION SERVICES

A crucial step in any evaluation of a Deaf person, whether psychiatric, medical, or neurologic, includes arranging for an interpreter (legally mandated since the Americans with Disabilities Act [ADA] of 1990)[6] and clarifying the roles of the Deaf patient's team members. This may involve using assistive listening or video remote interpreting services when access to live/in-person interpreters is not available, though it should be noted that many Deaf patients, like hearing patients, prefer live interpreter services to facilitate connection with the treatment team. Although many physicians use back-and-forth note writing with Deaf patients as a stopgap measure, this strategy does not satisfy the ADA requirements, in part because of varying degrees of literacy among Deaf patients.[7,8] For Deaf patients who know American Sign Language (ASL) (accounting for approximately 6% of Deaf Americans), ASL interpreters are required; some countries have counterparts of ASL (e.g., Russian Sign Language and Spanish Sign Language).[9] For those who are "language dysfluent" or "prelingual" (i.e., who have not been taught any formal language), which comprises approximately half of all Deaf individuals, a certified Deaf interpreter (a Deaf individual who has been trained in recognizing attempts to communicate by the prelingual or language-dysfluent patient) working alongside an ASL interpreter is required. Certified Deaf interpreters can use ASL to translate the dysfluent gestures to the interpreter, who then voices the ASL signing in English. Nuances of interpreter services, such as "signer" vs "ASL fluent," should be noted in the chart, as these have legal significance, with Deaf patients entitled to ASL-fluent interpretation vs the more general "signer" category. In the emergency department (ED), many maneuvers, such as using interpreters, may not be immediately available. However, it is critical when making high-stakes decisions with medicolegal implications (e.g., capacity determinations and dealing with end-of-life issues) that communication specialists be present; law suits (e.g., associated with noncompliance of ADA standards) have resulted from a lack of access to facilitated communication within care settings.[10] Although some Deaf individuals speak and lip-read, clinicians cannot assume that their spoken words match the intended meanings; therefore, interpreter services should be used. Even for skilled lip-reading Deaf individuals, variations in accent, pronunciation, and enunciation by the speaking individual can be barriers to accurate understanding. In general state commissions for Deaf and hard-of-hearing individuals can provide interpreter services.

Even in acute care settings, time should be devoted to providing both orientation and reassurance. Equally helpful is attention to visual stimulation. Interviewers should avoid making distracting motions (e.g., playing with pens or other objects or gesturing while talking) or being in a room with flickering lights.[11] Such distractions make it more difficult for visually-oriented people to concentrate; many high-functioning Deaf individuals report heightened surveillance of visual inputs, making them more sensitive to these disturbances.[12] It is also critical that distractions be eliminated when the Deaf patient is processing what the interpreter is communicating while formulating his or her response to the interpreter—i.e., speaking to or distracting a Deaf person who is watching an interpreter is analogous to interrupting a patient in conversation with another health care provider. Among Deaf people who use sign language, visual stimuli are processed in the superior temporal gyrus and other regions involved in auditory processing among hearing people.[13] Thus, incidental sights and distracters could impede the processing of language by Deaf patients and should be avoided. In addition, the insights and expertise of communication specialists regarding Deaf signing and language-dysfluent patients can make a critical difference in quality of care. The communication specialist can help ensure that all standards of each patient's communication needs are met by being sensitive to attempts at communication in the absence of formal language