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Review article

"Psychiatric assessment of deaf and mute patients – A case series"

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ABSTRACT

Deafness is negatively associated with higher distress, depression, somatization, and loneliness in patients of all age groups. The psychiatric presentation of patient also varies. Due to lack of proper communication, clinical approach often becomes quite difficult. We will be discussing various psychiatric presentations in 3 different deaf mute patients. We will also be highlighting the different clinical approach applied to all the patients. This case series might help in giving an insight into the psychiatric symptoms of deaf mute patients which might pave way for new diagnostic guidelines for future research and in clinical practice.

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1. Introduction

Prelingually deaf mute patients represent a difficult population in the field of psychiatric healthcare due to the prejudices regarding deafness. It is a common belief among psychiatrists that paranoia is the most essential psychopathology associated with deafness (Virole, 2006). Also, a profile of "primitive personality" of deaf people comprising of anxiety, impulsiveness and immaturity are considered as features of mental disorders among deaf people (de Ajuriaguerra, 1974). Generally, prelingually deaf mute patients have difficulty in expressing their feelings due to limited training in sign language and almost no spoken language. This is often due to the fact that prelingually deaf-mute patients are often not aware that they are experiencing any mental health problems, as they cannot share their experience with others. Basically, they don't have a language to describe their feelings to others. If mental health professionals have a poor understanding about the presenting symptoms in deaf mute patients, there is higher chance of making incorrect diagnosis leading to inappropriate treatment and prolonged hospital stay (Denmark, 1994).

Language plays a significant role in the assessment, treatment and management of mental health patients. The main difficulty faced by a mental health professional is the inability to communicate directly with their deaf mute patients. Deafness is not an area which receives sufficient exposure to medical students

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as a separate subject in the medical teaching. Medical students generally have good knowledge about the anatomy and physiology of ENT, but dealing with the psychological and sociological aspects of deaf mute patients is not taught as a speciality. Moreover, throughout the training period of psychiatrists, majority of psychiatry textbooks doesn't give enough references regarding management of psychiatric illnesses associated with deaf mute patients.

Hereby, we will be discussing a case series of 3 cases, all being prelingually deaf-mute. In the initial encounters with each patient, there was significant communication problem leading to delay in diagnosis in one of the cases, but each case were handled in different way. Diagnosis in case 1 was made mainly on the basis of detailed history taking and behavioral observation. Diagnosis in case 2 was made on the basis of 'sign language', while diagnosis of the case 3 was purely made on the basis of written communication. Diagnostic approach to the patient has also been described in detail.

2. Case 1: psychosis in a deaf mute patient

D, a 39 yrs old Hindu unmarried male, unemployed with no formal education, belonging to a middle socioeconomic status, nuclear family, rural background presented to the adult psychiatry OPD, Department of Psychiatry, PGIMER, Dr R M L Hospital, New Delhi with chief complaints of withdrawn behavior, wandering aimlessly, laughing and crying for no apparent reason, decreased sleep, decreased self care and maintaining mundane postures for a long time from the past 3.5 years. He was brought by his father for proper evaluation and management, after visits to various faith healers.

Exploration of history revealed that the patient was prelingually deaf and mute since birth. He used to communicate with his family via indigenous gestures and sign language. He was apparently well till 2011, well adjusted to personal and social domains, helping out in household chores, when he was observed by the family members to be more withdrawn to self and having decreased interaction with other family members. He would spend most of his day in bed, take a lot of time in getting dressed and going to the field, and eventually stopped stepping out of the house altogether. Gradually over 1–2 months, he was observed to be smiling and laughing without any apparent reason, while sitting alone in the house and gesturing to self. He would be hyper vigilant at night, observed to be repeatedly looking towards the door. Family members also started noticing that he would keep all the lights on at night while retiring to bed. When they would ask him to switch it off or attempt to switch them off themselves, the patient would get extremely irritable and on few occasions, even got physically assaultive to express his dissent.

After 6 months of withdrawn behavior, his family members reported that he would wander away from home and had to be kept contained within the house by sometimes resorting to locking him up indoors. There were incidents reported by the family when he would wander away aimlessly to the nearby hills greater than 20 km away, walking great distances without any apparent reason. He was sometimes found days later in a disheveled condition by distant relatives and neighbors and brought back home. His sleep was decreased to 4 h, instead of the usual 7–8 h. His oral intake had decreased to a level that he would not eat food for days at end, till force fed. He would not take adequate care of his personal hygiene, not taking bath or changing his clothes for days. Over the course of the illness, he stopped even brushing his teeth unless told repeatedly and would get annoyed with mother for her insistence. Earlier, the patient used to communicate via sign language, but since his symptoms worsened, he stopped communicating and would not give any reason for his abnormal behavior. He would give a vacant look whenever being asked. Past, family and personal history was not contributory. All investigations were within normal limits. His neurological examination did not reveal any focal lesion. Pure Tone Audiometry (PTA) revealed bilateral profound hearing loss. Psychometric assessment could not be done due to the deaf-mutism.

A proper mental status examination could not be done as patient was prelingually deaf and mute. Hence, Kirby's method for examination of uncooperative patient was applied. A middle aged patient of average built entered into interviewer room accompanied by his father. Gait was normal and, no abnormal movement was noticed. He was in a disheveled state, wearing unclean and unironed shirt and trouser and appeared not to have taken bath or shaved in the last few days. The patient was alert, holding comfortable voluntary postures. No play of expressions or response to what was being said or done. His affect was flat with a vacant stare. Withdrawal on pinprick was present. Posturing and negativism were observed in the patient.

On the basis of history and MSE a diagnosis of Other non organic psychotic disorders (ICD-10, F 28) was made and patient was started on T. Lorazepam 2 mg and T. Olanzapine for the suspected catatonic symptoms. Within approximately 1 month of starting the medications, he started showing significant improvement within 2–3 weeks. He was well maintained on T. Olanzapine 20 mg. Post discharge, he was seen for 2 follow up visits, wherein there was marked improvement in non verbal interaction and eye contact. He had started assisting his father in household chores and was more cooperative about treatment. After recovery, an attempt was made to communicate with the patient regarding his symptoms during the illness. As neither the clinician nor the hospital staffs were familiar with sign language, assistance was sought from the patient's family member who could understand the gestures of the patient. Patient reported that he was scared, as he used to feel that 'unknown people will kill him'. Now he reports significant improvement in his symptoms on medication.

3. Case 2: panic attacks in a deaf mute patient

S, 22 year old Hindu unmarried female, not formally educated, belonging to middle socio economic status nuclear family of urban background presented with mother to adult psychiatry OPD, Dr. R. M.L.Hospital, New Delhi with total duration of symptoms since 2009. She was brought by her family for proper evaluation and management.

History revealed that patient was prelingually deaf mute since birth. She was well trained in sign language, as she was attending special schools from childhood. Her mother was also well trained in sign language as the patient used to communicate with her mother through the same. She would communicate with the whole family through her mother only. Therefore, history was taken from mother only as she was able to communicate the patient's symptoms properly. Patient was apparently asymptomatic till 2009 and was well adjusted to her daily routine. She was otherwise a cheerful, well adjusted and gregarious girl. She started reporting of episodes of crying spells lasting not more than 15–20 min. She would explain by sign language that she had a feeling of choking sensation during the episode associated with shortness of breath. Patient would ask for more water for drinking as she would report dryness of mouth. Patient would report symptoms of restlessness, as she would keep on moving around inside the house. Patient's mother observed severe sweating during the episodes. On evaluation, patient would explain by sign language that these episodes were very distressful and would cause severe inner restlessness and anxiety. These were described as sudden onset without any precipitating event or situation. During these episodes, she would cling on to her mother, holding her hand