Communicating with deaf patients: 10 tips to deliver appropriate care

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Meet with the interpreter before the session. Discuss your goals and explain the meaning of psychiatric terms and symptoms

When treating deaf psychiatric patients, appropriate psychiatric care is possible when you maintain an awareness of deaf culture and language. Consider these 10 points:

1. Certified American Sign Language (ASL) interpreters are necessary. The Americans with Disabilities Act requires that all health care providers offer "auxiliary aids and services to provide effective communication." For deaf patients, often this means an interpreter. Certified interpreters:

- have passed fluency examinations
- are culturally competent
- follow standards of practice
- have a code of ethics
- are required to pursue continuing education to keep their skills sharp and up to date.

Visit the Registry of Interpreters for the Deaf at www.rid.org to search by state for freelance qualified ASL interpreters and interpreting agencies. Be aware that clinicians must pay for the interpreting service, which is not reimbursed by insurance. Rates vary by region.

2. ASL fluency levels vary. Approximately 90% of deaf children are born to hearing parents, and exposure to ASL may be delayed or minimal. As a result, the presence of a fluent ASL interpreter does not guarantee patient comprehension. The patient may not understand the questions being asked resulting in incorrect endorsement or denial of symptoms. Dysfluent patients' language may mimic that of a patient with a thought disorder or intellectual disability, resulting in misdiagnosis.[1]

3. Meet the interpreter before the session. Discuss your goals and explain the meaning of psychiatric terms and symptoms to help him or her communicate your message and interpret the patient's response.[2]

ASL is not visual English. Some concepts do not translate into ASL and need to be modified or omitted by interpreters. English idioms often used in diagnostic interviews, such as "feeling blue" or "feeling keyed up or on edge," do not have exact ASL translations.

An interpreter has to use his or her judgment on how to translate these concepts in ASL. Some symptoms such as "panic attack" and "auditory hallucination" do not have corresponding signs in ASL.

Interpreters may convey these concepts by describing or even acting them out. Ambiguity is difficult to maintain in ASL. Interpreters often have to give examples or lists of possible choices to communicate a concept. Some open-ended questions must be transformed into multiple-choice questions, which can be leading or narrow potential responses.

4. Be aware of privacy. Certified interpreters are required to maintain confidentiality. However, a deaf patient might not have the same interpreter over the course of treatment. The deaf community is close-knit, and a patient using multiple interpreters may worry about confidentiality. Deaf people are likely to use interpreters in a variety of settings and may feel uncom-

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fortable working with the same interpreter in a psychiatric setting and other social situations. The deaf patient always has final say over whether or not to work with a particular interpreter.

5. Avoid using families as interpreters. Even if they are fluent in ASL, family members can distort examination findings and will eliminate confidentiality. If a family member insists on serving as an interpreter, discuss his or her reasons. For example, some families use a form of idiosyncratic gestures often called "home signs" instead of ASL. In this case, you would need a family member present because an ASL interpreter would not be familiar with these. In other situations, you may have to educate family members about why a certified interpreter is more appropriate.

6. Don't rely on written English. A typical deaf person of normal intelligence has a fourth-grade reading level. Self-report measures of symptoms often are written for an eighth-grade reading or higher level. In psychiatry, subtle nuances in communication are critical, and relying on written English could cause misunderstandings.

Do not use written notes passed back and forth with your patient to avoid the expense of an ASL interpreter. Physicians have been successfully sued for refusing to hire interpreters in the hope of "getting by" with written notes. In these cases the judgments against the physicians were not covered by malpractice insurance.

7. Don't overpathologize. ASL is an expressive and dramatic language. In addition, deaf persons may have different personal space boundaries than hearing persons. Don't mistake these cultural norms as evidence of a mood disorder or character pathology.

8. Be cautious when assessing a deaf person for psychosis and "hearing-based" phenomena such as auditory hallucinations. Psychotic disorders historically have been overdiagnosed in deaf patients when clinicians rely solely on subjective reports of symptoms. Instead, err on the side of caution unless you identify objective, observable evidence (such as bizarre behavior or clearly stated delusional beliefs).[1]

9. Clarify. Deaf persons—just like hearing persons—do not like to appear unknowledgeable. A patient may "nod along," leading you to inaccurate conclusions and misdiagnosis. Use open-ended questions to elicit a full description of symptoms.

10. Be patient and plan ahead. Schedule longer sessions—as much as twice as long—to allow extra time for interpretation and double-checking comprehension. Remember that each question has to be asked, interpreted, answered, and interpreted again. Follow-up questions may be necessary to ensure comprehension.

References

1. Glickman N. Cognitive-behavioral therapy for deaf and hearing persons with language and learning challenges. New York, NY: Routledge; 2009.
2. Leigh IW, Corbett CA, Gutman V, et al. Providing psychological services to deaf individuals: a response to new perceptions of diversity. Prof Psychol Res Pr. 1996;4:364-371.