



Improving Communication Among Providers Serving D/deaf Populations In Mental Health Settings

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ABSTRACT

Mental health is as critically important as physical health. The status of one's mental health can be greatly impacted by environmental, social, psychological factors, and traumatic experiences that interfere with daily living. Deaf populations who utilize American Sign Language (ASL) for daily communication face a unique set of obstacles to accessing quality mental health care, and the lack of access to effective counseling due to linguistic barriers can contribute to the deterioration of mental health symptoms. This paper will guide non-D/deaf mental health clinicians to become more familiar with deaf culture and will underscore the potential of language accommodation to relieve burdens felt by deaf individuals.

Disclaimer: “Deaf” will be used interchangeably with “deaf” to demonstrate inclusivity with the multiplicity of deaf identity; the D is capitalized to show affiliation to a cultural community and hard-of-hearing people who primarily use ASL for communication.

While strides have been made toward enhancing linguistic access for the deaf population in the United States (e.g., providing closed-captions, utilizing ASL in real time for live reporting, establishing crisis hotlines, and improving internet usage for video remote interpreting [VRI] services), access remains severely limited for those receiving mental health support (NAD, 2022). There is a growing need for clinicians who are familiar with deaf culture and can competently serve members of the deaf population seeking mental health services. To address the gap between hearing practitioners and deaf patients as well as to ensure efficacious treatment, practitioners must familiarize themselves with tools of effective communication for deaf patients, implement inclusionary practices, and focus on increasing cultural knowledge. Research has shown that clinicians who strive for and practice cultural humility provide a more effective therapeutic process for patients with different backgrounds (Fisher-Borne et al., 2015). This paper aims to assist clinicians in understanding the language needs and cultural uniqueness of the deaf population, and to provide in-depth guidance for utilizing ASL interpretation in therapy sessions to ease deaf patients' hesitancy in accessing mental health services.

THE DEAF POPULATION IN UNITED STATES

Around 30 million people living in the United States have hearing loss (Hoffman et al., 2017). Twenty three percent of those 12 years or older have either mild or severe hearing loss, while moderate hearing loss is most prevalent in those who are 65 years old and older (Goman & Lin, 2016). The number of people who use ASL as their primary form of communication is approximately 250,000-500,000, according to Mitchell et al. (2006).

The deaf and hard-of-hearing community remains largely underrepresented and underserved in mental health in the United States. In one research study, about 90 percent of people from the deaf

community have observed that there were relatively few accessible mental health services for deaf individuals (Feldman & Gum, 2007). Several studies have indicated a lack of understanding about deaf culture among mental health clinicians and the language barrier prevents the deaf population from being able to effectively receive adequate support for social services (Steinberg et al., 1998; Mueller, 2006).

A 1996 study found that, at that time, there were only 20 registered deaf psychologists in the country (Pollard, 1996). As of 2001, there were 261 programs for the deaf population, including programs in outpatient settings, schools, psychiatric hospitals, and community mental health centers (Cohen, 2001). However, this number may not accurately reflect the amount of modern mental health clinicians able to provide culturally competent care to deaf patients in ASL. Indeed, the number of registered deaf mental health clinicians today is still low, which means that Deaf clients are often referred to adjunct services such as programs with ASL accommodation in social services.

DEAF CULTURE, LANGUAGE USAGE, & MISCONCEPTIONS

DEAF CULTURE

Deaf persons who identify strongly with Deaf culture may internalize belief systems about Deaf customs more so than those who identify as deaf. Deaf individuals may consider themselves members of the cultural and linguistic community rather than a disabled group (Napier et al., 2017). In the author's experience, the term "disabled" often feels like a forced label: Deaf individuals can feel it gives the false message that all deaf persons are "inferior," "hearing-impaired," and that they need to be "fixed" in order to be considered functional members of society. The culture of Deaf people includes an exclusive set of behavioral norms, values, and beliefs that differ from the general population. Given that deaf individuals with profound hearing loss are unable to respond to sound without the assistance of auxiliary aids, such as cochlear implants (CIs) and hearing aids, it is generally acceptable to tap an individual's shoulder, stomp the floor, or flick the lights, depending on the situation, in order to get their attention. Conversations can be initiated with a greeting followed by first and last name and school

affiliation. It is also important for any person engaging in a conversation with a deaf individual to look at their facial expressions rather than their hands so as to be able to understand the message they are trying to convey. These are a few of the social expectations that deaf community members typically adhere to.

LANGUAGE USAGE

ASL is a visual language consisting of its own grammatical rules and syntax, a structure that is fundamentally distinct from English. While signing, linguistic information is visibly transmitted and processed in the frontal lobe of the brain (Evans et al., 2019). Body movements, facial expressions, and the placement and location of the hands are important elements in conveying information.

Facial expressions can provide emphasis of interest or convey enthusiasm, depending on the nature of the conversation at hand. For example, if a lighthearted story or joke is being interpreted, it is acceptable—and even expected—that the interpreter smiles. In any situation, it is expected that the interpreter will duplicate the emotion and tone of the person being linguistically accommodated.

MISCONCEPTIONS

Treatments in mental health counseling are predominantly designed to accommodate hearing individuals. Standardized testing or evaluations rarely consider aspects of deafhood. Deaf individuals are more likely to experience higher rates of social isolation due to the language barrier that contributes to the problem of accessing mental health care. The unique linguistic accommodations deaf clients require can leave providers reluctant to work with deaf people.

Psychotic disorders, along with other neurological development disorders, are more frequently diagnosed in deaf psychiatric patients than in non-deaf patients (Landsberger & Diaz, 2010). Misdiagnoses are more likely to occur when clinicians misinterpret aspects of a deaf person's communication and associated behavior. Deaf clients tend to respond to general questions in an elaborate manner, often with a

narrative rather than giving a simple answer. This tendency is a common conversational pattern in the deaf community: for example, a deaf person explaining a traumatic experience to a therapist would focus on the nuances of the story, detailing every single plot point leading up to the event and demonstrating their reactions through facial expressions. A hearing clinician may interpret this behavior as “unwillingness to cooperate” or “inability to focus.” However, facial expressions that are crucial grammatical components of ASL can be misconstrued as “inappropriate expressions of affect” (Phillips, 1996; Leigh, 2010, p. 22). As a result of this mischaracterization, the deaf population is prone to misdiagnosis and more vulnerable to institutionalization; many deaf communities fear these outcomes and some avoid mental health services for this reason. (Leigh, 2010).

Professional mental health care for deaf clients is further undermined by common assumptions and misconceptions about deafness. For example, practitioners often believe that lip reading/speech reading and note-writing provide effective health communication (Iezzoni et al., 2004). These communication modalities are often ineffective for people who were diagnosed profoundly deaf at birth, or who were not able to acquire language at the same level as individuals who had years of practiced lip-reading/speech-reading. Deaf people who are familiar with spoken language are typically only able to understand about 30–45% of spoken English (Lieu et al., 2007). Furthermore, note-writing requires literacy proficiency to comprehend and interpret to the best of one’s knowledge and respond cohesively, but a deaf patient whose first language is ASL may not be as literate with written language (Pollard & Barnett, 2009). Smeijers and Pfau (2009) further argue that using note-writing with a native signer, who might not be fluent in the commonly used written language, can negatively impact ties of communication.

Using deaf culture as a foundation for understanding behavioral norms can lessen the chances of miscategorizing certain characteristics as symptoms of mental illness. Understanding the unique set of values in deaf culture, alongside considering the linguistic needs of the deaf individual, alleviates medical distress.

EFFECTIVE COMMUNICATION

The language needs of a deaf person vary, as deaf individuals exist on a spectrum: one may use oral speech and sign simultaneously, while another may not use oral communication and prefer to communicate exclusively in sign language. The nuances of preference in communication modalities should be taken into consideration when ASL interpretation is an option.

The 1990 Americans with Disabilities Act (ADA) states that accommodations must be paired with anti-discriminatory practices that prohibit exclusion and unequal treatment, and that such accommodations are an institution or business's responsibility to enact. Areas of accommodation include architectural standards, policies and protocol modifications, and communication access (ADA, 2021). This means that mental health care providers are responsible for finding and paying for a qualified ASL interpreter. Under the ADA, the goal of effective communication is to ensure both parties—those with disabilities and those without—have equal access to legible communication. This underscores the importance of clear communication, acknowledging that the deaf client has the right to understand the nuances in which messages are conveyed without hindrance.

A “qualified ASL interpreter” is defined as someone who has completed four years of an interpreting program at an accredited college, has received a certification from the Registry of Interpreters for the Deaf (RID), and possesses the skills to interpret effectively, accurately, and impartially. This includes the ability to decode and convey messages (both receptive and expressive) back to either parties involved, using any necessary specialized vocabulary (NAD, 2021).

Deaf individuals possess the legal right under the ADA to obtain, through an institution or service provider, an ASL interpreter for services they are seeking. Effective communication greatly influences patient and client interaction. Ensuring that the deaf individual has access to communication that is clear and transparent allows space for both persons involved in the therapy process to be equally heard and supported.

BUILDING RAPPORT WITH DEAF PATIENTS

Establishing rapport with deaf and hard-of-hearing individuals is critical, as it lays a foundation of mutual trust and respect during sessions. A working alliance facilitates the developmental process of exploring reasons which bring a person to mental health services. Bonding elements such as “respect, liking, and trust” increase effective therapeutic collaboration (Gladding, 2014, p. 143). In accordance with establishing mutual efforts, mental health clinicians can promote clients’ comfortability by acknowledging opposing worldviews in session and building the professional skills necessary to collaborate with culturally different clients.

Cultivating a thorough understanding of deaf culture and learning to effectively serve the deaf population are not limited to providing linguistic accommodations. Also required is an understanding of core values of deaf culture, along with an appreciation and respect for the uniqueness of each deaf individual (Leigh, 2010). A therapist who has some familiarity with Deaf culture, but who has minimal ASL knowledge, is not an appropriate substitute for an ASL interpreter. In one report, several participants maintained that medical professionals with negligible sign language communication skills were willing to settle for a minimal level of communication with deaf clients which they would never tolerate with hearing patients (Steingberg, 1998).

Comprehensible language provides the clinician with direct insight into the client’s life; however, when communication breaks down in therapy, the client’s progress can become jeopardized. Utilizing ASL interpretation for ASL-literate deaf individuals can reduce communication disruptions during sessions and help avoid ruptures in the therapeutic alliance.

IMPACT OF INACCESSIBLE ASSESSMENTS

Deaf people have a significantly more difficult time communicating their health needs with primary care physicians and generally feel less comfortable going for physical health check ups (Zazove et al.,

1993). In one study, deaf individuals who did not already have some level of hearing or language acquisition made fewer health care visits than those who did (Barnett & Franks, 2002). In another, patients with hearing loss reported having lower satisfaction with healthcare quality (Iezzoni et al., 2004). Providing deaf patients with ASL interpretation whilst receiving treatment for psychiatric care and substance-use counseling is of utmost importance, as study participants who received ASL interpretation used preventive services more frequently and reported feeling more satisfied than those who were not provided ASL interpretation (MacKinney et al., 1995).

Although research related to reading comprehension in deaf adults remains limited, it has been demonstrated that, on average, deaf students' reading levels did not exceed past grade four (Traxler, 2000). Considering the advancement of technology and recent emphasis on bilingual education, however, this finding may no longer be accurate. Instead, eliminating barriers of communication by identifying gaps in language and addressing misgivings, as many deaf clients are not properly informed of behavioral health care standards and procedures. Some examples include providing clarification around medication use and the need for follow-up care (Hommes et al., 2018). However, deaf-inclusive clinical mental health services vary from state to state: sometimes no deaf services or clinicians are available at all, in which case members of the deaf community often have no choice but to opt to use hearing-based services. Quality of care is necessarily diminished in these cases.

Since most mental health assessments do not include aspects of deaf culture, including ASL, undesired results such as misdiagnosis may occur during treatments, or patients may experience discomfort and reluctance when accepting medical approaches. It is therefore essential that materials are translated into a tangible assessment that allows both the client and the therapist to determine the best outcomes for treatment.

USING ASL INTERPRETERS

Clinical practitioners are frequently unaware of how to effectively utilize interpreters in mental health settings. Common mistakes include the clinician speaking too fast or addressing the interpreter instead of the client (Stansfield, 1981; Leigh, 2010). Spoken and signed language interpreters share a similar fundamental goal of ensuring messages between the listener and speaker are effectively translated in native and target languages (Christoffels et al., 2005): it is important for the clinician to understand that common goal.

It is generally recommended that the clinician briefs the interpreter with information before sessions with deaf patients in order to ensure the following:

1. interpreter placement
 - 1.1. The interpreter should be placed where they can be clearly viewed by the client without any visual interference, and where the interpreter's voice is audible to the therapist.
2. language clarification
 - 2.1. If acronyms, jargons, unique vocabulary or any other unfamiliar terms will be used during sessions, clarification is needed before the session.
3. brief review of confidentiality
 - 3.1. Interpreters are required not to reveal information discussed in session with external sources.

In addition, a break in session, though not generally common in spaces where clients are receiving direct support, is important when using interpreters; unlike clinicians, interpreters are rarely trained to “hold” and process intense emotional or relational experiences in the same way. A session break can occur with interpreter input: when the interpreter is having a difficult time dealing with the content of the session or is overwhelmed by the intensity and speed of the client’s statements, they may need a moment to collect themselves and it is not clinically inappropriate to allow them to do so. However, it may become clinically inappropriate if the clinician feels the interpreter’s emotional responses

are interfering with the client's quality of care. This is why, as discussed earlier, establishing boundaries to avoid emotional inference during the session is important and best done beforehand.

It is also imperative that interpreters comply and adhere to the code of conduct as stated by RID (2007):

Professional code of conduct certified and qualified interpreters must:

1. Adhere to standards of confidential communication.
2. Possess the professional skills and knowledge required for the specific situation.
3. Conduct themselves in a manner appropriate to the specific interpreting situation.
4. Demonstrate respect for consumers.
5. Demonstrate respect for colleagues, interns, and students of the profession.
6. Maintain ethical business practices.
7. Engage in professional development.

Any concerns about the interpreter's ability regarding confidentiality should be addressed with the mental health center's Human Resources department, if one exists. In addition to being ethical best practice, taking these steps before and during mental health sessions also removes the burden of providing interpreter guidance from the client, especially if they are in a place of emotional distress.

Deaf people require linguistic and cultural adjustments distinguishable from their hearing counterparts. Practitioners familiar with deaf culture and who utilize (reach out to, pay for, and develop working relationships with) ASL interpretation to assist in communication are rare. Integrating such practices allows the deaf individual to remain in the client role, which includes receiving comprehensive care from the clinician, while simultaneously minimizing the clinician's uncertainty of the interpreter's role prior to and after sessions. When clinicians become empowered to increase their familiarity with and cultural capacity for the varying and nuanced linguistic and cultural needs of the deaf population, they provide deaf people in their region with an important mental health resource that this population too often lacks.

INTERPRETER RECOMMENDATIONS

The recommendations for this section are optional but strongly encouraged. Clinicians may screen the interpreter for their qualifications by performing a brief check-in with the interpreter before the interpreter's first session. This interaction allows the clinician to determine if the interpreter is a good fit and is emotionally equipped to handle ongoing sessions, given that discussions about the client's trauma and adverse life experiences may be discussed. While interviewing interpreters, the clinician should decide if the interpreter has:

- The ability to refrain from making personal statements during sessions (e.g., offering opinions that the deaf client may or may not have expressed).
- The ability to effectively decode messages for the speaker and the listener and to accurately transcribe messages in spoken and signed language.
- A neutral reputation in the deaf community of being able to remain unbiased and maintain anonymity.
- A clear understanding of the roles involved (i.e., the role of the clinician, client, and the interpreter themselves).
- The ability to remain professional; personal emotions should not impede the session.

If a new interpreter is needed for any reason, the clinician's first steps should be to inform the deaf/HoH client before their next session and to provide a brief explanation for requesting a new interpreter, and if possible allow for client input and feedback. The clinician should be transparent in their reasoning for the ASL interpreter replacement, because transparency is the foundation of a trusting therapeutic alliance. Allowing the client's input in the decision-making process ensures the client's autonomy is intact while making sure the interpreter chosen has the ability to remain impartial and maintain emotional boundaries.

Therapists can also choose to optimize the use of the interpreting field, as ASL interpretation is not one-dimensional, and D/deaf individuals vary

in their experience acquiring proficiency in ASL; some have their own preferred communication style (National Institute on Deafness, 2019). Depending on local availability, there can be a variety of interpreters with specific knowledge and skill sets that may be useful for a given client's specific therapeutic context. Requests can be made based on cultural or linguistic needs, because some among the deaf population may require additional linguistic and sociocultural consideration. Black American Sign Language (BASL) is one example of an ASL variation. A deaf mental health client who identifies as Black or African-American may prefer to work with an interpreter who is from a similar racial group, not only because they may feel more comfortable communicating with them, but also because the client may feel the interpreter is more familiar with the nuances of BASL. This preference can also apply to deaf members of other marginalized groups who share common cultural struggles and experiences.

Interpreters can share a unique sense of closeness with the mental health care client when they are from similar linguistic and cultural communities that experience social oppression and discrimination. Having a connection to the person interpreting can result in greater empathy and trust between interpreter and client, since the interpreter can empathize with the client's experience. In that case, communication between the interpreter, mental health care clinician, and client becomes more precise and has a more comfortable flow.

CONCLUSION

The mental health field is becoming more aware of the deeply disrupting impacts that traumatizing experiences can cause across a person's experience of daily life, but more light needs to be shed on the traumatizing effect of not having proper access to mental health care due to discriminatory barriers. This experience is common and readily apparent with D/deaf populations in this country, and can have a significant negative impact on their mental health. Additionally, given the limited research on effectively serving deaf populations and the short supply of ASL-specific linguistic accommodations nationwide, resources to ameliorate this issue remain scarce. The author calls for more research addressing linguistics gaps in mental health care on

the following topics: providing accessible assessments for treatment plans, increasing deaf representation in the mental health field by hiring psychologists from a similar cultural background, and expanding resources for deaf populations to receive mental health support.

Ultimately, ASL interpretation must be provided by behavioral health care providers to ensure effective communication between the client and therapist. It is also critical for clinicians to better accommodate the client by learning about cultural dissimilarities and determining treatment approaches with cultural considerations in mind. D/deaf and hard-of-hearing clients benefit when mental health care clinicians educate themselves and thoughtfully provide culturally responsive care for this underserved population.

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