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Vania Nwokolo

The University of Texas Rio Grande Valley, vania.nwokolo01@utrgv.edu

Francisco Fernadez

The University of Texas Rio Grande Valley

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Psychiatric assessment of a Spanish understanding patient who is deaf – A Literature Review

Authors: Vania Nwokolo, MS4, & Francisco Fernandez, MD
University of Texas Rio Grande Valley School of Medicine

Abstract

Mental illness can be misdiagnosed amongst the population who are deaf or hearing impaired. It is important to have the effective tools and resources necessary to appropriately diagnose mental health diseases within this population. In this paper, the authors present a review of the literature on this topic and its significance.

Introduction

Mental illness is a health condition that is prevalent in the United States (1). Research has shown that nearly one in five adults in the United States are living with some form of a mental illness (1). To effectively diagnose and manage a mental disorder, communication between clinicians and patients is critical (2). However, in communities where some individuals have limited English-language proficiency, such as the Hispanic community, there seems to be a substantial gap between the need for mental health services and its availability (3). Research has shown that Hispanics with mental illness deal with many obstacles of obtaining adequate healthcare, including language barriers (4). Various solutions have been provided to bridge this gap, such as ad hoc interpreters (family members and local staff), telephone interpretation, professional interpretation, and mobile computer technology at the bedside (5). However, when these resources are not available, there is a huge barrier to adequate translation services (5).

Adding a hearing impairment can make mental health assessment and therapeutics more complex (6). Research has shown that approximately 6.8% of the world population considered

themselves deaf or have serious difficulty hearing (7). It has also been shown that about 1 in 7 Hispanic/Latino adults in the United States, suffer from some form of hearing loss (8). People who are deaf also have barriers to access the health care they need, such as limited health literacy and sign language barriers (9). However, there is limited research available concerning the evaluation, diagnosis, and treatment of mental health disorders in deaf individuals (10,11).

This literature review is the outcome of a clinical experience with a bilingual Mexican American male patient in a safety net clinic in the Rio Grande Valley.

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Discussion

Our experience demonstrated the problems of diagnostic assessment and treatment in an underserved indigent rural area. Both the medical and psychiatric diagnostic considerations were concluded based on written communication. In the initial phases of written communication, due to lack of sign language interpreters, staff assumed patient to understand primarily the Spanish language. The initial workup was done with typed up behavioral health intake questions, translated into Spanish. The patient was able to respond in written Spanish his symptoms of depression and trouble sleeping. However, as the written conversation continued, the patient noted the examiners predilection to communicate in English and he alerted all to his ability to also read and comprehend English. Due to this, the interviewers and the patient were able to write and respond to each other with follow up questions in English. The interviewers were able to deduce that the patient had issue with his sleep, including increased daytime sleepiness, spouse alerting the patient that he snores, observed episodes of the patient stopped breathing

during sleep, and abrupt awakenings accompanied by gasping or choking. Based on these finds, the patient was given a potential diagnosis of Obstructive Sleep Apnea.

Obstructive sleep apnea (OSA) is a sleep-related breathing disorder that is caused by periods of narrowing and obstruction of the pharyngeal airway while sleeping (12). OSA is a common, chronic disorder that predominantly affects middle aged men (13). It affects approximately 2-4% of the population (14). Obstructive sleep apnea that is untreated can lead to long term health issues, including cardiovascular disease, metabolic disorders, cognitive impairment, and depression (15).

Not only can OSA lead to Depression, but due to symptom overlap, OSA can be mistaken for Depression, leading to under-diagnoses (16). Overlapping symptoms include daytime sleepiness, fatigue/loss of energy, poor concentration, irritability, psychomotor retardation, and weight gain (16). However, whereas Depression will also present with symptoms of sadness, anhedonia, agitation and guilt, OSA will have accompanying symptoms of snoring, witnessed apneas and snort arousals (16). Due to possible discrepancies with diagnosing of these two disorders, it is imperative that clinicians utilize effective communication to always look for an underlying cause of depression, instead of simply diagnosing the patient with Major Depressive Disorder. For patients where there are barriers to communication, such as non-English understanding patients who are deaf, this may make effective communication strategies to come up with a true diagnosis of OSA a little more complex.

It is crucial that clinicians accurately diagnose patients presenting with symptoms that can be due to various causes. It may seem a harder obstacle diagnosing patients who may primarily speak and understand a language that is different from what the physician is used to, and much more a patient who is deaf. This may be due to a variety of reasons, such as lack of resources or

lack of training and confidence in dealing with this patient population. However, patient's health comes first, and clinicians must be creative in finding ways to effectively communicate with them in any way possible. When clinicians are unable to find the right resources to effectively communicate with patients who may have communication barriers, it can lead monolingual patients, especially those who are deaf, not being treated, leading to unwanted mental and medical health consequences.

Research has shown that people who are hearing impaired are at a greater risk for depression (17). According to a study by Hallam et. al, individuals who are deaf are 4.8 times more likely to have clinically significant depression than the population average (17). This is in accordance with other studies, such as the Emond et. al study which also indicated individuals who are deaf had high levels of self-reported depression, as well as anxiety (18-20). This may be in part due to the challenges individuals who are deaf face when trying to seek out mental health services, such as counseling or psychiatrist, that provide resources to facilitate communication tools that are more comfortable for them.

Studies show that there is a lack of clinicians and facilities that are proficient in American Sign Language and that have access to resources that can serve as interpreters for this population (21). Clinicians may misinterpret behaviors, attitudes and written responses of Spanish understanding patients who are deaf, leading to misdiagnosis and unsuitable management.

Conclusion

In the case above, written communication was the resource at hand employed to reach a psychiatric diagnosis in a Spanish understanding patient who is deaf. However, it was later proven that this patient not only read and wrote in Spanish, but in English as well. The

interviewers did not know sign language but could read and write in English and Spanish. If they could not read and write in Spanish and the patient only understood Spanish, this psychiatric assessment would have been even more complicated to obtain.

In many clinical settings, technology has been utilized for interpretive services (5). If a similar patient seeks mental health treatment, it is vital that the clinicians do their duty and use all these resources at hand to come up with an adequate diagnosis to give appropriate treatment. However, in underserved areas, these advances are not always readily available or even accessible. Reliance on written communication is key in these settings.

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