Lost in Translation: Navigating Diagnostic Biases in Deaf Psychiatric Inpatients

To the Editor: We present the case of a 34-year-old deaf mute man who presented to our facility after being found incompetent to stand trial for charges of trespassing. He had 3 prior hospital admissions for schizophrenia. His rapid improvement with treatment was clinically reminiscent of the resolution of a manic episode. We felt the need to question the accuracy of the admission diagnosis and revise it.

A literature review revealed that mood disorders in the deaf are the most frequently ignored diagnosis by nonspecialists, with psychotic disorders such as schizophrenia or unspecified psychosis being overdiagnosed.[1,2] Patients on specialty deaf inpatient units were less likely to be diagnosed with a psychotic disorder than deaf patients on nonspecialty units.[3]

Case report. Mr A presented to the psychiatric inpatient unit from jail after trespassing into a home in a wealthy neighborhood. On initial presentation, he was rapidly gesturing in an exaggerated manner, and his affect was very animated. Interviews were conducted via American Sign Language (ASL) interpreters who found it difficult to follow his thought process, describing it as rambling, racing, loose, and with flights of ideas. He had multiple grandiose delusions that he helps the Federal Bureau of Investigation, is an NBA player, and owns a multimillion dollar house. He repeatedly referred to a "mothership" parked in Arizona. He reported recent hydroponic and synthetic cannabinoid use.

Given his apparent disorganization, delusional thoughts, and erratic behavior, we continued using schizophrenia as his admission diagnosis. He was treated with a combination of haloperidol (up-titrated to 25 mg daily) and extended-release valproic acid 1,000 mg, reaching a therapeutic level of 61 µg/mL. His mental status improved over a 9-day hospitalization. By discharge, he had a calm, full-ranging affect, with less animated signaling, which interpreters equated with normal rate and rhythm of speech. He stayed focused on topic and was oriented to self, time, and place. He named the facility but could not identify it as a hospital. Instead, he described it as a place where "they give you money," "they help me find a job," and "they teach skills." He showed good self-care and no behavioral disturbances or social withdrawal. He cooperated well with the team and even made appropriate political jokes. He scored within average range on the Test of Nonverbal Intelligence-4.[4]

Mr A informed us that hearing aids have been useless to him in the past, as he could not understand English. He described previously experiencing auditory hallucinations as gestures similar to those of ASL and explained that this was not sound because "my ears don't work." We concluded that his mental status during the episode was a combination of grandiosity, mood lability, racing thoughts, and pressured speech, which was better attributed to a manic episode or substance abuse rather than schizophrenia.

The clinical presentations of deaf people in distress can be confusing for nonspecialist physicians, possibly leading to misdiagnosis and suboptimal management, which is further complicated by a lack of standardized, validated ASL assessment tools.[3] However, observable mental status findings such as emotional disconnectedness, social withdrawal, and incongruent affect could help direct the diagnosis.[5] An adequate deafness history is necessary to rule out dysfluency, which is the abnormal language pattern resulting from late or inadequate ASL training. Dysfluency could be mistaken for tangentiality and looseness of association typical of thought disorders.[6] It is also important to keep in mind that ASL is not readily translatable into grammatical English, which makes the written language of many deaf adults appear fragmented and confused.[4]

Additionally, the absence of early auditory stimulation and delay in acquiring language can affect neurocognitive processing domains including auditory and visual working memory, attention, and inhibition.[7] Also, suboptimal communication between deaf individuals and caregivers has been linked to problems in the normal experience of socialization, problem solving, and emotional regulation.[8] We feel this communication deficit could, in part, explain his inability to identify the function of the facility as a hospital or appropriately explain what the mothership was.

Our case adds to the literature highlighting the diagnostic discrepancy between nonspecialists and deaf clinical specialists. We conclude that non–ASL-fluent psychiatrists treating deaf patients should familiarize themselves with the diagnostic biases and communication barriers, demonstrate diagnostic flexibility accommodating the patient's unique presentation, and always interview deaf patients with the assistance of a qualified ASL interpreter.

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