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Communication Skills Assessment for Individuals Who Are Deaf in Mental Health Settings

ROGER C. WILLIAMS AND CHARLENE J. CRUMP

Introduction

Susan, a deaf 53-year-old woman, was hospitalized several times at a variety of public and private hospitals. Communication access ranged from virtually none to interpreters and staff fluent in American Sign Language (ASL). Each hospitalization found the respective treatment teams (including the interpreters) spending up to a week determining the best way to communicate with her. Even with these efforts, she was usually discharged without clear communication having ever been established. However, when she was admitted to a hospital program which had Deaf treatment services, she received a careful communication assessment. Among the findings were that her best means of expressing language differed from her best means of receiving language. When she signed, she tended to use ASL with many grammatical features borrowed from English, giving the false impression that her English language skills were better than they were. The language assessment showed that she had difficulty understanding English grammar-based signing and needed ASL grammar to receive and process information. In addition, she had difficulty with fingerspelling, often being unable to remember the beginning of the word by the time she arrived at the end. She could read words on paper, but she could not process the same words well through fingerspelling. This assessment altered how program staff communicated with her, and this led to a more successful treatment experience.

Most professionals working in the field of Deaf mental health, whether by training or by intuition, work to match the language output of the person with whom they are communicating. However, when, as with Susan, a person's expressive language skills differ from their receptive language skills (a condition known as "asymmetrical" language abilities), staff misjudge how to provide information, and the person receives information in a way they have difficulty processing. This is particularly true when the situation is compounded by language deprivation and/or mental illness.

Each signing professional worked diligently with Susan to provide the best language services they could. From the communication assessment, staff

learned, in addition to the fact that she needed language input in ASL, that she couldn't easily remember new words, that signing to her frequently had to be slow and repetitive, and that fingerspelling was usually an unsuccessful communication strategy. They also came to a better awareness that she often "blanked out" when people were communicating with her. It was not a dissociative trauma reaction. It was more likely a language processing problem. When these variables were taken into consideration, this level of communication accessibility shortened her hospitalization and, when used by other hospitals, reduced her length of stay by three days or more.

Susan had this information also, and she could use it to explain and advocate for what she needed to get the most effective treatment. She could, for instance, ask that medication information be written down, not fingerspelled, and that important diagnostic information be repeated in several sessions, with clear ASL interpretation.

Serena, a 58-year-old deaf female, was hired as a mental health technician at a group home that works with individuals who are deaf with mental illness. As part of her employment, she was required to take and pass a Medication Assistant Certified (MAC) Worker examination. This required readings, two days of classroom lecture, a written examination, and a performance examination. Serena is bright, but she struggled with the material. Even with sensitive hearing instructors working in conjunction with highly qualified interpreters, she could not comprehend and retain the required information, and still failed the examination.

On her second attempt, a communication specialist was brought in, and her deaf peers at the group home provided mentoring for her. Serena would seem to grasp the concepts while involved in a mentored task but was unable to transfer that information into the classroom. The same hearing instructors taught the class, but a different interpreter was brought in when one of the original team members was not available. This team interpreter happened to have experience in communication assessments and noted that while Serena's language output was primarily English-based signing, she seemed to respond better to questions that were in ASL. Also, despite being given specific information during the training by instructors through interpreters, in written form, and through mentoring with deaf peers, Serena would sometimes respond as if she had never had any exposure to the information. Although there was some improvement, she failed the second attempt as well.

Eventually, the second interpreter began to recognize that Serena showed some of the language dysfluency patterns associated with congenital rubella syndrome. Serena also seemed to forget new information, fingerspelled exceptionally slowly, and struggled with receptive fingerspelling—often asking others to write the new words down for her, an intuitive survival and self-advocacy skill. Staff observed that Serena occasionally tuned out while watching the interpreters. She asked questions regarding somewhat basic information that she had been repeatedly taught in previous sessions. Noting these linguistic factors, the interpreter asked Serena how she became deaf and was not surprised to find that her hearing loss etiology was congenital rubella.

While Serena was not a consumer for whom a formal communication assessment was required, she still benefited from an analysis of her language skills.

Based on the results of the communication assessment, her interpreters began using ASL (rather than matching Serena's language output), and more closely monitored when Serena was inattentive. When she started to tune out, they switched to a more dialogic interpreting style in which they would ask her what a concept meant and then dialogue with her about it. This required the use of consecutive interpreting and more time. Instead of fingerspelling words, the interpreters wrote them down for her. More time was spent at the group home with Serena performing the activities, rather than discussing them or watching peers. Additionally, a captionist was hired so that the information was provided in written English alongside ASL. With these supports, based on a better understanding of her communication abilities and needs, Serena passed the MAC exam on her third attempt.

The interpreters discussed with Serena what they learned about her communication abilities. This is not a typical task for interpreters but, in this case, it was welcome information. Serena learned how the rubella etiology of her deafness probably affected her language abilities. Serena began crying as the discussion progressed. She admitted that she knew she struggled more than she felt she should in many different environments but had always been told by her parents and teachers that she had an intellectual disability in addition to being deaf. As she has been able to incorporate these changes into her accommodation requests, her ability to succeed academically and vocationally has improved dramatically.

In Alabama and South Carolina, communication assessments are required for any person who is deaf and receives mental health services (Administrative Code, 2010; South Carolina Department of Mental Health, 2014; Williams & Crump, 2013). This chapter will provide a discussion of historical informal attempts to analyze sign language used by deaf persons and why they have not always been effective. We will discuss what information a quality communication assessment can provide and how it can assist in treatment and educational interventions. We then discuss the communication skills assessment developed by the Alabama and South Carolina Departments of Mental Health. This instrument and procedure can be found at www.mentalhealthinterpreting.net/communication-skills-assessment.html. We recommend that readers access this assessment while reading this chapter to provide an easy reference.

History of Communication Assessments in Deaf Service Programs

The need for communication assessments of deaf people with complex or idiosyncratic means of communication is becoming more recognized. This is partly in response to the growing awareness about the highly diverse ways deaf people communicate and more appreciation that "knowledge of sign

language" in staff is no indication they are qualified to meet these communication challenges. This interest in communication assessments is also a response to the growing recognition of how language deprivation remains a problem for some deaf people and how this deprivation impacts the development of language, communication, cognitive, and psychosocial skills.

There is good reason to believe that the presence of deaf people with significantly dysfluent language in clinical populations is very high when compared with hearing individuals. Approximately 2%–3% of the general population have a language disorder (Law, Boyle, Harris, Harkness, & Nye, 2000). For the population we service, that proportion is likely higher than the 50%. Black and Glickman (2009) found that 66% of the deaf population seen at the Westborough Massachusetts State Hospital Deaf Unit over a seven-year period had either grossly impaired or functional but non-fluent language skills. Glickman (2009) reviewed all the deaf psychiatric and vocational rehabilitation literature available to date, finding reports of similar communication challenges in most, if not all, Deaf mental health programs. His review found that in virtually every hospital which had a Deaf inpatient program, and reported their findings, staff believed they saw a large subset of deaf patients with significant language and communication challenges as well as an array of behavioral and psychosocial challenges. This was common enough that they presumed they were seeing some new kind of psychiatric disorder and they attempted to name and describe the disorder. In Chapter 1 of this book, Gulati names this condition "language deprivation syndrome" (See also discussions in Glickman, 2009; Gulati, 2014; and Hall, Levin, & Anderson, 2017).

The principal criteria for this proposed syndrome are language deprivation and dysfluency. To reliably make such a diagnosis, we need to improve and standardize communication assessments. The tool we present here is one way to begin that process. This tool is a work in progress and, as noted in the assessment manual, is designed to provide qualitative information about the subject's communication skills. It has not been subject to the rigorous psychometric requirements which would validate comparisons between subjects. The use of communication assessments is still in at an early stage in the clinical specialty of Deaf mental health. Hopefully, additional tools will be developed which will provide that level of rigor. Chapter 6 of this book, by Jonathan Henner, Jeanne Reis, and Robert Hoffmeister, documents progress towards having psychometrically validated ASL assessment tests. Their review emphasizes receptive ASL tests because they worry about bias introduced by unqualified examiners, and receptive tests are less subject to examiner bias. We worry about evaluator bias also (see section that follows on examiner qualifications) but believe that it is crucial to assess expressive skills as well.

Hearing people, listening to other hearing individuals who share the same language speaking with significant dysfluency, would immediately perceive that something is wrong. However, when hearing professionals with no experience serving deaf persons encounter language dysfluency, they frequently assume it

is either a normal result of being deaf, a manifestation of cognitive disability, or an indication of mental illness. They may also assume the interpreter, therapist, or language specialist pointing out the dysfluency is not competent. This means that language deprivation and dysfluency may be overlooked as possible reasons for emotional or behavioral challenges the person may show. It may also mean that treatment recommendations do not sufficiently consider how the person needs to receive, process, and express information.

The Alabama Department of Mental Health and South Carolina Department of Mental Health developed similar communication assessment instruments (Crump, 2005; Williams, 2003). They were inspired by, and built upon, the work of Greg Long, who created a communication assessment tool for individuals in employment settings (Long & Alvares, 1995). That tool was designed to improve the match between the communication skills required for successful employment in those settings and the abilities of the deaf worker. A presentation at the 2012 ADARA Breakout conference detailing each respective assessment instrument and procedure inspired the goal of merging the two assessments into one tool that would be employed in both states and made available to other programs. The assessment tool and procedure described here are the result of that collaboration.

Sign language interpreters typically perform an informal communication assessment at the start of an assignment. In the not-to-distant past, individuals were trained to spend a few minutes communicating with the client in the waiting room before a session. This, in theory, allowed the interpreter an opportunity to assess how the Deaf person communicated. Interpreters might ask the deaf person questions such as why they were coming for this appointment. They would observe what words the person fingerspelled and preferred signs for specific concepts. This informal assessment yielded an impression as to whether the person was difficult or easy to understand. This analysis was often shared with other professionals, including therapists, and typically included comments such as, "It's a tough one, they use ASL, but not well," "They have minimal language skills and are difficult to understand," or "They don't understand fingerspelling." While interpreters are usually appreciative of any information that can prepare them for the interpreting assignment, these brief, summary judgments were often overly simplistic, misleading, or wrong. They provided little insight into the specific nature of the person's communication skills and deficits.

These brief assessments also did not provide adequate guidance for the interpreters on how to adjust their interpreting to meet the needs of the client. In some situations, they even interfered with treatment. For example, the interpreter is mistakenly advised that the individual has some "home signs" when the individual is experiencing a psychotic episode and those "home signs" are neologisms, made-up words that are a product of mental illness. An interpreter who chooses to interpret highly dysfluent language into coherent or even articulate spoken English may deprive the therapist of needed clinical information regarding the client's state of mind. Yet, in this same example, an interpreter

who glosses, providing a word-for-word transliteration, or simply states that the message doesn't make sense, without providing an analysis of how the message is incoherent, may bias their interpretation in the direction of making the deaf consumer seem even more linguistically and intellectually incompetent.

Interpreters often worry that their interpretation may negatively skew the impression the clinician has of the deaf person. Interpreting the content, register, and emotion of a message is complex and difficult. Any interpretation inevitably alters the message and any difficulties in comprehension can potentially magnify that alteration.

Sometimes interpreters turn to people in the deaf consumer's life to gather more information about that person's communication abilities. This leaves room for misunderstanding. Family members, for instance, often hold inaccurate assumptions about the language abilities of their family members. They may tell clinicians or interpreters "he can't understand that" or "she doesn't know how to sign," statements which may be misleading. Interpreters lacking objective information about the person's language and communication abilities, and depending on inaccurate or incomplete information, expose these clients to risk of misdiagnosis or mistreatment.

Matthew, a hearing sibling of Marcus, who is a 40-year-old deaf male, accompanied Marcus to an appointment with a vocational rehabilitation counselor. Marcus had not been exposed to ASL until he was 15 and as a result showed very dysfluent sign communication. In the appointment, Matthew spoke for Marcus. Matthew told the counselor what job skills Marcus had and what he wanted. When the counselor, with basic conversational sign skills, inquired how Matthew could understand Marcus' language, Matthew replied "I know what he wants." In this situation, the counselor was never able to communicate directly with Marcus, who remained in an infantized and dependent position. A good communication assessment would have guided the counselor on the communication accommodations that Marcus needed not only in their interview but also on the job.

There are many stories like those of Marcus, Serena, or Susan to which professionals working with deaf people can relate. The wide variation in communication abilities of language-deprived deaf people makes it difficult for even a sign fluent therapist or qualified interpreter to communicate well with every deaf consumer. Having an objective communication assessment is one way to explore language abilities and deficits, eliminate ineffective communication approaches, and share what specific gestures or home signs, unique to this person, may mean.

Social and Medical Causes of Language Dysfluency in Deaf People

Human beings can develop language dysfluency because of many medical, psychiatric, and psychological conditions. The term "dysfluency" is used most

often to refer to speech articulation difficulties like stuttering. We're using the term differently. Following Pollard (2013), who, in turn, based his definitions on Andreasen's (1986) study of language, thought, and communication disorders in psychiatry, we use the term dysfluency to refer to two phenomena.

The first are specific disruptive errors in language use that are atypical for native users of a language. Examples would be unnecessary repetition of a sign or word or omission of key parts of speech.

The second kind of dysfluent communication refers to a general lack of proficiency that is significant enough to impair communication with someone who is proficient in the language. Thus, dysfluent language can refer to specific errors which may, or may not, be repeated or ongoing patterns. Our interest is primarily in ongoing patterns—that is, errors that are repeated reliably, for at least a period of time. A hearing person who is intoxicated, and who is slurring their speech, would be dysfluent until they sober up, for example. The medical cause, alcohol intoxication, would be widely assumed, especially if the person displays other behaviors we associate with intoxication. A person who has just had a stroke, and who struggles to remember words/signs, and speaks or signs in a slow, hesitant, halting manner, shows another form of dysfluency.

The first discussions of sign language dysfluency in recent Deaf mental health literature referred to well-known psychiatric causes. Alice Thacker was the first person to identify sign language dysfluencies in severely mentally ill deaf people that correspond to dysfluencies seen in hearing people (Thacker, 1994, 1998), and subsequent authors, including Trumbetta, Bonvillian, Siedecki, and Haskins (2001), continued this discussion. Pollard (1998b) has also made important contributions to the identification of sign language dysfluency related to psychiatric problems. Poizner and colleagues (Poizner, Klima, & Belllugi, 1987) studied deaf people who had experienced strokes and identified aphasias in sign language that correspond to aphasias in spoken language. We know also that deaf people with severe levels of autism can engage in behaviors like echolalia (repeating words or phrases) as well as have difficulty with pronouns like "I" or "me." Severe levels of developmental disorder can impair language development in deaf and hearing people alike (Morgan, Herman, & Woll, 2007). Both groups can also have specific language learning disabilities, although diagnosis these in deaf people is far more complicated (Pollard, 1998b). Crump and Hamerdinger (2017) have identified how common causes of hearing loss may impact language development in deaf people.

While the medical and psychiatric reasons for language dysfluency in hearing people may also be causal factors for deaf people and deaf people may have additional medical/neurological bases for language dysfluency associated with the etiologies of deafness, the single greatest factor accounting for poor language skills in deaf people is language deprivation. If one combines the inability to acquire spoken language as a native user with the lack of quality exposure to natural sign languages during the critical period for language development, you are deprived of the language learning experiences that

would result in a full, native language. Language deprivation in deaf children, of course, is not inevitable. It is the result of the choices that a society makes, as mediated through medical professionals and parents, about the extent to which deaf children are given the sign language exposure that would enable them to become native signers.

In saying this, we are aware that advocates for cochlear implantation of deaf children often object to the notion that they are depriving deaf children of language exposure. Of course, their intention is the opposite. Many claim that cochlear implantation makes spoken language accessible enough so that hearing impaired children can acquire it as native users. Both Gulati and Szarkowski, in their respective chapters of this book, critically evaluate these claims. It is not our intention to debate this, but to point out the practical reality, reconfirmed continuously in our work, that the language skills of deaf persons vary enormously and that implantation is no guarantee of spoken language acquisition. Some deaf children do well with implantation, but many others do not. If implantation comes with a message that the children should not be exposed to sign language, or if the children don't have sufficient quality ASL exposure, they will probably be poor signers also. Interpreters and clinicians who specialize in Deaf mental health encounter deaf people routinely who, with or without implantation, lack native language abilities in any language. This communication assessment is designed to give a broad picture of their communication abilities and deficits.

One of the most sophisticated and important questions in Deaf mental health care is this: are the language problems we are observing due to a psychiatric or medical condition or are they more likely a result of language deprivation in childhood? Indeed, you can infer how sophisticated someone is about Deaf mental health by their knowing enough to ask this question.

We don't yet have a research-based way to answer this question, though we have an increasing body of skilled observations, by many knowledgeable informants, about particular kinds of dysfluencies that manifest in sign languages. Many people have observed, for instance, that deaf people with severe language deprivation frequently do not reference time clearly, or establish subject, predicate, and object unambiguously, or follow the common topic, comment structure of ASL (Black & Glickman, 2005; Glickman, 2009; Glickman & Harvey, 2008; Witter-Merithew, 2017). They often don't indicate clear transitions or segues from one topic to the next, or they mix relevant and irrelevant information in a way that a more skilled "storyteller" would not. These kinds of language dysfluencies often result in the conversational partner asking a lot of structuring and clarifying questions (i.e., who, what, when, where, how). These language dysfluencies can certainly resemble certain kinds of dysfluencies associated with psychosis. In time, we hope research will enable us to more definitively relate the specific kind of language problem with specific etiologies. We are just beginning to even appreciate the complexity of this diagnostic challenge.

One thing we can say conclusively, however, is that dramatic and quick changes in language abilities, either for the better or worse, occur because of medical changes in the brain. When someone's language problems are due mainly to language deprivation, and the person is now an adult, any improvements because of language and communication learning will be slow and incremental, taking months, if not years.

In Deaf mental health, it is unfortunately common to lack good background information about some of our patients. This is partly because the persons themselves are not good informants and the people around them are not able to judge their language and cognitive abilities. Thus, we have worked with people whom we suspected showed language dysfluencies likely due to mental illness (for example, very loose, tangential, paranoid, or bizarre thinking) and, using this communication evaluation tool, were able to demonstrate dramatic improvement in language and communication following administration of psychiatric medication. We understand we are using some faulty logic here, akin to the observation that if you hit something with a hammer, and it goes into a piece of wood, it must therefore have been a nail. In the real world of psychiatry, especially in Deaf mental health and psychiatry, we are asked to intervene without good information informing our assessment. This communication evaluation provides some crucial data points for intervention and may be especially valuable when clinicians cannot get good history.

Appropriate Referral Questions for a Communication Assessment

Any communication assessment starts with "what do you want to know about the person's language and communication abilities and deficits?" As with all evaluations, communication assessments are done for a reason. Integral to conducting a communication assessment is determining what is the referral question being asked and what information is needed to provide an answer. People who know what questions to ask make the best assessment referrals. While a general question like, "tell me about this person's communication skills and weaknesses?" is acceptable, vague questions will often elicit vague responses. The more precise the question, the more likely one is to get a satisfactory answer. Generally, communication assessments are called for when someone uses an atypical or nonstandard form of communication or when they have difficulty expressing themselves or being understood.

Typical questions which can be addressed by a communication assessment include:

- To what extent does this person use standard American Sign Language?
- Which ASL vocabulary and grammatical structures seem to be used well and which others seem weak or lacking?
- Is there a difference between the best way this person expresses him/herself and how he/she best receives information?

- Is there a variant of sign communication that works best in communicating with this person?
- Can this person benefit from the use of a sign language interpreter in a therapy group or classroom or do their language requirements necessitate a tutor or one-on-one instruction?
- What language competencies or experience would be needed on the interpreting team?
- What kind of communication supports are needed for this person to benefit from a treatment/rehabilitation/educational plan?
- Can you describe the kinds of sign language dysfluencies that you see?
- Can you provide any guidance about what the nature of the language errors the person is making may mean?
- Has there been a change in this person's language and communication abilities over this time period? If so, what is the nature of the change?
- Is fingerspelling an effective way to communicate with this person?
- Does this person understand and use well a contact language like Signing Exact English?
- Can this person follow a conversation when the other individual signs and speaks at the same time?
- How extensive is the vocabulary of this person in English and ASL? Do they use vocabulary from some other sign language?
- Does this person utilize home signs that only a few people know?
- Does this person use standard signs in some idiosyncratic way?
- Are reading and writing effective communication methods for this person?
- Does this person have comprehensible speech? How effective are they at spoken communication?
- Is speech reading an effective communication strategy for this person?

Because the process of obtaining these communication assessments is new, and because our knowledge of how language deprivation impacts specific language abilities is still rudimentary, we would expect that, with time, research, and experience, we will be able to answer additional questions. Given the unique communication challenges in Deaf mental health, it is our belief that the growth of this clinical specialty will be highly correlated with growing understanding about communication assessment, including using these results to guide educational programming, mental health interventions, interpreting, and other interventions with deaf people.

Communication Assessments and Treatment or Remediation Interventions

How can a good communication assessment assist with treatment or remediation interventions? To begin with, the communication assessment guides

the team as to how their client needs to receive information. We have seen that knowing that a person "communicates in sign language" is not enough information to guide interventions when the person's sign skills are dysfluent or atypical. Thus, knowing that a person cannot process more English-like variants of sign, even though her own expressive signing tends to be more English-based, is vital information. Knowing that a signing person does not really understand complex ASL grammatical features like classifiers, and needs information presented in short, concrete sign phrases, is also very helpful, provided the team can accommodate those communication needs.

Communication assessments yield information about idiosyncratic ways that a particular consumer communicates, such as the use of home signs, the mixing of signs from American and foreign sign languages, the tendency to mouth some words in a foreign language the person has been exposed to (e.g., a consumer who signed TOMORROW but mouthed "mañana"), or the appearance of what may be sign neologisms (e.g., a consumer who invented a sign for a computer keypad on his nose) or clanging (the repetition of sign parameters like handshape in a way that isn't meaningful semantically), both of which are likely indicators of a psychotic thought process. It can provide guidance for communication with deaf persons who have additional challenges that impact sign communication such as deaf-blindness or cerebral palsy, or motor rigidity related to strokes and other neurological conditions. One deaf patient, for instance, was unable to move the fingers of his nondominant hand. This raised diagnostic questions (it turned out to be due to a stroke) as well as greater challenges in understanding him.

Our new attention to language dysfluency among deaf people has raised the bar considerably about the communication skills needed in providers and teams. It's fair to say that most signing clinicians, even if they are deaf themselves, cannot communicate effectively with every deaf consumer, especially when the person has experienced very severe language deprivation. It's also fair to say that there are some deaf consumers with whom virtually no one can communicate well. It is important to recognize this because signing clinicians are routinely expected to be able to communicate well with every deaf consumer, and their inability to do so, coupled with lack of appreciation by supervisors and administrators of the language deprivation problem, contributes to talented people leaving this field.

As certified Deaf interpreters become more available, teams working with deaf consumers increasingly ask, "do we need a CDI?" This question is hard to answer in the abstract, because the skills of specific CDIs, and specific standard interpreters, vary also. A better question to ask, and one more suited to the goals of a communication assessment, is "what are the communication competencies and deficits of this person, and what are the communication skills that are needed in providers and interpreters who work with this person?" This question inevitably leads one to ask the corollary— "what are the communication skills of our 'signing' staff, and do we need to supplement

their communication skills, in some instances?" Communication assessments of staff can help answer these questions.

Thus, as our fields' sophistication about addressing communication diversity in deaf people develops, we will increasingly understand that it takes a team of people to do this work and that at least one member of the team must be a genuine sign communication expert, not merely a person who "knows sign language." As we come to seriously grapple with the implications of language deprivation and dysfluent language, we believe we will come to appreciate that it is unrealistic to expect "sign fluent clinicians," even if deaf themselves, to be able to communicate effectively with every deaf person served by their program.

In addition to providing guidance about necessary communication skills in staff, communication assessments can inform the process of interventions like counseling and teaching. They can advise providers about *how* information is best conveyed. For instance, communication assessments may clarify whether a person needs communication supports beyond the provision of an interpreter such as one-to-one-tutoring, visual aids, hands-on learning, a dialogic style of teaching (i.e., not lecture, but question and answer, with dialogue), and careful "unpacking" of abstract ideas. The communication assessment may specify the importance of interpreting teams working consecutively, not simultaneously, at a pace that follows the needs of the consumer, not the provider. As we learn more about best practices for language and communication skills development in late language learners, we would expect communication evaluations to incorporate these findings (See the pedagogic recommendations in Chapter 7 by Spitz and Shephard).

Communication assessments are not psychological assessments, but they can certainly contribute to a fuller picture of the cognitive abilities of the client. Language and communication skills are strongly related to the "fund of information" that a person has regarding issues like physical and mental health, interpersonal relationships, sexuality, society and the law, and how to work with a counselor or an attorney. A person who is very language deprived is also very likely to be information deprived. This means they don't just need an interpreter. They need staff prepared to help them learn language, communication, and specific content areas.

As Pollard discusses in Chapter 4, language deprivation has a major impact upon whether a person accused of a crime is competent to participate in their own defense. Deaf mental health clinicians who sign well, but lack the expert communication skills required to evaluate very dysfluent consumers, can find that a well done communication assessments informs and complements their own assessment of the client or defendant's cognitive abilities and legal competency. In our appendix, we include a communication assessment that was used as part of a forensic assessment of a deaf defendant, and that was used to support the conclusion that the person was not competent to work with her attorney in her defense.

While the assessments can be shared with Deaf and signing members of a treatment team who would have the necessary cultural background and linguistic understanding to readily make sense of the report, these reports are also written for practitioners involved in medical, mental health, and legal systems, which are primarily made up of people with no background in Deaf mental health. This can guide supervisors and administrators about needed resources, policies, and practices. This might include justifying additional time needed to provide clinical services or supporting the hiring of communication specialists. Hopefully, it will advance the day when naïve administrators no longer get away with assuming that just providing a signer or an interpreter constitutes communication inclusion for every deaf consumer. We hope it will also advance the day when clinicians and interpreters doing this work are given the time and resources needed to adapt their interventions to people with complex communication needs.

As the field of Deaf mental health progresses, one clear indicator of our growing sophistication will be the skillfulness with which programs and personnel respond to this communication diversity among deaf consumers. An effective response to this communication diversity is certainly dependent upon a solid communication assessment.

The Structure of the Communication Assessment

The communication assessment used in Alabama and South Carolina is designed to assess an individual's relative strengths and weaknesses across a continuum of communication modalities. It is also designed to identify an individual's most effective communication strategies. It is structured so to permit those with severe language deficits to demonstrate skills. The definition of competence does not necessarily reflect a high degree of fluency or skill. The assessment was originally developed for use with individuals with significant communication dysfluencies and uses stimulus materials designed for easy comprehension. It does not allow for meaningful comparisons between individuals, nor does it compare one individual to a group norm. Attempts to interpret scores in these ways represent invalid applications of this instrument.

Given the significant heterogeneity of the communication skills and experience of the population, collection of background information is invaluable in understanding how an individual communicates. The assessment looks at the whole person and their communication environment. It looks at their language and communication history, their communication strengths and weaknesses, and the degree of fit between these abilities and weaknesses and the communication demands of the environments they navigate. Data is collected in these domains:

- cause and nature of their hearing loss
- family history

- social background
- psychiatric history
- medical history
- educational background
- familiarity with, and use of, interpreters and adaptive equipment
- visual or motor disabilities that impact language
- other medical issues such as dementia, stroke, cerebral palsy, or traumatic brain injury

The language and communication capabilities examined include speech recognition and production, reading comprehension, writing, expressive and receptive fingerspelling, expressive and receptive manual communication skills, and familiarity with assistive communication devices. In addition, the evaluation attempts to describe and understand the specific kinds of sign language dysfluencies that are present.

Family communication background for each family member includes their age and gender, hearing status (hearing, hard-of-hearing, deaf), and method and quality of communication with the client (American Sign Language; contact languages, such as Pidgin Signed English or Manually Coded English systems; cued speech; speech and lipreading; written notes; home signs; gestures; or other communication strategies). Some family members may use more than one system and will have different levels of fluency in different communication modalities. All applicable modes of communication used by each family member with the client should be indicated. This information should be obtained for each member of the client's household now and during childhood.

As part of our evaluation, we also observe, where possible, the person communicating in their natural social contexts such as with family, friends, and associates. We observe how the person communicates with others with whom they do not share a language or easy means of communication. Among other things, these observations help identify how aware the client is of communication limitations within their environment and how flexible they are in addressing those.

Of course, a person's formal school experiences will have a dramatic impact on the development of their language skills. As much as is possible, either from client report or record review, we attempt to identify the complete trajectory of their school experience. Considerations include the setting in which education occurred—mainstream, residential, contained classroom, among others, and determining the fluency of their language models. This information is essential in trying to determine potential language deprivation, as opposed to dysfluency caused by some process. An individual educated for 12 years within a signing residential school for the deaf in a regular curriculum who uses ASL poorly presents different concerns from someone with a similar lack of ASL fluency who has attended mainstreamed classrooms without an interpreter for the same 12 years.

A thorough communication assessment should include determining the person's familiarity with, and ability to use, a variety of assistive listening devices (e.g., videophones, hearing aids, signaling devices, assistive animals). We typically ask about each in the interview portion. We also ask a variety of questions designed to assess their experience and skill working with standard and deaf interpreters. We frequently find, for instance, basic knowledge gaps such as assuming the interpreter is the person generating the message or having no idea how to obtain an interpreter when they need one.

During the administration of the assessment, the assessor(s) shift between communication methods. These transitions (as between speech recognition and speech or writing and fingerspelling) should be explained to the client. Signing clients may express a lack of enthusiasm for the speech-oriented components of the assessment; and oral deaf clients may express reluctance to shift from the speech-oriented subtest to the subtest assessing signing skills. The purpose of the assessment may need to be explained several times, with repeated efforts made to encourage the client to continue with focused effort on all components. If the client's comprehension permits, the assessor may describe the process of the assessment and inform the client that all areas of communication will be included and specifically mention that speech, speech recognition/lipreading, reading, writing, fingerspelling, and signs will each be used. It is expected that individuals will have relative areas of strengths and weaknesses, and some areas of the assessment will be easier and relatively enjoyable while other areas may present some struggle for the client. Nevertheless, the assessor will make every effort to assist the client as much as possible to complete each component. The sole exception is the assistive communication section, which should only be used if the client uses a device or aid. The assessors note any differences between expressive or receptive communication abilities within specific modalities. For example, it's not at all uncommon to find that a person receives information better in one sign modality than another. We have met persons who consistently demonstrate that they depend on ASL to receive information but whose language output is closer to Signed English. This is one of many reasons the individual is not asked directly for their communication preference, although it is often volunteered during the interview. Our experience has been that individuals will often answer what they think the "right" answer should be. Throughout the interview, the assessor should be looking for examples of dysfluency which are tabulated on a separate section. For instance, we regularly look for common kinds of language weaknesses such as (see the complete assessment for additional examples):

- Poor vocabulary
- Isolated signs/phrases
- Inability to sequence events in time
- Spatial disorganization (space, referents, sign inflection, etc.)
- Sign features formed incorrectly

- Missing syntaxial aspects (topic-comment, subjects, pronouns, verbs, etc.)
- Repeated signs
- Excessive use of gesture and pantomime
- Refers to self in third person
- Inappropriate facial and/or emotional expression

If the client demonstrates these characteristics during the interview, it is noted on the assessment form. Additional dysfluencies not identified may be added, at the assessor's discretion, such as signs from a foreign sign language being used with no recognition that they are not ASL or using signs which were created by an unqualified interpreter.

The scores from each of the areas (speech and speech recognition, reading and writing, fingerspelling, and expressive and receptive ASL) are then tallied and a written report is produced. This report describes the results of the assessment, the demographic and historical data collected, and, perhaps most importantly, recommendations for how information is best provided to the client.

Qualifications of Assessors

One indicator that Deaf mental health care is being done badly is when people assume the attitude that any level of signing competence is "good enough." The idea that all one needs to communicate well with deaf people is a little sign language is not far removed from the assumption that all deaf people can lipread. It took several decades for the awareness of ASL as a language to become widely accepted, something that can still be an ongoing issue. It also took decades for the field of interpreting to adopt formal standards, training, and credentialing process. We need to adopt the same high standards for the new field of communication assessments with deaf people. Not just anyone can do it. Just "signing" does not quality you. Just being Deaf does not qualify you. Just being an interpreter, certified or otherwise, does not qualify you. There is a distinct knowledge base and skill set required to do this work; and even if there aren't many people yet who can do it, an untrained, unqualified person is likely to do more damage than no assessment alone.

We have unfortunately seen situations where assessments are being completed by individuals lacking sufficient training and/or oversight. In these cases, the appearance of a valid communication assessment may give legitimacy to conclusions which are not supported by actual evidence.

Like any assessment, the CSA requires that the assessor(s) be trained and qualified to administer the instrument. This is a test of the client's communication skills across the entire continuum of communication methods. Administration by an assessor who possesses less than native-level skills in the areas tested will not only represent an unethical use of this test and do a great injustice to the client but will also result in an invalid assessment.

In order to responsibly administer this instrument, the assessment team should consist of a native sign language user who is deaf and a sign-fluent hearing person. Sign fluency is defined as a person who possess demonstrated fluency in American Sign Language by attaining a Superior Plus on the Sign Language Proficiency Interview, a Certification from the National Registry of Interpreters for the Deaf, certification from the National Association of the Deaf at Level 4 or higher, Level 4.5 or higher on the Educational Interpreter Proficiency Assessment, A Master or Advanced level from the Texas Board for Evaluation of Interpreters, or an equivalent. This includes the ability to fingerspell fluidly and proficiently, at a rate of about four letters per second or slightly slower than ordinary conversation. Receptive fingerspelling skills must be excellent. In addition, the assessor who is hearing (or at least one member of the assessor team) must be able to hear and understand speech at the level of a quiet conversation or have access to this information through alternative strategies. This also includes being able to speak clearly and fluently, without strong accent or speech impairment, or being able to utilize alternative strategies, such as an interpreter. Depending on the communication competencies of the subject, the assessors should also be proficient in manually coded English systems and visual-gestural communication. She or he must also be familiar with the assistive communication device or aid used by the client, if applicable. Each person would assess within their primary language strengths, but also must be willing to consult with the other member of the team when making determinations regarding language competencies.

The assessor(s) should have a minimum of eight hours of training in the assessment which includes an overview of instrument, an overview of types and patterns of dysfluency, and samples of collected information and written assessments. After completing the training, new assessors should have a review by a qualified assessor of five assessments that include videotaped sample of their assessments, the raw data collected, and the final report. We also recommend ongoing training, on an annual basis, consisting of at least eight hours which may include additional training in assessment tools or in language use and dysfluency.

Assessments should be done by at least two individuals working collaboratively whenever possible. The team should include at least one native signer who is Deaf, particularly when a consumer's language is significantly dysfluent.

As with any new process, caution is important. When individuals who are unqualified, or who work without having supervision/consultation, provide assessments, the misused of this tool and process can result in significant harm to the clientele. One of the problems in the emerging Deaf mental health specialty is that we don't yet have systems in place to assess and certify persons capable of doing this work. Our concern about unqualified individuals performing these assessments is based on too much bad experience.

In psychology, there is something called the Dunning-Kruger effect (Kruger & Dunning, 1999), whereby people believe their abilities are much higher than

they really are. When this happens, people can fail to recognize their own biases and limitations, at great cost to the people they serve. If this is true for people in general, it is certainly true in our new clinical specialty where standards and formal training and credentialing processes are rare. As the list of qualifications for communication assessors should make clear, this is highly demanding and specialized work, and an assumption of humility about one's own abilities is good clinical practice. Any review of a communication assessment must include a review of the process and assessor who produced the assessment.

Conclusion

The use of a comprehensive communication assessment can provide many benefits to the organization which uses them. It can provide the treating professionals with guidelines for the most effective use of staffing and other resources in performing their work. Not only does this make treatment more effective, it reduces the potential for wasting valuable resources providing treatment in a manner not accessible to the client. It provides clear evidence of compliance with the standards of The Joint Commission, which provides accreditation for healthcare facilities, as well as documenting the individual assessment of needs required by the Americans with Disabilities Act. It also provides consumers with a better understanding of their own language and gives an avenue for them to better advocate for communication to happen in a way that is effective for them. Our consistent experience has been that the time required to do a communication assessment is paid back tenfold by improvements in service effectiveness and efficiency.

One of the hallmarks of the growing sophistication of Deaf mental health is our increasing ability to respond to the enormously wide range of communication abilities and deficits that we see in deaf people. As a field, we are moving beyond descriptions of clients as "signers" or "ASL users" to much more nuanced and objective appreciation of their language abilities. Hopefully, we are leaving behind the days when people's communication abilities were summarized with statements like "low functioning deaf" or "grass roots deaf." Likewise, with staff, we are also moving beyond the idea that "knowledge of sign language" is an adequate statement of the requirements needed to do this work.

Imagine, for a moment, what Deaf mental health would look like if we routinely performed comprehensive communication assessments on both the individuals receiving services and the staff providing services, and we used these assessments to organize our intervention efforts. Imagine how much more effective and individualized our work would be, not to mention how many errors we would avoid. In time, we believe we will get there, and we will look back on the days when people thought that "he uses sign language" was enough information on which to base one's work as unbelievably naïve. We might then ask ourselves, "How could we have been so simple-minded about this complex and challenging work?"

Appendix: Sample Communication Assessment Report

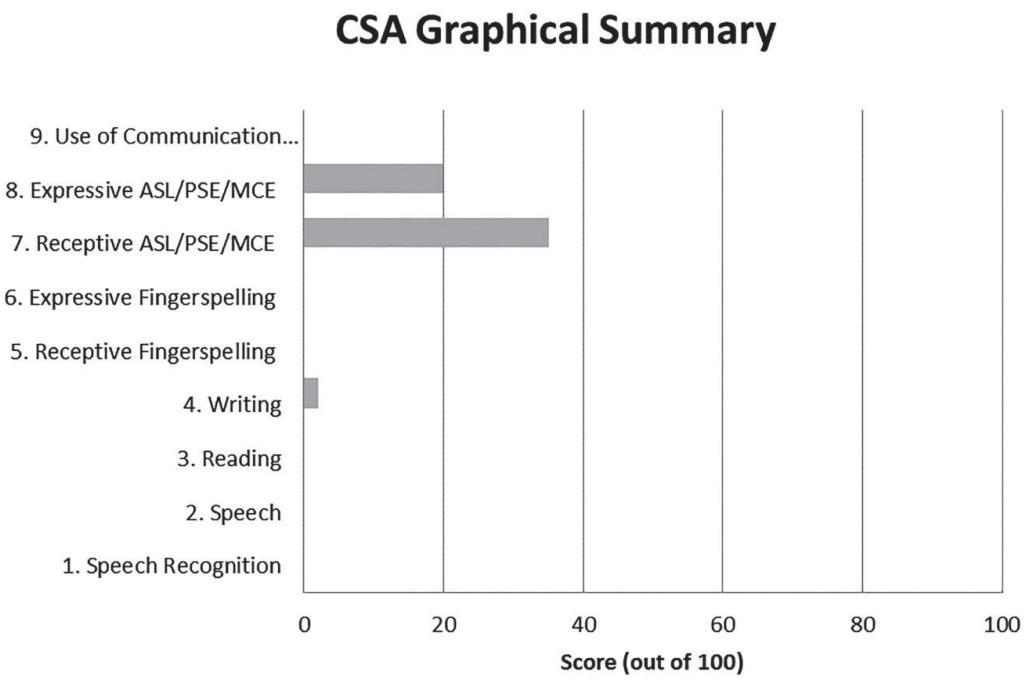

Figure 5.1 Sample communication assessment

Referral Information

Ms. Smith was referred for the Communication Skills Assessment by her attorney, Michelle Jones of the County Public Defender's Office. During an earlier interview with Ms. Jones, the sign language interpreter had raised a concern about her language competence and ability to understand the language needed in a legal situation.

Background Information

Ms. Smith is a 35-year-old white deaf female, who came to the United States as a young adult, with no motor disabilities or vision impairment. She reported no difficulty in seeing or understanding the examiner. Background information was obtained from Ms. Smith and, as will be detailed in the report, she has severe language dysfluency, so some of the collected information is unclear or potentially inaccurate. This was particularly true when trying to get her educational history.

Ms. Smith has a severe congenital sensorineural hearing loss. She reports that she became deaf at six years of age, although she was not sure of the reason. She was unable to provide any information about the etiology of her hearing loss. She is the only deaf person in her family. No one in her family

knows sign language and they communicated with her by speech, which she reports she did not understand. She is the second eldest of four children, although her older brother is deceased. Her parents divorced when she was 12 and she remained with her father, who has since passed away.

Ms. Smith attended a small hearing school until age 12 but had no access to the instruction. She could not identify anything she learned during her time in school but did enjoy playing with the other students. She left school when her parents divorced, and her father did not have the funds to pay for continued schooling. In 1995, at age 22, she immigrated to the United States from her birthplace in a foreign country with her new husband and moved to two other locations before moving to her current residence. She lives with her husband, Johnnie, who is also deaf. Her father-in-law lives in the house next door. Her only language instruction has been provided by her husband, who apparently uses an idiosyncratic mixture of her native country's sign language and American Sign Languages.

Ms. Smith had a basic understanding of the role of an interpreter and was aware that she had used one in the past. She did not know how to arrange for an interpreter, stating that her husband had that information. She knew she needed an interpreter for her interactions with her attorney or the court but did not seem to know that it was reasonable to ask for an interpreter for medical appointments or other situations. She does not wear a hearing aid or use an amplified telephone. She states she had a hearing aid for a short time when she was a child but that she was not able to keep the aid. She is unaware of signaling devices and does not have them. She did not know about videophones but her husband has a cellular phone with text capacity. She would like to be able to have a phone but states she does not know how to read or write, which was consistent with this evaluation. She does not have captioning on her television.

Testing Administration

Ms. Smith was interviewed at the County Detention Center in X town. The initial interview and testing instructions were conducted in American Sign Language and gestures. The interview was done by a Qualified Mental Health Interpreter and a Peer Support Specialist and native user of American Sign Language. Ms. Smith appeared to understand the instructions, although multiple repetitions were sometimes necessary. She was unsure of her answers, often stating that she did not know sign language and that she was not able to complete sections which required speech or writing. She was very attentive to the examiner's responses and scoring and was visibly concerned when unable to complete a task. Once Ms. Smith understood the instructions, she was cooperative. Overall, her performance is thought to be a good representation of her communication abilities.

Testing Results

Ms. Smith's profile is consistent with her reports of a complete lack of formal language instruction. She was not exposed to accessible language until age 29, significantly past the critical window for language learning, roughly until age eight. She has had limited opportunity to develop her language skills in either English or American Sign Language. She does not have fluency in any area of communication. She has difficulties across the communication spectrum. For everyday communication and during the test administration, Ms. Smith performed best in American Sign Language with considerable gestures and sign-mime. She has no usable skills in the oral or written communication domains. She does not know fingerspelling as she has no knowledge of the English needed to understand fingerspelling.

Ms. Smith's American Sign Language reflected her limited contact with the Deaf community and ineffective education. She had difficulty with vocabulary and with many of the abstract grammatical structures of ASL. When sentence structure or non-manual markers dictate sentence meaning, she was not able to comprehend the sentence, focusing on the few signs she recognized, rather than understanding the whole sentence.

Similarly, her expressive ASL was lacking in ASL grammar or structure. For example, there was no evidence of eyebrow movement to indicate topic or the use of incorporated numbers in her sentences. She had some nonstandard signs, some signs from her native Sign Language, and at least one which was completely incomprehensible. When understanding ASL, she has difficulty with sentences that use the rhetorical question format or require spatial visualization. She could answer questions about identity and concrete events but could not understand any question which required reference to an abstraction. For example, she could not answer a question such as "What would make you happy?" or "What do you wish for?"

Her signed communication was fraught with dysfluencies, including a lack of vocabulary, incorrect or absent grammar, major gaps in fund of knowledge, and a lack of spatial structure or non-manual markers.

Scoring Grid

The scoring grid provides a quick visual representation of the assessment results. While this individual does not have full fluency in any communication modality, her relative strengths are in expressive and receptive ASL. But, as can be seen, even in those areas, she is experiencing significant challenges.

Conclusions

Ms. Smith is a 35-year-old white female, deaf from birth, of unknown etiology. Her communication strength is in the manual communication arena and this should be used as her primary mode of communication. However, in no

communication arena were her communication skills sufficient to understand abstract or complicated information. Her oral and written skills are insufficient for any communication, although someone who knows her very well may be able to identify familiar words from her lip movements. Ms. Smith is aware of her communication limitations and perceives this is the result of intellectual deficiency, although her communication pattern is more consistent with language deprivation. She is likely to nod or respond as she thinks is appropriate without comprehending the interaction.

She is aware of some of the technological devices available such as captioning or text phones. However, her ability to use these devices is impaired by her lack of competence in English.

Ms. Smith would need significant and extensive instruction to improve her knowledge of American Sign Language or to gain a basic understanding of English. It is unlikely that she would ever gain full fluency in any language, but she could improve her language skills. This could include an expansion of vocabulary and an improved ability to identify time sense and perspective (i.e., did the event she is reporting happen in the past or at present and was she an observer or a participant?). The types of errors she made during the interview were fairly consistent and more likely reflect a lack of education and language exposure than a neurological or learning disorder.

As to the specific questions which resulted in Ms. Smith's referral, Ms. Smith's limited communication skills and inability to handle abstract information prevent her from comprehending or expressing the information needed to understand legal proceedings, including her ability to assist her attorney in her defense, understand her legal rights, or make choices about available options. She is able, with an experienced deaf/hearing interpreter team using a combination of Visual-Gestural communication and American Sign Language, to communicate about concrete events and provide information about the events which led to her arrest. However, she lacks sufficient language fluency to understand witnesses in a courtroom during a proceeding, refute testimony or assist her attorney when cross-examining witnesses. She lacks knowledge about the roles of individuals in a courtroom and did not know what a judge did or that there were other attorneys than Ms. Jones.

Outside of legal settings, information provided to Ms. Smith should be provided using examples, demonstration, and visual representation, rather than depending on language to understand needed information. She should also have access to interpreters who are familiar with Visual-Gestural communication, ideally in deaf/hearing teams.

References

Administrative Code Chapter 580-2-9. Community Programs Standards. (2010). Alabama Department of Mental Health.

Andreasen, N. (1986). Scale for the assessment of thought, language and communication. *Schizophrenia Bulletin, 12*(3), 473–482.

Black, P., & Glickman, N. (2005). Language deprivation in the deaf inpatient population. *JADARA, 39*(1), 1–28.

Black, P., & Glickman, N. (2009). Language and learning challenges in the Deaf psychiatric population. In Neil S. Glickman (Ed.), *Cognitive behavioral therapy for deaf and hearing persons with language and learning challenges*. New York: Routledge.

Crump, C. (2005). *Communication assessment for individuals who are deaf or hard of hearing* (Unpublished instrument).

Crump, C., & Hamerdinger, S. (2017). Understanding etiology of hearing loss as a contributor to language dysfluency and its impact on assessment and treatment of people who are deaf in mental health settings. *Community Mental Health Journal, 53*(8), 922–928. Springer Publishing. doi:10.1007/s10597-017-0120-0

Glickman, N. (2009). *Cognitive behavioral therapy for deaf and hearing persons with language and learning challenges*. New York, NY: Routledge Publications.

Glickman, N., & Harvey, M. (2008). Psychotherapy with deaf adults: The development of a clinical specialization. *JADARA, 41*(3), 129–186.

Gulati, S. (2014). Language deprivation syndrome. ASL lecture series. www.youtube.com/watch?v=8yy_K6VtHJw

Hall, W. C., Levin, L. L., & Anderson, M. L. (2017). Language deprivation syndrome: A possible neurodevelopmental disorder with sociocultural origins. *Social Psychiatry and Psychiatric Epidemiology*. doi: 10.1007/s00127-017-1351-7

Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessment. *Journal of Personality and Social Psychology, 77*, 1121–1134.

Law, J., Boyle, J., Harris, F., Harkness, A., & Nye, C. (2000). Prevalence and natural history of primary speech and language delay: Findings from a systematic review of the literature. *International Journal of Language & Communication Disorders*, *35*(2):165–188

Long, G., & Alvares, R. (1995). The development of a communication assessment paradigm for use with traditionally underserved deaf adults. *Journal of the American Deafness and Rehabilitation Association, 29*(1), 1–16

Morgan, G., Herman, R., & Woll, B. (2007). Language impairments in sign language: Breakthroughs and puzzles. *International Journal of Language and Communication Science, 42*(1), 97–105.

Poizner, H., Klima, E. S., & Belllugi, U. (1987). *What the hands reveal about the brain*. Cambridge, MA: The MIT Press.

Pollard, R. (1998a). *Mental health interpreting: A mentored curriculum* [Videotape and users' guide]. Rochester, NY: University of Rochester School of Medicine.

Pollard, R. (1998b). Psychopathology. In M. Marschark and M. D. Clark (Ed.), *Psychological perspectives on deafness* (Vol. 2, pp. 171–197). Mahwah, NJ: Lawrence Erlbaum Associates.

Pollard, R. (2013). *Mental health and deaf individuals: On-line training for clinicians*. Missouri Department of Mental Health. Retrieved from http://dmh.mo.gov/deafsvcs/training.html

South Carolina Department of Mental Health, Services for the Deaf and Hard of Hearing (2014). *Serving clients with Limited English Proficiency*. Columbia, SC.

Thacker, A. (1994). Formal communication disorder: Sign language in deaf people with schizophrenia. *British Journal of Psychiatry, 165*, 818–823.

Thacker, A. (1998). *The manifestation of schizophrenic formal communication disorder in sign language* (Doctoral Dissertation). St. George Hospital Medical School.

Traumatic brain injury: Hope through research. (2002). Office of Communications and Public Liaison. NIH Publication No. 02-2478. National Institute of Neurological Disorders and Stroke, National Institutes of Health. Retrieved from www.ninds.nih.gov/disorders/tbi/detail_tbi.htm

Trumbetta, S. L., Bonvillian, J. D., Siedecki, T. Jr., & Haskins, B. G. (2001). Language-related symptoms in persons with schizophrenia and how deaf persons may manifest these symptoms. *Sign Language Studies, 1*(3), 228–253.

Williams, R. (2003). *Communication skills assessment* (Unpublished instrument).

Williams, R., & Crump, C. (2013). *Communication skills assessment* (Unpublished instrument). Retrieved from www.mentalhealthinterpreting.net/communication-skills-assessment.html

Witter-Merithew, A. (2017). Language analysis team report. Center for Atypical Language Interpreting, Northeastern University. www.northeastern.edu/cali/wp-content/uploads/2017/01/CALI-Language-Analysis-Team-Report_PUBLIC.pdf