2009

Incorporating American Sign Language (ASL) into OT: A Clinician's Manual and Workshop

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Incorporating American Sign Language (ASL) into OT: A Clinician’s Manual and Workshop

by

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A Scholarly Project
Submitted to the Occupational Therapy Department
Of the
University of North Dakota
In partial fulfillment of the requirements
For the degree of
Master’s of Occupational Therapy

Grand Forks, North Dakota
May 2009
This Scholarly Project Page, submitted by Kristin Pfeifer-Fylling, MOTS, in partial fulfillment of the requirements for a Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and in hereby approved.

Cindy Janzen Helweg
Faculty Advisor

1-10-09
Date
PERMISSION

Title: Incorporating American Sign Language into OT: A Clinician’s Manual and Workshop

Department: Occupational Therapy

Degree: Master’s of Occupational Therapy

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ACKNOWLEDGEMENT

I would like to thank my husband and family for their support and encouragement throughout the development of the scholarly project and the Occupational Therapy program. Without your love and support I would not have been able to reach my goals and accomplishments.

I would like to thank my advisor Cindy Janssen-Holweger MOT, OTR/L for her support and encouragement throughout the development of my scholarly project and throughout the program. Her support and guidance has been indispensable for which I am grateful and privileged to have worked with her.

I would like to thank the University of North Dakota Occupational Therapy staff and faculty for their support in the development of my career as an occupational therapist. I appreciated their encouragement and support over the year. Each staff member has contributed significantly in my professional development for which I am thankful.
ABSTRACT

The purpose of this scholarly project is to educate occupational therapists on American Sign Language (ASL) to enhance communication when working with Deaf individuals. Currently, in the United States, 12% of the population has trouble with their hearing, ranging from small auditory deficiencies to complete deafness. Many of these individuals communicate by using ASL which is now the 3rd most commonly used primary language in the United States (Barnett, 2002). In addition, Deaf individuals are found to have more difficulty with activities of daily living (ADLs) which may indicate more involvement with OT. Because most healthcare workers OTs are not familiar with ASL, miscommunication occurs between the OT and Deaf individuals during therapy sessions.

A literature review was conducted with the use of PubMed, ASL textbooks and the internet. The literature review determined a need for healthcare workers to know ASL as this is the most effective and efficient method of communication with deaf individuals. Some studies also described health care concerns of Deaf individuals that warrant OT involvement. Finally, the literature for more knowledgeable healthcare providers suggested methods for educating healthcare workers on ASL.

Since OTs work directly with Deaf individuals on ADLs, a workshop and manual was designed with the guidance of the Adult Learning Theory and the Social Learning
Theory. Since most OTs use workshops to fulfill their continuing education requirements, a workshop would be the most appropriate method to educate them on ASL. Also, a manual was designed for OTs to reference when needed, and to help them transfer their skills into daily practice.

The workshop and manual will provide OTs with the skills needed to effectively and efficiently evaluate their Deaf clients using ASL. It is recommended that all participants of the workshop continue learning and expanding their knowledge of ASL by attending ASL courses in their community. This will allow the OTs to become more informed and fluent when using ASL to evaluate and intervene with their Deaf clients.
CHAPTER I
INTRODUCTION

The Center for Disease control (CDC) reported in 2006 that twelve percent (37 million) of the United States population had trouble with their hearing. This number was a substantial increase since 2000 when 31.5 million U.S. adults reported trouble with their hearing. While the population of people with impaired hearing has increased, so has the use of American Sign Language (ASL) which has become the third most commonly used primary language in the U.S. (Barnett, 2002). The problem that arises in healthcare is that most healthcare workers do not know how to use ASL or communicate effectively when working with clients from the Deaf culture.

To begin to understand communication in the Deaf culture, one must understand who they are. These are individuals who were born deaf, have lost their hearing prelingually, or have lost their hearing before the age of three. The hard of hearing (HH) population was not addressed since they do not share the same cultural norms as the ASL users. Although both deaf and HH individuals experience many of the same issues when accessing healthcare, they both remain different in the fact that they do not share the same cultural experiences.

Research supports the belief that many Deaf individuals are fearful of seeking medical care due to the lack of awareness and miscommunication between the individual who is Deaf and the healthcare provider (Steinberg, Barnett, Meador, Wiggins & Zazove, 2005). Many modes of communication are attempted such as: lip reading, note writing
and interpreting services. However, these methods are generally not very effective (Steinberg, Barnett, Meador, Wiggins & Zazove, 2005). In a study by Witte and Kuzel (2000) researchers indicated that participants in the study felt more comfortable with healthcare providers who knew even a small amount of sign language. This article presented a need for ASL to be incorporated into healthcare.

As with other healthcare providers, occupational therapists (OT) also provide services to Deaf individuals but may have difficulty communicating with them. The role of OT in healthcare is to support participation in life through occupational performance. Werngren-Elgstrom, Iwarsson, Elmstahl, and Dehlin (2005) conducted a study that found that three fourths of the deaf individuals were dependent in one or more activities of daily living (ADLs). In order to effectively intervene with Deaf individuals, OTs need to know how to communicate with them during evaluation, intervention, and client education. The purpose of this scholarly project is to develop a workshop to educate OTs on how to effectively use ASL with Deaf clients, using the OT Practice Framework to support participation in life through occupational performance.

Chapter two presents a literature review that supports a need for implementing ASL into the healthcare setting. Chapter three describes the methodology, which includes a detailed description of how the research was obtained and incorporated into the literature review. Chapter three also provides an overview of chapter four and how the literature and theory guides the overall organization of the workshop. Chapter four is the product which is a workshop for the incorporation of ASL with the profession of Occupational Therapy. A manual is also provided as a supplement to the workshop. Chapter five is the final chapter and includes an overview and conclusion of the scholarly
project. It also discusses future needs and suggestions associated with ASL in healthcare.
CHAPTER II

LITERATURE REVIEW

Many healthcare providers educate themselves in order to communicate with other cultures more competently and effectively. Many other providers, however, fail to recognize the Deaf culture as a population that possesses unique methods of communication. This failure prevents these healthcare providers from increasing their knowledge and understanding of Deaf individuals, which decreases the quality of care that they can provide. Many healthcare personnel lack awareness of the Deaf and hence are unable to treat Deaf individuals effectively and efficiently.

Currently, in the United States, 12% of the population has trouble with their hearing, ranging from small auditory deficiencies to complete deafness. According to the Center for Disease and Control (CDC) (2006), this is a substantial increase from 2000, when 31.5 million U.S. adults reported trouble hearing. Statistically, 37 million Deaf individuals constitute 12% of the population in the United States. Because of this high percentage, it is important for healthcare providers to become competent and knowledgeable concerning the Deaf culture. To understand the Deaf culture, one must understand their language. Currently, ASL is the 3rd most commonly used primary language in the United States (Barnett, 2002) Because most healthcare workers are not familiar with ASL, miscommunication occurs between healthcare workers and Deaf individuals. Research supports the belief that many Deaf individuals are fearful of
seeking medical care because of possible miscommunication and a lack of awareness between the Deaf individual and the healthcare provider (Steinberg, Barnett, Meador, Wiggins & Zazove, 2005).

To understand the culture of people who cannot hear, one must examine its language and terminologies. The term “deaf” has two separate meanings. “Deaf” with a lowercase d refers to individuals who lost their hearing after they were able to talk. These individuals have embraced the hearing culture and simply have the physical condition of not being able to hear and understand speech (Sneed & Joss, 1999). The term “Deaf” with a capital D refers to those individuals who were Deaf before they could speak and have immersed themselves in the deaf culture. These two meanings are separate entities and should not be confused with each other. The content and focus of this literature review will focus on Deaf individuals, since they have embraced the Deaf culture for most of their lives, and they use ASL as their main method of communication (Sneed & Joss, 1999).

Because of differences in language between the Deaf culture and non-deaf cultures, individuals who are Deaf experience significant miscommunications with their physicians. Deaf individuals usually do not obtain proper information regarding their diagnoses and treatments. Educational materials and resources that Deaf individuals receive from their physicians are often written for a higher reading level than they are able to comprehend. Only 13% of the Deaf population has attended college, whereas 30% of the hearing population continues their education to the collegiate level (Zazove, Meador, Aikens, Nease, & Gorenflo, 2006). This reveals that Deaf individuals are not treated effectively, which correlates to a decrease in the quality of care they receive.
Zazove et al. (2006) suggested that healthcare providers should consider the Deaf culture before treating a patient who is Deaf. Many available techniques can help them provide sufficient care to such individuals. Employing appropriate etiquette techniques and taking time to understand deaf individuals and to treat them effectively would significantly increase the quality of care they receive. Knowing and understanding basic etiquette techniques would allow healthcare personnel to provide better care for these individuals, which would decrease miscommunication and fear and result in better medical care.

Many healthcare providers do not know or understand ASL enough to interact with their Deaf clients effectively. Meador & Zazove (2005) discussed the knowledge necessary to treat patients effectively. Competence in and application of ASL by healthcare personnel would help individuals who are Deaf feel more comfortable when accessing healthcare. This would consequently decrease the miscommunication most commonly seen in interactions between Deaf and hearing individuals. Meador & Zazove (2005) suggested that individuals who are deaf would experience less fear during healthcare visits if their providers knew basic ASL. The authors supported the importance of implementing ASL into the healthcare system. Implementation of ASL in healthcare would significantly decrease miscommunication between the healthcare provider and Deaf individual.

Because most healthcare providers’ knowledge and use of ASL is limited, they substitute other means of communication. Many healthcare personnel rely on a Deaf person’s ability to lip read, use interpretation services, and write notes. These techniques, however, are ineffective and often create more difficulties (Steinberg, Barnett, Meador,
Wiggins, & Zazove, 2005). According to Lieu, Sadler, Fullerton, & Stohlmann (2007), lip reading is ineffective, since only about 30% to 40% of communication can be detected through this mode. Individuals are forced to piece together whatever communications and information are not visually noticeable. This may lead to miscommunication and a lack of trust in the healthcare providers, since they are unable to properly interact and establish rapport. Stancliff (1998) interviewed individuals who are Deaf in order to determine the effectiveness of lip reading. One interviewee stated, “Lip-reading is okay for a casual conversation, but when you start talking about my body, I need to know exactly what is going on.” This example demonstrates the need for ASL to be incorporated into healthcare settings in order to provide Deaf individuals with the best care possible. Miscommunication in healthcare settings is not only frustrating for the individuals, but it can also be detrimental to them.

Interpretation services are another option for healthcare providers when working with Deaf individuals (Steinberg, Barnett, Meador, Wiggins, & Zazove, 2005). This is the most effective means of communication, but the shortage of interpreters limits availability, the expense limits the practicality of the option, and the presence of another person hinders confidentiality. Barnett (2002) stated, “Section 504 of the rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA) require the provision of interpreter services to achieve effective communication when communicating with Deaf patients or Deaf family members of patients.” The ADA warned, “Failure to provide Deaf people with equal access to health services could lead to legal action being taken against providers” (Ubido, Huntington, & Warburton, 2002). Because of the expense, however, many healthcare providers do not offer interpreting
services, because the cost often exceeds the reimbursement for medical services (Barnett, 2002). Many interpreters charge $160 for a two hour block of time, which is generally not covered by insurance. Additionally, many healthcare employees do not know how to contact interpreting services. Many employees do not realize that they need to hire an interpreter who has the right level of medical experience in regards to the terminology special medical terms and concepts. Many Deaf individuals abandon any efforts to explain themselves to their healthcare providers and refrain from pressing them for information. Individuals who are Deaf also often abstain from asking questions about the reliability and accuracy of the interpreter’s communication of information received from healthcare personnel (Sadler et al., 2001).

The other main issue of interpreting services is confidentiality. Many individuals who need healthcare are reluctant to speak through a third person, especially in a healthcare setting, where information is personal and intimate. Family members sometimes help interpret communications between a deaf person and a healthcare provider, but this can be uncomfortable, since such personal information is discussed in this type of setting. Medical personnel with basic ASL skills will allow Deaf individuals’ visits to remain confidential, since they do not have to involve an interpreter, family member, or friend. In addition, healthcare personnel are more experienced with medical terminologies and could translate information more effectively than an interpreter could. Many family members do not have any medical background and may not interpret the information from the healthcare provider correctly. It can be detrimental for individual not to receive proper information pertinent to his or her health.

Note writing is another method of communication commonly used by healthcare
providers, but it is largely ineffective (Steinberg et al., 2005). This type of communication is difficult not only for the ASL user but for the healthcare provider as well. Writing notes takes time and patients can become quickly fatigued depending on the status of their health. It can be tiring for a Deaf individual continuously to try to convey his or her point to the healthcare provider. In a study by Iezzoni, O’Day, Killeen, & Harker (2004), one respondent commented, “I’m tired of writing notes and making do... Could hearing people imagine having to write down all their communication events, all day, every day?” (p. 358) when an individual has a critical condition, writing is even more of a nuisance. Writing is also difficult because the grammar and syntax used by the Deaf community is different from the English grammar. Many healthcare providers have difficulty reading what Deaf individuals write and often view them as incompetent or un-educated based on the syntax and grammar of their writing. Due to this lack of awareness, many healthcare providers treat Deaf individuals as inferior.

A third reason that writing is difficult is the amount of time it requires. Healthcare providers can spend only a limited amount of time with each client, and writing can be frustrating for both the provider and the Deaf individual. During treatment, the healthcare provider may not be able to answer all of the individual’s questions and concerns. This may lead to other complications if the individual does not receive sufficient information from the physician or healthcare provider. It can also decrease his or her trust in the provider. Ubido, Huntington & Warburton (2002) stated, “There are few places where it is more inconvenient or even dangerous to be misunderstood than a busy hospital ward” (p. 248). Moreover, because most of the appointment is devoted to writing, these individuals do not obtain the information necessary to understanding the importance of
prevention in the reduction of further healthcare risks.

A study by Stebnicki and Coeling (1999) indicated that Deaf individuals preferred medical personnel who know basic sign-language. The communication problems associated with lip reading, interpreters, and writing can lead to devastating effects on healthcare. Tamaskar, Malia, Stern, Gorenflo, Meador, and Zazove (2000) distributed a survey to 140 deaf individuals in order to obtain a better understanding of their healthcare experiences. Based on the results of the survey, deaf and hard-of-hearing individuals are less likely to receive preventive information from their physicians and healthcare providers. Rather, they are more likely to receive such information from members of Deaf clubs. Individuals demonstrated a lack of knowledge about health factors such as exercise, smoking cessation, and weight management. All of these components are crucial in health improvement and disease prevention, but Deaf individuals were not informed about them by their healthcare providers. Prevention is a key component in maintaining health and well-being. Providing Deaf individuals with preventative information would allow them to be more knowledgeable and aware of possible risk factors associated with their health. Tamaskar et al. (2000) indicated that Deaf individuals are not given proper information on prevention, which would help them lead healthy and enriched lives. It is crucial for healthcare providers to know some basic ASL in order to communicate information effectively to their patients so that the patients can understand the importance of preventing diseases.

A study by Witte & Kuzel (2000) interviewed Deaf individuals in order to learn about their healthcare experiences. Participants in the study reported difficulties in making appointments and receiving test results via a Teletypewriter (TTY). The TTY is a
device that allows individuals who are Deaf, hard of hearing, or have speech impairments to use telephones. A TTY device is required at both ends of the conversation. This device allows the Deaf individual and the recipient to type messages back and forth to one another instead of talking and listening.

Many clinical personnel utilized a TTY but did not understand how to use the device effectively. Individuals do not receive proper care not only because healthcare employees lack the knowledge needed to use TTYs and other communication devices, but also because they are deficient in the knowledge and sensitivity necessary for working with the Deaf population. For example, in an article by Witte & Kuzel (2000), an individual commented on her experiences in the waiting room by stating, “I go in and say, ‘Please let me know. I’ll be sitting over here.’ But the receptionist often just stands there calling out my name, and then when I don’t respond, she’ll move on to the next patient.” An article by Iezzoni et al. (2004) interviewed a participant, who stated,

You can’t hear the receptionists. You hope you’ll know when they call your name. Then you go into another room, and they tell you to take off some of your clothes, all of your clothes, or none of your clothes. If you get that wrong, you’re in trouble. Then you don’t hear the doctor at the door. They come in, and you don’t know whether you’ve taken the right clothes off. Each thing seems little in itself. But when it all happens one after the other, you feel very anxious (p. 360).

In a study by Sadler et al. (2001) participants discussed their frustrations with the
Many clinics do not use TTY devices, because of this the Deaf individuals were unable to answer their calls, and had no way of conversing with hospital personnel. It is crucial for receptionists to be aware of other populations, such as the Deaf culture, and know how to work with them effectively in order to create a more positive and nurturing environment. Participants commented on miscommunication and lack of empathy for Deaf individuals, which demonstrated a need for healthcare providers and support staff who are more competent in dealing with the Deaf culture and language.

While the above described communication methods are generally ineffective, there is one method that works very well: basic ASL. Witte & Kuzel (2000) indicated that participants felt more comfortable with healthcare providers who knew even a small amount of ASL. The researchers concluded that Deaf individuals' knowledge of medical terminology is similar to that of immigrants. Although Deaf individuals are not immigrants, they feel as though they are because of the communication barrier. Sadler et al. (2001) stated, “Until providers begin to learn ASL and begin to acquire cultural sensitivity, the Deaf community will remain at risk for less-than-optimal health care and access to health information” (p.108). The researchers indicated a need for ASL to be incorporated into the healthcare setting in order to provide the highest quality of care possible to all Deaf individuals.

Proper training of healthcare providers would decrease the frequency of misunderstandings that often lead to mistreatment of deaf clients (Sadler, Huang, Padden, Elion, Galey, Gunsauls, et al. 2001). One hospital in Skyesville, Maryland, operates a unit specifically designed to meet the needs of Deaf individuals. This unit has interpreting services available 24 hours a day. At this hospital, personnel evaluate all areas of the healthcare system.
individuals’ lives in order to ensure that their therapy and hospital stay are meaningful and helpful. They also work diligently to involve these individuals in meaningful activities while they are in the hospital in order to promote positive behavior and help decrease the chances of isolation and depression. This has been especially effective. If healthcare providers would take time to understand the Deaf culture and would embrace their values and beliefs, then miscommunication and anxiety would be decreased. This would help establish trust between healthcare professionals and Deaf individuals (Stancliff, 1998).

Occupational therapists (OTs) can assist Deaf individuals on many different levels. Werngre-Elgstrom, Iwarsson, Elmstahl, & Dehlin (2005) compared elderly Deaf and hearing individuals’ dependence on others and examined how visual impairments and limitations decrease their quality of life. All participants were recruited from rural and urban areas in the same geographical region in Sweden. Participants included 45 deaf individuals (26 female and 19 male), who constituted 46% of the study, and 135 hearing individuals (78 males, 57 males), who constituted the other 54%. The median age of both groups was 75 years old, and ages ranged from 65 to 92. The questionnaire covered demography, economy, housing, social and physical environments, ways of living, functional capacity, health, quality of life (QOL), and healthcare utilization.

The structure of the study was twofold. First, researchers investigated functional limitations and dependence in personal activities of daily living (ADLs), limitations and dependence in instrumental activities of daily living (IADLs), and perceived health among elderly deaf individuals. Second, researchers compared their findings on ADL dependence and perceived health among elderly Deaf sign-language users with the ADL
dependence and perceived health of individuals who could hear. The study concluded that elderly Deaf individuals rely solely on their vision. Age, however, often brings visual impairments and limitations. When their vision decreases, elderly Deaf individuals become more dependent on activities of daily living (ADL).

More than half of the elderly Deaf participants had functional limitations and were dependent on others for their mobility. The limitations consisted of decreased stamina, difficulty bending and kneeling, and severe loss of sight. The ADL staircase assessed elderly, deaf, sign-language users’ need for care in performing activities of daily living (P-ADLs) such as bathing, dressing, toileting, transfers, and feeding, as well as independent activities. The study indicated that 3/4 of the Deaf individuals were dependent in one or more activities (most commonly transportation and cooking), while only a few demonstrated dependence in P-ADLs. Those who were dependent in P-ADLs were also dependent in all IADLs. More males than females were dependent. The authors suggested that individuals who are deaf are more dependent in their ADL’s than those who have their hearing. There was not a significant difference, however, between the I-ADLs of hearing and deaf individuals. Deaf sign-language users showed a higher frequency of depression due to their ADL dependence.

Despite the fact that elderly Deaf individuals were more dependent in most areas of their lives, they reported a higher value on perceived health than elderly hearing individuals did. OTs strive to improve their clients’ QOL and help them become more independent. When healthcare providers know basic sign-language skills, they can communicate with Deaf individuals more effectively. Similarly, if an occupational therapist is able to communicate with Deaf individuals, then he or she will be able to
establish trust and help rehabilitate them, helping them become more independent in their ADLs. This, in turn, would improve their QOL (Werngren-Elgstrom et al., 2005).

Few articles have focused on elderly Deaf individuals’ QOL and little is known about their health and well-being in everyday life. Tamaskar et al. (2000), however, found that Deaf clubs create a support network and are a main source of communication among Deaf sign-language users. These clubs provide them with social interaction and allow them to engage in meaningful activities. Deaf clubs are important for sign-language users because they promote active lives, which are a key component in physical and mental health. Social and cognitive activities decrease an individual’s risk of dementia and depression. Staying involved and participating in activities also reduces mortality rates over a six-year life span. The researchers interviewed 45 Deaf individuals to determine how their levels of activity corresponded with their health. They concluded that a higher number of activities at the Deaf clubs, especially social events, correlated with higher senses of well-being.

Many healthcare providers are unaware of the benefits of active involvement in Deaf clubs. OTs endeavor to assess their clients’ health and well-being and to determine ways to improve their quality of life (QOL). It is important to increase awareness of Deaf clubs so that all healthcare providers understand their benefits. OTs should know what resources are available to Deaf individuals and where they are located in order to provide the individuals with information about how to become involved in healthy activities. Further, it is difficult for many elderly individuals to arrange transportation to and from activities at their Deaf clubs, which discourages participation. Decreased participation may cause individuals to become depressed, since they are not actively engaging in
events and social interaction. OTs can help individuals find ways to go to and from their Deaf clubs so that they can continue engaging in activities and leading a healthy life (Werngren-Elgstrom, Brandt, & Iwarsson, 2006).

Many Deaf individuals experience depression and decreased QOL due to lack of awareness of and limited participation in activities. An article by Werngren-Elgstrom, Dehlin, & Iwarsson (2003) delved deeper into the understanding of pre-lingually Deaf individuals’ QOL. The study consisted of 97 individuals, and their mean age was 75. Each individual was interviewed to investigate his or her health-related QOL and to determine the prevalence of depression and insomnia within the Deaf elderly population. The researchers found that “among the elderly deaf population, communication problems associated with their disability may strengthen feelings of isolation and have a negative impact on subjective wellbeing. In extension, there is an increased risk for mental health problems” (Werngren-Elgstrom et al., 2003, p. 14). Therefore, depressive symptoms and sleep disturbances are more frequent among elderly Deaf sign-language users than within the hearing population. This places Deaf individuals at risk for decreased QOL. From the information gathered from the interviews, the researchers determined that “pre-lingually deaf persons reported an overall lower health status, than the hearing control group,” (Werngren-Elgstrom et al., 2003, p. 14).

Many authors have agreed that Deaf individuals have a higher risk for depression than individuals among the hearing population. Anxiety is also common among Deaf individuals. Kvam, Loeb, & Tambs (2006) further described higher levels of emotional distress. Their research compared mental health among Deaf individuals to mental health among hearing individuals. The study took place over a two-year period and consisted of
51,975 individuals (47% male and 53% female), both Deaf and hearing. The study encompassed a broad age range of 20 years old and older, and the mean age was 50.2. Each participant was asked a series of questions pertaining to his or her mental health and was audiologically tested to determine his or her level of hearing loss.

Kvam, Loeb, & Tambs (2006) concluded that greater hearing loss correlated to more mental health issues. In addition, emotional distress was two to four times higher among Deaf and hard of hearing (HOH) individuals than among hearing individuals. Mental distress, which included feeling fearful, hopeless, or blue, was twice as common in the Deaf population than in the hearing population. Kvam, Loeb, & Tambs (2006) also concluded that Deaf females experienced more mental health issues than any other participants. Individuals, who lost their hearing in the early months of their lives, rather than simply before age three, experienced less mental health issues. The participants in the study demonstrated a desire for all healthcare personnel to be mindful of symptoms (such as depression and mental distress) that are frequently seen in the Deaf population.

An article by Luey, Glass, and Elliott (1995) focused on social workers’ experiences with Deaf individuals and ways of improving such interactions. The authors concluded, “Social workers must join each deaf or hearing-impaired person in a full and multifaceted exploration of all pertinent dimensions of life-hearing, communication, language, culture, and politics” (p. 181). In addition, such exploration is necessary for developing a positive relationship, for assessing needs correctly, and for delivering high quality service.

Betancourt (2006) determined that it is important for healthcare providers to understand various cultures, races, and ethnicities. Failure to understand and embrace
Other cultures leads to miscommunication and lack of trust in healthcare providers, which results in non-adherence to their advice. Many healthcare providers will assume the client is “non-compliant” rather than realizing that the individual may not understand the provided material or instructions. There are many things that a healthcare provider should do when treating someone from a different culture in order to ensure appropriate medical treatment and care. These actions include clearly explaining the issue to the client, discussing financial issues (to ensure that prescriptions are feasible), determining fears, and ensuring that the patient understands the treatments. Betancourt’s article focuses mainly on pharmacists’ views and experiences with other cultures, but this applies to all other healthcare professionals as well.

Betancourt (2006) further elaborated on the concept that healthcare providers need to understand other cultures’ beliefs, values, and needs. He also noted that non-compliance is due mainly to a communication breakdown between healthcare professionals and their clients. The author presents steps that can help avoid miscommunication and non-compliance. First, the provider should explain the healthcare issues clearly and effectively, ensuring that the client understands his or her condition. Second, the provider must consider social and environmental factors, address any fears and concerns associated with the treatment, and provide the client with many opportunities to ask questions, to ensure that he or she understands what is expected. All of these factors would contribute to a better understanding of the patient, which would help the patient to be more compliant, which would improve the patient’s QOL. Betancourt (2006) supports the idea that healthcare providers should become more competent in understanding the Deaf culture. In order for Deaf individuals to receive
proper treatment, healthcare professionals must gain competency and compassion (Betancourt, 2006).

Stebnicki and Coeling (1999) published a powerful quote that illustrates the barrier between the hearing population and the Deaf culture: “A deaf person, unaided and independent, can travel wherever he wants, whenever he wants. The question is whether he will be able to communicate with anyone when he gets there” (p. 356). This quote emphasizes the very real communication barrier between the hearing population and Deaf individuals.

Since the literature has indicated that healthcare providers need to be educated in ASL, how best to educate them must now be determined. Speck (2006) described the adult learner theory as an effective way to educate healthcare employees. Malcolm Knowles, founder of the adult learning theory, suggested that adults learn differently from children (2002). Knowles used the term andragogy, which is the process of engaging adult learners in the learning process. Knowles discussed many aspects that separate andragogy from pedagogy. First, the idea of self-concept suggests that as a person matures, he or she becomes less dependent and more self-directed. Second, the idea of experience suggests that as individuals mature, they gain experience, which becomes a significant resource when they learn new information. Third, the idea of readiness to learn addresses the way an individual becomes oriented more to the developmental tasks of an individual’s social roles. Next, the idea of orientation to learning describes the shift from subject to problem centeredness. Last, the idea of motivation explains that motivation is more internal for an adult learner (Smith, 2002).

Speck (1996) indicated that adults will commit to learning if it has a realistic
purpose. Adult learners need to see the learning’s application to the real world and its relationship to their professional needs. They often experience difficulty in learning if they feel that their competence is being “criticized.” Therefore, it is important to allow the learner to control his or her learning. Adults also need to receive feedback and positive reinforcement regarding their professional progression in learning new tasks and skills. It is also beneficial for adults to participate in small group activities in order to move beyond understanding to the process of application. Small group learning promotes generalization of newly learned skills, which allows the learner to apply the skills more effectively in a variety of contexts and situations. It is also important for the learner to have access to additional resources so that he or she can follow up on learning, which helps him or her transfer skills into daily practice (Speck, 1996).

Another theory that could support learning for healthcare providers is the social learning theory. According to this, an individual must have prior experience personally or professionally in order for the learning process to be effective. Bastable (2006) stated that “role modeling is a central concept of the theory,” (p. 49). Healthcare providers have extensive experience in working with clients and colleagues. These experiences can significantly contribute to their ability to learn new information. Bastable described how a great deal of learning occurs through observation and positive reinforcement. Bandura (1977) developed four steps to direct the social learning process. The four steps comprise the attentional phase, the retention phase, the reproduction phase, and the motivational phase. The attentional phase is especially pertinent to learning; it suggests that a learner benefits from a role model. A positive, competent, confident role model would be best for observation in order to promote quality learning. The retention phase constitutes the
storage and retrieval of the learned and observed information. The reproduction phase is when the learner begins to utilize skills that were learned and observed. The last phase is the motivational phase, in which the learner applies the observed behaviors. These phases demonstrate the need for observation in order to generalize new skills.

Methods of teaching via the social learning theory include overhead transparencies, pamphlets, brochures, handouts, and demonstrations. All of these learning techniques are beneficial to adult learners. Together, these techniques provide both visual and auditory learning experiences. Every learner has a unique style for learning and obtaining information. A variety of learning materials allows the adult learner to learn the information actively and thoroughly. These teaching methods could be integrated into a workshop for healthcare providers. Since most healthcare providers use workshops to fulfill their continuing education requirements, it appears that a workshop would be the most appropriate method to educate them on ASL.

In summary, the literature supports the need for improved communication between Deaf individual and healthcare providers. Research further indicates that ASL is the most effective method of communication. A workshop for healthcare providers would be the most effective means of educating the healthcare providers.
CHAPTER III

METHODOLOGY

Extensive literature search was conducted which indicated a need for better healthcare communication with the Deaf population. The literature review indicated that ASL was most useful with the Deaf population. It also indicated that lip reading, note writing, and interpretation services are not very effective modes of communication with the Deaf population. In a study by Witte & Kuzel (2000) researchers indicated that Deaf individuals felt more comfortable with healthcare providers who knew even a small amount of sign language.

Analysis of the literature indicated a need for ASL education of healthcare workers. It was determined that a workshop would be most beneficial because healthcare workers have such broad backgrounds. This would allow healthcare providers to bring in their own experiences to help themselves and others understand concepts associated with the use of sign language in the profession of OT.

Although all healthcare professionals would benefit from education on the Deaf population and language, it was decided that OT would be the main focus first. Because Deaf individuals also have more impairment with ADLs, it is likely that OTs would intervene with Deaf individuals. OT has the unique perspective of viewing the individual client’s occupational performance within the context in which they live. The deaf cultural has a powerful influence over their occupational performance. The Deaf culture is an important aspect of a Deaf individual’s life. OT’s recognize the cultural and social
context in order to understand the client more thoroughly.

In order to narrow the focus to just the OT profession, the OT Practice Framework was utilized to guide the development of the workshop (AOTA, 2008). The framework helped to structure the workshop in order to provide sufficient information on ASL within the scope of the OT Practice Framework.

The areas that were focused on were the main constructs from the Framework used in the workshop included: Performance in Areas of Occupation, Client Factors, Performance Patterns, Performance Skills, Context, and Environment. The learning sessions were organized to teach ASL to OTs using words from each construct of the framework to aid in OT evaluation, intervention, and client education.

Models that guide the workshop include: The Adult Learning Theory, Social Learning Theory, and the OT Practice Framework (Knowles, 1913; Bandura, 1925; AOTA, 2008). The adult learning theory was utilized as it focuses on andragogy which is engagement of the adult learner in the learning process. The adult learning theory targets self-concept, previous experience, readiness to learn, orientation and motivation (Smith, 2002). These are all key components when educating and working with adult learners. Participants in the workshop will benefit most from this learning experience if they incorporate their previous experiences.

The social learning theory was integrated as a main component of the workshop involves communication with other workshop participants. Bandura (1925) described that much of learning occurs via observation and positive reinforcement. This workshop embraces observation and hands on interactive activities which will allow for better understanding of the material presented. Overhead transparencies, various resources and
demonstration is offered throughout the entirety of the workshop. The variety of materials utilized covers a wide range of learning styles. This will ensure that the various learning styles are accommodated, and that all participants are learning through a style of which they are comfortable with.

The overall structure of the workshop was guided by the work of Fink (2003). The workshop was designed with four units. The first unit introduces sign language. It encompasses the need for ASL in healthcare, important definitions, information about the culture and proper etiquette to use with the Deaf population. Unit two delves deeper into learning basic ASL and important terms. It covers fingerspelling, numbers and common gestures associated with sign language. Unit three begins to incorporate sign language into the OT practice framework. The areas covered in this unit consist of: Performance in Areas of Occupation, Client Factors, Performance Patterns, Performance Skills, Context and Environment. Last, unit four is an integration session where participants incorporate their knowledge and skills learned from the course. This unit consists of three activities to help incorporate the skills obtained from previous units in the workshop. These activities are done with another participant in the workshop. First, a meet and greet activity will be utilized to help the therapist effectively establish rapport with the Deaf population. The next activity is an OT evaluation. A sheet is provided that addresses each area of the OT Practice Framework. Each area will have questions that the OTs will need to ask each other using sign language. The last activity includes an interactive role play exercise on client education. Participants are given a case study and asked to educate a patient client on hip precautions using their newly acquired ASL skills. The workshop is repetitive in order to comfortably and properly transfer their skills into daily practice. Each unit
scaffolds, or builds, upon one another in order to encompass and incorporate all basic components of the Deaf language.

Bloom’s taxonomy was also utilized and followed closely with the structure of the workshop. The areas of Bloom’s taxonomy that were embraced include: knowledge, understanding, application, analysis and synthesis (Bloom, 1956). Units one and two utilized the knowledge. These units educate the learner on the Deaf culture, and basic terminology necessary for successful use of ASL. Unit three uses Bloom’s knowledge as well as understanding. In this unit, participants are using previous signs and incorporating them into new information. In this unit participants are learning new skills as they incorporate ASL into the OT Practice Framework. The last unit covers Bloom’s application, analysis and synthesis. In this unit they are applying their skills into various activities and case studies. Participants are asked to retrieve information used throughout the workshop and apply it to different scenarios. This technique will allow them to transfer their skills into daily practice, and apply their skills across a variety of contexts and situations.

The literature review embraces the need for ASL to be incorporated into the healthcare setting. OT’s will be able to evaluate their Deaf clients more effectively and efficiently with knowledge of the Deaf culture and language. The social learning theory and adult learning theory were both implemented as they utilize techniques to effectively educate employees. Chapter four is the product which implements ASL into the OT Practice Framework to educate therapists on how to effectively and efficiently evaluate their clients.
Description:

The workshop is divided into four units which consists of: Etiquette techniques, and sign language associated with the Deaf culture in the healthcare setting. This workshop is designed for all healthcare disciplines to obtain a great understanding of the Deaf culture.

Objectives:
At the conclusion of this workshop, participants will be able to:
• Understand the Deaf population as a culture and own separate entity
• Understand appropriate ways of interacting with individuals who are Deaf
• Successfully sign medical terminologies specific to each profession
• Communicate effectively with individual’s who are Deaf in the healthcare setting

Agenda:

8:00 a.m.  Registration - Refreshments provided
8:45     Unit I:
                   Introduction to ASL - presentation
                   Etiquette techniques - presentation
10:15    Break
10:30    Unit II:
                   Implementation of basic sign language - presentation and lab
12:00 p.m. Lunch - on your own
1:00     Unit III:
                   Incorporating ASL into OT - presentation and lab
2:00     Break - refreshments provided
2:15     Incorporating ASL into OT - continued
3:15     Unit IV:
                   Implementation of ASL into OT - integration activities
3:45     Questions
         Answers
         Wrap-up
4:00     Conclusion of Workshop

Presenter:
Kristin Pfeifer-Fylling, OTS, has had experience working with the Deaf population. She has taken four levels of American Sign Language at the University of North Dakota. While on fieldwork for Occupational Therapy she has seen the need for ASL to be incorporated into the healthcare setting, in order for individuals who are Deaf to obtain the highest quality of care. Through implementation of the workshop, both healthcare providers and the Deaf Clientele will feel more comfortable interacting with one another.
A Workshop To Teach OTs ASL To Improve Occupational Performance In Deaf Individuals

By: Kristin Pfeifer-Fyalling
Objectives

• Will be able to demonstrate ability to ask clients basic questions.
• Understand the Deaf population as a culture and own separate entity
• Understand appropriate ways of interacting with individuals who are Deaf
Introduction

American Sign Language

A  S  L
Activity

• Have you ever worked with a Deaf individuals before?
• What were your experiences working with them?
Implications for OT

• Why do OT's need to know sign language?
  • This workshop will show you how to communicate with clients, using the framework to address occupational performances.
Introduction to the Deaf Culture

- 9-10% of Americans have hearing loss, making it the second most common disability among Americans.

- ASL is the third most commonly used language in the U.S.

(Barnett, S. 2002)
Introduction to the Deaf Culture

• Capital $D$: Term used to refer to individuals who were Deaf prelingually and embrace the Deaf culture.

(Sneed & Joss, 1999)
Introduction

- **Lowercase d**: Term used to refer to individuals who are deaf but do not consider themselves part of the deaf culture.

(Sneed & Joss, 1999)
Introduction

• ASL is not universal, just as the hearing population does not all speak the same language.
  – Understand the Deaf clientèle and make appropriate accommodations
Methods of Communication

• Note Writing

• Lip Reading

• Sign Language-interpreting
Note Writing

- commonly used with healthcare providers, however it has been reported to be ineffective

- Writing notes takes time and many clients may become quickly fatigued depending on the status of their health.

(Steinberg, Barnett, Meador, Wiggins & Zazove, 2005)
Lip Reading

• lip reading has also been shown to be ineffective as only about 30% to 40% of communication is detected through this mode of communication.

• Because only 30% to 40% of lip reading is detected, individuals are forced to piece together communication and information that was not visually noticeable by the listener.

(Stancliff, 1998)
Sign Language

• Deaf individuals are more comfortable with healthcare providers who can just know basic sign language, even though they are not proficient or fluent (author, year)

(Meador & Zazove, 2005)
Etiquette

- No Secrets- Do not exclude Deaf individuals from conversations

- Allow extra time when working with Deaf clientèle
  - Takes them longer to conclude conversations
  - May ask the same question multiple times

- If need to use lip reading as a technique avoid over enunciating as it is more difficult to read.

(Meador & Zazove 2005)
Etiquette

• Make sure the Deaf individual has a clear visual field during conversions
  • Deaf patient can clearly see the interpreter and the healthcare provider
  • Be aware of any glare from windows that might decrease visibility

(Meador & Zazove, 2005)
Etiquette

• When communicating through an interpreter face the Deaf individual

• Be mindful of positioning when entering a room where a Deaf individual is present
Ways to Improve Service

• Have flashing lights or a number system in all waiting rooms

• Allow for longer consultation times

• Provide Deaf awareness training for all healthcare providers in your facility.

(Ubido, Huntington, & Warburton, 2002)
Improving Services

• On call 24 hour interpreting service

• Provide clear health information in the form of simple and clear pamphlets, and/or videos that contain subtitles.

(Ubido, Huntington, & Warburton, 2002).
Break

• 15 minute break!
Introduction to Signing

• Learning the Basics
  - Use your dominant hand when signing

  - Two-handed *symmetrical* signs – use both the non-dominant hand and dominant hand in conjunction with one another.

  - Two-handed *non-symmetrical* signs – the dominant hand moves while the non-dominant hand remains stationary.

  (Smith, Lentz & Mikos, 1988, p. 11)
Introduction to Signing

• Fingerspelling
  – Should be done slightly to the right of the face, and below the chin.

• When to use fingerspelling:
  – Names of People
  – Names of Cities and States
  – Titles of Movies of Books
  – Brand Names
  – Avoid “bouncing” each letter
  – Fingerspelling is not a substitute for signing
    – More appropriate to gesture, point, describe, etc....

(Smith, Lentz & Mikos, 1988, p. 33)
Fingerspelling

A

B

C

D
Fingerspelling

E
F
G
H
Fingerspelling

I

J

K

L
Fingerspelling

M
N
O
P
Fingerspelling

Q
R
S
T
Fingerspelling

U
V
W
X
Fingerspelling

Y

Z
Introduction to Signing

• Learning to sign numbers: 1-20

1 2 3
Introduction to Signing
Introduction to Signing
Introduction to Signing
Introduction to Signing
Introduction to Signing
Introduction to Signing
Introduction to Signing

- Days of the week: Monday-Sunday

Monday: Make an a letter "M" and rotate forearm in circular motion

Tuesday: Make "T" and rotate forearm in circular motion
Introduction to Signing

Wednesday: Make the letter "W"

Thursday: Make the letter "H"
Introduction to Signing

Friday: Make the letter "F"

Saturday: Make the letter "S"
Introduction to Signing

Sunday
Introduction to Signing

- Parts of the day: Morning, afternoon, night

Morning

Afternoon
Introduction to Signing

Night
Basic Terminology

- Telling someone your name and title
- Asking one for their name
- Expressing pleasure in meeting someone
- Are you Deaf?
- Are you of hearing?
Basic Terminology

• Name

• Occupational Therapy
  (Fingerspell)
Basic Terminology

- Nice to meet you
- Deaf
Basic Terminology

• Hearing

• Me
Basic Terminology

- Yes

- No
Basic Terminology

- Good
- Bad
Basic Terminology

- Please

- Thank You
Basic Terminology

• Show
  
• Copy
Basic Terminology

• Do

• Any Problems?
Basic Terminology

• Years

• Hours

• Long
Basic Terminology

• What

• When
Basic Terminology

• Who

• Why
Basic Terminology

- Finish/Done

- Help
Basic Terminology

- Where
- How
Basic Terminology

• Family
Basic Terminology

• Volunteer

• Interests
Basic Terminology

• Sit

• Stand
Basic Terminology

• Walk

• Cook
Incorporating Sign Language Into Occupational Therapy
Communicating with the OT Practice Framework

- Performance in Areas of Occupation
- Client Factors
- Performance Patterns
- Performance Skills
- Context and Environment

Performance in Areas of Occupation

- Bath

- Shower

Sign:
- “Do you bath or shower?”
- “Show my how you get into the bath/shower”.
Performance in Areas of Occupation

• Bathroom

• Demonstration:
  • Any problems with toileting?
Areas of Occupation

- Dressing

Sign:
- Show me how you get dressed?
- Any problems dressing?
Areas of Occupation

• Eating/Feeding

Sign:
• Show me how you feed yourself?
• Any problems eating?
Areas of Occupation

• Grooming

Brush Hair

Brush Teeth

Shave
Areas of Occupation

Sign:

• Show me how you shave.
• Show me how you brush your hair.
• Show me how you brush your teeth.
Areas of Occupation

• Sexual Activity

Sign:
  • Are you sexually active?
  • Would you like information?
Areas of Occupation

• Incorporation of the PLISSIT Model
  • P=Permission
  • L=Limited
  • I=Information
  • S=Specific
  • S=Suggestions
  • I=Intensive
  • T=Treatment
Areas of Occupation

• Toileting

Sign:
• Do you have problems with toileting?
• How is your bladder/bowl management?
Areas of Occupation

• Pets
  Cat  Dog

Sign:
• Do you have pets?
• Can you care for them?
Areas of Occupation

• Communication Management

Sign:
• How are your communication skills?
• Any Problems?
Areas of Occupation

• Transportation

Sign:
• Do you drive?
Areas of Occupation

• Finances

Sign:
• Do you manage your finances?
• Who helps you?
• Any problems?
Areas of Occupation

• Health management

Sign:
  • Do you manage your health?
  • Do you manage your Medication?
Lunch

• Lunch is on your own
• Meet back at 1:00
Areas of Occupation

• Religion

Sign:
• Are you Religious?
• Do you belong to an organization?
• Any problem's with your spirituality?
Areas of Occupation

- Safety

Sign:
- Do you feel safe?
Areas of Occupation

• Shopping

Sign:

• Do you shop for yourself?
  – Grocery
  – Clothing
Areas of Occupation

• Rest

Sign:
• Do you take naps?
• How long?
• How many a day?
Areas of Occupation

- Sleep

Sign:
- How many hours of sleep do you get a night?
- Do you wake up at night?
Areas of Occupation

• Education

Sign:
• Did you finish high school
• Did you go to college?
Areas of Occupation

• Work

Sign:
• Do you work?
• Where?
• How long?
Areas of Occupation

- Interests

Sign:
- What are your interests?
- Any loss of interests?
Areas of Occupation

- Volunteer

Sign:
- Do you volunteer?
- Where?
Break

• 15 minute break
• Refreshments provided
Areas of Occupation

• Leisure

Sign:
• What do you do for Leisure?
• Any problems?
Areas of Occupation

• Participation

Sign:
  • Do you participate in activities?
  • Any problems?
  • Loss of interest?
Areas of Occupation

- Social Participation

Sign:
- Do you participate in:
  - Work activities?
  - School activities?
Areas of Occupation

• Community Participation

Sign:
  • Are you involved?
  • Do you want to be involved?
  • Any problems?
Areas of Occupation

• Family Participation

Sign:
  • Do you socialize with family?
  • How often?
  • Any problems?
Client Factors

- Values

Sign:
  - What is important to you?
Client Factors

• Spirituality/Beliefs

Sign:
  • What is your spiritual belief?
Client Factors

• Attention

Sign:
• How is your attention?
• Can you pay attention easily?
Client Factors

• Memory

Sign:

• How is your short-term memory?
• How is your long-term memory?
• Do you remember things?
Client Factors

• Orientation

Sign:
  • What day is it?
  • Where are you right now?
  • What is your name?
Client Factors

Orientation Continued

Time: O'Clock
Performance Pattern

• Habits

Sign:
  • What Habits do you have?
Performance Pattern

• Roles

Sign:
• What are your roles?
• Any loss of interest in roles?
  » Personally?
  » With organizations?
Performance Pattern

• Routines

Sign:
• Do you have a daily routine?
• Any problems with your routine?
  » Personally?
  » With organizations?
Performance Skills

• ROM Testing

Sign:
  • Copy me.
  • Any pain?
Context

• Cultural

Sign:
  • Are you actively involved in your culture?
  • What cultural activities do you participate in
Context

• Cultural

Sign:
• Are you actively involved in your culture?
• What cultural activities do you participate in
Context

- Family
  - Mother
  - Father
Context

• Physical

Sign:
• Do you live in a house?
• Do you have problems getting around in your home?
Context

• Social

Sign:
  • Who do you socialize with?
  • Are you in a relationship?
  • Do you socialize with family and friends?
Integration

• Meet and Greet
  • Select a different partner from across the room
  • Introduce yourself, express pleasure in meeting them, and ask what their interests are.
  • You have 5 minutes! When the 5 minutes are up switch and find another partner whom you have not worked with today.
  • We will do this 3 times
Integration

• OT evaluation
  • Refer to the sheet in your folders labeled “OT Evaluation”.
  • Choose a partner
  • Ask your partner all of the questions on your sheet.
  • You have 15 minutes!
Integration

• Patient Education
  • Refer to the sheet in your folder labeled “Patient Education.”
  • Choose a partner
  • Read the case study and come up with your own way to educate a Deaf individual on hip precautions.
    You have 15 minutes!
Integration

• Knowing sign language and information about the Deaf culture, what would you have done differently when interacting with a Deaf individual?
• Referring back to the first activity regarding your experiences working with Deaf individuals
Resources for Continued Learning

• American Sign Language Medical Dictionary.
  – By: Elaine Costello, Ph.D

• Level 1: Signing Naturally
  – By: Cheri Smith / Ella Mae Lentz / Ken Mikos

• Level 2: Signing Naturally
  – By: Cheri Smith / Ella Mae Lentz / Ken Mikos
Resources for Continued Learning

• The Perigee Visual Dictionary of Signing
  — By: Rod R. Butterworth & Mickey Flodin

• Sign Language Made Simple
  — By: Karen Lewis & Roxanne Henderson

• Look for ASL classes offered in your community!!
Questions and Answer

• Any Questions? Comments?
• Feel free to ask questions following the workshop.
• Email any questions or concerns: kpfeifer@medicine.nodak.edu
Thank You!

• Thank you for your hard work and cooperation. I hope this session will help you work more effectively and confidently with your clients who are Deaf.
Resources

Resources

CHAPTER V

SUMMARY

Research demonstrated a need for sign language to be incorporated into the healthcare setting. Currently there is approximately 37 million Deaf individuals residing in the United States, which constitutes for twelve percent of the U.S. population. It is important for healthcare providers to become more competent of how to appropriately and effectively communicate with their Deaf clients.

Research indicated that lip reading, note writing and interpreting services were not effective modes of communication with their Deaf clients. Only 30% to 40% of communication is detected through means of lip reading. Using this mode of communication Deaf individuals are forced to piece together information which can be detrimental in healthcare if individuals are receiving limited information regarding their treatment or diagnosis. Note writing was also utilized but also shown to be ineffective. Healthcare is a fast paced environment and writing notes is time consuming. Lastly, many clinics do not utilize interpreting services based on the expenses. Many interpreting services often exceed the cost of the visit.

While there are several communication methods that are shown to be ineffective, basic sign language is suggested to be the most effective. Witte & Kuzel (2000) indicated that participants felt more comfortable with healthcare providers who knew even a small amount of sign language. The authors demonstrated a need for sign language to be
incorporated into the healthcare setting.

Research demonstrated a need for more competent healthcare providers. However, this scholarly project focused on the profession of OT. This particular profession was chosen as it has the unique perspective of viewing the individual client’s occupational performance within the context in which they live. In order to narrow the focus to just the OT profession the OT practice framework was utilized. The framework helped to structure the workshop in order to provide sufficient information pertaining to the OT scope of practice. The areas of the OT practice Framework that were emphasized included the: Performance in Areas of Occupation, Client Factors, Performance Patterns, Performance Skills, Context and Environment. Each were thoroughly addressed in order for OT’s to be able to effectively and efficiently evaluate their clients and establish rapport.

Although OT was the main focus in this scholarly project it would be beneficial for all healthcare profession to attend workshops and courses that pertain to the understanding of the Deaf culture. With the help of other healthcare professionals this workshop can be expanded to meet the needs of other professions so that they can also work effectively and efficiently with their Deaf clients.

Suggestions for better healthcare are implemented for more effective interaction with Deaf clients. First, healthcare providers need to make sure that individuals understand medical information before they leave. Staff also needs to be trained on how to use TTY devices in order to communicate via telephone. Secondly, healthcare providers should be competent with basic sign language and finger spelling in order to provide proper treatment. Last, it is also important to have certified interpreters staffed or
readily available at the hospitals and clinics to provide services. These three components can significantly increase the quality of care given to individuals who are deaf and make their experiences in the healthcare setting more positive.

Even though many healthcare providers do not understand the Deaf culture or know how to use sign language, there are things that they can do to eliminate fear and misunderstandings among Deaf individuals. Most importantly healthcare providers must treat individuals with respect even if they are unable to communicate with them. This will allow the practitioner and deaf client to establish trust in one another. Also, it is important for healthcare providers to immerse themselves in the language as much as possible in order to communicate more effectively with them, and learn more about their culture and language.
APPENDICES
Meet and Greet Activity:

1. Find a partner who you have not yet worked with in the workshop.

2. Using sign language: Introduce yourself, express pleasure in meeting them, and ask what their interests are.

3. You have 5 minutes! When the 5 minutes are up switch and find another partner whom you have not worked with today.

4. We will do this 3 times
APPENDIX B
Integration Activity 2

OT Evaluation:

Instructions:
1. Choose a partner
2. Using ASL: ask your partner all of the questions on the sheet
3. You have 15 minutes!

BADLs
U/E Function:

Sign: “Copy me” and then do the ROM screening method.

Hygiene:

Sign: “Show me how you bath or shower.”

Dressing:

Sign: “Show me how you dress.”

Grooming:
Sign: “Show me how you brush your teeth.”
   “Show me how you comb your hair.”
   “Show me how you shave.”

Bed Mobility:
Sign: “Show me how you sleep.”

Transfer:
Sign: “Show me how you sit.”
   “Show me how you stand.”
   “Show me how you walk.”

IADLs
Cooking:
Sign: “Show me how you make a sandwich.”
   OR “Show me how you make...” and then point to a recipe in a cookbook.

Driving:
Sign: “Do you drive”

Finance/Money
Sign: “Show me how you write.”
Sign: Do you work?

Where?

How long?

**Interests**

Sign: What are your interests?

Any loss in interests?

**Client Factors**

**Values**

Sign: What is important to you?

**Spirituality**

Sign: What is your spiritual belief?

**Performance Patterns:**
Roles

Sign: What are your roles?

Routine

Sign: What is your daily routine?

Performance Skills

ROM Testing

Sign: Copy me. Then perform ROM test

Context

Family

Sign: Do you have children?
   How many?
Patient Education Activity

Instructions:
1. Choose a partner
2. Review the scenario
3. Using ASL: Brainstorm how you can instruct the Deaf patient on hip precautions.
4. You have 15 minutes!

Scenario:
Elda is a 70 year old female who underwent surgery for a total hip arthroplasty. What are some hip precautions that Elda would need to follow? How can you address these precautions using sign language?
FIGURE
Figure 1

Using ASL in OT

Unit 1
- Introduction of American Sign Language
  - 1. Need
  - 2. Deaf Terminology
  - 3. Culture
  - 4. Etiquette

Unit 2
- Learning Basic ASL Terms
  - 1. Fingerspelling
  - 2. Common Gestures
  - 3. Number

Unit 3
- Using ASL with the OT Practice Framework
  - 1. Areas of Occupation
  - 2. Performance Skills
  - 3. Client Factors
  - 4. Context

Unit 4
- Integration of ASL
  - 1. Establish Rapport
  - 2. OT Evaluation
  - 3. Patient Education
  - 4. Context

Knowledge

Knowledge

Knowledge Understanding

Application/Analysis/Synthesis

Bloom Taxonomy
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