RURAL HEALTH CARE AND THE DEAF COMMUNITY:

AN EDUCATIONAL PROGRAM FOR

PROFESSIONAL NURSES

by

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of the requirements for the degree

of

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For Aunt Nancy

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ABSTRACT

The estimated number of deaf People in the United States ranges from 350,000 to 2 million. A 1995 report from JAMA stated that physicians are not utilizing sign language interpreters to communicate with Deaf patients. Health care professionals appear to share common misconceptions about Deaf people and the psychosocial implications of being deaf. Deafness is primarily a handicap of communication and language. Health care delivery to the Deaf community is critically affected by this barrier to communication.

The purpose of this professional project is to develop an instructional program aimed at sensitizing and educating rural professional nurses to the special needs of rural Deaf clients and their families. The project will consist of an educational program for nurses, including nurse practitioners, nurse administrators, and nurse researchers. The short-term goal is the sensitization of these health care professionals to the special issues of rural Deaf clients and their families. The long-term goal is for rural professional nurses to work toward communication access for rural Deaf clients and their families and compliance with the Americans with Disabilities Act.

The program will be in the form of a two-hour semi-interactive educational presentation. The impact of the educational presentation will be monitored at the individual level, with a recommendation for further evaluation at the system and suprasystem levels. Implications for nurse researchers and nurse administrators are also addressed.

American Deaf culture needs to be recognized as a distinct subculture within American society. The health care needs of the rural Deaf community may not be met adequately unless attention is paid to the special communication barriers encountered by this group. Rural nurses, with their holistic approach, are in a favorable position to assist the rural Deaf client in the elimination of these barriers, and to provide easier access for the rural Deaf community to the health care system.

CHAPTER 1

INTRODUCTION TO THE PROJECT

The Purpose

The purpose of this professional project is to develop an instructional program aimed at sensitizing and educating rural professional nurses to the special needs of rural Deaf clients and their families. The term Deaf is intended to mean a specific group of persons sharing a common culture and not simply an audiologic condition. Throughout this paper, the capitalized Deaf will be used when referring to the cultural aspects of the community and its members. When related to the audiological condition of deafness, lower case deaf will be used.

The relationship between the nurse and the client is a connection which is essential to the provision of quality care. Deafness frequently interferes with this relationship due to communication barriers and cultural differences between Deaf and non-Deaf persons. Nurses, including nurse practitioners, nurse administrators, and nurse researchers, need to be aware of the special communication issues of Deaf people. They must also be prepared to adapt and implement any appropriate arrangements which will optimize communication and promote the nurse-client relationship.

The hearing culture has referred to members of the Deaf community as handicapped, hearing-impaired, or disabled. Rather than accepting these labels, Deaf individuals have begun to insist that the hearing world view the Deaf community as the Deaf view themselves: a distinct linguistic and ethnic minority. Deaf persons are not in need of help. Deaf people want access, education, and equal rights (Colonomos & Bienvenu, 1992). In keeping with the philosophy of transcultural nursing, the recognition of the American Deaf culture by professional nurses is an important goal of this project.

Background and Significance of the Project

Overview

The background and significance of the project will begin with a brief history of its inception. This will be followed by a definition of the Deaf community and concepts of health care as they relate to Deaf persons. Application of these concepts to rural nursing theory and implications for rural nursing practice will be discussed. Finally, a summary will be presented of the Americans with Disabilities Act as it relates to health care access for the Deaf.

History of the Project

The idea for this project came partly as a result of a personal interest in the subject of deafness and my experience with my own family members, many of whom are markedly hard of hearing. This life experience has given me a respect for the conscious effort that must be made in order to attain and maintain clear and precise communication with deaf and hard of hearing individuals. It has also made me aware of the great number of individuals who take for granted the ease of verbal communication, and therefore have little understanding or patience for those who are aurally challenged.

As a student of American Sign Language and Deaf culture, I was interested in knowing if members of this minority population believed that a problem existed in the delivery of health care to Deaf clients. My curiosity was piqued by a report from the Journal of the American Medical Association which stated that physicians are not utilizing sign language interpreters to communicate with Deaf patients. Ebert and Heckerling (1995) found that while 63% of physicians surveyed knew that sign language should be the initial method of communication with patients that sign, only 22% were utilizing sign language interpreters. Writing was the method of choice used to communicate with deaf

clients. The researchers added that since most of the members of the Deaf community rely on sign language for communication, misdiagnoses can often be made when alternative methods of communication are used in place of signing.

The above report inspired an investigation into Montana's Deaf community. Of interest was the perception of rural Deaf clients in terms of access to and utilization of health care. A small scale qualitative study was conducted based on the grounded theory method. This investigation was performed as part of a graduate level nursing course entitled Rural Health: Needs and Perceptions at Montana State University. The subjects were leaders and members of various Deaf clubs in Montana. From this project emerged three major issues: (a) ignorance on the part of the health care provider of the difference between Deaf and hearing cultures, (b) the communication barriers between these groups, and (c) suggestions for improvement of communication in the form of health care practitioner education (Cassella, 1998). It became clear that the members felt strongly about a necessity to educate health care professionals about the special needs of Deaf clients.

Conceptual Framework

Community-focused nursing process is the conceptual framework for this project. The phases of the nursing process that involve the community as client are the same as with individually focused nursing care. The process begins with the establishment of the contract or partnership agreement. The phases include assessment, diagnosis, planning, implementation and evaluation (Shuster & Goeppinger, 1996).

The community health assessment begins with the gathering of data. This entails not only the collection of existing data, but also the identification of missing data (Shuster & Goeppinger, 1996). Compilation of existing and missing data, along with data interpretation, are the first steps in the assessment phase of the nursing process.

The grounded theory method of qualitative data analysis provides a systematic method which is used to identify and explore problems (Corbin, 1986). It is a method which allows nurses to capture the complexity of client issues and explore the intricacies of the clients' everyday life. In both the nursing process and the processes of grounded theory, the focus is on the perspective of the informant. The assumption is that what is important is to explore the view of the participant. This is the basis of client-

centered care. In terms of this project, the conceptual framework emerged from the problems identified by the Deaf community as client.

Defining the Deaf Community

The concept of community can be defined in various ways. One meaning refers to a locality-based entity or group whose function is to meet a wide variety of collective needs (Shuster & Goeppinger, 1996). Another definition designates a community as "an aggregate of people with similar characteristics" (Capuzzi, 1996, p. 352). The use of the term community in this paper is probably best reflected by The World Health Organization's (1974) Expert Committee Report on community health nursing: "A community is a social group determined by geographic boundaries and/or common values and interests. Its members know and interact with one another. It functions within a particular social structure and exhibits and creates norms, values and social institutions" (p. 7).

The National Center for Health Statistics through its Health Interview Survey has estimated that 21 million Americans have some degree of hearing impairment (National Information Center on Deafness [NICD], 1987). However, there are no recent national surveys to estimate the number of people who are deaf. As a result, the estimated number

of deaf people in the United States ranges from 350,000 to 2 million (NICD, 1987). The State of Montana has similarly ambiguous statistics. The Montana Association of the Deaf has a membership of 109 persons (J. Allen, personal communication, November 5, 1995). However, according to a prominent leader of Montana's Deaf community, this number in no way represents the total number of deaf persons in the state. This key informant believes that the number may be as high as 5000.

It is difficult to define the Deaf community because all of its members do not share a single distinctive trait. For example, the Deaf community is not like a racial or ethnic group where it is generally clear whether or not a person is a member. Instead, there appears to be a number of factors which must be considered when trying to discern who the members of the Deaf community are (Baker & Cokely, 1980). These factors include degree of deafness, age of onset of hearing loss, and the extent to which the person identifies with the Deaf group.

The degree of hearing impairment can vary widely among deaf individuals, ranging from mild loss to profound deafness. Hearing loss may also affect an individual at different stages of life. Pre-lingual deafness is defined as occurring sometime before the age of language

acquisition, usually at about age three years. When learning to speak, write, or speech-read, a prelingually deafened person will have no spoken language frame of reference. If a person becomes deaf sometime after this age, they are termed postlingually deaf and in most cases will have a fairly strong spoken language base (National Technical Institute for the Deaf [NTID], circa 1975).

The terms pre- and postvocationally deaf are also used to characterize deaf persons. These classifications refer to hearing status while acquiring job skills, usually around age 18 (NICD, 1987). A person who became deaf prior to this age has had fewer opportunities to obtain job skills and to interact with hearing people in pre-work settings. This person may be prepared inadequately for the interpersonal relationships they encounter in the job market and have problems with English language skills. Those deafened after this age, having already begun to interact as adults in the business or education fields, may personally or professionally encounter serious problems adjusting to their hearing loss (NICD, 1987).

A necessary condition for understanding the constituency of the Deaf community is the comprehension of the concept attitudinal deafness (Baker & Cokely, 1980). A person's identification with and acceptance by any group

requires the acceptance and support of the group's values and goals. Thus, a member of the Deaf community accepts and supports the values and goals of that community. Attitudinal deafness is a more important factor in defining the Deaf community than audiometric deafness, or whether or not a person is actually deaf. Not everyone who is deaf is a member of the Deaf community. Some individuals who suffer a hearing loss prefer to identify with the "hearing world", functioning as members of that group. Likewise, because some hearing people actively support the values and goals of the Deaf community, they too are considered members of the group (Baker & Cokely). One very specific way in which a person demonstrates acceptance of and support for the values and goals of the Deaf community is by showing respect for its conventions and culture. This would include the single most identifying feature of Deaf American culture: the use of American Sign Language (ASL).

ASL is a visual-gestural language created by Deaf people and used by approximately 500,000 Deaf Americans and Canadians (Baker & Padden, 1978). It is not a "manually coded" form of English or any other spoken language (Humphries, Padden & O'Rourke, 1980). Unlike spoken languages, the medium for ASL is visible, rather than aural. Like other languages, ASL has its own vocabulary, grammar,

syntax, and idioms. Traditionally, it has been very difficult for hearing persons to learn ASL. Up until the last two decades, only a few classes truly taught the grammar and syntax of ASL (many classes taught groups of signs, but not the language that Deaf people use). The general convention has been for Deaf people to be very cautious about sharing their language with hearing people. The reason for this cautious attitude can be clearly demonstrated in the following excerpt from a speech given by Barbara Kannapell, a sociolinguistic specialist and a Deaf woman, at the 1977 National Symposium on Sign Language Research and Teaching:

> It is important to understand that ASL is the only thing we have that belongs to Deaf people completely. It is the only thing that has grown out of the Deaf group. Maybe we are afraid to share our language with hearing people. Maybe our group identity will disappear once hearing people know ASL. Also, will hearing people dominate Deaf people more than before if they learn ASL? (Baker & Cokely, 1980, p.59)

This attitude, sometimes labeled by hearing persons as "Deaf suspicion", is not difficult to understand once it is recognized that the Deaf community, like other cultural minority groups, has experienced its share of oppression and

discrimination. Deaf people have been dominated by hearing persons in a number of ways, including education and employment. It is a generally accepted belief that the only area in which Deaf persons have not been dominated is in the values and attitudes of the community (Baker & Cokely, 1980). If hearing persons were to learn and become fluent in the language and culture of Deaf people, then they might have a means of influencing the values, attitudes, and goals of the Deaf community.

The above information is not intended to deter, but rather to educate hearing persons as to the reasons why some members of the Deaf community may initially be reluctant to share their culture and language. A hearing newcomer into such a community may experience an initial period during which some community members will need to observe the person in terms of their attitude toward Deaf people and their culture. If an attitude of respect for the values and goals of the Deaf community is shown, then the person will be allowed closer contact and interaction.

Health Care and the Deaf Community

Many health care professionals share some common misconceptions about Deaf people and the psychosocial implications of deafness. Deafness simply means that hearing is nonfunctional for the ordinary purposes of life

(DiPietro, Knight, & Sams, 1981). It is important to make a distinction between the impairment, disability, and handicap of deafness. The impairment is the physical damage to the auditory pathway. The disability is the loss of hearing. The handicap is being cut off from verbal language acquisition and transmission, which affects communication. Deafness is primarily a handicap of communication and language. Deafness presents a barrier to communication with the hearing world. This is the single most critical factor affecting health care delivery to the Deaf community (DiPietro et al.). It is noteworthy that Deaf persons do not consider themselves handicapped, i.e., they have no communication barriers among themselves.

Unlike their hearing counterparts, most deaf children of hearing parents are denied what Carver (1996) describes as one of the most potent learning and socialization tools: ambient communication. Ambient communication refers to the incidental learning that is acquired from informal sources. These sources include casual participation in (or mere presence during) conversations at home, school, or work. A hearing child acquires much knowledge about his cultural and social environment during casual discussions between parents, teachers, or co-workers. Deaf children and adults are often not included in these types of conversations, nor

are they able to "eavesdrop" on their social environment. Unless information is directed specifically toward the Deaf person in a form that can be understood (remember that ASL, not English, is the primary language of the Deaf community), general knowledge tends to be restricted.

Educators of deaf children are often forced, unfortunately, to sacrifice topics such as health education in favor of the more fundamental subjects including mathematics and English. Hence, some of the "fundamentals" of health care, such as proper hygiene, nutrition, and safety, not to mention the names and functions of specific body parts, are often missing from the Deaf person's knowledge base (Kleinig & Mohay, 1990). This limitation can adversely affect that person's awareness of when, where, why, and how to seek appropriate medical attention (DiPietro et al., 1981).

Another common finding among Deaf patients is that many have limited knowledge of their own health histories. This is easily understood when it is considered that the primary exchange of information regarding an ill deaf child is between the parent and the health care provider. Usually the time is not taken after an illness to explain to the child what was wrong. It is not unusual for a Deaf adult to have to contact a hearing sibling or parent in order to

uncover details of their own medical history (DiPietro et al., 1981). Often, no sources of information can be found.

A widespread misconception among the general hearing population, including hearing health professionals, is that a deaf person can understand speech through speech-reading. Even in a given situation where the Deaf person is comfortable with English and in a locale where communication can be optimized (i.e., not the average Emergency Department), only 30 to 40% of English sounds are visible on the lips (DiPietro et al., 1981; Kleinig & Mohay, 1990). The rest are either invisible or identical to other sounds. The potential for misunderstanding is great. For example, "How do you spell your name?" can look just like "How do you spend your time?" Speech-reading is a skill, like many other skills, for which some people seem to have more talent. There is no apparent correlation between the level of speech-reading skill and intelligence.

Writing is frequently used as an alternative form of communication, but has many limitations. The average prelingually Deaf adult reads at about a fourth grade reading level (DiPietro et al., 1981). This can seriously limit what information can be conveyed through writing, particularly when using medical terminology or when referring to specific anatomical parts or physiological

function. In addition, many practitioners may tend to abbreviate the information given via written message, because it is so time consuming. Comprehension is also limited when the Deaf patient is given information booklets or other written materials designed for health education. Often these types of materials are written in English above a fourth grade level.

The end result of most interactions between hearing health care providers and the Deaf community will be incomplete communication with a Deaf person. Surveys of hearing-impaired patients report that in hospital settings, the patient understands approximately one-third of what the hospital staff tell them (Schein & Delk, 1980). It is important to consider that many Deaf persons will feign understanding of what a hearing person has communicated to them so as not to offend the hearing person. Difficulties in understanding diagnosis, treatment, and preventative practices can confuse, anger, embarrass, and often frighten a Deaf person. This can easily complicate compliance and deter the person from future participation in preventive health care programs.

Application to Rural Nursing Theory

Lee (1991) identifies one of the defining characteristics of rurality as being the low population density of rural areas. Decreased communication, transportation, networking and human interaction, and availability of specialized services are among the factors that are affected by the rural environment. There are obvious implications for delivery of health care to the rural Deaf community.

Health care providers in rural areas are likely to have fewer opportunities and less experience in dealing with Deaf clients due to the smaller Deaf population. Subsequently, there would be decreased incentive for providers to improve communication skills or become educated in the proper interaction with Deaf clients. Accurate assessment, compliance with treatment, patient teaching, obtaining informed consent, and explanation of alternative therapies all require precise two-way communication. The effectiveness of all of these activities is hampered with less than optimal communication between client and provider.

Rurality implies a geographic barrier to health care services in locations where specific services may be limited or unavailable. Even in areas where services may be available, Deaf persons often face barriers to obtaining

them. One example is the isolation from a particular health care provider or service that a Deaf person may experience in the absence of Telecommunication Devices for the Deaf (TDD or TTY).[1] Although some communities have responded to the needs of the Deaf community by providing TDD/TTY service for emergency calls to hospitals and Emergency Medical Service first responders, most rural Deaf persons remain isolated from direct telephone access to health care professionals. Telephone access must be made through use of a relay service. As of 1993, all telephone companies are required to provide telephone relay services for deaf, hard of hearing, and speech impaired people (The National Academy/Gallaudet University, 1992).

Geographic and communication barriers can also influence the rural Deaf community's awareness of specific public health programs. Due to the lowered cost, many specific public services, such as cardiopulmonary resuscitation classes, blood pressure screening clinics, and flu shot clinics, are advertised by radio. Rural Deaf individuals with adequate reading skills must be pro-active in finding such an advertisement in the local newspaper. Church services may include announcements of such upcoming wellness clinics, but few rural congregations include ASL interpretation as part of regular church service. Those

Deaf individuals living near a rural city may be a member of the local Deaf club, where announcements may be made regarding local health programs. However, these clubs are absent in the more rural or frontier areas. Rural Deaf persons in these areas may not be aware that these programs exist.

Lower personal income is also a factor affecting health care for the rural Deaf community. Deaf persons tend to be under-employed, usually due to a lack of understanding and flexibility on the part of their employers (Rosenthal, 1988). Limited finances and inadequate insurance coverage adversely affect the amount of money spent on health care. In addition, the language barrier between the Deaf patient and the hearing provider usually requires a longer health care visit. If a fee is charged for the additional time, the Deaf person suffers the additional cost.

The cost of services related to the hearing impairment also increases the financial burden of health care. These services include payment for a Certified Interpreter for the Deaf. In an attempt to try to contain health care costs, whether it be by the client, the health care facility, or a third party, the path likely chosen is to try to "get by" without an interpreter. Again, the end result is

incomplete communication with the Deaf person leading to misinterpretations regarding health status.

Implications for Rural Nursing Practice

The most important implication for rural nursing of Deaf clients is an understanding of (a) the differences between Deaf and hearing cultures, and (b) the communication barriers presented by deafness. Unlike the standard medical model, which tends to view deafness as a deficit to be corrected, a more holistic, or cultural, view of deafness is that of a difference to be understood and accepted.

Rural professional nurses need to commit to self-education regarding Deaf people and Deaf culture, especially if members of the Deaf community reside within their geographic realm of practice. Education also needs to focus on the adjustments that are necessary for the delivery of quality health care to Deaf consumers. Each member of the Deaf community must be assessed as an individual, with respect to the varying levels of attitudinal deafness, English language ability, education, and potential barriers to the awareness of health practices.

Familiarity with community services, if any, that are available for Deaf clients is another important consideration. Contacts should be made with the state

Registry of Interpreters for the Deaf in advance of need in order to determine the availability of qualified interpreters. Ideally, the interpreting professionals would be equipped with medical terminology skills. A list of various interpreters should be readily available as a particular interpreter should only be used with the consent of the Deaf person. An interpreter must also be available for the Deaf parent of a hearing child if the child is the client. Similarly, an interpreter should be present for the deaf child of hearing parents, as the interpreter is usually better prepared to explain illnesses and procedures to the deaf child. Family members should not be used as interpreters. A family member may not possess adequate interpreting skills or may be biased in such a way as to not fully interpret all communication. Also, it is imperative that family members not be utilized as interpreters without the specific consent of the client for obvious confidentiality reasons. A Certified Interpreter for the Deaf is bound by a Code of Ethics in matters of confidentiality. A brief pre-conference with an interpreter is also in order if the practitioner has never before utilized a qualified interpreter. This is necessary to become familiar with the "rules of etiquette" when using an ASL interpreter.

Rural community health agencies can also commit to the improvement of quality health care for the Deaf population. This can be accomplished by providing education on deafness to staff members, development of guidelines for the realization of services to Deaf clients, and arrangement of communication accessibility. Communication accessibility is accomplished through use of TDD/TTY services, certified interpreters, and adherence to the mode of communication selected by the Deaf patient. Deaf consumers can also be encouraged to learn more about health care practices by consumer health education courses offered through agencies serving the Deaf community.

The involvement of Deaf consumer representatives in the development of these rural health programs is essential. The first step toward the breaking of communication barriers between the hearing and Deaf worlds is for the hearing society to show respect for the Deaf community and its members.

The Americans with Disabilities Act

The Americans with Disabilities Act (ADA) was signed into Federal law in July, 1990. One of the disabilities covered by the provisions of the ADA is hearing loss (Self Help for Hard of Hearing People [SHHH], 1993). The ADA requires that hospitals and health care providers "find ways

to ensure the safety of patients with hearing loss and make sure such individuals can communicate effectively. Under the ADA, health care providers must have a way to communicate with their deaf and hard of hearing patients" (SHHH, p. 11). Communication access is the term applied to the actions that health care providers take in order to ensure that deaf and hard of hearing individuals can communicate and understand. It is achieved by way of rendering services that furnish an environment where persons with hearing loss can communicate.

Title III of the ADA prohibits discrimination against deaf and hard of hearing people in places of public accommodation (The National Academy/Gallaudet University, 1992). The definition of public accommodation includes the office of a health care provider. In addition, these groups are also protected by Section 504 of the Rehabilitation Act of 1973 which covers health care providers who receive Medicare payments (Northern Virginia Resource Center [NVRC], 1995). At no cost to the deaf individual, health care providers are required to provide appropriate auxiliary aids and services to ensure communication access for deaf patients or the deaf family members of patients. These aids and services include qualified interpreters for individuals who use ASL.

According to the Deaf Counseling, Advocacy, and Referral Agency (as cited in NVRC, 1995):

> Typical examples of situations in which interpreters should be present [include]: obtaining medical history, informed consent, and permission for treatment; explaining diagnoses, treatment and prognosis of an illness; psychotherapy; communicating prior to and after major medical procedures; and explaining medication, medical costs, insurance issues, and patient care upon discharge from a medical facility. (p. 8)

A summary of the law as applied to health care providers may be found in Appendix A.

Objectives of the Project

The Deaf community needs to be recognized as a distinct subculture within society, having its own language, history, and customs. The health care needs of the rural Deaf community may not be adequately met unless there exists an awareness of the communication barriers these individuals encounter. Rural professional nurses, with their holistic approach, are in a favorable position to assist the rural Deaf client in the elimination of these barriers, and to

provide easier access for the rural Deaf community to the health care system.

The project will consist of an educational program for professional nurses. The short-term goal is the sensitization of these health care professionals to the special issues of rural Deaf clients and their families. The long-term goal is for rural professional nurses to work toward communication access for rural Deaf clients and their families and compliance with the Americans with Disabilities Act. The objectives of the project are to assist professional nurses to (a) gain an awareness of American Deaf culture, (b) develop an understanding of the communication barriers that exist between Deaf and hearing cultures, and (c) recognize cultural differences in terms of barriers to accessing health care.

Footnote

[1]The abbreviation TTY stands for Teletypewriter, a term used by the Deaf community when referring to the telephone communication device used by many Deaf people. In recent years, the term Telecommunication Device for the Deaf (TDD) emerged and is a term coined by the hearing. Many Deaf persons do not use TDD when referring to this device as the members of Deaf community were not consulted in the official change of the name. Many feel this is an example of hearing domination over Deaf culture.

CHAPTER TWO

LITERATURE REVIEW

The review of the literature was conducted with respect to the major themes mentioned in the purpose of the project. The first section will concern communication barriers between deaf patients and health care providers. A discussion of Deaf culture in the context of transcultural nursing will follow.

Communication Barriers

Dearth of Research

There is a limited amount of literature regarding deaf persons in relation to nursing practice. Wright (1993) postulates that this lack of nursing literature may reflect that this linguistic minority has not been considered to require special consideration. Because deaf individuals look like anyone else, Oloman (1969) believed that health care providers expected deaf clients to communicate orally. Montgomery (1981) considered this expectation to arise from an audiocentric attitude. This is a traditionally oralist position reflecting the educational and medical notion that the "correct" way of communicating with deaf people is

through verbalization and speech-reading (Levene, 1983; Montgomery; Taylor, 1986).

Through the development of a framework that emphasizes an understanding of cultural differences, it is possible that nurse education can alter this audiocentric viewpoint (Wright, 1993). It is important to note, however, that the majority of nurses are members of the hearing population. Perceptions of deafness probably start with informal socialization in a hearing society.

Stigma

Speech has been historically linked to intelligence. This has been the foundation of the oralistic approach to communication with deaf persons (Carty, 1972; Chovaz, 1989; Harding, 1986; Thomas, 1987). It has also been the root of the stigmatization of deaf people in a hearing population. Becker (1981) explains that stigma is an experience which is embroiled with the condition of deafness for most deaf people. Approximately ninety percent of all deaf children are born to hearing parents (Dolnick, 1993; Schein & Delk, 1980). The great majority of deaf people, particularly older deaf people, experienced their first few years of life unable to satisfactorily communicate with their hearing parents. Language acquisition and the development of

socialization skills were latent, not beginning until the child attended school. This emotional predicament was further complicated by the choice parents needed to make regarding educational methods. The choice was to have their children learn the "oral" method of speech and lip-reading, or to "send the child away" to a residential school where they would learn sign language (Becker).

Until the 1960's, signing was treated as a poor substitute for language (Dolnick, 1993). The use of American Sign Language was forbidden in oral schools, however, the stigma around using it was a common bond among deaf children. As adults, many of these individuals continue to demonstrate ambivalence regarding the use of their language. In contrast, the eight percent of deaf children born to deaf parents (Schein & Delk, 1980) learn sign language early in the home and develop adequate communication skills. They do not experience the conflicts of deaf children of hearing parents and tend to have a higher self-esteem (Becker, 1981). Deaf people from deaf families see themselves as carrying on a cultural tradition to which little or no stigma is attached.

Effects of Public Misconceptions on Communication

Johnson (1986) believes that the general public knows little about deaf people. Harding (1986) agrees, and adds that since health care education does not include the effects of deafness, nurses tend to share the same misconceptions as the general public. Hospital staff members do not understand the parameters of deafness and how deaf people communicate (Ludders, 1987). Some reports have indicated that nurses believe deaf people can and should lip-read (Carty, 1972; Levene, 1983; Taylor, 1986). Yet, historically, forced participation in speech therapy and lip-reading has been at the core of Deaf oppression. Hearing professionals have developed the rules, norms, and standards for the behaviors of deaf people. These audiocentric and paternalistic attitudes of professionals have caused deaf people to have a negative self-concept, feel inferior, and be distrustful of the hearing majority (Chough, 1983; Kannapell, 1983). This mistrust phenomenon can partially explain why deaf persons tend not to seek professional help. Since hearing professionals are likely to be ignorant about the implications of deafness, communication problems will interfere. Additionally, deaf persons are apt to fear that hearing people will not maintain confidentiality. Kannapell (1983) stresses that

members of the Deaf community evaluate health care services and then communicate that evaluation to other members. If services are poor, they will not participate.

Loss of Interactive Communication

As mentioned in the previous chapter, it is the loss of communication between hearing and deaf people that is the handicap of deafness, not loss of hearing. Yet historically, it is the deaf person who is expected to adopt an oral method of expression. Wright (1993) concluded that Deaf people are generally unsatisfied with the communication between themselves and health care staff. He further contends that nurses and other health care staff will also be dissatisfied in their interactions with Deaf people since communication is a two-way process. Carty (1972) has indicated that while nurses are able to meet the physical needs of the deaf client, their psychological, social, and spiritual needs are not being addressed. The audiocentric attitude toward deafness that is found in the general hearing population is also found among nurses, indicating that nurses are not being prepared professionally to provide culturally sensitive care for the deaf patient.

Deafness as a Culture and the Deaf Community

Transcultural Nursing

The concept of transcultural nursing evolved out of a need to use culturally-based knowledge to guide nursing decisions and actions. This philosophy promotes the provision of nursing care within the cultural context of the client (Morse, 1987). Transcultural nursing's goal is to provide nursing care consistent with beneficial health outcomes to people of different or similar cultures (Leininger, 1995). In order to achieve this goal, the nurse must have knowledge and understanding of both the client's and her own culture, particularly in terms of health beliefs, practices, and norms. Nurses also need to be able to elicit information from an individual client with regard to the client's views of these beliefs in order to avoid stereotyping. The nurse must also possess an understanding of the appropriateness of conventional nursing interventions for an individual client, and, must be willing and able to negotiate an acceptable compromise (Morse).

The meaning of Deaf culture and the Deaf community takes on particular importance in order to provide culturally sensitive care to Deaf clients. The traditional mode of thought regarding deaf people is a focus on their

"condition", i.e., the fact that they do not hear. All other aspects of their lives are viewed as a consequence of this fact. Padden and Humphries (1988), however, believe that the attention given to the physical condition of not hearing has obscured awareness of the far more interesting facets of Deaf peoples' lives; their rich cultural heritage.

Brief History of American Deaf Culture

Historically, wherever Deaf people have lived, they or their ancestors have created their own culture and sign language (Baker & Padden, 1978). This is evidenced by the existence of British Sign Language, Chinese Sign Language, Danish Sign Language, and so on. Little is known about American Deaf culture prior to 1817. It is estimated that in the early 1800's, between 2000 and 6000 deaf people were living in the U. S. (Baker & Cokely, 1980; Baker & Padden). Some probably immigrated from the British Isles and Europe, while others were born in America. In 1814, Thomas Hopkins Gallaudet, a student of ministry at Yale University, met the deaf daughter of a prominent Connecticut physician, Mason Cogswell. Having some success in teaching the deaf girl to read and write, Gallaudet was encouraged by the physician to consider opening a school for deaf children. It was estimated that there were about 89 deaf persons in Connecticut alone, and so both Cogswell and the community

raised enough money to send Gallaudet to England to learn methods for instructing deaf people (Baker & Cokely).

During the early nineteenth century, schools for the deaf in Great Britain focused on the oral method of speech training and lip-reading. When Gallaudet arrived, he learned that the directors of these schools would not share their teaching methods with him. Rather, they preferred that the Americans hire British instructors to teach American deaf children (Baker & Cokely, 1980; Benderly, 1988). However, during his stay in London, Gallaudet had seen a demonstration of the French method of instructing deaf students. This technique incorporated French Sign Language. He moved on to Paris for the purpose of studying these methods, returning to Connecticut the following year.

Accompanying Gallaudet on his journey home was a Deaf instructor from Paris, Laurent Clerc. In 1817, with funds from the State of Connecticut and the U. S. Congress, Gallaudet and Clerc established the Institution for Deaf Mutes, now called the American School for the Deaf in Hartford (Baker & Cokely, 1980; Baker & Padden, 1978; Benderly, 1988). One very important consequence of the establishment of the school was that deaf individuals were brought together for the first time in American history. This fostered the development of the American Deaf culture

and community. Early American "home" signs (signs created and used by deaf Americans) were blended together with some of the signs from French Sign Language and the combination became American Sign Language (ASL). Additionally, some of the instructors taught by Laurent Clerc later became the directors of Deaf schools in New York, Kentucky, Virginia, Indiana, Pennsylvania, Ohio, and Quebec (Baker & Padden). Hence, deaf persons were brought together throughout North America, the use of ASL spread, and American Deaf culture evolved.

Culture versus Pathology

Wixtrom (1988) asserts that deafness can be viewed either culturally or as a pathology. From the cultural viewpoint, deafness is seen as a difference in a characteristic which is to be accepted. It is an attribute which differentiates a normal deaf person from a normal hearing person. This differs greatly from the view which considers deafness as a defect, or pathologic condition which distinguishes abnormal deaf persons from normal hearing persons. This traditionally pathologic view neither accepts or supports a separate Deaf culture. The cultural view of deafness rejects the assumption that medical progress toward treating the hearing defect is welcome (Dolnick, 1993). Since deafness is not considered a

deprivation, talk of cures and breakthroughs is inappropriate and offensive to Deaf people.

Woodward (1972) proposed the conventional use of the lowercase deaf when referring to the audiological condition of not hearing, and the uppercase Deaf when referring to that particular group of deaf people who share a language and a culture. The members of the American Deaf culture reside primarily in the United States and Canada, and they share a set of beliefs about themselves and their connection to the larger society (Padden & Humphries, 1988). Sign language is inherent in the Deaf culture and is used as a primary means of communication. Culturally Deaf persons are distinguished from the group of adults who are losing their hearing as a result of age, trauma, or illness. The knowledge, beliefs, and practices that make up the culture of Deaf people are not readily accessible to this group of people, even though they share a similar audiological condition.

Culture and Community

Padden (1980/1989) makes the distinction between culture and community, and asserts that while there may be many deaf communities, including a national deaf community, there is only one true Deaf American culture. She defines a culture as "a set of learned behaviors of a group of people

who have their own language, values, rules for behavior, and traditions" (Padden, 1980/1989, p. 4). If a person is born into a culture, her personality and behaviors are shaped by those cultural values. A person may also be born into one culture, and then later in life become enculturated into another by learning its language, values, and practices. Such is the case with a deaf child born into a hearing family. It is not until later in life that this person may become aware of and embrace Deaf culture. A community is defined by Padden as a social system sharing somewhat of a location, common goals, and responsibility for its members. The notion of community is somewhat more tangible than culture. For instance, a person's beliefs and actions are mainly influenced by culture, but the majority of social interactions and work are accomplished within the community. The Baker-Cokely model (1980) describes the Deaf community as having four distinct aspects or spheres. The audiological aspect refers to the condition of hearing. The linguistic aspect is that of sharing a common language. The social aspect involves the comfort level in socializing with the Deaf community, and the political realm relates to working toward the political goals of the Deaf community or having political influence. An attitudinally deaf person who can identify with at least two of these four factors can

be considered a member of the community. When a person shares in all four of these spheres, then they are considered to be in the core of the Deaf community (Baker & Cokely, 1980).

Higgins (1987) points out that Deaf communities have formed partly as a result of negative experiences encountered by deaf persons in a hearing society. They are also a positive means for Deaf people to achieve a sense of wholeness and belonging. While members of Deaf communities are citizens of the larger society, many hold to significantly different cultural beliefs and practices. Members of Deaf communities share much of the culture of their society, but some also use and produce a distinct culture as well. It is the culture of Deaf Americans that sets them apart from their hearing counterparts (Higgins, 1987).

Although there are many aspects of Deaf culture, the three most significant are language, communication etiquette, and social relations (Higgins, 1987; Padden, 1980/1989). The major identifying feature of Deaf American culture is American Sign Language. ASL is used and respected, even though not all culturally Deaf people are highly proficient in its use. Because the language makes use of the hands, there is a certain sacredness attached to

how the hands are used to communicate. Nonsensical use of the hands to communicate, i.e., gestures in the absence of related context, is not a part of Deaf culture. Some Deaf persons may choose to use speech in activities that involve non-Deaf people, but speaking is not considered appropriate behavior on the cultural level. Exaggerated speaking behavior is thought of as undignified and even derisive toward Deaf people. Lastly, there is a high emphasis on social relations among Deaf individuals. Social activities are considered an important way of maintaining contact with other Deaf people. In many cases, social activities are the only access to other cultural members, i.e., to others with whom communication is not an issue. Since the time Deaf people share together in a comfortable and communicative atmosphere is usually limited, a particular importance is placed on social occasions (Padden, 1980/1989).

The availability of literature regarding deafness as a culture is somewhat limited. Only a few examples of the cultural values held by Deaf people have been presented. It is worth noting that the culture itself has yet to be studied in depth.

Summary

It has been only recently that Deaf people have been described as having a culture. Most of the earlier

literature focused on details of their hearing deficiency, not on the normal aspects of their lives. The values of this group reflect the ideology and manner in which Deaf people react to their social environment (Padden, 1980/1989). These values are foreign to the majority hearing culture, and this lack of knowledge supports the barriers to communication between Deaf people and nursing professionals.

CHAPTER 3

METHODOLOGY

The purpose of this project concerns the development of an instructional program aimed at sensitizing and educating rural professional nurses to the special needs of rural Deaf clients and their families. In the first chapter, it was stated that the conceptual framework for this project included community focused nursing process. We know the phases of this process as assessment, diagnosis, planning, implementation and evaluation. Paramount to the planning and implementation phases of the process is the nursing intervention. It is this approach that is unique to the nursing method of problem solving. The project design outlined below will be characteristic of a nursing intervention, and, as such, the terms project and intervention will be used interchangeably.

Project Design

Required Resources

The educational presentation is intended for nurses, including nurse practitioners, nurse administrators, and nurse researchers. This will be a small scale intervention specifically targeted for Yellowstone County, Montana. The

personnel required consist only of the presenter, who is currently a graduate nursing student with an interest in promoting health care access for Deaf individuals. The speaker will receive no payment for her services. In the event that a Deaf person who uses ASL is a member of the audience, a Certified Interpreter for the Deaf will also be required.

In terms of financial and technological resources, this project will require very little. Financial considerations include the following:

1. Postal costs. This is a minimal amount for obtaining information on the subject matter and for requesting permission to use copyrighted material. The journal articles, books, and other reference materials were obtained at no cost to the presenter.

2. The cost of printing and copying handout materials and advertising for the presentation. Again, the educational materials will be of minimal expense. Each presentation will be scheduled in advance with individual organizations. Any additional advertising will be in the form of flyers which may be posted around the institution to serve as a reminder to attendees.

3. The expense of visual aids. This will consist of slides created via computer software which will be used to outline and reinforce various concepts.

4. The possible payment of a Certified Interpreter for the Deaf, should there be any Deaf persons present in the audience. Standard rate of remuneration for a certified interpreter is in the range of $20 to $25 per hour, with a minimum charge of two hours.

Technological requirements are only that of a slide projector. The intended facilities which will hold the presentations should be able to furnish a meeting room for the presenter and her projector.

Target Audience

The target audience will be adult learners. These include nursing staff and nurse practitioners who provide direct patient care in one of the following areas in Yellowstone County: in-patient acute care settings, emergency departments, out-patient clinics or community health agencies, and the offices of primary care providers. Nursing administrators will also be targeted as members of the audience. As organizational leaders, their awareness of the special health issues of the Deaf community will be vital to the reform of institutional policy. Additionally,

a prospective portion of the intervention will be to work with the nursing administrators on the review and possible revision of institutional policies and procedures.

Strategic Approach

The program will be in the form of a two-hour semi-interactive educational presentation. Two hours was designated as an appropriate time frame in order to (a) adequately present and explore the information, (b) assure attendance by those whose schedules may not allow for a program of longer duration, and (c) avoid oversaturating the listeners with a surplus of information and understimulating them with too little.

An outline of the educational program can be found in Appendix B. As the participants are being seated, a pre-test about deafness will be given to each person (see Appendix C). The audience will be asked to complete the test. When all members are finished, the test will be collected and put aside for later evaluation.

After an introduction to the topic and an overview of the objectives of the program, an interactive discussion will ensue. A very short story will be told in American Sign Language. Each audience member will be invited to give their interpretation of what was signed. The speaker will then explain the story and ask the members to share their

feelings of difficulty in understanding. A parallel will then be drawn to the experience of Deaf persons in a hearing world. Following this, participants will be asked to share their experiences of working with deaf clients. Of special interest will be their individual institutions' policy and usual practice of working with deaf clients. The participant will be asked to share their feelings regarding these encounters, and whether they felt they were able to achieve effective communication.

The didactic portion of the program will be next. A brief lecture will be given, and the learners will be invited to interrupt with comments or questions regarding the material. The specific topics to be addressed are summarized in Appendix B. Emphasis will be on the need to recognize Deafness as a culture, and that the most important nursing implication regarding health care for the Deaf is the communication barrier. English is a second language to most Deaf people. Therefore, it is imperative that communication access in the form of a Certified Interpreter for the Deaf be provided for those clients who prefer signing as their primary mode of communication. Provision of this communication access is also an obligation of health care providers under the ADA. A summary of the laws as

applied to health care providers can be found in Appendix A, and will be distributed to members of the audience.

After a ten-minute break, the group will reassemble and the post-test on deafness will be distributed. When the test is completed, the answers will be given out and the participants will be asked not to change their post-test answers. The questions will be reviewed by the presenter, and the participants will be asked to give rationale for their answers. The audience will be invited to engage in dialogue regarding any thoughts they may have on their chosen answers. The post-test will then be collected.

The final portion of the program will be in the form of a group discussion. Participants will be asked to identify potential barriers to health care for the Deaf population or compliance with the ADA at their respective institutions. The members will be encouraged to offer suggestions to alter and improve present practices.

Rationale for Approach

Consistent with the principles of adult learning is a developmental, experiential approach (Knowles, 1980). Discussion provides a venue for the adult learner to react to the ideas, experience, insights, and knowledge of the teacher or of peers. Interaction strategies also generate alternative ways of thinking and feeling, and can promote

depth in the learners' mental processing which leads to improved retention and recall of information (Seaman & Fellenz, 1989). A more flexible, fluid discussion allows the adult learner to explore other systems of knowledge and to test others' perceptions of their ideas. The depth of the adult's life experiences encourages and supports group dialogue as a means of attaining or interpreting new information.

Provision of a Certified Interpreter for the Deaf will require a change in the knowledge, attitude, and behavior of most health care providers. The most effective strategy to implement this change would be a normative/educative approach. With any social group, behavior is shaped by the group's attitudes, values, and norms, namely, its normative culture (Chin & Benne, 1984; Thompson & Kinne, 1990).

Attitudes are influenced by a normative environment. The idea behind the normative/educative method is to readjust the attitudes and values of the providers. The normative culture of nurses needs to be readjusted and clarified in order for a change to occur. For this to be accomplished, the learner needs to recognize that a set of values is already in place. Freire (1970) refers to this process as <u>conscientization</u>, where learners achieve "a deepening awareness both of the sociocultural reality which

shapes their lives and of their capacity to transform that reality" (p. 27). He describes the educational experience as a continuum where the learner moves from the lowest to highest level of awareness, or from a place where there is no comprehension of how forces are shaping one's life to a high level of critical consciousness marked by problem analysis, self-awareness, and self-reflection (Merriam & Caffarella, 1991).

By working openly with the values of the adult learner group, a manipulative method of change is avoided (Chin & Benne, 1984). The goal of the normative/educative approach to change is to modify the perspective of the learners. This change of attitude is necessary not only so that behavior is modified, but, more importantly, so that a desire to change will be instilled. The reframing of the learner's perspective is a necessary condition for attitudinal, value, and behavioral change. Consequently, the values and attitudes underlying the drive to change behavior are what will keep the behavior modification in place.

The choice of this method of intervention was based on Lewin's force field theory. This model provides a psycho-social view of the change process (Sullivan & Decker, 1988). In the force field theory, differing forces exist within a

field that either impede or facilitate change. Once these restraining and driving forces are identified, they can be manipulated in such a way to shift the balance toward the direction of the desired change.

In the analysis of this change intervention, the major restraining forces would be the lack of education on the part of nurses, nurse practitioners and nurse administrators regarding deafness and Deaf culture and the cultural influences that have created their perceptions of deaf individuals. Lack of awareness of Deaf culture is one force which can be readily manipulated. If these providers were to receive education about deafness and its implications for health care, what was once a restraining energy could become a powerful driving one. Increased knowledge may lead to increased compliance with the desired change. Another restraining force which could be turned into a driving energy is that of time constraint. Generally the time is not taken to locate and utilize a Certified Interpreter for the Deaf. Most providers will try alternate methods of communicating with Deaf clients, such as by writing or having the client lip-read. These methods are generally very time-consuming, frustrating, and ineffective. However, when an interpreter is utilized, the communication process is facilitated to the point of taking about the same amount

of time as with a hearing client. Using an interpreter saves time. Once the provider has experienced the ease and quality of this method of communication, there should be a strong drive to utilize interpreters on a regular basis.

The desire for improved communication with the client is a powerful driving force already in place. Nurses are motivated to implement changes which will provide better services to the client, the community, or both. Staff education can only strengthen the energy behind the desire to change. Another driving force is compliance with the ADA. However, it is more likely to end up as an outcome of the desire for improved communication between the nurse and the client or community, rather than a coercive reason for instituting a change in behavior.

CHAPTER 4

PROJECT OUTCOME

Evaluation of Results

The evaluation of this project will take several forms. Social change theory incorporates basic systems theory as part of its structure. As such, the measurement of social change should be conducted at various levels (Thompson & Kinne, 1990). The impact of the educational presentation will be monitored at the individual level, with a recommendation for further evaluation at the system and suprasystem levels.

On the individual level, the change in the knowledge base of each of the participants will be evaluated by a pre- and post-test given at the time of the educational presentation (See Appendix C). Test questions will be designed to evaluate the beliefs and attitudes of the participant with regard to communication access for Deaf clients. The outcome will be considered positive if the post-test reflects an enhanced understanding of the special communication issues of Deaf people.

Limitations

It is of ultimate importance that the evaluation of this intervention be monitored periodically over time. This will ensure that the desired change remains in effect at all system levels past the initial wake of the intervention. A key concept in the management of change is the realization that the evaluation of change interventions and the recognition of the possible need for further interventional strategies are continual processes.

Summary

The educational program on Deaf awareness for professional nurses provides a framework for the author to implement this program in Yellowstone County, Montana. Through participation in this program, professional nurses have the opportunity to (a) share their experiences and feelings of working with deaf clients, (b) become sensitized to and aware of the existence of American Deaf culture as a distinct American subculture, (c) become educated to the special needs of Deaf clients, and (d) work toward the improvement of quality nursing care to the Deaf community.

Implications and Recommendations for Further Study

Further Evaluation of Change

As stated earlier, the evaluation of social change should be conducted at several levels. It is therefore recommended that in addition to the assessment of the educational program at the individual level, the impact of the program should be monitored at the system and suprasystem levels by nurses involved with the provision of health care to the Deaf community.

On the system level, a comparison study could be made on the utilization of qualified interpreters by health care providers. If the intervention has been successful, the number of health care providers requesting Certified Interpreters for their Deaf clients will increase. Another type of system evaluation can also be conducted through a survey of Yellowstone County's Deaf community. It is anticipated that a health care provider who has participated in this program will have increased consumer satisfaction.

Finally, a method of evaluating the suprasystem for change is to look for revisions in the institution's policy on communicating with hearing impaired persons. This policy

should closely reflect compliance with ADA guidelines. For Deaf persons that sign, the policy should also be similar to that of communication with non-English speaking persons.

Expansion of the Program

Nurses are not the only health care professionals who require cultural sensitization and education in order to improve quality of care. It is suggested that this educational program be expanded and modified to include providers in the medical, dental, and other allied health professions. Also, it is hoped that a program of this type will extend beyond the confines of Yellowstone County, Montana. Health care professionals striving to improve their quality of service in other rural areas would benefit from this program as well.

Implications for Nurse Researchers and Administrators

It has been noted that the amount of information regarding nursing practice and Deaf culture is limited. Transcultural nurse researchers have yet to make a substantial contribution to the literature on the Deaf culture. With the development of educational awareness programs on Deaf culture, it is expected that these scholars will become cognizant of the need for sound, qualitative research in this area.

Nurse administrators are in a position to implement change in institutional policy. Compliance with the Americans with Disabilities Act should only serve as a starting point from which to improve the quality of care to Deaf individuals. Nurse administrators are urged to create methods by which funding and policy will enrich the provision of health care to the Deaf community.

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APPENDICES

APPENDIX A

SUMMARY OF THE AMERICANS WITH DISABILITIES ACT

Summary of The Americans With Disabilities Act*

The Americans with Disabilities Act (ADA) was signed into law in July, 1990. One of the disabilities covered by the provisions of the ADA is hearing loss.

The ADA requires that hospitals and health care providers find ways to make sure that patients with hearing loss are safe, and that providers can communicate clearly with deaf and hard of hearing patients. Under the ADA, providers must have a way to communicate clearly with their deaf and hard of hearing patients.

Communication access means the actions that health care professionals take in order to make sure that deaf and hard of hearing individuals can communicate and understand. Title III of the ADA prohibits discrimination against deaf and hard of hearing people in places of "public accommodation". Public accommodation can mean the office of a health care provider. At no cost to the deaf person, providers are required to furnish help and services to make sure that deaf patients or the deaf family members of patients have communication access. These services include skilled interpreters for people who use ASL.

According to the Deaf Counseling, Advocacy, and Referral Agency, examples of when interpreters should be present:

- getting a medical history from a patient
- getting informed consent from a patient
- getting permission for treatment
- explaining a diagnosis
- explaining how the illness will be treated, and how the nurse practitioner/physician thinks the patient will respond to treatment
- talking to a patient before and after a major medical procedure
- explaining medication
- explaining medical costs and insurance
- explaining how to care for a patient after they leave the hospital

*Adapted from Cassella, N. (1998). "Rural Health Care Access for Deaf Clients". Manuscript in preparation.

APPENDIX B

OUTLINE OF EDUCATIONAL PRESENTATION

Outline of Educational Presentation

I. Pre-test on deafness

II. Welcome and Introduction

A. Discuss Purpose of the Program

1. Objectives

a. Recognize American Deaf culture as a distinct subculture within American society

b. Develop an awareness of the communication barriers between Deaf and hearing cultures

c. Understand the differences between hearing and Deaf people in terms of barriers to accessing health care

B. History of the Project

1. Personal interest

2. JAMA article

C. Interactive discussion

1. ASL story

2. Audience response to comprehension difficulties

3. Audience participation regarding experience with Deaf clients

4. Discussion on reasons for not using interpreters

III. Lecture portion

A. Defining the Deaf Community

1. Factors to consider:

2. Degree of hearing loss

3. Age of onset of hearing loss
    a. Pre- or Post-lingual
    b. Pre- or Post-vocational
4. Identification with the Deaf group
    a. Respect for Deaf culture
    b. Attitudinal v. audiometric deafness
    c. Use of American Sign Language (ASL)

B. Health Care and the Deaf

1. Handicap of Deafness
    a. Impairment - physiologic damage
    b. Disability - loss of hearing
    c. Handicap - communication barrier
        - most critical factor affecting health care!
2. Effect of Communication Handicap
    a. Inadequate health knowledge base
    b. Limited awareness of health history
    c. Misconceptions among hearing
    d. Incomplete communication

C. Application to Rural Health Care

1. Low population density
2. Less opportunity for interaction

3. Geographic barrier to services
4. Less awareness of health programs
5. Lower personal income

D. Implications for Rural Nurses

1. Recognize cultural differences and communication barriers
2. Assess the individual
3. Become familiar with local services
4. Commit to improvement of quality health care to Deaf individuals

E. Americans with Disabilities Act

1. Enacted to ensure the safety of hearing impaired individuals
2. Prohibits discrimination in places of public accommodation
3. Ensures communication access to deaf and hard of hearing persons
4. Communication access
    a. actions taken to ensure that hearing impaired persons can communicate and understand
    b. achieved by providing an environment where persons with hearing loss can communicate
5. Examples of Interpreter Use:
    a. Obtaining history, informed consent, permission for treatment
    b. Explaining diagnosis, treatment, prognosis
    c. During psychotherapy
    d. Communicating before and after a major medical procedure
    e. Explaining medication, medical costs, discharge instructions

IV. Break

V. Group Discussion

A. Group post-test about deafness

B. Problem solving on how to alter present practices

C. Discussion on potential barriers to health care for Deaf persons

D. Question and Answer Period

VI. Concluding remarks

APPENDIX C

PRE- AND POST-TEST ABOUT DEAFNESS

Deafness Pre (Post) Test

T F 1. Deafness is a visible disability.

T F 2. Hearing-impaired generally means all types of hearing loss from mild to profound.

T F 3. "Deaf and dumb" or "deaf-mute" are proper terms to use.

T F 4. Everything said vocally can be lip-read.

T F 5. All deaf people can lip-read.

T F 6. Lip-reading is a measure of intelligence.

T F 7. Sign Language is universal and the same.

T F 8. All deaf people use American Sign Language (ASL).

T F 9. Sign language is another form of English.

T F 10. Deaf people don't use the phone.

T F 11. Deaf people are not eligible for drivers licenses.

T F 12. Deaf people consider themselves handicapped.

T F 13. Deaf people avoid interacting with hearing people.

T F 14. Deaf people can't go to college.

T F 15. The majority of deaf people are unemployed.

T F 16. Deaf people don't dance.

T F 17. Medical professionals are knowledgeable of the various aspects and implications of deafness.

T F 18. Deafness is primarily a handicap of communication and language.

T F 19. In a clinic or hospital setting, the best person to assist in interpreting is a nurse or physician who has taken some sign language classes.

T F 20. It is a good idea to use a family member as an interpreter, since they know the client best.

T F 21. Deaf people around the world use ASL.

T F 22. Some ideas can be expressed only in English.

T F 23. ASL is among the ten most-used languages in America.

T F 24. People who were born deaf can't really learn English

T F 25. Facial expression is important in ASL.

Answers to Deafness Pre (Post) Test

1. Deafness is a visible disability.
    - **False** - Deafness is considered an "invisible" handicap

2. Hearing-impaired generally means all types of hearing loss from mild to profound.
    - **True** - Hearing-impaired generally mans all types of hearing loss from mild to profound

3. "Deaf and Dumb" or "deaf-mute" are proper terms to use.
    - **False** - These are antiquated words and create a negative image of deaf people. *Deaf, hard of hearing*, or *hearing-impaired* are preferred terms

4. Everything said vocally can be lip-read.
    - **False** - Only 30%-40% of English sounds are visible on the lips. The rest must be filled in or guessed through context.

5. All deaf people can lip-read.
    - **False** - Some deaf persons can lip-read, depending on the speaker, familiarity with English, etc. Lip-reading is a skill, like many other skills, for which some people seem to have more talent. The hardest situation to lip-read are lectures, T.V., and those with foreign accents.

6. Lip-reading is a measure of intelligence.
    - **False** - There is no apparent correlation between the level of speech-reading skill and intelligence.

7. Sign Language is universal and the same.
    - **False** - Sign languages vary from one country to the next. Many countries have two sign languages, equivalent to our Signed English and American Sign Language.

8. All deaf people use American Sign Language (ASL).
    - **False** - Deaf people vary in their communication mode and language, ranging from spoken English, to signed and spoken English, to various manual codes for English, to Pidgin Signed English (PSE) to various dialects of ASL. There are many regional variation in all types of sign language.

9. Sign language is another form of English.
    - **False** - ASL is a separate language with its own structure and grammar. PSE is a mixture of rules borrowed from English and ASL. Manual English is an imperfect code for spoken English.

10. Deaf people don't use the phone.
    - **False** - Deaf individuals do talk on the phone through the use of their residual hearing and telephone amplifiers, as well as through the use of computers, TTYs, Message relay services, and sign language interpreters.

11. Deaf people are not eligible for drivers licenses.
    - **False** - Many deaf people drive and have auto insurance. Statistically, deaf persons have above average driving records.

12. Deaf people consider themselves handicapped.
    - **False** - Deaf persons consider themselves normal.

13. Most Deaf persons would welcome a cure for deafness.
    - **False** - The cultural view of deafness rejects the assumption that medical progress toward treating the hearing defect is welcome. Since deafness is not considered a deprivation, talk of cures and breakthroughs is inappropriate and offensive to Deaf people.

14. Deaf people can't go to college.
    - **False** - Many deaf people go to college, either to one of the special college programs for deaf students, or to hearing colleges, with or without the use of an interpreter. Many deaf people hold Bachelor's or Master's Degrees.

15. The majority of deaf people are unemployed.
    - **False** - Most deaf people are able to find employment, although they continue to be under-employed, due to lack of understanding and flexibility on the part of their employers. Deaf people can hold competitive positions in a wide range of professional and technical fields.

16. Deaf people don't dance.
    - **False** - Many deaf people enjoy music and dance through the use of their residual hearing and the vibrations they feel

17. Medical professionals are knowledgeable of the various aspects and implications of deafness.
    - **False** - Many social service and medical professionals are grossly uninformed or misinformed about deafness, leading many families with deaf children or adults to choose unfortunate plans of action.

18. Deafness is primarily a handicap of hearing.
    - **False** - Deafness is primarily a handicap of communication and language.

19. In a clinic or hospital setting, the best person to assist in interpreting is a nurse or physician who has taken some sign language classes.
    - **False** - In this kind of setting a Certified Interpreter for the Deaf should be utilized, if the client requests an interpreter. To use anyone other than a qualified interpreter is a violation of the Americans with Disabilities Act. Similarly, a qualified interpreter should be present for the Deaf parent of a hearing child if the child is the client, or for the deaf child of hearing parents, and the interpreter is usually better prepared to explain illnesses and procedures to the deaf child. To use a person who has taken one or two classes in sign language as an interpreter would be similar to using a person who has taken Spanish 101 to interpret a medical consultation for a person who primarily speaks Spanish.

20. It is a good idea to use a family member as an interpreter, since they know the client best.
    - **False** - Family members should not be used as interpreters., A family member may not possess adequate interpreting skills or may be biased on such a way as to not fully interpret all communication. Also, it is imperative that family members not be utilized as interpreters without the specific consent of the client for obvious confidentiality reasons.

21. The best way to communicate with a deaf person is by using ASL.
    - **False** - The best way to communicate with a deaf person is by using the mode of communication with which they are most comfortable. For some deaf persons this could mean using ASL, for others, it could mean any of the other variations of sign language, or through writing, or via speech-reading. Deaf persons are individuals with unique personalities and skills.

22. Some ideas can be expressed only in English.
    - **False** - Every language has special words and phrases that are unique. Some ideas may be more neatly expressed in English; other ideas may be more neatly expressed in ASL. But there is no idea that can only be expressed in English; similarly, there is no idea that can only be expressed in ASL.

23. ASL is among the ten most-used languages in America.
    - **True** - With approximately 500,000 users (as of 1988), ASL ranks with German, French, and Portuguese as one of the most-used languages in America

24. People who were born deaf can't really learn English
    - **False** - There are an increasing number of scholars who were born deaf and who mastered the spoken language of their country.

25. Unfortunately, most Deaf people view themselves as needing help.
    - **False** - Deaf persons view themselves as a linguistic and cultural minority. Deaf persons are not in need of "help". They simply want access, education, and equal rights.