

GUIDELINES ON
CHILDREN'S ADVOCACY CENTER
SERVICES FOR CHILDREN WHO ARE
DEAF/HARD OF HEARING

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Preface

What began as a project of the Aetna Foundation Children's Center to develop a program that addressed the needs of Deaf/Hard of Hearing children has progressed to be guidelines specific to Children's Advocacy Centers (CACs). These Guidelines represent the work of many different individuals with a wide and varied background and knowledge in creating systems of service for Deaf/Hard of Hearing individuals. It is hoped that the Guidelines will assist the staff and team at CACs to provide the most appropriate and thorough response possible to children who are Deaf/Hard of Hearing and are seeking the unique services offered by a Children's Advocacy Center. These guidelines are offered to provide further guidance on ways that Children's Advocacy Centers may successfully meet the following NCA standards for Accreditation as they pertain to children with unique needs for services:

- Child-Appropriate/Child-Friendly Facility: A Child Advocacy Center provides a comfortable, private, child-friendly setting that is both physically and psychologically safe for child clients and their families.
- The CAC promotes policies, practices and procedures that are culturally competent.
- The CAC promotes forensic interviews which are legally sound, are of a neutral, fact finding nature, and are coordinated to avoid duplicative interviewing.

- The CAC promotes investigative interviews that are culturally competent (rated criteria).
- Specialized medical evaluation and treatment services are available to all CAC clients and coordinated with the multidisciplinary team response to provide follow-up referrals and/or treatment as necessary.
- Specialized mental health services must be made available as part of the team response, either at the Children’s Advocacy Center or through coordination with treatment providers.

By recognizing and responding to the specific needs of children who are Deaf/Hard of hearing, CACs can provide help and healing to children at high risk for continued or further abuse.

Incidence and Cultural Considerations

According to Gallaudet Research Institute, there are approximately two million people in the United States who are profoundly Deaf. (Durity, 2004). In addition, the same study reported that 50% utilize a communication mode other than speech and that about 40% have one or more disabilities in addition to deafness. As many as 90 % of Deaf /Hard of hearing children grow up in families with parents who either do not sign, learn minimal sign language, or who use gestures or home signs to communicate with their deaf child (GRI, 2002; Karchmer & Mitchell, 2003; Mitchell & Karchmer, 2004a). They may have been surrounded by rich language input, but were unable to access it; often unbeknownst to their caregivers, but sometimes because caregivers are aware but in denial and do not address the need for their children to learn communication skills. The struggle to reach cognitive and psychosocial milestones results not from the inability to hear, but rather because the environments that Deaf /Hard of hearing individuals live and grow up in are not designed to meet their needs.

With few exceptions, English is understood only 30 – 40 % of the time by lip-reading and auditory input constitutes the rest of what a Hard of Hearing person receives. In addition to being particularly or totally inaudible, many words look the same on the lips, such as bat, mat, and pat, leaving the lip readers to figure out the total message by “filling-in the blanks.” For example, if instead of asking “where did he touch you” an interviewer asks “What part of your body did your stepfather touch with his hand?” (after a child has disclosed that the stepfather touched her) gives the oral Deaf individual a greater opportunity for understanding the question since there are several expanded clues. Regardless of the communication mode chosen, there is limited opportunity to learn how to express or label human emotions. There is a limited sign language vocabulary of emotions, coupled with the inability to “hear” the depth of emotions via the auditory channel. In sign language the depth of emotion is conveyed by using facial expressions, whereas hearing people, in general, may not show depth of emotions on their faces.

In addition to the limited opportunity for learning about emotions, there is a lack of incidental learning such as occurs on the playground, in classroom conversations, casual conversations between adults in the same room, or on television. This absence of incidental learning results in pronounced information gaps about the world for the Deaf/Hard of hearing child. Additionally, there is a lack of appropriate cultural and linguistic resources related to education about safety and sexual abuse.

Deaf/Hard of hearing children often lag behind their hearing peers in the mastery of a first and primary language, and consequently, in acquisition of world knowledge. Prior to the recent advances in technology used to evaluate hearing and programs to screen newborns, many Deaf/Hard of hearing children were not diagnosed until after the age of two years, often missing several critical years of potential language acquisition.

Deaf/Hard of hearing individuals may experience a number of commonalities in their life experiences while growing up, but there is also great diversity within the population on many levels. At one end of the spectrum are children who have normal language development in American Sign Language (ASL), but do not read lips or use their voice. At the opposite end of the spectrum, are individuals with some hearing and ability to use spoken language with or without the assistance of technology, and who may or may not also use ASL or some form of signed communication. These children, who are usually referred to as “hard of hearing,” sometimes as “hearing impaired,” nonetheless function differently than fully hearing children in subtle but important ways.

Frequently, parents may not be aware of how much their hard of hearing child is actually missing and make the erroneous assumption that they do not need to learn to sign with the child because he or she is able to speak and understand spoken language. The trauma experienced as a result of physical or sexual abuse may then be intensified by additional trauma specifically related to communicative isolation (Harvey, 2003).

Deaf/Hard of hearing children also vary in terms of the etiology of their hearing loss, the presence or absence of other disabilities, language and educational experiences, and whether they were born Deaf/Hard of hearing or became Deaf after developing speech. They will generally exhibit social, psychological, and linguistic differences related to whether or not their parents are Deaf or hearing. The early acquisition of a fully accessible language, such as ASL, has a resounding effect on the Deaf child’s overall social, emotional, and intellectual development. Conversely, when Deaf/Hard of hearing children are unable to have full access to the language in which they are immersed, all areas of development are negatively impacted overtly and surreptitiously.

Knowledge of all the factors described above plays a critical role in helping the professional interviewer avoid erroneous stereotypes, generalizations or assumptions about subgroups within the population, and instead to focus on the individual needs of each Deaf/Hard of hearing child in a forensically sound and culturally affirming manner. Cultural competence in working with this population includes sensitivity to factors contributing to increased vulnerability to sexual abuse, which will be explained in the next section.

Sexual Abuse in the Deaf and Hard of Hearing Population

During the past two decades, it has been well-established in the literature on Deafness and abuse that Deaf/Hard of hearing children experience sexual abuse at rates significantly higher than hearing children. (Mertens, 1996; Sullivan, Vernon, and Scanlan, 1987). Deaf adults have reported that as children, they had experienced more frequent sexual abuse by a greater number of perpetrators and experienced overall childhood maltreatment one and one-half times more frequently than their hearing counterparts (Embry, 2001).

There are a number of reasons for the inflated rates. Deaf/Hard of hearing individuals often do not have equitable access to education and information as a whole. Instruction about sexuality and socially appropriate sexual conduct may not be provided, with the assumption that the students are incapable of understanding (Reynolds, 1997). In educational settings, teachers may not be sufficiently competent in the student's optimal language or communication mode to provide clear instruction and discussion on the topic. Without this knowledge, Deaf/Hard of hearing individuals may not realize that it is wrong for an adult (or adolescent) to be sexual with a child, or that they have the right to say "no" and not be touched or forced to participate in an activity with which they are uncomfortable. Victims may

blame themselves or feel guilty if they are physically responsive to unwanted stimulation (Potts and Lewis, 1989). If the perpetrator is someone who has been affectionate and kind to them, or who is a caretaker, the individual may be confused about what has happened even though something feels “wrong.” Or they may think this is something that happens to everybody (Reynolds, 1997; Mouny, 1988; Mouny and Fetterman, 1989; Westerlund, 1990, 1993).

Deaf children and teens, like many children without any disability, are often not believed by professionals or family members when they report abuse, and for a Deaf/Hard of Hearing child with a limited ability to communicate and speak for themselves in a hearing world, they are not able to counter the arguments of those who both speak for them and abuse them (Wambach, 2005). Given the vulnerability of this population, it is imperative that the forensic interviewing of Deaf/Hard of hearing children be approached with an appreciation of the unique experiences and needs of the population as well as recognition of individual differences, as these factors will impact interviewer-child dynamics and interviewing strategies. Furthermore, it is critical that Deaf/Hard of hearing children, as well as all children at risk for child sexual abuse, not be “re-victimized” during the forensic interview process by professionals who inadvertently create additional trauma by interacting with the child in ways that might be construed by the child as insensitive or culturally uninformed (Westerlund, 1990, 1993; Mouny and Fetterman, 1989).

Use of interpreters

Direct communication is preferable to using an interpreter. “Direct communication” can occur if the interviewer uses a language and communication mode that the child is agreeable to and one which she can best express him or herself. For many, if not most, Deaf children, this means that the interviewer, whether Deaf or hearing, must be highly proficient in ASL, a resource that this seriously

lacking in many Children's Advocacy Centers. Although the forensic interview is not an ongoing therapeutic relationship between the child and the interviewer, it involves highly emotionally-charged material which the child may have great difficulty revealing because of its very sensitive nature. It is important that the Deaf/Hard of hearing child understand that the forensic interviewer will be emotionally neutral during the interview, and this does not mean that they do not agree with or understand the child, and that this approach is used with all children of all abilities and disabilities. If at all possible, an interview conducted by a Deaf/Hard of hearing person is preferable to using interpreters because it can be empowering, validating, and comforting for the Deaf child to see another Deaf/Hard of hearing individual in a position of authority. For some children, this may be the first time they have met a person in authority who is deaf and who can sign fluently with him/her.

Title III of the Americans with Disabilities Act guarantees Deaf/HOH persons equal access to services, including the right to the services of a qualified interpreter for the Deaf. If a Children's Advocacy Center is fortunate enough to have a fluent signer on staff, that person may communicate directly with the Deaf client but should not attempt to serve as an interpreter between the Deaf/HOH client and other CAC staff. Nor should other non-certified fluent signers, such as family members or friends, serve as Interpreters. There are two types of Certified Interpreters: Manual, or Sign Language Interpreters, and Oral Interpreters (spoken English or other language).

Certified Interpreter for the Deaf: This is a hearing person who has fulfilled the requirements to become a Certified Interpreter. There is a range of training, skill, and experience levels among Certified Interpreters. Some are qualified to work in legal situations, and the CAC will usually want an Interpreter with that level of expertise. Certified Interpreters for the Deaf interpret in two ways – voice

to sign, and sign to voice. The Interpreter translates the words of the hearing person into American Sign Language (voice to sign) and the signs of the Deaf/HOH person into spoken language (sign to voice).

Certified Deaf Interpreter (CDI): A CDI is an Interpreter who is Deaf and who works in tandem with a hearing Interpreter to provide services for specialized populations within the Deaf Community. In addition to excellent communication skills and general interpreter training, the CDI may also have specialized training and/or experience in use of gesture, mime, props, drawings and other tools to enhance communication. The CDI has knowledge and understanding of Deafness, the Deaf Community, and/or Deaf Culture which, combined with excellent communication skills, can bring added expertise into both routine and uniquely difficult interpreting situations.

A CDI may be needed when the communication mode of a Deaf consumer is so unique that it cannot be adequately accessed by Interpreters who are hearing. Such situations may involve individuals who:

- use idiosyncratic non-standard signs or gestures such as those commonly referred to as "home signs" which are unique to a family
- use a foreign sign language
- have minimal or limited communication skills
- are deaf-blind or deaf with limited vision
- use signs particular to a given region, ethnic or age group
- are experiencing a situation which is highly emotional or confusing

- have characteristics reflective of Deaf Culture not familiar to hearing interpreters.

In these unusual situations, the CDI and the hearing Interpreter can work together as a team to make communication possible between the Deaf child or parent and the hearing CAC staff or MDT member.

The CDI observes the Deaf person's sign language or gestures and translates it into American Sign Language which s/he signs to the (hearing) Interpreter for the Deaf. The Interpreter speaks the message to the CAC staff or team member. When the Interviewer asks a question, the Interpreter for the Deaf signs the message in American Sign Language to the CDI. The CDI expresses it in language the child or parent can understand. Another possible approach to consider is that the Deaf individual may prefer to read the written questions and respond in writing. While this procedure may take longer and be somewhat tedious, it may be the preferred method of communication for the Deaf individual.

Oral Interpreters

Oral Interpreters facilitate spoken communication between individuals who are Deaf /HOH, who use speech and speech reading (lip reading) as their primary method of communication, and other persons. Oral Interpreters are used in settings where speech reading skills are not effective, such as in the classroom, conference, or other group setting, situations where the speaker is not present, such as telephone or public address systems, and situations in which the speaker is present, but his/her speech is difficult to speech read. The Interpreter employs a variety of skills and methods to convey the message and emotions of the speaker to the Deaf/HOH person. An Oral Interpreter may also be asked to "voice" for the Deaf/HOH person in situations where the voice of the Deaf/HOH person may not easily be understood by the listener(s).

Following a report of abuse and prior to scheduling the evaluation, the CAC will want to have as much information as possible regarding the Deaf child or parent's preferred form of communication

and skill level. (See Sample Intake Form) If the person uses sign language, the intelligibility to a Sign Language Interpreter will vary depending on the person's age, developmental level, education, skills, home environment, presence of other disabilities, emotional state, etc.

Unless it is clear that the child/parent will be understood by the Interpreter for the Deaf, it is wise to employ a CDI to work with the Interpreter for the Deaf as a standard operating procedure. This will avoid delays and potential miscommunication. If the CDI is not needed, s/he can leave. It is better to have the CDI present and not needed than to have the Team and family present for the Interview and have to wait while a CDI is called in.

The Interpreter(s) should know ahead of time any special signs the child may use, home signs, name signs, etc. The Interpreter should be present during the pre and post-Interview team meetings where the sharing of such information by service providers and parents may occur. The Interpreter(s) presence at those meetings is not for the purpose of providing consultation on Deafness, Deaf Culture, or for sharing opinions about the child or family, however.

Challenges in Interviewing Deaf and Hard of Hearing Children

Interviewing Deaf/Hard of hearing children is challenging for several reasons. First, the lack of language that is common in the population contributes to delays and gaps in cognitive and psychosocial development, which affects the way the interview must be structured. Second, the presentation of information to a visually-oriented individual and the translation of or rendering of questions in ASL requires cross-linguistic and intercultural competence, whether the interviewer is fluent in ASL or works with an interpreter. Third, Hard of hearing children may seem to understand but are in fact not getting clear or full information, miss the point, experience heightened confusion, and are at great risk for re-

traumatization. Finally, there is the need to understand that, particularly in smaller communities, there may be an overlap in relationships within this close-knit, somewhat insular community that may need to be explored to insure confidentiality of the interview and process.

The presence of one or more interpreters, in addition to the interviewer, may be overwhelming for a young child or a child not familiar with interpreters. The child may “freeze up” or dissociate even if they have the cognitive and language skills to provide reliable information. The child may experience confusion or embarrassment in front of the interpreter or interviewer and need additional time to feel comfortable with the interpreter, and also to understand the role the interpreter plays during the interviewing process. The child may direct her/his responses, questions, and comments to the interpreter rather than the interviewer, because the Deaf child will want to ensure, by reading the interpreter’s non-verbal cues, that the interpreter understands and can relate the content and emotions implicit in what they are saying. The forensic interviewer, whether they are working with an interpreter or not, should always address the child rather than the interpreter so that the child can “read” the emotions and non-verbal cues of the interviewer. Not all Deaf/Hard of hearing children have had experience working with interpreters and for some, the forensic interview may even be the first time. Others may have worked with interpreters primarily in school settings where the individuals providing interpretation or facilitation of communication may have had dual or multiple roles such as providing tutoring, functioning as a teacher aide or co-instructor, etc. Some Deaf/Hard of hearing children may not have the world knowledge, sophistication, or linguistic abilities to grapple with the construct of interpretation.

The Deaf child may try to read the facial expressions of the interpreter and/or the interviewer to see if she understood and if she is “saying the right things” and has gained the approval of the interpreter

and/or interviewer. When a Deaf child is engaged in a conversation with another person, she will look for facial cues to determine the mood, attitude, or feelings of the other person. The Deaf/Hard of hearing child who has experience working with interpreters may be vigilant in watching the interpreter to ensure that she delivers the message accurately to the interviewer. Deaf children are often aware they are frequently misunderstood by hearing people, and may become frustrated by the communication barrier and provide simplified, watered-down, or even contradictory responses because they get tired of repeating themselves or of having to explain again what they signed even with skilled interpreters.

Deaf and Hard of hearing individuals largely draw upon visual cues to determine what is happening in their environment and to facilitate communication. Also, the eyes can only be in one place at a time; if the child is drawing, reading, looking at a photograph or picture, the interviewer has to pause before continuing, to ensure the child is either looking at the interpreter or at the interviewer. The interview process will usually be at a slower pace and will take a longer amount of time to complete, whether the interviewer is communicating directly with a Deaf/Hard of hearing child, or working with a certified sign language interpreter. In most cases, at least twice the usual amount of time should be allotted. An exception may be when the child is developmentally on target with his/her chronological age and the interviewer can communicate fluently in the child's primary language and mode of communication. However, extra time should always be available to allow for more elaborated sentences that allow the Deaf/Hard of Hearing child more time to accurately interpret the content.

The needs of Hard of hearing persons (i.e., those who have a fair amount of facility with understanding and expressing themselves in spoken English) are often overlooked or only superficially understood. Although there are approximately 14 to 17 million Hard of hearing individuals in the United States, there are many professionals who fail to understand the unique psychological and

communication needs of this population as opposed to those who are profoundly and/or culturally Deaf (Harvey, 2003). Hard of hearing children as a group pose a unique set of challenges to the interviewer.

The interviewer will need to examine his/her own set of beliefs or preconceived ideas about hearing loss. Often, hearing persons assume that because the Hard of hearing person speaks clearly, they have the same ability to hear as a hearing person. They might also believe that if the Hard of hearing person is using a hearing aid or has a cochlear implant, they can hear normally. Communicating with Hard of hearing children usually requires the interviewer to make some modifications in how they speak, including the pace of delivery, stress, volume, and choice of terms, and to maintain eye contact and minimize background noise. It is important to note that Hard of hearing individuals often have trouble with localizing sound if more than one person is speaking, and there will likely be more missed communications if there is a delay in identifying the speaker.

Hard of hearing individuals also vary in their comfort with or preference for sign language in different situations. Some children with useful hearing for spoken language may not need an interpreter to communicate one-to-one with persons they know in familiar situations. However, those who know ASL may need or prefer sign support in unfamiliar situations such as the forensic interview. If possible, it should be ascertained prior to the child arriving for the interview if the child would prefer to use an interpreter, as the child may accede to the interpreters so as not to appear impolite.

Hard of hearing children often grow up in families in which parents and siblings serve as communication “brokers” for the child in situations with people unfamiliar with the child’s speech. In addition to interpreting for the child, “brokers” often serve as the sound alerter for the Deaf child, directing where they need to look to hear. For these reasons, it is important that only one CAC staff member serve as the “broker” for the child during the interview/exam when no family members may be

present. It is important for the child to know that the family members will not be helping with communication during the interview and why, and to be vigilant for signs that the child feels embarrassed, awkward, or reticent to inform the interviewer when she isn't able to understand.

Even when the interviewer is fluent in ASL, she will need to take time to evaluate the Deaf/Hard of hearing child's fund of basic knowledge about his/her family, background, knowledge of sexual signs, and vocabulary related to sexual and emotional topics. As with all forensic interviews, time must be set aside for rapport building between the interviewer and the child. Some children may not know the names of all family members or may have name signs for them but be unable to spell their names or understand how step-siblings or aunts and uncles may be related to the family. Having pictures or photographs of family members readily available can be helpful. It cannot be assumed that because of a Deaf child's chronological age, she has achieved a corresponding developmental age. Deaf/HOH children are likely to be delayed in their ability to express themselves and quite conceivably will have an impoverished vocabulary to convey subtleties related to emotions and psychosocial experiences. Similarly, compared with hearing children, Deaf/Hard of hearing children have far less opportunity to receive information about topics related to sexual abuse and personal safety unless it is taught to them directly.

Many Deaf children normalize their experience of having been sexually or physically abused because their fund of knowledge may be limited. More often than not, their parents are unable to communicate with them on a level sophisticated enough to explain what kinds of interactions are unacceptable or inappropriate, thus preparing them to deal with potentially abusive situations. In the absence of shared accessible communication, Deaf/Hard of hearing children and their parents cannot discuss the abuse that has already occurred, and there are likely to be misunderstandings if such

discussions or disclosures are attempted by the child or the parents. Communication issues may lead some parents to disbelieve a child who attempts to report abuse or inappropriate sexual experiences.

Deaf/HOH children, like many children, may discuss the abuse with their peers and discover that their friends have been abused also. This may serve to reinforce the Deaf child's perception that physical and sexual abuse "typically" occur, and subsequently, the child will not be inclined to tell an adult. The Deaf/Hard of hearing child may not realize that the abuse was wrong, or they may experience denial, shame, or guilt for not stopping or preventing the abuse (Mertens, Wilson, and Mouny, 2005). As a result of limited access to education about sexuality, appropriate intervention, and the insularity within the population; some Deaf adults may be survivors themselves and may normalize inappropriate and abusive sexual experiences, and thus possibly minimize or discount the veracity of reports made by their own children. A study of 47 cases of Deaf parents with Deaf and hearing children involved in the California Child Protective Services system found a high percentage (36 percent) of the mothers had been abused as children, were victims of domestic violence, were likely to be substance abusers, and were largely poor and unemployed (Charlson, 2005).

Hearing children ages 10 to 12 tend to have a basic understanding of the court process and why we have a legal system (Hoffman-Rosenfeld, 2004), but in the authors' experience Deaf/Hard of hearing youth generally do not have the signs/vocabulary necessary for a minimal understanding of what the judge and jury do, what a court reporter is, or what the bailiff's job might be. In addition to the importance of a sufficient foundation of vocabulary necessary for the child to express him/herself, another critical factor is the child's ability for memory and recall. If there is a deprivation of language, this can interfere with short-term and long-term memory functions, memory capacity, recall strategies, and organization (Edwards, 2004). These developmental differences may make the interviewing process

more challenging with Deaf/HOH children and require a commitment of additional resources, including consultation with various experts, use of interpreters, and specialized training for interpreters and consultants.

The Physical Environment for the Interview

Whether or not a Deaf/Hard of hearing individual uses sign language, it is important to be aware of the environment or setting in which the interview is conducted. Some environmental concerns to consider:

- Ensure there is not loud background noise occurring during the interview. This could include such noise as copiers, air conditioning, or ventilation systems that may be amplified by the child's hearing aid.
- Provide good lighting and a dark, solid background. Avoid standing in front of a window or strong light.
- Be sure the Deaf person has a good view of your face and lips. S/he may be trying to get some of the meaning by lip reading.
- Eliminate any distractions whether they are visual and/or auditory.
- Do not put obstacles in front of your face; such as covering your mouth with your hand
Eliminate anything placed on a table that would be a visual barrier, such as a flower vase.
- Ensure a good angle of vision so that the Deaf/Hard of hearing child can lip read the interviewer.
- Ensure that there are assistive listening devices if the child uses a device such as an FM system.
- Use visual aids (drawing, dolls, blackboard) as possible and make certain these are legible.
- Offer the option of written questions/answers if this seems more comfortable for the child.

Few CAC's have a forensic Interviewer who signs fluently. For those that do, the Interpreter for the Deaf will be interpreting the Interview for the observers. In most situations, however, the arrangement in the Interview room will be as follows:

- The child and the forensic Interviewer will face one another.
 - If a CDI is used, s/he will sit next to the CAC Interviewer. The (hearing) Interpreter for the Deaf sits next to the child and faces the CDI.
 - If no CDI is needed, the Interpreter for the Deaf sits next to the CAC Interviewer.

At CAC's where the Interview is videotaped, ideally there should be two cameras situated so as to record frontal views of everyone who is signing. Images from both cameras can be recorded simultaneously on a split screen.

Tips for Effective Communication

Due to their youth, Deaf/Hard of hearing children do not have the years of experience Hard of hearing adults have in learning how to navigate and cope with communication barriers in their everyday world. They do not have the expertise in knowing how to self-advocate by asking the interviewer to slow down or repeat what was missed or misunderstood.

Many Hard of hearing persons are not even aware that they are actually misunderstanding what the other person is saying because they have learned to habitually "fill in the blanks" during conversations with hearing persons. Thus, it is that likely a Hard of hearing child will nod in agreement to a question that they don't understand rather than ask for clarification or to have the question repeated. The child may also appear to be inconsistent in his or her recounting of what happened due to previous misunderstandings of the questions being asked. It is important for the interviewer to ask the child to paraphrase or repeat back the question to ascertain accurate understanding. The forensic

interviewer should find the following guidelines, offered by Trychin (1993, p. 43) helpful in interviewing Deaf/Hard of hearing children.

- Get the child's attention before you speak. Face, and speak directly to, the Deaf client.
- Accept that the Deaf person may be looking at the Interpreter.
- Remember that when the Interpreter speaks, he/she is not speaking for him/herself. The Interpreter is speaking for the Deaf person.
- The Interpreter must transmit everything that is being said by each party exactly as it is presented. Do not ask the interpreter to omit, change or add anything.
- Do not shout, exaggerate the movement of your lips, or overemphasize your speech
- Speak at a rate that allows you to enunciate each syllable, especially if the child lip-reads. Be aware that the interpreting process takes time. Occasionally the Interpreter may ask the speaker to slow down or repeat.
- Do not have anything in your mouth such as gum, candy, or food during the interview.
- Speak clearly and at a moderate pace.
- Use facial expressions and gestures.
- Give clues when changing the subject or topic.
- Rephrase when the child doesn't understand; don't keep repeating the same question over and over.
- Don't use a loud voice, expecting the child to "hear" you.
- Be patient, relaxed, and positive.
- Talk directly to the hard of hearing child, not the interpreter if present.

- When in doubt, ask the Deaf/Hard of hearing child what works best for them in terms of improving communication.

In addition to thinking about how to optimize communication access, the forensic interviewer must also be aware of the challenges of translating material from English to ASL, especially when legal terminology is involved. In American Sign Language (ASL), one first establishes the topic or subject to be discussed, and then asks questions about that topic or situation. Knowing the general context of the information or questions they are about to receive greatly increases the likelihood that the child will understand what is being said: Deaf and Hard of hearing individuals are often able to formulate a set of expectations regarding what is being communicated once they understand the context. The skilled signing interviewer will be able to make the shift between asking questions in a non-leading manner and using appropriate ASL to pose the questions. The certified interpreter should also have this ability and thus it is critical to use certified interpreters with extensive experience in forensic and mental health interpreting.

ASL and other signed languages of Deaf communities around the world are distinct in their composition from one another and the spoken languages of the countries in which they exist, but are similar in that they are tailored for the eye, rather than the ear. Pointing and touching are intrinsic parts of ASL and are used to establish pronouns such as “he,” “she,” and “they,” as well as to establish location. The sign “to touch” is the middle finger of the dominant hand gently touching/tapping the opposite hand, palm facing down, but when we talk about touching various parts of the body, or various parts of the body hurting, the sign is made at or near that body part. It has been postulated that natural signed languages are more suggestible in how they convey information (O’Rourke and Beail, 2004), and that this is potentially problematic in forensic contexts. However, these authors do not believe that

translation from a spoken to a signed language automatically results in leading questions because of the grammatical structure of the language. Rather, it may be the case that the language needs of some Deaf individuals require that more information be provided before abstract constructs can be presented. In this regard, the boy/girl drawings often used in a forensic interview can be very helpful in helping the child indicate what body parts were involved in the touching.

The court may be expecting a literal translation without feeding the child too much information; not leading the child, and so on; however, the translation between the two languages requires some contextual explanations, especially when the Deaf/HOH individual does not have the fund of knowledge needed to process the constructs being conveyed.

LaVigne and Vernon (2003) explore language and due process as it relates to Deaf/Hard of hearing individuals and the considerations are relevant to forensic interviewing of Deaf/Hard of hearing children. Deaf/HOH individuals may not have print literacy, or full (age-appropriate) competence in either ASL or English. This further complicates the ability to deal with terms that have specific connotations or usages, such as the defendant who enters a plea of “no contest,” thinking that this means he will not compete, as in some kind of race (LaVigne and Vernon, 2003, p. 883).

The individual who has lived with confusion and misunderstanding all her life may not recognize that she has not understood the question, let alone be aware of the ramifications of his/her response. A hard of hearing individual or a deaf person that uses spoken language as her primary means of communication may choose words that sound similar, look similar on the lips, or are configured similarly in print, but have a totally different meaning than the one she intends to convey. Other examples are individuals who unknowingly reply to a misunderstood question with an off- the-point response, choose signs that do not fit the intended meaning, or use signs that the interpreter understands to mean something different than

intended; all of which may result in the interviewer or prosecutor receiving a different message than was originally intended. The implications for the child/individual/victim, or the alleged perpetrator could be dire.

Other considerations:

The Deaf Community is small and closely connected, and confidentiality is a sensitive issue. All Deaf adults in a city, even a state, are likely to know one another. Further, they are also likely to know the Certified Interpreters, either from previous medical, social service, educational or other settings, or because the Interpreters may have Deaf family members.

Even though it is understood that the communication is strictly confidential, the client may be uncomfortable with certain Interpreters in the CAC setting. The Interpreter may also feel it is inappropriate for him/her to serve in some cases because of other connections to the family. Both the family and the Interpreter should be given the identity of the other prior to a CAC evaluation out of respect for the privacy of all concerned. Once an acceptable Interpreter is assigned, use the same Interpreter for all appointments at the CAC if at all possible.

Work with only a small number of self-selected Interpreters who have been oriented to the CAC purposes, services, and facility. These will be Interpreters who have the personal and professional qualities to work with the information revealed in child sexual abuse cases. You will want the most highly trained and experienced Interpreters for CAC cases.

The purpose of this article is to assist those in the child protection field to become aware of the unique needs of deaf and hard of hearing children while conducting a forensic interview. The interviewer must understand that the quality of the forensic interview depends largely on the interviewer's ability to

ask questions in a language and communication mode that the child is developmentally, cognitively, and culturally able to best understand and/or is most comfortable with.

Summary

Successful communication is generally the responsibility of both the speaker and the listener, but when working with a deaf or hard of hearing child, the investigator /interviewer must assume an increased responsibility for ensuring complete and accurate communication so as not to re-victimize the deaf or hard of hearing child during the forensic interview. It is important to learn as much as possible about the child's language and communication needs, experiences, and preferences in advance.

Working with qualified deaf and hearing consultants, as well as deaf and hearing professional interpreters, is essential. Even when the alleged abuse has occurred within the Deaf community or a school for deaf students, involvement of deaf professionals and support persons is often vital to empower and support the victim. Such consultation or involvement may be possible via distance technology when live meetings are not feasible.

General Considerations in the forensic medical examination of Deaf/Hard of Hearing Children

Whenever Deaf/HOH individuals present to a new setting, they are often concerned about their ability to understand what is occurring, what is expected of them, and whether their limitations will be understood by others. In their eagerness to adjust and please, Deaf and HOH children and adults may not request needed clarification or repetition for information they have received incorrectly or incompletely from staff they encounter at a Children's Advocacy Center. Deaf /HOH individuals customarily rely on family members to interpret, repeat, or alert them to people that may be speaking to them ("brokers" as mentioned above). They may be anxious about what they are missing in terms of

verbal and non-verbal communication and because they are visually-oriented, may constantly scan their environment for cues.

Medical professionals that conduct assessments of Deaf/HOH children should be aware and informed on how best to communicate prior to meeting the child. If the physician or nurse does not sign, and sign language is the communication of choice for the child, the physician will need to have the sign language interpreter present for all components of the examination. If this is the case, then the physician should ensure that he or she is always looking at the child rather than the interpreter when they speak. This not only shows respect to the child but also allows the child to “read” the emotional underpinnings that accompany the words which are then interpreted as sign. When the child replies, he or she may choose to look at the medical professional or may look at the interpreter. Regardless of where the child looks, the physician should continue to look at the child whenever he speaks to the child and whenever the child signs. If the child is able to lip read, then he or she may opt to communicate directly with the physician, or with an oral interpreter who is trained to repeat the words in an enunciated fashion that is more “readable” to the child. Regardless, the physician should maintain eye contact with the child whenever they are communicating. The physician should pronounce his/her words deliberately, enunciating each syllable but without exaggerated movement of the lips, speaking at a pace that allows him to do this. Oral Deaf individuals have acquired skills not only with lip-reading, but also in “filling in the blanks”; this includes the ability to understand a multi-syllabic word when only one or two syllables are heard, as well as the ability to intuit an entire sentence or the general context of the subject matter when only part of the words or explanation is heard. It may be easier for oral Deaf individuals to hear a sentence with elaboration of details than a brief sentence. For example, “Did any part of your body hurt when your stepfather touched you with his middle?” may be understood more

readily than “Did it hurt?” For these reasons, the medical professional should expect that any medical history conducted with a Deaf/HOH child will take longer even if they can speak directly to the examiner without an interpreter.

Preparation for the medical assessment

The number of people that the Deaf/HOH child has to talk to should be limited when possible. This may entail gathering the medical history during the course of a forensic interview if a sign language or oral interpreter is needed. If the medical professional is going to gather the medical history directly from the child, then he or she should also prepare the child for the exam, and maintain communication with the child during the entire time of their appointment, even if it involves a wrap-up session with a case manager or social worker. When one person is responsible for all facets of communication with the Deaf/HOH child during their appointment, this can greatly reduce the child’s anxiety about what they are missing and what is expected of them.

The clinician should take special care to carefully explain what will occur during each facet of the medical assessment. The child should be clearly told by the physician, “I will tell you everything that is going to happen before it happens.” A simple explanation should be provided to the child regarding the physician’s role: “It is my job to see how your body and your feelings are doing so I can figure out the best way to help you and to help your family. I am going to ask you some questions about whether anything has ever happened to you that made you sad, scared, mad or confused. Then I can figure out the best way to do the check up and the best way to help.” This introduction can be altered depending on the extent to which such information will be gathered by the physician.

The Medical History

The medical professional should attempt to follow their usual protocol and questions when gathering the medical history from a Deaf/HOH child. This includes taking the medical history in the presence of the parent if that is the physician's usual practice. It is useful to be informed of any language or developmental delays, or any other disabilities, prior to conducting the assessment. As discussed above, measures should be taken to reduce redundancy; for example, the physician should try not to ask any questions already answered during the forensic interview. However, if the Deaf/HOH child requires an emergent medical evaluation preceding the forensic interview, then the physician should gather the information necessary to appropriately diagnose and treat the child.

It is important to tell the Deaf/HOH child that if they are not certain of the question or information that the physician is providing they should request clarification or repetition as many times as they need to. They can be offered the option of writing down their answers or questions when other methods of communication seem inadequate. Because of the difficulty that hard of hearing children often have in communicating effectively with their parents, it is important to establish whether the child thinks their parents believe and/or support them. If the child thinks their parent does not believe them, or does not know whether their parent believes, then they may be reluctant to share information related to abuse because they fear it could anger the parent or lead to other unwanted circumstances, such as removal from their home. It is important to identify a supportive person outside of the home that the child can reliably trust and share their concerns and fears with.

The Medical Examination

After the medical history, it is important to tell the child what will happen during the examination component; the child should be informed of each procedure just before it occurs as well. The medical professional should first explain what each bit of equipment is and what it does prior to the child

disrobing. The child should be allowed to have the support person of their choice in the room during the exam, and the examiner should continue to speak directly to the child rather than to the support person in explaining the medical procedures and results of the exam. Every effort to maintain face-to-face contact with the child should be taken: raise the head of the exam table up so that the examiner can see the child during the exam and do not allow drapes, etc., to block this view. Do not “talk shop” with other medical staff or personnel during the examination other than to request swabs or specific assistance with procedures. Do not talk and perform a procedure at the same time; explain first, then perform the procedure. Because Deaf/HOH children are visually oriented, they may opt to view colposcopic images on the computer if the examination room is equipped in such a manner. In addition, drawings of the various examination positions (supine, prone knee-chest, etc) will greatly facilitate the child’s understanding of, and cooperation with, positioning. When the examination is done, have the child sit up, fully draped, and ensure that he or she understands the results of the examination prior to speaking with the parent.

Working with Parents

Working with hearing parents whose children are Deaf/HOH or with parents who are Deaf/HOH and whose children have normal hearing, each presents unique challenges. As discussed previously, many times communication between the parent and child in either of these situations is suboptimal. It is especially important to ensure that parents understand most examinations of sexually abused children and adolescents are normal but this does not mean abuse did not occur, and that the medical diagnosis, as well as the investigation, relies primarily on the child’s history. Due to communication difficulties, the parents may not know what the child has said about the abuse, and may not know or understand whether abuse occurred. It is incumbent that the medical and Children’s

Advocacy Center staff help the parents understand the importance of believing and supporting in the recovery of their child.

Summary

The medical assessment of a Deaf/HOH child who is a suspected victim of sexual abuse requires adequate planning to optimize both communication and comfort. Efforts to minimize the number of redundant questions, the number of CAC staff that communicates with the child, and the confusion inherent in a new environment will ameliorate the anxiety and trauma hearing impaired children may experience. Maintaining face-to-face contact with the child throughout the medical assessment, whether or not an interpreter is utilized, can help establish trust and cooperation with the child. Finally, the medical professional can provide important reassurance when examinations are normal that may facilitate healing and recovery for the child and their family.

Considerations for mental health treatment of Deaf/Hard of Hearing Children

In consideration of providing mental health treatment services to Deaf/HOH children, it is preferable to have a clinician that is either Deaf/HOH or fluent in sign language so that the clinician can communicate directly with the child. However, when this optimal plan is not available, mainstream therapists can moderate their practice to provide clinical services to Deaf/HOH children but there is much to consider, and many considerations must be made for this to work.

When working with any child, the clinician must have a more than adequate understanding of any cultural considerations that are present. This is particularly true when working with Deaf/HOH individuals. Not only must clinicians be aware of the oppression, stigmatization, and isolation that Deaf/HOH people often face, they must have extensive training and experience in working with children

who have been sexually abused. The trauma of the sexual abuse may be dramatically increased when combined with the issues of Deafness.

A clinician, who is not fluent in sign language, must find a certified interpreter that will commit to working with the clinician and client over the long haul. The clinician should prepare the interpreter for the types of traumatic information that will be discussed so that the interpreter can operate without emotional reaction to the information being processed. In addition, the interpreter must thoroughly understand the issues of client confidentiality related to the provision of mental health treatment.

The clinician should be sensitive to the language preference of the child. The child may prefer to read questions and write answers rather than use an interpreter. While this will make the sessions much longer, the child's preference for language should be followed where possible. The clinician should also take a good social history from the parent's and the child's perspective to ascertain the types of interactions the child has had with the hearing world, the child's level of comfort, the child's background and educational progress etc.

As noted in the above sections, the clinician should maintain facial and eye contact with the client, not the interpreter, even though the client will be gaining non verbal information from both the interpreter as well as the clinician. The National Child Traumatic Stress Network (www.nctsn.org) has created a number of well documented, thorough presentations related to the treatment issues of Deaf/HOH children. For further information, please see:

http://www.nctsn.org/nctsn_assets/pdfs/Trauma_Deaf_Hard-of-Hearing_Children_rev_final_10-10-06.pdf

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Glossary of Terms and Abbreviations

ADA: Americans with Disabilities Act. Federal legislation which guarantees access to education, the workplace, and public places for persons with disabilities.

ASL: AMERICAN SIGN LANGUAGE: A visual/gestural language used by many deaf people in the United States and Canada. Its grammar and syntax are not the same as English.

(Linguistic research during the past thirty years has demonstrated that American Sign Language (and any of the world's indigenous sign languages) meets all of the requirements for human languages - it is a rule-governed, grammatical symbol system that changes over time and that members of a community share. Sign Language consists of specific hand shapes, movements of the hand, specific locations of the hand, and facial expressions. Every country has its own sign language which has been developed by the Deaf population of that country. There are regional differences (dialects) in sign language, as there are in spoken languages. Deaf persons are often better able to communicate across national lines than are hearing people.

AMPLIFICATION: The use of hearing aids and other electronic devices to increase the loudness of sound so that it may be more easily received and understood.

ASSISTIVE LISTENING DEVICES: A group of systems, including personal hearing aids, FM systems and infrared systems, that enhance listening and auditory awareness for use of the telephone, television, amplified alarms and signals.

ATRESIA (medical term): Closure of the ear canal and/or absence of an ear opening.

AUDIO LOOPS / INDUCTION LOOPS: Assistive listening device which enhances the use of hearing aids in schools, theaters, religious settings, and public buildings and auditoriums. The ADA requires the inclusion of these systems in a host of public places.

AUDIOGRAM: A graph on which a person's ability to hear different pitches (frequencies) at different volumes (intensities) of sound is recorded.

AUDIOLOGIST: A licensed professional with a degree in the science of hearing (Audiology) who conducts hearing tests, evaluates hearing loss, and fits amplification devices. The audiologist is an important source for information on hearing aids, cochlear implants and other interventions.

AUDITORY/ORAL EDUCATION: An approach based on the principle that most deaf and hard-of-hearing children can be taught to listen and speak with early intervention and consistent training to develop their hearing potential. The focus of this educational approach is to use the auditory channel (or hearing) to acquire speech and oral language. The goal is for these children to grow up to become independent, participating citizens in mainstream society. Also known as Oral Deaf Education.

BACKGROUND / AMBIENT NOISE: Environmental noise that competes with the main speech signal.

BILATERAL HEARING LOSS: A mild to profound loss of hearing in both ears.

CDI (Certified Deaf Interpreter) – A Deaf person certified to interpret ASL into a gestural language system understandable to the Deaf client or patient. Able to understand unique language systems of the client/patient and translate communication into American Sign Language.

CART: See **REAL-TIME CAPTIONING**

COCHLEAR IMPLANT: An electronic device surgically implanted to stimulate nerve endings in the inner ear (cochlea). An external receiver and processor are worn like a hearing aid.

CODA (Child of Deaf Adults) - Many hearing children of Deaf parents grow up in a Deaf-Culture environment. They may learn to sign before they learn to speak. An international non-profit organization of the same name (CODA) was founded for this population of adult hearing children of deaf parents in 1983.

CONGENITAL HEARING LOSS: Hearing loss present at birth or associated with the birth process, or which develops in the first few days of life.

CUED SPEECH: A visual representation of the phonemes of spoken language, which uses eight hand shapes in four different locations in combination with the natural mouth movements of speech, to distinguish all the sounds of spoken language. It is offered by trained cued speech therapists.

EDUCATIONAL INTERPRETER: A person who is able to perform conventional interpreting, together with special skills for working in the educational setting.

FINGERSPELLING: Representation of the alphabet by finger positions in order to spell out words.

HOH (HARD OF HEARING): Hearing loss severe enough to interfere with school or work.

HEARING AID: An electronic device that conducts and amplifies sound to the ear.

HEARING IMPAIRED: This term has lost acceptance because of the term "impaired" which connotes negative meaning. The preferred term is "deaf and/or hard of hearing".

HEARING LOSS: Hearing loss was originally defined in medical terms before the development of modern audiology. Today, professionals tend to use the consistent, research-based terminology of audiology. The following numerical values are based on the average of the hearing loss at three frequencies: 500 Hz, 1,000 Hz, and 2,000 Hz, in the better ear without amplification. The numerical values for the seven categories vary among professionals.

Normal Hearing (-10 dB to 15 dB)

Slight loss (16 dB to 25 dB)

Mild loss (26 dB to 30 dB)

Moderate (31 dB to 50 dB)

Moderate/Severe (51 dB to 70 dB)

Severe loss (71 dB to 90 dB)

Profound loss (91 dB or more)

HOH: Hard of Hearing

HOME SIGNS: Gestural signs unique to a family, home, or small group.

IDEA : *Individuals with Disabilities in Education Act*

- a. Ensures that all children with disabilities have available to them a free appropriate public education that emphasizes special education, designed to meet their unique needs and prepare them for employment and independent living,
- b. Ensures that the rights of children with disabilities and their parents are protected,
- c. Assists States, localities, educational service agencies, and Federal agencies in providing for the education of all children with disabilities, and
- d. Assesses and ensures the effectiveness of efforts to educate children with disabilities

INTERPRETER OR TRANSLITERATOR FOR THE DEAF: A person who facilitates communication between hearing and deaf or hard-of-hearing persons through interpretation or transliteration. The Interpreter translates from one language to another, such as between Spoken English and American Sign Language.

LIPREADING: See Speechreading.

NAME SIGNS: Deaf, and many hearing signers, have "name signs", unique signs of identification. A person's name sign is based on something descriptive about the person, or on a hand shape from the manual alphabet, related to the person's given name, profession, physical characteristics, etc.

ORAL DEAF EDUCATION or ORALISM: An approach based on the principal that most deaf and hard-of-hearing children can be taught to listen and speak with early intervention and consistent training to develop their hearing potential. Also known as Auditory-Oral Education.


ORAL INTERPRETER or TRANSLITERATOR: Communicates the words of a speaker or group of speakers to an individual who is deaf by inaudibly mouthing what is said so that it can be read on the lips.

PIDGIN SIGNED ENGLISH (PSE), also known as Contact Signing. PSE lacks rules and therefore is not a true language. It is viewed by sign linguistics experts as a way to "bridge" the gap between native ASL speakers and native English speakers. It contains a mix of ASL rules and English grammar. The signs used in PSE come from ASL, but they are not used in an ASL way, but rather in a more normal English pattern.

POSTLINGUAL DEAFNESS: Loss of hearing after first learning a language.

PRELINGUAL DEAFNESS: Refers to hearing loss which occurs before the child develops language.

REAL-TIME CAPTIONING: On-line captioning for television screens and monitors giving the printed speech of live speakers.

(**CART** - Communication Access Realtime Translation) With this method, everything that is said is "captioned" live for deaf and hard of hearing clients, in classrooms, churches, meetings, and conferences.  The CART captioning may be on a small screen that can be read by only one deaf person, on an overhead (for a small group), or displayed on a large screen. The CART provider quickly types into a stenotype machine using machine shorthand, and the computer software translates that shorthand into captions, matching the shorthand against what is in a specialized shorthand dictionary stored in the computer. The process is so fast that there is hardly any lag time between what is said and what the deaf person is able to read.)

RELAY SERVICE: Relay services allow deaf and hard of hearing people to communicate with hearing persons on the telephone, using either a TTY or the internet, through a relay operator or communications specialist.

RESIDUAL HEARING: The amount of usable hearing which a deaf or hard-of-hearing person has.

SECTION 504: In the Vocational Rehabilitation Act of 1977, Section 504 provides for the accessibility needs of disabled persons.

SIDEKICK: Small, portable electronic communication device popular with the Deaf which attaches to the belt. It includes e-mail, instant messaging, Web browsing, calendar, phone, and other features.

SIGNED ENGLISH SYSTEMS: Sign systems developed for educational purposes, which use manual signs in English word order; sometimes with added affixes which are not present in American Sign Language. Signing Exact English and Seeing Essential English are two examples.

SIMULTANEOUS COMMUNICATION or SIM-COMM: Communication using both manual and oral methods. The new term for sim-comm is Sign supported speech.

SPEECHREADING. The interpretation of lip and mouth movements, facial expressions, gestures, elements of sound, structural characteristics of language, and topical and contextual clues. Sometimes referred to as lipreading.

TELEPHONE RELAY SERVICE – A service which allows people who cannot hear over the telephone to communicate with businesses and friends via an operator. People who have a telecommunication device for the deaf, TDD (also called TTY or TT), can type a written message to the operator who, in turn, verbally relays the message to the intended party or vice versa. (see also Video Relay Service).

TOTAL COMMUNICATION. using any means of communication – sign language, voice, fingerspelling, speechreading, amplification, writing, gesture, visual imagery. The sign language used in total communication is more closely related to English. The philosophy of total communication is that the method should be appropriate to the individual child.

UNILATERAL HEARING LOSS: A mild to profound loss of hearing in only one ear. Unilateral loss is now believed to adversely affect the educational process in a significant percentage of students who have it.

VIDEO RELAY SERVICE: This is similar to the Telephone Relay Service, but a relay operator provides translation between spoken word and American Sign Language (ASL), rather than spoken word and text. The hearing user communicates by voice, the non-hearing user communicates by video using ASL, and the relay operator serves as a liaison, communicating by voice to the hearing party and by video using ASL to the non-hearing party.

