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Look for the Signs: Occupational Therapists' Experiences with Deaf Culture

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Look for the Signs: Occupational Therapists' Experiences with Deaf Culture

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CERTIFICATE OF APPROVAL

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Abstract

While research suggests that the Deaf cultural and linguistic identities are often undervalued in healthcare settings (Lezzoni, O'Day, Killeen, & Harker, 2004), there is a lack of research exploring interactions between occupational therapy practitioners and culturally Deaf individuals. The purpose of this study was to explore the experiences of occupational therapy practitioners who have provided services to a Deaf client. Four practitioners were recruited to participate in qualitative interviews. The inclusion criteria were that within the last year, the practitioner had provided direct services to a Deaf client who primarily communicated via American Sign Language (ASL). Interpretive phenomological methods were used to analyze the transcribed interview data for themes. The first theme to emerge reflected on the therapists' experiences with cross-cultural communication. A second theme explored cultural etiquette, including the value of maintaining eye contact. A third theme was cultural perceptions and practice considerations for the participants, encompassing perceived impacts of particular deficits on this population. The fourth theme that emerged was striving for cultural knowledge with the intention of improving cultural sensitivity and overall quality of care. The experiences included in this study offered the potential for improving the cultural relevance of services for members of the Deaf community. This may improve the effectiveness of occupational therapy services, including strengthened rapport, improved ability to communicate, and better therapy outcomes. By understanding the impact of cultural considerations on practice for the Deaf community, practitioners might be more sensitized to the needs of other cultural groups.

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Chapter 1: Introduction

Imagine being prescribed a medication, without having any idea about what would happen if you took it or what the side effects would be. Imagine your provider explains a medical procedure you will undergo, using a language that you've never heard before. Imagine that you could not hear you name called in the waiting room, so after a long time of waiting you now you must re-schedule your appointment for next month. These are the realities that may await Deaf individuals when faced with communication barriers in healthcare settings (Sheppard, 2014; Steinberg, Wiggins, Barmada, & Sullivan, 2002).

Approximately 48 million Americans experience some degree of hearing loss (Clason, 2017). A large group of these Americans consider themselves to be members of the Deaf community, sharing cultural features such as language, history, art, entertainment, customs, and beliefs. Deaf as written with a capital "D" signifies a member of the Deaf identity, and deaf as written with a lowercase "d" refers to the disability of deafness as determined through the medical model (O'Brien, Kroner, & Placier, 2015). To function in a hearing world, there is often a demand for Deaf individuals to form relationships with hearing individuals. For example, over 90% of Deaf children are born to hearing parents, and 90% of Deaf parents have hearing children (Mitchell & Karchmer, 2002).

At the heart of the Deaf cultural community is a shared language, American Sign Language (ASL), which is a central component to the Deaf identity (O'Brien et al., 2015). ASL is a language completely distinct from English, including unique etiquette and syntax. Therefore, English is typically learned as a second language for prelingually Deaf individuals. The World Federation of the Deaf (WFD), an international organization that advocates for equal rights for Deaf individuals, advocated that signed languages should be recognized and respected, and societal services and information should be available in these signed languages (2016). The National Association of the Deaf (NAD) is a civil rights

organization in the United States that advocates for the rights of Deaf individuals on a national level in many areas of life, including improved access to healthcare services (2019). According to the NAD (2019), federal laws, including the American with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, support participation in healthcare services and effective communication with service providers. Under the ADA, service providers are required to provide appropriate auxiliary aids or services when necessary to support effective communication. These can include qualified interpreters, written materials, captioning, and computer-aided transcription services. However, there was evidence supporting that communication within a healthcare setting was challenging for an ASL user, potentially leading to serious health consequences and creating a fearful atmosphere (Olson & Swabey, 2017). Medication misuse and misconstrued diagnoses or treatment options were examples of adverse implications that resulted from miscommunications in healthcare settings (Scheier, 2009).

Healthcare providers acknowledging and incorporating their clients' cultural values into treatment can lead to improved client compliance, improved quality of care, and improved health outcomes (Henderson, Horne, Hills, & Kendall, 2018). Occupational therapy is an evidence-based healthcare profession that utilizes a client's meaningful occupations, or everyday activities, to create an individualized treatment plan that promotes their participation in daily life (American Occupational Therapy Association [AOTA], 2017). This is a client-centered profession, meaning "an occupational therapy practitioner will keep the focus on the things you need and want to do—your goals, your activities, your independence" (AOTA, 2017). Therefore, despite the client's condition or abilities, occupational therapy intervention is aimed at supporting and enhancing that client's functional performance from a holistic perspective. In the field of occupational therapy, it is

widely accepted that practitioners must consider the client's cultural context in order to effectively address quality and satisfaction with functional performance (AOTA, 2014). Benefits of culturally competent healthcare services included increased communication effectiveness and feelings of trust, increased ease of setting meaningful goals, and improved familial involvement (Murden et al., 2008).

Theoretical Rationale

A model of cultural competence developed by Campinha-Bacote (2002) provides a theoretical basis for conducting culturally sensitive healthcare research, assuming a direct positive correlation between level of provider competence and ability to provide culturally responsive services. This model, referred to as the Model of Care by Black & Wells (2007), "views cultural competence as a process, not an end point, in which health professionals continually strive to achieve the ability to effectively work within the cultural context of the client" (p. 46). This cultural competence was defined as the dynamic interaction between five domains: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural humility, a term included within cultural desire, was defined as the lifelong process in which a practitioner is passionately motivated to learn from various cultural informants and is genuinely open to accepting cultural differences in order to provide culturally responsive services (Campinha-Bacote, 2002). The process of developing cultural competence was represented by the dynamic intersection of these five domains. This intersection grows larger as the practitioner develops any of these domains, which indicated that the practitioner could provide higher quality services within their client's cultural context (Black & Wells, 2007). A review of the literature revealed that the effectiveness of occupational therapy services could be improved with increased cultural relevance.

Additionally, the literature indicated that the Deaf community often did not have its linguistic and cultural needs met in healthcare settings.

Chapter 2: Review of the Literature

Cultural Competence

One definition of a culturally competent healthcare system stated that it "acknowledges and incorporates…the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (Betancourt, Green, Carrillo, & Ii, 2003, p.294). Similarly, the definition proposed by Henderson, Horne, Hills, & Kendall (2018) stated "cultural competence is using one's understanding to respect and tailor healthcare that is equitable and ethical after becoming aware of oneself and others in a diverse cultural encounter" (p. 599). In other words, these definitions suggested that cultural competency within a healthcare setting recognizes the impact that culture has on one's experience of illness or disability, and promotes client-centered care and culturally relevant care in an effort to reduce healthcare disparities between cultures. Culturally competent healthcare services have led to improved client compliance, quality of care, and health outcomes (Henderson et al., 2018). It is also stated that cultural competence promoted "effective interaction, which results from healthcare providers applying their cultural skills in communicating with clients" (p.598). The Model of Care formed the theoretical foundation for this exploratory research and viewed cultural competence as a continuous process that practitioners actively engage in pursuit of providing more effective services to their client (Black & Wells, 2007).

Occupational therapy practitioners must consider the client's cultural context in order to effectively address quality and satisfaction with functional performance (AOTA, 2014). Based on their review of the literature, Murden et al. (2008) concluded, "effectiveness and quality of care can improve when culturally relevant occupations are selected, and interventions are meaningful to persons and made compatible with their values and

traditions" (p. 192). Additional benefits of culturally competent occupational therapy services, as identified by Murden et al. (2008), included increased communication effectiveness and feelings of trust, increased ease of setting meaningful goals, and improved familial involvement. Challenges that resulted from language or cultural barriers risk treatment compliance and outcome success for members of cultural minorities (Grandpierre et al., 2018).

Multicultural education opportunities have been shown to improve occupational therapy practitioners' perceived levels of cultural competence as well as the practitioner's skills and attitudes impacting culturally relevant care (Brown, Phillip Muñoz, & Powell, 2011). In a study by Murden et al. (2008) that surveyed occupational therapy students regarding multicultural education opportunities, 90% of respondents agreed or strongly agreed with the statement "cultural factors influence a client's occupational performance" (p. 196). Additionally, 95.8% of these same respondents agreed or strongly agreed with the statement "cultural factors should be considered in the occupational therapy process," and 98.6% of respondents agreed or strongly agreed with the statement "overlooking cultural influences could affect the outcome of the occupational therapy intervention" (p.196). When presented with the statement "how aware are you of methods to reduce cultural barriers?" 75% of these respondents reported limited to no awareness (p.198). Furthermore, 83.3% of the respondents reported little to no awareness of access to translation services. These results highlight the importance of considering cultural context during the occupational therapy process, as well as a need for strategies to reduce cultural barriers.

Multicultural education can introduce strategies for reducing cultural barriers during the occupational therapy process. Brown et. al (2011) also explored multicultural education that was incorporated into various occupational therapy programs and identified that cultural background and sociopolitical factors were content areas frequently addressed. The

multicultural practice skills identified as most important by these programs were choosing culturally relevant occupations and plans for care, interpreting the client's verbal and nonverbal language, and learning strategies for interviewing clients. Other practice skills that the respondent programs identified as important to develop were communicating effectively, locating appropriate resources for the client, and establishing rapport.

Deaf Culture in Healthcare

A Deaf person is often regarded as a hearing person who is lacking their ability to hear (Shinton & Mairs, 2009). While deafness tends to be regarded as a disability based on the inability to hear, members of the Deaf community do not consider themselves as having a disability (McAbee, Dragsow, & Lowrey, 2017). Baynton, Gannon, & Bergey (2007) described the Deaf community as "a cultural, linguistic minority within the larger hearing population" (preface viii). Members of the Deaf community proudly share the same culture, sculpted by language, history, art, entertainment, beliefs, and so much more.

The Deaf culture includes values, behaviors, and traditions that dictate how Deaf individuals interact within both the hearing world and the Deaf world. According to Bayton et al. (2007), "these cultures do not include all who lack hearing but rather those deaf people who use sign language, share certain attitudes about themselves and their relation to the hearing world, and identify themselves as part of a Deaf community" (p. 4). A shared history unites the Deaf community as well as produces variations of the culture within it. According to Padden and Humphries (2006), "the collective experience of Deaf people is not necessarily one that every Deaf person shares or even knows directly, but the residue of this history permeates the experience of Deaf people" (p.142). The Deaf culture encouraged adapting the environment to support vision as the primary sense for sharing and obtaining information, in addition to dictating etiquette for social interaction including rules for turn-taking and the value of maintaining eye-contact (Gallaudet University, 2015). Additionally, appropriate

ways for gaining a Deaf person's attention included gently tapping their shoulder, waving within their line of sight, or flicking a light switch a few times. While there is no written form of the community's shared language, American Sign Language (ASL), a rich variety of unwritten literature is expressed through performance art. This includes poetry based on visual patterns that is performed live or digitally recorded. Bayton et al. (2007) also claimed that a Deaf person marrying another Deaf person serves as an expression of cultural values. A wide variety of social, political, and economic organizations formally represented the values of the Deaf community. These included The National Association for the Deaf, local Deaf clubs, The National Fraternal Society of the Deaf, and several newspapers or magazines written by and for Deaf people (Bayton et al., 2007).

Scheier (2009) concluded that "healthcare professionals are often not cognizant of Deaf culture and values and therefore do not understand Deaf behaviors" (p.9). Absence of awareness and inclusivity of Deaf cultural needs had led to diminished accessibility and quality of healthcare services for Deaf individuals (Sheppard, 2014). As stated by Kuenburg, Fellinger, and Fellinger (2016), this lack of knowledge "may lead to assumptions and misconceptions about deafness that undermine professional care" (p.2). The term *audism* refers to discrimination against Deaf individuals based on their inability to hear (Eckert & Rowley, 2013). According to Bauman (2004), "audism manifests itself in beliefs and behaviors that assume the superiority of being hearing over being Deaf" (p. 240). Blackaby (2018) asserted that exposure to oppression and prejudice behaviors may have contributed to feelings of distrust towards healthcare professionals; especially healthcare professionals that were strongly influenced by the medical model and therefore considered health to be an "absence of disease" (p.7). When a healthcare provider focused on deafness as a disability, that Deaf individual often considered themselves a "medical abnormality" or felt "damaged and broken" (Sheppard, 2014, p.508-509). Furthermore, Sheppard (2014) found that

negative experiences often led to Deaf individuals declining preventative health measures or avoiding healthcare interaction altogether.

Deaf Communication in Healthcare

At the heart of the Deaf culture is a shared language, ASL, which is a central component to the Deaf identity (O'Brien et al., 2015). "What makes Deaf people a cultural group instead of a simply loose organization of people with a similar sensory loss is the fact that their adaptation includes language" (Bayton et. al, 2007, p. 4). Sheppard (2014) identified that the greatest difficulty that culturally Deaf individuals experience in healthcare settings is a communication barrier. Kuenburg et al. (2016) reported that "language and communication barriers have been linked to challenging health care access in culturally and linguistically diverse populations" (p.1). In addition to scheduling appointments, miscommunication between a healthcare provider and Deaf client has led to adverse outcomes, including errors in medication use (Laur, 2018). Meador and Zazove (2005) included an anecdote to demonstrate this risk of medication misuse as a result of miscommunication. In this anecdote a Deaf mother poured antibiotics into her daughter's infected ear, misinterpreting the instructions for liquid oral antibiotics that were meant to be ingested. A Deaf woman described in Steinberg et al. (2002) believed pills prescribed to her may have terminated her pregnancy, recalling a lack of clear communication with her doctor regarding the pills purpose prior to use. Communication challenges often contributed to a Deaf client's feelings of fear, mistrust, and frustration while accessing healthcare services (Steinberg, Barnett, Meador, Wiggins, & Zazove, 2006)

A common misconception about ASL is that it is derived from English, when in actuality ASL utilizes a unique syntax structure (Lezzoni, O'Day, Killeen, & Harker, 2004; Pendergrass, Nemeth, Newman, Jenkins, & Jones, 2017; Scheier, 2009; Steinberg et al., 2006). English is typically learned as a second language for prelingually Deaf individuals,

where hearing is lost before age 3, which is a challenging task (Steinberg et al., 2006). Upon high school graduation, these individuals typically read on average at a fourth grade reading level (Bat-Chava, Martin, & Kosciw, 2005). Though these language differences exist, many primary ASL users found themselves expected to communicate through written English in healthcare settings (Lezzoni et al., 2004; Pendergrass et al., 2017; Scheier, 2009; Steinberg et al., 2006; Steinberg et al., 2002). Despite their level of education or primary language, some members of the Deaf community have felt their physicians perceived them as "stupid" or "unintelligent" based on errors in written English (Lezzoni et al., 2004; Meador & Zazove, 2005). Speechreading, or the process of reading spoken English from the speaker's lips without auditory input, was another inadequate form of communication often relied on during healthcare interactions (Lezzoni et al., 2004; Scheier, 2009; Sheppard, 2014; Steinberg et al., 2006; Steinberg et al., 2002). On average, researchers reported that 30%-45% of spoken English words were distinguishable while speechreading (Scheier, 2009; Sheppard, 2014; Steinberg et al., 2002). Shainton & Mairs (2009) concluded that speechreading "is visually tiring and stressful and often relies heavily on second guessing what is being discussed" (p. 181).

A number of researchers found that the use of a certified ASL interpreter to mediate the language barrier often improved overall effectiveness of communication in a healthcare setting (Pendergrass et al., 2017; Sheppard, 2014; Steinberg et al., 2006). Olson & Swabey (2017) asserted that "interpreting involves conveying a message from one language to another language and occurs in real time between people who do not use the same language" (p. 191). In other words, an interpreter must be able to understand what is being said in one language and deliver that same meaning to the recipient in another language by adapting to the syntax and context of each respective language. However, access to certified ASL interpreters has been reported to be a challenge in healthcare settings (Olson & Swabey,

2017; Skøt, Jeppesen, Mellentin, & Elklit, 2017). In some instances the Deaf client preferred not to use an interpreter, for reasons including privacy concerns and discomfort if the same interpreter had previously been used in another setting (Scheier, 2009; Sheppard, 2014; Skøt et al., 2017). Deaf ASL users may have relied on a family member or friend to interpret for them, an arrangement that was often inadequate in healthcare settings (Pendergrass et al., 2017; Scheier, 2009; Skøt et al., 2017; Steinberg et al., 2006). Some reasons for this inadequacy include unfamiliarity with healthcare jargon, compromised privacy, client feelings of exclusion, diminished ability to speak freely due to the relationship with the interpreter, or accidently or intentionally mistranslated information.

Problem Statement

There is research showing that the Deaf community often does not have its linguistic and cultural needs met in healthcare settings and research showing that increased cultural-relevance improves the effectiveness of occupational therapy services. However, there is currently a lack of research exploring interactions between occupational therapy practitioners and culturally Deaf individuals, including strategies for communication and an understanding of Deaf culture. The purpose of this study was to explore the experiences of occupational therapy practitioners who have provided direct skilled services to a member of the Deaf community. The knowledge gained in this study has the potential to improve the quality of occupational therapy services for the Deaf population, including improved communication effectiveness and better rapport with clients. The study aimed to answer the following questions:

- What are the experiences of occupational therapy practitioners providing clinical services and communicating with Deaf clients?

- How do these occupational therapy practitioners recognize or consider Deaf culture in their clinical practice?

Chapter 3: Methodology

Research Design

Occupational therapy practitioners were asked to share how they experienced the phenomenon of providing skilled services to a Deaf client. Consistent with hermeneutical phenomenology (Creswell & Poth, 2018), the meaning of each practitioner's experience was interpreted to explore the impact on occupational therapy practice with this population. The proposal for this study (Appendix A) was reviewed and approved by the Ithaca College Institutional Review Board with the approval number IRB 0918-08 (Appendix B).

Research Team

Kelsey Englerth conducted this research study in partial fulfillment of the research requirement of the degree of master's of science in occupational therapy at Ithaca College. She previously had completed her bachelor's degree in occupational science at Ithaca College, including all research coursework in the curriculum. Coursework consisted of a research methods course, a quantitative concepts course, and a research seminar during which she refined skills needed to produce a written research report and worked closely with faculty to develop a research design. Kelsey has also completed a Deaf Studies minor at Ithaca College, participating in coursework exploring Deaf culture and learning American Sign Language.

Dr. Carole Dennis was a full-time professor in the Occupational Therapy Program at Ithaca College and served as the primary advisor for this study. Dr. Dennis had previously collaborated with students and colleagues in a variety of research studies and had experience advising occupational therapy students on their theses. She also had experience with the methodology employed in this study. Dr. Shannon L. Scott was an assistant professor in the Occupational Therapy Program at Ithaca College as served on the committee for this study. Her doctoral dissertation included a qualitative component.

Kip Opperman was a lecturer of American Sign Language and Deaf Culture at Ithaca College. He was involved with the local Deaf community and also worked as an American Sign Language interpreter in a variety of settings. His knowledge and expertise helped promote accuracy of the information and integrity of the referenced sources.

Recruitment and Participants

Occupational therapy practitioners were recruited using a snowball approach. Each member of the research team distributed an e-mail invitation to personal and professional contacts. This e-mail introduced the study and requested that the invitation be shared with the recipient's colleagues (Appendix C). As outlined in the Informed Consent Form (Appendix D), occupational therapy practitioners were given a $25 gift card for their participation in the interview process.

This study included four occupational therapy practitioners who had provided direct skilled services to a Deaf client, including evaluation and treatment, within the year prior to interview. American Sign Language (ASL) was the Deaf client's primary method of communication. Two of the participants were school-based therapists in schools for Deaf children, therefore they had consistent interaction with the Deaf community (SB-1 and SB-2). Another participant was an occupational therapist in an outpatient setting who had treated many Deaf clients in the year prior to interview and over her career (OP). The final participant was an occupational therapist in an inpatient rehabilitation setting who had worked with one Deaf client within the year prior to her interview and over her career (IP). Table 1 depicts relevant demographic information for the participants of this study.

Data Collection and Analysis

Each participant agreed to participate in qualitative interviews regarding their experiences with Deaf culture on two separate occasions. According to Yin (2016), qualitative interviews follow a conversational approach and use an individualized set of

open-ended questions to truly understand the participant's world. Field notes were recorded during each interview to assist with this process. Time between each interview allowed the participants to further reflect on their responses and allowed the researchers to analyze responses for opportunities to increase depth of information. Participant responses were video-recorded and transcribed for analysis using a private TEMI account.

Interpretive phenomenological methods set forth by King, Horrocks, and Brooks (2019) were used to analyze the transcribed interview data for themes. This process involved familiarization with the data, identifying a comprehensive list of themes that encompass all information relevant to the research questions, and then clustering overlapping themes to better represent commonalities across the data. Participants were asked to verify the researcher's understanding of their responses in order to ensure an accurate representation of their experiences and increase trustworthiness of the data. To further establish trustworthiness of the data and ensure quality, peer-debriefing among the research team was regularly practiced. Limitations of the study included a relatively small sample size and a reliance on participant recall. Additionally, Kelsey Englerth was a novice researcher on the team. Consistent with risk associated with qualitative interviews and interpretive thematic analysis, researcher bias may have influenced the study.

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Chapter 4: Manuscript

Background

While a Deaf person is often regarded as a hearing person who is lacking their ability to hear, members of the Deaf community do not consider themselves as having a disability (McAbee, Dragsow, & Lowrey, 2017; Shinton & Mairs, 2009). Baynton, Gannon, and Bergey (2007) described the Deaf community as "a cultural, linguistic minority within the larger hearing population" (preface viii). Deaf as written with a capital "D" signifies a member of the Deaf identity, and deaf as written with a lowercase "d" refers to the disability of deafness as determined through the medical model (O'Brien, Kroner, & Placier, 2015). Deaf culture has united the Deaf community through a shared history, artistic expression, behavioral etiquette, and a set of values and beliefs, along with much more (Padden & Humphries, 2006). At the heart of Deaf culture is a shared language, American Sign Language (ASL), which is a central component to the Deaf identity (O'Brien et al., 2015).

Absence of awareness and inclusivity of Deaf cultural and linguistic needs has had a significant impact on accessibility and quality of healthcare services for Deaf individuals (Sheppard, 2014). Scheier (2009) concluded that "healthcare professionals are often not cognizant of Deaf culture and values and therefore do not understand Deaf behaviors" (p.9). In fact, "negative encounters between Deaf patients and hearing providers held such significance" that Deaf individuals would often forgo preventative healthcare "and even shun health care entirely" (Sheppard, 2014, p.508). According to Kuenburg, Fellinger, and Fellinger (2016), a lack of awareness of Deaf cultural and the health needs of Deaf individuals "may lead to assumptions and misconceptions about deafness that undermine professional care" (p.2). For example, research conducted by Sheppard (2014) indicated that focusing on deafness as a disability may have led Deaf children to consider themselves a

"medical abnormality," leaving that individual "feeling broken and damaged" even in their adult life (p.508-509).

Sheppard (2014) identified that the greatest difficulty that culturally Deaf individuals experience in healthcare settings is a communication barrier. According to Kuenburg et al. (2016), "language and communication barriers have been linked to challenging health care access in culturally and linguistically diverse populations" (p.1). Miscommunication between healthcare providers and Deaf individuals has led to an incomplete or inaccurate medical history, as well as lead to adverse outcomes including misunderstood diagnosis, errors in medication usage or following medical advice, and difficulty scheduling appointments (Laur, 2018). Communication challenges often contributed to Deaf person's feelings of fear, mistrust, and frustration while accessing healthcare services (Steinberg, Barnett, Meador, Wiggins, & Zazove, 2006). A common misconception is that ASL is derived from English, when in actuality ASL is a distinct language that utilizes its own unique syntax structure. This has often led to inadequate methods of communication being relied upon in healthcare settings including written English or Speechreading, which is the process of reading spoken English from the speaker's lips without auditory input (Lezzoni, O'Day, Killeen, & Harker, 2004). Shinton and Mairs (2009) concluded that speechreading "is visually tiring and stressful and often relies heavily on second guessing what is being discussed" (p. 181), as many words are indistinguishable on the lips alone. While the use of a certified ASL interpreter to mediate the language barrier often improved overall effectiveness of communication in a healthcare setting, access to certified ASL interpreters was a challenge in healthcare settings (Olson & Swabey, 2017). The process of interpreting involves transferring a message between languages, preserving the underlying meaning to ensure both parties understand the message in the same way.

Occupational therapy is a client-centered profession that utilizes evidence-based rationale and a client's meaningful occupations, or everyday activities, to create an individualized treatment plan that promotes participation in daily life (American Occupational Therapy Association [AOTA], 2017). In the field of occupational therapy, it is widely accepted that practitioners must consider the client's cultural context in order to effectively provide services that address both the quality of and satisfaction with functional performance (AOTA, 2014). In a study by Murden et al. (2008) that surveyed occupational therapy students regarding multicultural education opportunities, 90% of respondents agreed or strongly agreed with the statement "cultural factors influence a client's occupational performance" (p. 196). Additionally, the *Principle of Autonomy* within the Occupational Therapy Code of Ethics requires occupational therapy practitioners to accept an ethical responsibility to "facilitate comprehension and address barriers to communication" with regards to cultural and language difference (AOTA, 2015, p. 5). The Model of Care (Campinha-Bacote, 2002), assumes a direct correlation between the level of provider competence and the ability to provide culturally responsive services. *Cultural competence*, according to the Model of Care is "a process, not an end point, in which health professionals continually strive to achieve the ability to effectively work within the cultural context of the client" (Black & Wells, 2007, p. 46). This model assumes that a practitioner can provide higher quality services within the client's cultural context through an intersection of five domains: *cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire* (Camphina-Bacote, 2002).

Benefits of culturally competent healthcare services include increased communication effectiveness and feelings of trust, increased ease in setting meaningful goals, and improved familial involvement (Murden et. al, 2008). Additionally, acknowledging and incorporating

the client's cultural values can lead to improved client compliance, improved quality of care, and improved health outcomes (Henderson, Horne, Hills, & Kendall, 2018). Conversely, language or cultural barriers pose a risk to treatment compliance and outcome success for members of cultural minorities (Grandpierre et al., 2018).

Problem Statement

There is research showing that the linguistic and cultural needs of the Deaf community are often overlooked in healthcare settings (Sheppard, 2014). However, there is currently a lack of research exploring the interactions between occupational therapy practitioners and culturally Deaf individuals, including strategies for communication and an awareness of Deaf culture. The purpose of this study was to explore the experiences of occupational therapy practitioners who have provided direct services to a member of the Deaf community. The knowledge gained from this study has the potential to improve the quality of occupational therapy services for the Deaf population, including improved communication effectiveness and rapport with clients. This study aimed to answer the following questions: what are the experiences of occupational therapy practitioners providing clinical services and communicating with Deaf clients, and how do occupational therapy practitioners recognize or consider Deaf culture in their clinical practice?

Methods

This study utilized a hermeneutical phenomenological design (Creswell & Poth, 2018). Recruitment for this study used a snowball sampling approach to select participants who met the inclusion criteria. In order to be a candidate for this study, participants were required to be an occupational therapy practitioner who had provided services to a Deaf client within the year prior to their interviews. ASL was the Deaf client's primary method of communication. Each participant completed semi-structured qualitative interviews on two

different occasions and were asked open-ended questions about their experiences in providing skilled occupational therapy services to a Deaf client. Interpretive phenomenological methods set forth by King, Horrocks, and Brooks (2019) were used to analyze the transcribed interview data for themes. This process involved familiarization with the transcribed data, identifying a comprehensive list of themes that encompassed all information relevant to the research questions, and then clustering overlapping themes to better represent the commonalities across the data. Member-checking occurred throughout the interview process, when participants were asked to verify the researcher's understanding of their responses in order to ensure an accurate representation of experiences and increase trustworthiness of the data.

Kelsey Englerth was a graduate student in a combined Bachelor's of Occupational Science and Master's of Occupational Therapy program at Ithaca College. She had completed all research coursework in the curriculum, as well as a Deaf Studies minor at Ithaca College. The research team also included Dr. Carole Dennis and Dr. Shannon L. Scott, who were faculty members in the Occupational Therapy Program at Ithaca College with experience utilizing the methodology employed in this study. Kip Opperman, who was a lecturer of ASL and Deaf Culture at Ithaca College, informed the study with expertise regarding these topics as well as his extensive experience with the Deaf community. To further establish trustworthiness of the data and ensure quality, peer-debriefing among this research team was regularly practiced.

Results

Table 1 provides relevant demographic information for the participants of this study. Four primary themes emerged from interpretive phenomenological analysis of the transcribed data: communication methods, interaction etiquette, cultural perceptions and awakenings,

and striving for cultural knowledge.

Theme 1: Communication Methods

Communication methods that were employed by the participating occupational therapy practitioners included ASL, writing back and forth, speechreading, using an interpreter, Picture Exchange Communication System (PECS), and an iPad app for translation services. The occupational therapy practitioners reported varying degrees of perceived success with these methods.

The two participants from medical settings perceived the use of an interpreter to be the easiest and most effective way to communicate with Deaf clients. SB-1 used an interpreter to explain complicated results during family conferences, when risk of miscommunication was high. SB-2 said that an interpreter is the best way to "respect their right to have full access to language." Additionally, IP described the unique experience of using both a hearing interpreter and a Deaf interpreter at the same time to communicate with her Deaf client. She understood the rationale for this to be "the person who is Deaf is able to describe and communicate more effectively to someone who is also Deaf versus somebody who is hearing and has learned signed languages."

Three of the occupational therapy practitioners stressed the importance of maintaining eye contact with the client instead of the interpreter, stating in their experience this may not be the natural inclination of a hearing therapist. OP felt most successful with interpreters who found a way to incorporate the client's emotions into their signing. The environment in participant SB-1's setting was set up with round or oval tables, which facilitated the use of ASL and an interpreter because each person had a clear view of who was signing. Other environmental factors that supported the use of signing included wider hallways to allow signers to walk next to each other and increased number of windows throughout the building

to sign through. Another effective strategy that SB-1 identified was collaborating with the interpreter prior to the start of a meeting to decide how occupational therapy lingo would be translated. For example, as no signs for the terms "visual perceptual" or "sensory processing" exist, extra collaboration was required to ensure that the meaning was preserved across languages.

Across the interviews, participating therapists mentioned a lack of access to certified interpreting services. Both occupational therapy practitioners in medical settings described multiple instances where an interpreter was not available at the time of the appointment and sessions were therefore conducted using an alternate communication method. In order to improve the likelihood that interpreting services could be provided, they needed to schedule appointments far in advance. SB-2 was motivated to learn ASL partially because it would allow her more flexibility when scheduling sessions. Additionally, this same occupational therapy practitioner believed that as information was adjusted through the interpreting process to ensure student understanding, the interpreter would occasionally provide more direction than the therapist was intending, consequently guiding the client's behavior or approach to the task in a particular way.

Theme 2: Interaction Etiquette

The occupational therapy practitioners reflected on their interactions with Deaf clients, including etiquette unique to this population as impacted by Deaf culture and the use of ASL. For example, all participants spoke to the importance of maintaining eye-contact with Deaf individuals, especially when communicating via ASL. SB-1 described the concept of "Deaf personal space," a piece of etiquette that is formally taught to Deaf children in her experience. To describe her perception of the term, she said "there is optimal distance from another person for you to see that space, and other people should not walk [into] that or come

too close to it." The purpose of this space was to allow enough room to physically produce and visually read signs.

While reflecting on her perceptions of the community, SB-2 stated "there's always people who go above and beyond, but I think in the Deaf school it's like everyone goes above and beyond." She included that she felt a strong sense of community and collaboration while in Individualized Education Plan (IEP) meetings, which she attributed to the cultural community. Etiquette differences between hearing and Deaf culture were present in these IEP meetings. For example, it is common to be typing on a laptop or tablet during meetings in hearing culture, this is offensive by the Deaf community because it compromises the eye contact essential for effective communication. In addition, while it can be considered rude to have side conversations during meetings in hearing culture, it is not uncommon to have ASL side conversations during meetings.

SB-2 recalled a time when she assumed a teacher in the school was able to hear spoken language because she occasionally spoke English, but this assumption was false and resulted in frustration for both parties. She stated, "I didn't realize that it would be appropriate to ask, hey how would you like to communicate." SB-1 recalled writing her first report and having the school principle reply, "please never say hearing impaired again," instead being directed to write "hard-of-hearing" or "Deaf" with a capital D.

Theme 3: Cultural Perceptions and Awakenings

In relation to Deaf individuals OP stated "they've lived in a hearing world…the person who is feeling awkward is you because maybe you aren't used to dealing with the Deaf world." Based on their experiences, the participants in this study formed their own perceptions of what working with the Deaf community entails. To form these perceptions,

most of the occupational therapy practitioners reported moments of cultural awakenings or unexpected acquisitions of new knowledge.

Both school-based practitioners identified fine motor and visual perceptual skills to be especially important to develop within the Deaf community because deficits in these areas impacted functional communication. Reflecting on her experiences and perceptions, SB-1 stated "average is not good enough for people who have grown up Deaf, like they probably have a higher standard than we have." Similar impacts were experienced by OP, whose client had a hand injury preventing functional communication. SB-1 reported that she is limited in accurate assessment of these skills in the Deaf population because there are no assessments normed on this population. In contrast, OP stated that any standardized assessment could be utilized with the Deaf population because there is no assessment that "requires them to be a native hearing person." SB-2 used a variety of standardized assessments with her clients, including ones that test visual motor integration and motor proficiency skills. Standardized assessments with visual aids for her students to reference were particularly useful. She indicated that she believes that an assessment will never be truly standardized for this population due to the language adaptations that must be made.

SB-1 specifically recalled a client with cerebral palsy expressing frustration at his inability to communicate secondary to his physical deficits. When she assured him that they would work together to establish functional communication that met his physical abilities, he responded by thanking her and stated, "all the other OTs tried to fix me." This relates to SB-2's claim that someone who's Deaf is not broken and doesn't need to be fixed. She believes that "what they need is access to language, is access to ASL." In the experiences of OP, Deaf clients put extra care into ensuring clarity of communication. She recalled, "I think

knowing that there's the barrier for communication can be a blessing in some ways because they do ask for clarification before somebody else might."

Through comparing her experiences in Deaf schools and in hearing schools, SB-1 perceived that the academic standards set by the Deaf community are impacted by cultural assumptions and that the career goals of Deaf children are narrow in comparison to those expressed by hearing children. She had not experienced a Deaf child express a desire to join the healthcare field, including occupational therapy. SB-1 suggested that a Deaf occupational therapist would be more beneficial to her clients because they could catch subtleties in ASL and fine motor skills that a hearing therapist might miss, as well as better understand the client's cultural needs. However, she had not experienced success in finding a Deaf occupational therapist that could serve as a role model for the students. A moment of cultural awakening for SB-2 was the realization that written English was a distinct language from ASL. Acknowledging her previous assumption, she stated, "that's something I definitely didn't realize was that there's this large number of Deaf people who don't have excellent written language skills." This language difference also contributed to OP's perception that the practice of communicating large amounts of important information without an interpreter present should be discouraged due to the higher risk of miscommunication and misunderstanding. In comparison IP did not distinguish between Deaf culture and other cultures, reporting that Deafness did not influence her treatment more than any other language barrier had. Utilizing an ASL interpreter was not unlike using other language interpreters for this participant, and she stated "I think his cognition was more impactful than his communication."

Theme 4: Striving for Cultural Knowledge

All participating occupational therapy practitioners demonstrated a motivation to seek information, with the intention to improve cultural sensitivity and communication effectiveness. When asked why this was important, SB-1 responded "that's part of being an OT," stating that an occupational therapy practitioner cannot be client-centered unless they are continuously learning about their client. Similarly, IP stated "I think the hallmark of what we do as occupational therapists is we continue to learn and use that knowledge to create interventions and occupations that are most valuable to our clients." OP claimed that this is an essential piece in the process of building rapport, stating "it's really tough to be an effective clinician if you can't connect with your patient."

These occupational therapy practitioners recalled asking questions of colleagues, interpreters, Deaf individuals, or other experienced individuals in order to improve their own practices. Other methods for exploring Deaf culture mentioned across participants included exploring Deaf culture by reading or referring to online resources, watching videos or news sources representative of the Deaf community, taking classes, and attending community events. IP stated, "you can't have best practice if you don't investigate," speaking to her belief that a therapist should be an active participant in the pursuit of new knowledge. SB-1 stated, "sometimes it feels like I'm on the outside and there's just parts of it I just won't be able to understand… that's true of any culture that isn't mine." Identifying herself as the "minority culture" in the Deaf world, this practitioner expressed openness to exploring her client's culture. She also recalled having her signing corrected often by Deaf colleagues, stating "please correct me; I don't want to be saying stupid things." Having learned ASL socially, and not within the context of professional practice or occupational therapy, SB-1

recognized that there were language nuances that she was unaware of. She stated, "every time somebody told me something, I really tried to absorb it."

SB-2 demonstrated a motivation to learn ASL because she believed that this skill would improve her relationships with clients and colleagues, thus improving overall service delivery. She admitted that she likely would have attempted to communicate via written language or gesturing had she not been educated by her exposure to the depth of ASL through experiences with an interpreter. She stated, "I was really motivated because I knew what I was missing out on by not knowing ASL," including the client's intent and emotions behind the vocabulary. She felt that communicating directly with her students lead to a "better therapy session" because she could position herself better while signing, better develop rapport, and have more flexibility with her schedule. Additionally, relevant to providing services to children who are developing ASL skills in school, going through the process herself made her more aware of the motor skills required to produce ASL.

Discussion

The results of this study support Camphina-Bacote's Model of Care (2002). Within the context of the Model of Care, each occupational therapy practitioner demonstrated a unique position across domains of providing culturally relevant care for members of the Deaf community. For some occupational therapy practitioners, *cultural knowledge* was enhanced by previous or frequent encounters with the Deaf population and led to a greater awareness of the cultural and communicative influences of this population. Three of the participants in this study reported cultural encounters with the Deaf population prior to clinical encounters, citing this as beneficial to their professional preparedness and ability to communicate. However, a lack of cultural knowledge regarding the communicative needs of Deaf community members was often also difficult for the participant themselves to recognize

because they did not know what information they might be missing. An example was SB-2, who concluded that being unable to communicate directly or use an interpreter to facilitate this communication sacrificed valuable information.

All of the occupational therapy practitioners' motivation to strive for further *cultural knowledge* demonstrated *cultural desire* and showed an understanding of *cultural humility* (Campinha-Bacote, 2002). By seeking information and accepting correction to mistakes, participants in this study were able to adapt to the needs of their clients and provide enhanced client-centered services. Comparing Deaf culture to their own hearing culture helped develop the pracitioner's *cultural awareness* domain, including strategies for acknowledging how their own culture impacted their assumptions and interactions with their Deaf clients (Black & Wells, 2007).

Consistent across multiple interviews was the notion that particular diagnoses, injuries, or other functional limitations were particularly impactful on the Deaf population, especially when the ability to express or perceive ASL was compromised. This indicated that failing to understand the significance of functional deficits in the context of cultural participation and communicative interaction may sacrifice the client-centeredness of occupational therapy. For example, the child with cerebral palsy expressed frustration that his previous occupational therapy practitioner tried to "fix" him instead of implementing a way he could communicate functionally.

Implications for Occupational Therapy

The experiences of the participants in this study offer the potential to inform and improve the cultural relevance and effectiveness of occupational therapy services for members of the Deaf community through factors such as strengthened rapport, improved ability to communicate, and better therapy outcomes. Furthermore, by understanding the

impact of cultural considerations on practice for the Deaf community, occupational therapy practitioners might be more sensitized to the needs of other cultural groups. For example, the methods for seeking cultural knowledge identified in this study may be helpful to other occupational therapy practitioners who want to improve cultural sensitivity when providing services to clients with other various cultural identities.

The results of this study may also be used to inform occupational therapy research and education. Future research could be conducted exploring the links between occupational therapy and the Deaf population, such as the perceptions originating from the Deaf community who have accessed services, and can determine if increased cultural awareness when working with the Deaf population does benefit treatment outcome. It would also be valuable to know how knowledge regarding culturally relevant services is taught to occupational therapy students in entry-level education, including knowledge relevant to this population. This could help identify entry level educational opportunities that might improve preparedness to meet the linguistic and cultural needs of the Deaf population.

Limitations of the Study

Limitations of this study include a relatively small sample size and a reliance on participant recall. The primary researcher was a novice and was advised by seasoned faculty researchers for this study. Consistent with risk associated with qualitative interviews and interpretive thematic analysis, researcher bias may have influenced the study. However, it is relevant to note that this is one of the first studies to investigate occupational therapy interactions with Deaf culture.

Conclusion

Occupational therapy practitioners have opportunities to increase their cultural competency through the experiences and suggestions for seeking cultural knowledge offered

by participants in this study. An increased understanding of the cultural and linguistic needs of Deaf clients can enhance the client-centeredness and cultural relevance of occupational therapy services for members of this population. This may lead to a positive therapeutic relationship between the provider and client as well as improved occupational therapy outcomes.

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Tables

Table 1

Participant Demographics

Participant Label	Geographical Location	Current Practice Setting	Reported OT Experience
SB-1	West Region	School for the Deaf	30 years
SB-2	West Region	School for the Deaf and Blind	12 years
OP	Northeast Region	Outpatient	20 years
IP	South Region	Rehabilitation Hospital	20 years

INSTITUTIONAL REVIEW BOARD FOR HUMAN SUBJECTS RESEARCH PROPOSAL

1. General Information:

a. Funding: This research will be funded by the Department of Occupational Therapy at Ithaca College.
b. Location: Determined in collaboration with participating occupational therapists.
c. Time Period: Upon IRB approval, anticipated October 2018- October 2019.
d. Expected Outcomes: I will be presenting the results from this research at the Occupational Therapy Graduate Research Colloquium. Results may also be shared with an external audience at a state or national conference, and may be submitted for possible publication.

2. Related Experience of Researchers:

Kelsey Englerth is a graduate student at Ithaca College. She has completed her bachelor's degree in occupational science and is continuing to complete her master's degree in occupational therapy at Ithaca College. Kelsey has completed all required research coursework in the curriculum, consisting of a research methods course and a quantitative concepts course. Completed coursework also includes a research seminar, refining skills needed to produce a written research report and working closely with faculty to develop a research design. Kelsey has also completed a Deaf Studies minor at Ithaca College. Coursework included exploring Deaf culture and learning American Sign Language.

Dr. Carole Dennis is a full-time professor in the Occupational Therapy Program. Dr. Dennis has collaborated with students and colleagues in a variety of research studies and has experience advising occupational therapy students on their theses, and has experience with the methodology to be employed in this study. Dr. Shannon L. Scott is an assistance professor in the Occupational Therapy Program. Her doctoral dissertation included a qualitative component. Portions of this research were recently published. Kip Opperman is a lecturer of American Sign Language and Deaf Culture at Ithaca College. He is involved with the local Deaf community and also works as an American Sign Language interpreter in a variety of settings.

3. Benefits of the Study:

The participants of this study may enjoy the opportunity to reflect on their experiences of their occupational therapy practice, while contributing to a wider knowledge base regarding occupational therapy services for Deaf clients. The participants' experiences offer the potential to optimize occupational therapy services with Deaf community members, including increased cultural sensitivity, improved communication effectiveness, and better rapport with clients. By completing this study, Kelsey Englerth will have finished her independent research thesis required for graduation from the occupational therapy program at Ithaca College with her master's degree. This study will be presented at the Occupational Therapy Graduate Research Colloquium in March 2019 and also has the potential for scholarly publication or presentation at a national conference. The findings of this study may also inform

professional development, education, and research for occupational therapy practitioners.

4. Description of Participants:

a. Number of participants: 3-5 occupational therapy practitioners
b. Salient Characteristics: Participants must be occupational therapy practitioners who have provided direct skilled services to a Deaf client, including evaluation and treatment, within the last one year. The client must have been completely Deaf at the time of treatment and primarily communicated through American Sign Language. All participants must be 18 years or older.

5. Description of Participation:

Participants will be asked to participate in interviews to share their experiences of working with Deaf clients. In person meetings are preferred for this study, which will take place at a mutually agreeable location. Accommodations will be made for video or phone interviews if necessary. Kelsey Englerth will be conducting the interviews. Participants will be asked to attend at least two interviews, each lasting 30-60 minutes for a total time of 120 minutes. Time between interviews will allow the participants to further reflect on their responses and allow the researchers to analyze responses for opportunities to increase depth of information. Member checking will take place in order to ensure an accurate understanding and increase trustworthiness of the data.

6. Ethical Issues:

a) Risks of Participation:
   It is anticipated that engaging in these interviews will pose minimal risks for the participant. There may be psychological risk associated with asking participants to recall experiences, in the event that these experiences were upsetting. To minimize this risk, participants will be encouraged to seek support from local counseling services of their choice if necessary. All participants will also be aware that they may decline to answer or withdraw from the study at any time.
b) An Informed Consent Form is attached.

7. Recruitment:

a) Procedures:
   Participants will be recruited through a snowball sampling approach. Kelsey Englerth will e-mail faculty in the Ithaca College Occupational Therapy Department, who may still be practicing. She will also e-mail settings that employ occupational therapy practitioners in Rochester, New York. Rochester has a large population of Deaf community members, including those attending the National Technical Institute of the Deaf, and is also the permanent home of Kelsey.
b) Inducement to Participate/Extra Credit:
   Occupational therapy practitioners will be given a $25 gift card for their participation in this study. They will receive the amazon.com e Gift Card within one week of the conclusion of their first interview. Participants may

withdraw at any time during this study. If participants withdraw from the study before the first interview, they will not receive the gift card. If they withdraw from the study after the first interview, they will receive the gift card in its entirety.

8. Confidentiality/Anonymity:
The confidentiality of all participants will be maintained. No identifying information regarding the participants, their clients, or their specific place of work will be included in any written reports or presentations, and pseudonyms will be used for each participant. Interviews will be video and audio recorded and transcribed using a private TEMI account. All data associated with the study will be kept in the Ithaca College Occupational Therapy Department, stored within the locked offices of Carole Dennis, Smiddy Hall 204D and Shannon Scott, Smiddy Hall 204C. Only the researchers will have access to that data. The data will also be stored on password-protected computers and accessed through a private Sakai site or Zoom account. The data, including signed consent forms, will be maintained for 3 years and destroyed at that end of that time.

9. Debriefing: N/A

10. Compensatory Follow-up: N/A

Proposed Date of Implementation: September 2019

ITHACA COLLEGE

Sponsored Research

October 24, 2018

Kelsey Englerth, Graduate Student
Department of Occupational Therapy
School of Health Science and Human Performance

Re: IRB 0918-08 - The Experiences of Occupational Therapy Practitioners Working with Deaf Clients

Thank you for responding to the stipulations made by the Institutional Review Board for Human Subjects Research (IRB). You are authorized to begin your project. This approval is issued under the Ithaca College's OHRP Federal-wide Assurance #00004870 and will remain in effect for a period of one year from the date of authorization.

Please add the IRB approval number (IRB **0918-08**) to ALL recruitment and consent materials.

After you have finished the project (when data collection is complete and there is no further risk to human subjects), please complete the *Notice-of-Completion Form* found on the Sponsored Research website. Please note that review/approval of future proposals is contingent upon submission of this form.

Should you wish to continue the approved project beyond the expiration date you may request an extension by sending an email to irb@ithaca.edu before October 23, 2019. The project can be extended up to three years. *If the project expires, you must complete a new application for expedited review.*

Please note that if there are any adverse events resulting from this research, they must be reported to the IRB at irb@ithaca.edu.

Sincerely,

Warren J. Calderone

Warren Calderone
Director of Corporate, Foundation Relations, and Sponsored Research
Institutional Review Board for Human Subjects Research

Recruitment E-Mail

Dear xxxx,

My name is Kelsey Englerth and I am a graduate student in Ithaca College's Occupational Therapy program. For my Master's thesis, I will be conducting interviews for a study exploring the experiences of occupational therapy practitioners who have provided direct skilled services to a member of the Deaf community. I write Deaf with a capital "D" intentionally in order to signify a member of the Deaf identity. Understanding these experiences offer the potential to optimize the quality of occupational therapy services for Deaf community members. The findings of this study may also inform occupational therapy professional development, education, and research.

To be considered for this study, the occupational therapy practitioner must have provided direct skilled services to a Deaf client, including evaluation and treatment, within the past year. Recent experience is preferred, therefore please be advised that you may or may not be chosen for this study as a result. The client must have been Deaf at the time of treatment and primarily communicated through American Sign Language.

Please consider participating in this study should you meet these criteria, and/or pass this information to colleagues who you believe may be interested in participating. Participants will receive a $25 gift card for their participation in the interviews. For further information or to express interest in participating, please contact Kelsey Englerth at kenglerth@ithaca.edu.

Thank you for your time and consideration.

Kelsey Englerth

INFORMED CONSENT FORM

1. Purpose of the Study
   The purpose of this study is to explore the experiences of occupational therapy practitioners who have provided care to a member of the Deaf community.
2. Benefits of the Study
   By participating in this study, you will have the opportunity to share your experiences while contributing to a wider knowledge base regarding occupational therapy services for Deaf clients. Understanding your experiences offers the potential to optimize the quality of occupational therapy services for Deaf community members. The findings of this study may also inform occupational therapy professional development, education, and research. You will receive a $25 amazon.com e Gift Card for your participation in this study.
3. What You Will Be Asked to Do
   You will be asked to participate in interviews on two occasions, after which the researcher may reach out for further clarification. This is designed to allow time to reflect on your experiences between interviews, as well as allow the researchers to develop questions based on your responses. You can expect each interview to last between 30-60 minutes, however this timeframe can be flexible depending on the experiences that you would like to share. You may be asked to verify the researcher's understanding of your responses.
4. Risks
   Participation in these interviews poses minimal risk for you. As we are asking you to recall personal experiences, it is possible that you may feel uncomfortable or upset. To minimize this risk, you are encouraged to seek support from local counseling services of your choice if you feel that would benefit you.
5. Compensation for Injury
   If you suffer an injury that requires any treatment or hospitalization as a direct result of this study, the cost for such care will be charged to you. If you have insurance, you may bill your insurance company. You will be responsible to pay all costs not covered by your insurance. Ithaca College will not pay for any care, lost wages, or provide other financial compensation.
6. If You Would Like More Information about the Study
   If you would like more information about this study at any time, please contact Kelsey Englerth at kenglerth@ithaca.edu or 585-465-8552. The faculty advisors for this study are Carole Dennis, cdennis@ithaca.edu, and Shannon L. Scott, sscott3@ithaca.edu.
7. Withdraw from the Study
   You may decline to answer any interview question or withdraw from this study at any time. If you withdraw from the study before the first interview, you will not receive the amazon.com e Gift Card. If you withdraw from the study after the first interview is completed, you will receive the gift card in its entirety.
8. How the Data will be Maintained in Confidence
   Your confidentiality will be maintained. No identifying information regarding your name, your clients, or your specific place of work will be included in any written reports or presentations, and pseudonyms will be used. Interviews will be video and audio recorded, and transcribed using an outside service. All data associated with the study will be kept in the Ithaca College Occupational Therapy Department, stored within the locked offices of Carole Dennis and Shannon Scott. Only the researchers will have access to that data. The data will also be stored on password-protected computers and accessed through a private, password-protected site. The data, including your signed informed consent form, will be maintained for 3 years and destroyed at that end of that time. This study has been reviewed and approved by the Ithaca College Institutional Review Board, approval number IRB 0918-08b.

I have read the above and I understand its contents. I agree to participate in the study. I acknowledge that I am 18 years of age or older.

_____
Print or Type Name

_____ _____
Signature Date

I give my permission to be audiotaped and videotaped.

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Signature Date