Communication Assessment Profile
For Deaf Individuals with Language Dysfluency

By
Kathleen Lanker

May 2015
Introduction

Overview

Within the deaf populace, there is a large number of individuals who are considered low-incidence and are underserved. The low-incidence term refers to a population that has a disability that does not occur often (National Center on Accessible Instructional Materials, 2012). These individuals can be characterized as deaf adults with language dysfluency regardless of the communication modality (e.g., speech, sign language, reading, writing, and gestures) (Long, 1996). Several different protocols of Communication Assessment Profiles exists; however, there is not one which attempts to standardize the communication skills inventory process of data collection.

The Profile affords an assessment of the deaf individual’s strengths and weaknesses across a spectrum of communication modalities, which is designed to identify and assist the mental health team in communication strategies. This assessment is not to be used as a comparison between individuals or to compare this individual to a group norm (Williams, 2009).

This Profile was not designed for Deaf/Blind individuals which require a different approach to the dual sensory loss, nor was it designed for deaf children or adolescents under 18 years of age.

Description of the Population

According to Dowhower and Long (1992), deaf adults with language dysfluency have been referred to as “low functioning, low achieving, multiply handicapped, hearing impaired, developmentally delayed, severely handicapped deaf, and disadvantaged deaf” (Long, 1996, p. 1). In deaf mental health literature, deaf people who are “low functioning” are assigned the terms of “high risk” or also known as the “traditionally underserved deaf” (Glickman, 2013, p. 44). They can also be categorized as low incident group or disability. Language dysfluent deaf individuals are faced with barriers (e.g., communication modality, educational level, intellectual level, reading level, fund of information [FOI] gap (Pollard, 1998), Deaf cultural norms vs. hearing cultural norms, etc.). They may not effectively communicate with others because of these barriers, and more.
| Traditional approaches to communication assessments | Traditional approaches to assessments are hearing-based being administered to non-hearing individuals, i.e., deaf individuals. The results from those assessments demonstrated a presence of a communication disorder and a possible diagnosis from a hearing-based perspective. This disorder focused on the deaf adult’s deficits and how those deficits affected his or her life, which provides a medical-pathological perspective. Traditional hearing-based tests rely heavily on standards where the deaf adult is compared with a comparable hearing adult who is from a normative group. From this comparison, predictions of hearing-based behaviors are generalized and placed upon the deaf adult with language dysfluency, leading to failure in diagnosis and treatment. |
| Rationale to the new approach to a communication assessment | The Communication Assessment Profile (known as the Profile) is not a test to ascertain the weaknesses in a deaf adult with language dysfluency. Dysfluency means deaf person who is not a skilled user of the language (Glickman & Crump, 2013, p. 107). Their communication with the language is not clear and to the native’s “eye,” it is peculiar. This Profile is designed to collect the necessary information about the deaf adult’s “strengths and weaknesses across the spectrum of communication modalities” (Williams, 2009). Chomsky (1965) views competency as the individual’s knowledge of his or her language where performance of the language is the actual usage of it in concrete situations. Halliday (1976) is more concerned as to what the individual does with the language in a sociolinguistic environment. Campbell and Wales (1970) proposed a broader range of language competence where it focuses on the knowledge to interpret and produce meaningful responses appropriate to the situation, more so than just grammatical knowledge. Competency will be viewed from the perspective of how the individual uses his or her language in a sociolinguistic environment and what is his or her knowledge of his or her language, be it signed or spoken. Fluency in a language means the overall signing proficiency (Lennon, 1999) (Italics for word change by author). The skill degree (or level) of a language is the type of proficiency the individual has in that language – native, near native, excellent command (signing and writing), very good command, good working knowledge, and basic working knowledge. (See Appendix A for details of skill degrees). Therefore, competency in a communication modality does not correspond with fluency or skill degree of the language (performance). It is structured to permit the deaf individual to demonstrate his or her communication skills within his or her... |
It is important while conducting this assessment that the persons performing the assessment not assign “hearing” terminology to the deaf individuals’ experiences (Atkinson, 2006; Glickman, 2007; Morere, Dean, & Mompremier, 2009; Paijmans, Cromwell, & Austen, 2006). In addition, to remember that hearing and deaf people are from two different thought worlds (Glickman, 2013, p. 14).

<table>
<thead>
<tr>
<th>Overview of the assessment process</th>
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<tbody>
<tr>
<td>The Communication Assessment provided here is an attempt to standardize some of the background information collected from the questions to ask in the accompanying DVD. The DVD is of a signing deaf professional in the community who will provide the same signing modality during the questioning or intake phase. The DVD contains the Skills Inventory. If the intake phase spans more than one-day where a different sign language interpreter (SLI) is used, the Skills Inventory intake process will be the same since the DVD will be an unchanging format of the same signed questions.</td>
</tr>
<tr>
<td><strong>Part One</strong> describes the Client Communication Profile, the collection of background information, such as: education, client’s medical history, family’s medical history, hearing loss information, and if known, other possible disabilities (i.e., known as deaf plus or deaf + refers to a deaf individual who has a hearing loss in addition to other conditions that affect the individual, e.g., medically, physically, emotionally, educationally, or socially) (Morris, 2009).</td>
</tr>
<tr>
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</tr>
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<td><strong>Part Three</strong> is the Client Environment. This section examines the social skills the deaf adult has or does not have. Here, the emphasis is on the Deaf Cultural norms in socialization with other deaf individuals and hearing individuals (e.g., greetings, attention getting, conversations, turn-taking and leaving taking).</td>
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<td><strong>Part Four</strong> focuses idiosyncratic or dysfluent use of sign language. Many behavior and language patterns can emulate psychotic behaviors. There is a checklist section to annotate if during observation any of the items were noticed.</td>
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<td><strong>Part Five</strong> deals with the Skills Inventory section with an accompanying DVD where a Signer asks a question and the deaf client responds. There is a form to assist the SLI or CS</td>
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| **Part Five** deals with the Skills Inventory section with an accompanying DVD where a Signer asks a question and the deaf client responds. There is a form to assist the SLI or CS |
in jotting down the responses.

- Part Six is a recommendation report in commenting on how to communicate with the deaf client with language dysfluency.

It is recommended that the SLI or the communication specialist (CS) observe and record the information for this Profile; however, it has been arranged for a clinician to collect the necessary information.

**Note of warning.** If the deaf client is a sexual offender and/or predator, some of the images on the DVD and in the hardcopy booklet may not be appropriate for viewing or may violate the deaf client’s terms or conditions of parole (or probation) agreement.

Please preview the images first before showing to the deaf client. Hardcopy of these images are available for use to select from if the terms of agreement does not allow the deaf client to use a computer or any other electronic devices for displaying the images. Consequently, not being able to use an electronic device for the Skills Inventory section, will place this assessment into a non-standardized status.

It is highly recommended, to seek out the deaf client’s parole (or probation) officer for details of the terms or conditions of parole (or probation) agreement so the Skill Inventory section of this Communication Assessment Profile will not be in violation of that agreement.
The purpose of the Client Communication Profile is to develop a picture of the deaf client’s background, abilities, and his or her preference of communication modality.

The Profile will discern the deaf client’s vocabulary and fund of information (FOI), which is the amount of information the client retains from experiences, to recognize the communication approach according to his or her abilities and needs.

There will be a need to collect data from the deaf client, his or her family members, caregivers, and outside resources, such as but not limited to: medical reports, school records, vocational and psychological evaluations, and audiological reports.

When collecting information via observation, it is highly recommended that the observer be someone who is fluent in American Sign Language (ASL), other signing systems, Deaf culture, and Deaf norms. If the observer also is a participant (participant-observer), having this knowledge will be paramount when interacting with the deaf client. A Communication Specialist (CS) in the field of deafness and sign language is preferable. The environmental settings for these observations need to be: deaf with deaf, deaf with hard of hearing, and deaf with hearing people.

Date Assessment Conducted: __________________________________________

Date of Assessment Report: _________________________________________

Who administered the Assessment:

______________________________________________________________
(Print Name and Title)

______________________________________________________________
(Print Name and Title)

______________________________________________________________
(Print Name and Title)

SLI or CS used: Yes No

SLI or CS used what communication modality: __________________________
Data Collection Strategies

Information from: medical reports, school records, vocational and psychological evaluations, and audiological reports.

<table>
<thead>
<tr>
<th>Type of Report</th>
<th>Date of Report</th>
<th>Source</th>
</tr>
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<tbody>
<tr>
<td>Psycho-social</td>
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<td>Educational</td>
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<td>Vocational</td>
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<td>Audiological</td>
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<tr>
<td>Medical</td>
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</table>

(Long, 1996; Communication Profile, 2008).
Information from: family members, guardian, foster family members, group home, friends, and caregivers

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Date of Interview</th>
<th>Hearing Status</th>
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</table>

Use one of the following terms for hearing status: deaf, HOH (hard of hearing), or DB (deaf/blind), or hearing (Long, 1996; Communication Profile, 2008).

The next table, on the following page, focuses on a description of the deaf client interacting with others. If there is an observer/participant-observer who monitored the deaf client communicating with various people, please note the hearing status of the observer/participant-observer and when the deaf client was communicating, along with what the hearing status of the other person was. A brief description of the environment or setting and the activity taking place is needed. An example could be: Setting is the mall, and the Activity is shopping, Date of Observation is 12/06/2014, Observer’s Hearing Status is H, Observer’s Relationship is parent.
(Long, 1996; Communication Profile, 2008).

<table>
<thead>
<tr>
<th>Setting/Environment</th>
<th>Date of Observation</th>
<th>Activity</th>
<th>Observer's Relationship</th>
<th>Observer's Hearing Status</th>
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</table>

Use one of the following for hearing status: deaf, HOH (hard of hearing), or D/DB (deafblind), or hearing.
Client Identification

Client Name: __________________________________________________________
Race/Ethnicity: ________________________________________________________
Date of Birth: _____ / _____ / ________
Age: ________________________________________________________________
Gender: Male  Female  Other: ________________________________
Address: ___________________________________________________________________
________________________________________________________________________

Phone Number: (_____) _______ - _________ (v/TTY (or TDD)/VP)
Marital Status: _________  If in a relationship, partner/spouse’s hearing status: _____
     Does partner/spouse consider the client to be disabled:  Yes  No

Does the client consider him/herself to be disabled:  Yes  No
Does the family consider the client to be disabled:  Yes  No
Religious affiliation: ____________________________________________________

Employment:
Current occupation/status: ________________________________________________
If employed, name of employer: _____________________________________________
Address: __________________________________________________________________
City: ___________________________  State: _________  Zip Code: _________

Phone number: (_____) _______ - _________ (v/TTY (or TDD)/VP)

Contact person: _________________________________________________________
<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship (1)</th>
<th>Hearing Status (2)</th>
<th>How do they communicate (modality)? (3)</th>
<th>Quality of communication (4)</th>
<th>Do they consider the client disabled?</th>
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</table>

(1) Examples are: parents, spouse, children, siblings, roommate, friend, etc.
(2) Deaf (D), Hearing (H), Hard-of-Hearing (HoH), Deaf-Blind (DB), or other.
(3) How does the person listed under name communicate with the deaf client. The modality can be ASL, gesture, mime (pantomime), home-made signs, a blend of other sign languages. Also see Appendix C for pedagogical signing system types.
(4) This refers to the individual listed having a perceived ability to communicate with the deaf client. Is that communication ability: Excellent, Good, Fair, Poor, None?
Describe the client’s involvement in the Deaf community, e.g., involved or go to Deaf club, Deaf events and/or Deaf movies, etc. Does the client interact with other deaf individuals? If yes, do these other deaf individuals have similar linguistic skills and cultural mores? Does the client use Deaf norms or is more hearing culture oriented?

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Family members’ attitude towards communication with each other and the client.

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(Long, 1996; Communication Profile, 2008).
# Hearing Loss Information of Deaf Client

Date of last audiological evaluation: ________________________________

Age of onset of hearing loss: ________________________________

Stable or progressive hearing loss: ________________________________

How does deaf client self-identify hearing loss:      Deaf  Hard-of-hearing  Hearing

<table>
<thead>
<tr>
<th>Hearing loss:</th>
<th>Self-reported</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family-reported</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Infant hearing</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

If Yes, who performed? ________________________________

Otoacoustic emissions (OAE) results: ________________________________

Auditory brainstem response (ABR) results: ________________________________

Degree of hearing loss dB (decibels): (left) __________ (right) __________

(See Appendix B for details on decibel meanings.)

Severity of hearing loss left ear:  Mild  Moderate Severe  Profound

Severity of hearing loss right ear: Mild  Moderate Severe  Profound

Diagnosis of hearing loss type left ear: Conductive  Sensorineural  Mixed

Diagnosis of hearing loss type right ear: Conductive  Sensorineural  Mixed

Etiology: ________________________________

Known or potential language/cognitive impact of etiology:

__________________________

__________________________

Amplification Devices Used:
<table>
<thead>
<tr>
<th>Device</th>
<th>Which ear left/right?</th>
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</thead>
<tbody>
<tr>
<td>Hearing aid</td>
<td>Behind the ear (BTE)</td>
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<td></td>
<td>On the ear (mini BTE)</td>
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<td></td>
<td>In the ear (ITE)</td>
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<td></td>
<td>In the canal (ITC)</td>
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<td></td>
<td>Completely in the canal (CIC)</td>
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<td></td>
<td>Analog or Digital</td>
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<tr>
<td>Cochlear implant</td>
<td># of channels</td>
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<td></td>
<td>Date of implantation</td>
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<tr>
<td></td>
<td># of channels</td>
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<tr>
<td></td>
<td>Date of implantation</td>
</tr>
<tr>
<td>FM system</td>
<td></td>
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<tr>
<td>Telephone amplifier</td>
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<tr>
<td>CapTel</td>
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</table>

(Williams, 2009).

**Assistive Services and Equipment Used:**

<table>
<thead>
<tr>
<th>Service/Equipment Type</th>
<th>Check if yes</th>
</tr>
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<tbody>
<tr>
<td>Used a SLI before?</td>
<td></td>
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<tr>
<td>Does deaf client understand role of SLI?</td>
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<tr>
<td>Is deaf client comfortable using an SLI?</td>
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<tr>
<td>Does the deaf client know how to obtain an SLI?</td>
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<tr>
<td>Does the deaf client have or use a VP or TTY?</td>
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<tr>
<td>Does the deaf client use closed captioning on their TV or computer?</td>
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<tr>
<td>Does the deaf client have or use a signaling device?</td>
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<tr>
<td>Does the deaf client have or use a hearing dog?</td>
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(Williams, 2009).
Vision Requirements:

Is large print needed? Yes  No

If yes, what font size/style is needed: ____________________________

Does the background color need to be something other than white? Yes  No

If yes, what color? _______________________

Does the font color need to be something other than black? Yes  No

If yes, what color? _______________________

Does the deaf client need to be closer to the clinician and/or SLI to see? Yes  No

Does the SLI require a specific position for the deaf client to see? Yes  No

If yes, what is the needed arrangement: ____________________________

Motor Impairments:

Does the deaf client have any motor impairments? No  If yes/explain: ________________

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Developmental Disability (give type and degree, if known): ________________

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(Williams, 2009).
Briefly describe, from clinician’s perspective, the benefits and/or uses the deaf client receives from his/her amplification system (e.g., environmental sound awareness, speech discrimination, comfort, etc.). If the client does not use an amplification system, why not?

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Briefly describe, how the deaf client believes he/she benefits from his/her amplification system (e.g., environmental sound awareness, speech discrimination, comfort, etc.). If the client does not use an amplification system, why not?

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(Long, 1996).
Parents or Legal Guardian(s) of Deaf Client

Did deaf client want the amplification devices?  Yes  No  Why or why not?

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(Long, 1996).
Hearing Loss Information on Family Member

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<tr>
<th>Relationship to deaf client:</th>
<th>Date of last audiological evaluation:</th>
<th>Age of onset of hearing loss:</th>
<th>Stable or progressive hearing loss:</th>
</tr>
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Medical and Secondary Disability Information of Deaf Client

Describe any physical/health considerations that may impact the language and socialization:

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Describe any visual, motor, cognitive, and/or other disabilities that may impact the language or socialization:

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Is the deaf client color blind?  Yes  No
Is the deaf client dyslexic?  Yes  No
Medical and Secondary Disability Information of Deaf Client

List (past and present) medications (prescribed and non-prescribed) and health supplements (e.g., vitamins, minerals, etc.), along with dosage, frequency, period taken, effectiveness, side effects, reactions, etc., that may impact the language (expressively or receptively):

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### Educational Background of Deaf Client

Type of schools attended (check all that apply):

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<th>Name of School(s)</th>
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<thead>
<tr>
<th>Teacher's Hearing Status (1)</th>
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<tr>
<th>Grades Attended</th>
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</table>

- Mainstreamed
- Self-contained
- Residential - Day
- Residential
- Home schooled
- No formal schooling
- Other
- Other

(1) This column is about the teacher's hearing status: Hearing, Deaf, and Hard-of-Hearing.  

(Long, 1996; Communication Profile, 2008).
What accommodations were used within the educational setting to enhance communication?

<table>
<thead>
<tr>
<th>Check which type was utilized</th>
<th>Type (2)</th>
<th>Which school type (3)</th>
<th>What grade level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notetakers</td>
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<tr>
<td>Oral transliterator</td>
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<tr>
<td>SLI</td>
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<tr>
<td>SpLI</td>
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<tr>
<td>Teachers who signed</td>
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<td></td>
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<tr>
<td>CART</td>
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<tr>
<td>No accommodations</td>
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</tbody>
</table>

(2) SLI is Sign Language Interpreter. SpLI is Spoken Language Interpreter

(3) Types are: mainstreamed, self-contained, residential, home schooled, no formal schooling, oral program or other.

(See Appendix C for examples of pedagogical signing systems if SLI and or Teachers who signed was selected.)

(Long, 1996; Communication Profile, 2008).
Highest educational achievement: ________________________________
(Grade level, certificate, GED, HS diploma, Vocational training, post-secondary education – specify degree)
If currently in school, provide name of school: ________________________________

What educational instruction language (natural sign language or pedagogical signing system) was used? (Mann & Prinz, 2006). If using a SpLI, which spoken language was used?

At what age did the deaf client learn a sign language or a sign system? ______________
Where did the deaf client learn the sign language or sign system? ______________
(e.g., K-12 school, college, religious institution, etc.)

Describe considerations related to the deaf individual’s communication strategies with teachers and school peers. What were the most effective strategies used?

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Describe any impacts of the deaf client’s communication, e.g., moods, thinking, approaching a problem (e.g., attempt to solve, accept or let it go).

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The purpose of this section is to collect data on the deaf client’s abilities in the various communication modalities: gestural, reading, writing, speech and verbal, auditory, speechreading (lipreading), use of a sign language interpreter (SLI), use of a deaf interpreter (DI) or a certified deaf interpreter (CDI), use of a Communication Specialist (CS), and use of technology.

This section's rationale is to ascertain the deaf client’s communication modality, how well he or she works within a communication modality whether it is the preference mode or not and which cultural conformity will be followed – hearing or Deaf rules/norms. The most important gathering of data are the types of vocabulary and fund of information (FOI), which is the amount of information the individual retains from experiences, to recognize the communication approach according to his or her abilities and needs.

As mentioned in Part One, the individual who will be observing must be someone who is fluent in American Sign Language (ASL), other (pedagogical) signing systems, Deaf culture, Deaf norms and is a member of the mental health team. It is paramount the observer have this knowledge when interacting with the deaf client. A CS, in the field of deafness and sign language, is preferable. The environmental settings for these observations need to be: deaf client with another deaf person, deaf client with a hard of hearing person, and deaf client with a hearing person. Sample data may be needed for analysis. A deaf client whose primary access to communication is via the visual-gestural presentation, will require videotaping of his or her signing. The videotaping can be accomplished during a session. The CS, SLI, or DI/CDI may be required to examine the video.

It is recommended by the Registry of Interpreters for the Deaf (RID) that the working interpreters – hearing or deaf – be certified. The certified hearing interpreter is referred to as a sign language interpreter (SLI) whereas the certified deaf interpreter is referred to as a CDI.

Due to the complexities of the languages, cultures, psychiatric assessment and mental health treatments involved, the certified interpreter (SLI or CDI) must be addressed and considered as a professional mental health team member. It is suggested to refer to the RID Standard Practice Paper on Use of a Certified Deaf Interpreter (Appendix D) and Interpreting in Mental Health Settings (Appendix E).
**Deaf Client’s Communication Modality/Modalities**

What modes of *expressive communication* does the individual use?  
(Check all, below, that apply.)

<table>
<thead>
<tr>
<th></th>
<th>Has no usable ability</th>
<th>Has some minimal ability</th>
<th>Has limited use for insignificant routine communication</th>
<th>Has used in some situations</th>
<th>Is fluent or has used in most situations</th>
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</thead>
<tbody>
<tr>
<td>Speech</td>
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<td>Sign Language</td>
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<td>Fingerspelling</td>
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<td>Lexicalized Fingerspelling</td>
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<td>Communication devise</td>
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<td>Gestural</td>
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<td>Sign supported speech</td>
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<td>Writing</td>
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<td>Drawing/showing pictures</td>
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<td>Cued speech</td>
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<td>Other</td>
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</table>

Of those items checked above, which is (are) the deaf client’s language or communication modality of preference: ____________________________________________  
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Of those items checked above, in which language or communication modality is the deaf client most fluent: ____________________________________________  
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(Long, 1996; Communication Profile, 2008).
What modes of **receptive communication** does the individual use?
(Check all, below, that apply. What is the deaf individual’s preferred mode(s) of communication?)

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<tr>
<th>Mode</th>
<th>Has no usable ability</th>
<th>Has some minimal ability</th>
<th>Has limited use for insignificant routine communication</th>
<th>Has used in some situations</th>
<th>Is fluent or has used in most situations</th>
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</thead>
<tbody>
<tr>
<td>Speech</td>
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<tr>
<td>Sign Language</td>
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<td>Fingerspelling</td>
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<td>Lexicalized Fingerspelling</td>
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<tr>
<td>Communication Device</td>
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<tr>
<td>Gestural</td>
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<td>Sign supported Speech</td>
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<td>Writing</td>
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<td>Drawing/showing pictures</td>
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<tr>
<td>Cued speech</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Of those items checked above, which is (are) the deaf client’s language or communication modality of preference: ____________________________

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Of those items checked above, in which language or communication modality is the deaf client most fluent: ____________________________

__________________________

__________________________

(Long, 1996; Communication Profile, 2008).
Provide some examples of communication used by considering the following:

- Greeting others
- Getting people’s attention (hearing culture and Deaf cultural ways)
- Turn-taking
- Expressing likes and dislikes
- Communicating choices or preferences
- Communicating needs
- Asking questions for information, personal needs, and directions
- Expressing displeasure, frustration, anger, hurt, etc.
- Requesting clarification
- Making himself or herself understood
- Modifying his or her message to fit the needs of the listener
- Self-initiating a communication modality
- Depending on family members, friends, or caregiver to help with communication
- Yielding in communication (e.g., giving up, nodding head, passive behaviors, etc.)
- Striving to communicate to, and under what circumstances (e.g., hearing people who do not sign/do sign, deaf people who sign/do not sign)
- Producing effectiveness in communicating

(Long, 1996; Communication Profile, 2008).
Provide examples of types of information this deaf client communicates spontaneously (passively, dependently and/or assertively) found in the above.

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(Long, 1996; Communication Profile, 2008).
Deaf Client’s Communication - Gestural

Comments on the deaf client’s use of gesture/pantomime for communication. Consider the following:

- Use and understandability
- Eye contact
- Appropriate facial expressions
- Comfort level
- Self-initiates
- Use of props
- Other

In what situations would gestures/pantomime be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

In what situations would gestures/pantomime not be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

(Long, 1996; Communication Profile, 2008).
Deaf Client’s Communication - Literacy

(Attach a reading and writing sample.)

Comment regarding the deaf client’s use of reading and writing communication. Consider the following:

- Use and understandability (of writing, it is legible, print/cursive, etc.)
- Approximate grade level
- Visual or other physical considerations (high contrast, etc.)
- Comfort level
- Self-initiates
- Other

In what situations would reading/writing be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

In what situations would reading/writing not be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

(Long, 1996; Communication Profile, 2008).
Writing Sample

(Provide more paper, if needed)

1. (Deaf client’s name) ________________________________
   ________________________________
   ________________________________
   ________________________________

2. ________________________________
   ________________________________
   ________________________________
   ________________________________

3. ________________________________
   ________________________________
   ________________________________
   ________________________________

4. ________________________________
   ________________________________
   ________________________________
   ________________________________
Deaf Client’s Communication – Speech or Verbal

Comment regarding the deaf client’s use of speech for communication. Consider the following:

- Use and understandability (can the clinician understand)
- When is speech used or attempted by the deaf client
- How intelligible is the deaf client’s speech to familiar and unfamiliar persons
- Comfort level
- Self-initiates
- Other

In what situation would speech be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

In what situation would speech not be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

(Long, 1996; Communication Profile, 2008).
Deaf Client’s Communication – Auditory

Comment regarding the deaf client’s use of auditory ability with or without amplification with communication. Consider the following:

- Receptive use and understandability (from the deaf client’s perspective)
- When is auditory ability used or attempted
- How effective is the deaf client’s auditory ability with familiar and unfamiliar people
- Considerations for reduced noise or lighting
- Recommendations for audiogram, include justification for this documentation
- Other

In what situations would auditory abilities be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

In what situations would auditory abilities not be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

(Long, 1996; Communication Profile, 2008).
Deaf Client’s Communication – Speechreading

Comment regarding the deaf client’s use of speechreading/lipreading for communication. Consider the following:

- Use and understandability (from deaf client’s perspective)
- When is speechreading used or attempted
- How successful is the deaf client’s speechreading abilities with familiar and unfamiliar people
- Proficiency/quality (simple words, concrete words and phrases in isolation, or in context; simple/routine instructions, yes/no questions, wh-questions, two or more successive questions, simple conversation, complex or abstract conversation, technical conversation)
- Comfort level
- Other

In what situations would speechreading/lipreading be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective—deaf or hearing.

In what situations would speechreading/lipreading not be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective—deaf or hearing.

(Long, 1996; Communication Profile, 2008).
Deaf Client’s Communication – With an Interpreter

Comment regarding the deaf client’s use of interpreter for communication. Consider the following:

- Use and understandability (from deaf client’s and interpreter’s perspective)
- How successful is the deaf client’s use of interpreters (both familiar and unfamiliar interpreters)
- Understands the role and responsibilities of an interpreter
- Interacts appropriately with interpreter
- Advocates for interpreter use
- Comfort level
- Other

In what situations would interpreting be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

In what situations would interpreting not be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

(Long, 1996; Communication Profile, 2008).
Deaf Client’s Communication – With a Deaf Interpreter (DI or CDI) or Communication Specialist (CS)

Comment regarding the deaf client’s use of a DI or CS for communication. Consider the following:

- Use and understandability (from deaf client’s, DI’s or CS’s perspective)
- How successful is the deaf client’s use of DIs or CSs (both familiar and unfamiliar interpreters)
- Understands the role and responsibilities of a DI vs. language instruction
- Interacts appropriately with DI or CS
- Use of props
- Comfort level
- Other

In what situations would deaf interpreting/CS be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

In what situations would deaf interpreting/CS not be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

(Long, 1996; Communication Profile, 2008).
Deaf Client’s Communication – With Technology

Comment regarding the deaf client’s use of technology for communication. Consider the following:

- Use and understandability of equipment (from deaf client’s perspective)
- Use and understandability of communication attempts
- Management of equipment, risks to setting
- Current use (pager, TTY, videophone (VP), amplified phone, cochlear implant, hearing aid, FM system, flashing alarm or knocker, visual signaling devices, vibrating pager/alarm, hearing dog, etc.)
- Additional considerations
- Other

In what situations would technology be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

In what situations would technology not be acceptable for communication (e.g., treatment, group, one-on-one, routine, non-imperative, casual, etc.)? Please note which perspective is used – deaf or hearing.

(Long, 1996; Communication Profile, 2008).
This section examines the social skills the deaf adult has or does not have. Here, the emphasis is on the Deaf Cultural norms in socialization with other deaf individuals and hearing individuals, (e.g., greetings, attention getting, conversations, turn-taking and leaving taking).

A sample video of the deaf client’s language ability and vocabulary is recommended. This will allow the sign language interpreter (SLI) or the communication specialist (CS) to review and/or analyze the deaf client’s language and communication modality. The goal here is to investigate how to communicate.

If at all possible, videotape several sessions for the SLI or CS to examine. If the videotapes cannot be included with this profile of the deaf client, then have the SLI or CS work with this Profile form to provide his or her perspective of the deaf client’s language.

The Communication Complexity Scale (CCS) by Brady, Fleming, Thiemann-Bourque, Olswang, Dowden, Saunders, and Marquis (2012) was designed to describe a deaf child’s communication status who has a severe intellectual disability and developmental disability causing a communication style to incorporate presymbolic manner. Presymbolic communication is also referred to as home-made signs. The complexity scale becomes a foundation for assessing communication modalities and language for deaf adults with language dysfluency, for this Profile. Definitions and examples were changed to align more with a deaf adult.

The Receptive signing section is performed by the SLI or CS who then observes the linguistic reaction given by the deaf client. When observed, the SLI or CS will record his or her impressions.

The Expressive signing section is the observable language performed by the deaf client which is recorded.

A note to the SLI or CS is, for any linguistic clarification needs, it is suggested to obtain the book, *Linguistics of American Sign Language: An Introduction*, by Clayton Valli and Ceil Lucas, 5th edition, 2011.
The adapted CCS is not suggesting the deaf client has a mental disability or illness nor providing examples of various communication behaviors found in a mentally ill deaf client. The CCS is to assist in describing the various levels of communication and how that communication type is reflected and its intended use by a SLI or CS when monitoring the linguistic behavior of the deaf client under certain situations.

Each number category in the Communication Complexity Scale table, 0 to 11, may not appear in numerical order during the intake or therapeutic session. However, the SLI or CS should note if any behaviors do occur in each of the categories and document the behaviors. The categories will be explained to assist the SLI or CS in the usage of the CCS. Some of the categories build upon a previous category when observing behaviors and or responses.

**Number 0** appears when the clinician moves in his or her chair and the deaf client does not react by looking in the direction of the clinician. This tells the SLI or CS there was no response to the action presented.

**Number 1** refers to attention getting behavior which is performed by the clinician, SLI or CS for eye contact to be made. Remember, without eye contact the deaf client will not be able to “hear” what the clinician is saying. If the person employing attention getting behaviors is not familiar with what is Deaf culturally acceptable, it is suggested to get the book *For Hearing People Only*, by Matthew S. Moore and Linda Levitan (2003). There are attention getting behaviors that can have a negative effect or negative meaning, so care is needed to not perform those behaviors. Deaf cultural acceptable behaviors are not always the same in hearing culture.

**Number 2** has a single action taking place. This action can be an object, an event or a person which is referred by the acronym OEP. The deaf client sees the SLI raise his or her hands to denote the clinician has spoken or is speaking. Thus the OEP action is the SLI raising his or her hands, to begin signing.

**Number 3** contains a single OEP plus one potentially communicative behavior (PCB) that has an appropriate behavioral response. An example is, the clinician has the deaf client’s attention and asks a question, the deaf client replies. Here the SLI or CS is not looking at the type of response provided but that a response, following the conversational turn-taking and acceptable social interaction, was given.

**Number 4**, a continuation of Number 3, displays a backchanneling cue. This is an indication from the deaf client that he or she understood or saw the signs being shown. Not all back channeling cues mean the recipient understood the message being sent. Deaf individuals are known to nod their head when in fact this behavior is only done to appease the speaker. Many deaf individuals do not want the speaker to know what their fund of information (FOI) gap is or how extensive the gap is. More than one observation should be noted for this category to ascertain if the deaf client did understand the message being sent versus an appeasement gesture being furnished.
**Number 5** comprises the deaf client looking at the clinician then the SLI. The looking, i.e., scanning, is between two persons.

**Number 6** scans between two persons, as in Number 5, and this category includes a scan to an object or an event. The object could be a picture on the wall or the clinician shows the deaf client a psychological test. Here the deaf client will be scanning between the object/event and the clinician and SLI.

**Number 7**, a continuation of Number 6, but now the clinician asks the deaf client to perform or copy the clinician’s demonstration of the psychological test. Other demonstrations could be asking for the deaf client’s hands to be extended or walking across the room.

**Number 8** has three OEPs the deaf client will be tracking. The deaf client will scan to the clinician, the SLI, the OEP, and will close the triadic eye gaze by making eye contact with the clinician. The OEP could be the psychological test.

**Number 9**, a continuation of Number 8 such that, after closing the triadic eye gaze with the clinician, the deaf client follows that action with looking at the SLI for more interpreted information – clinician, SLI, OEP, clinician, ending with SLI.

**Number 10** refers to the level of the deaf client in answering, at least one, of the questions found in this Profile or the clinician’s intake form. With this category, an augmentative and alternative communication (AAC) is expected. AAC are other forms of communication expressed that is not ASL. Acceptable forms of communication are: pantomimes, gestures, sounds, writing, drawings, electronic communication devices and more, but no ASL signs.

**Number 11**, the final category, is a continuation of Number 10 with answering at least two or more Profile questions with AAC and an ASL sign.
<table>
<thead>
<tr>
<th>Number</th>
<th>Definition</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No response</td>
<td>Opportunity is presented, but deaf client does not look.</td>
<td>Clinician takes a seat while the deaf client is looking away the entire time.</td>
</tr>
<tr>
<td>1</td>
<td>Alerting – a change in behavior</td>
<td>A hand or foot wave, foot tapping chair or floor, hand tapping deaf client’s shoulder or desk for getting attention and eye contact is made.</td>
<td>The clinician performs a Deaf culturally accepted attention getting behavior and upon initiating the behavior the Deaf client makes eye contact with the clinician.</td>
</tr>
<tr>
<td>2</td>
<td>Single object/event/person (OEP) orientation</td>
<td>Deaf client focuses attention onto single OEP.</td>
<td>Clinician begins speaking and deaf client’s eye contact moves to the Sign Language Interpreter (SLI).</td>
</tr>
<tr>
<td>3</td>
<td>Single object/event/person (OEP) orientation plus 1 PCB*</td>
<td>Deaf client focuses attention onto single OEP and presents a behavior.</td>
<td>Deaf client is focused on SLI and presents a behavioral response.</td>
</tr>
<tr>
<td>4</td>
<td>Single object/event/person orientation plus more than 1 PCB</td>
<td>Deaf client focuses attention onto single OEP, presents a behavior, demonstrates understanding via back channel cues or continuators ¹.</td>
<td>Deaf client is focused on SLI, presents a head nod or signs YES ².</td>
</tr>
<tr>
<td>5</td>
<td>Scanning between two persons</td>
<td>Deaf client shifts attention between clinician and SLI.</td>
<td>Deaf client looks to SLI for interpreted message and then to clinician for facial expressions and body language.</td>
</tr>
<tr>
<td>6</td>
<td>Dual orientation between a person and an object/event</td>
<td>Clinician presents an opportunity to the deaf client.</td>
<td>The clinician administers a psychological test where the deaf client looks to the clinician and the test.</td>
</tr>
<tr>
<td>7</td>
<td>Dual orientation plus 1 or more PCBs</td>
<td>Clinician presents an opportunity to the deaf client and deaf client reacts.</td>
<td>The clinician administers a psychological test where the deaf client looks to the clinician then copies clinician’s demonstration of the test.</td>
</tr>
<tr>
<td>8</td>
<td>Triadic eye gaze</td>
<td>Deaf client looks to clinician, the opportunity, then back to clinician.</td>
<td>The deaf client sees the clinician and looks to see the demonstration the test, followed by making eye contact.</td>
</tr>
<tr>
<td>Number</td>
<td>Definition</td>
<td>Description</td>
<td>Example</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9</td>
<td>Triadic eye gaze plus more than 1 PCB</td>
<td>Deaf client looks to clinician, the opportunity, back to clinician, then to SLI.</td>
<td>The deaf client sees the clinician and looks to see the demonstration the test, followed by making eye contact with clinician then lastly to SLI for interpreted instructions.</td>
</tr>
<tr>
<td>10</td>
<td>One word verbalization, sign, or AAC** symbol selection</td>
<td>The clinician is asking intake form required questions to the deaf client.</td>
<td>Deaf client shakes head, pantomimes, or makes a sound.</td>
</tr>
<tr>
<td>11</td>
<td>Two or more word verbalizations, signs, or AAC symbol selections</td>
<td>The clinician continues to ask questions of the deaf client’s medical and mental health history.</td>
<td>Deaf client shakes head and signs NOT-UNDERSTAND, draws pictures and makes vocal sounds, or writes words with a pantomime.</td>
</tr>
</tbody>
</table>

*PCB – Potentially communicative behavior (behaviors such as vocalizations, gestures, eye gaze, or switch closures that appear to be purposeful in response to the stimulus and that could be viewed as communicating behavior regulation, joint attention, or social interaction).

**AAC – Augmentative and alternative communication. These are other forms of expressing thoughts, ideas, wants, feelings and needs via gesture, pantomime, electronic communication devices, writing, and drawings. American Sign Language, for this project, is not considered under the AAC category.

1 Back channel cues or continuators – are events (also known as tokens) which let the speaker/signer know if the utterance was understood or not (Kita & Ide, 2007; Schegloff, 1982).

2 Signs are represented in upper case when being translated for written purposes, e.g., DISCUSS, COMMUNITY, and more. This form is called glossing (Baker-Shenk & Cokely, 1980).
## Receptive Signing

Identify the deaf client's proficiency in each of the following categories.

<table>
<thead>
<tr>
<th>Does the deaf client understand:</th>
<th>Receptive Signing Proficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Excellent</td>
</tr>
<tr>
<td>Eye contact is required during a conversation</td>
<td></td>
</tr>
<tr>
<td>Instructions accompanied by gestures</td>
<td></td>
</tr>
<tr>
<td>Simple, routine instructions</td>
<td></td>
</tr>
<tr>
<td>Yes/No questions</td>
<td></td>
</tr>
<tr>
<td>Wh-questions</td>
<td></td>
</tr>
<tr>
<td>Rh-questions</td>
<td></td>
</tr>
<tr>
<td>Two or more successive questions</td>
<td></td>
</tr>
<tr>
<td>Simple conversation</td>
<td></td>
</tr>
<tr>
<td>Directions (e.g., east, west, left, right, up, down)</td>
<td></td>
</tr>
<tr>
<td>Directional verbs</td>
<td></td>
</tr>
<tr>
<td>Noun-verb pair distinction</td>
<td></td>
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<tr>
<td>Negation (head shakes or negative sign)</td>
<td></td>
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<tr>
<td>Interruptions (e.g., asking for clarification vs. taking the floor)</td>
<td></td>
</tr>
<tr>
<td>Fingerspelling</td>
<td></td>
</tr>
<tr>
<td>Lexicalized Fingerspelling</td>
<td></td>
</tr>
</tbody>
</table>

(Long, 1996).
Expressive Signing

Identify the deaf client's proficiency in each of the following categories.

<table>
<thead>
<tr>
<th>Does the deaf client:</th>
<th>Expressive Signing Proficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use fingerspelling</td>
<td>Excellent</td>
</tr>
<tr>
<td>Use lexicalized fingerspelling</td>
<td></td>
</tr>
<tr>
<td>Use simple, concrete signs</td>
<td></td>
</tr>
<tr>
<td>Produce signs that are clear and understandable</td>
<td></td>
</tr>
<tr>
<td>Express complete thoughts</td>
<td></td>
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<tr>
<td>Provide sufficient detail</td>
<td></td>
</tr>
<tr>
<td>Use conceptually correct signs (e.g., “right turn” vs. “all right”)</td>
<td></td>
</tr>
<tr>
<td>Express ideas clearly</td>
<td></td>
</tr>
<tr>
<td>Ask Y/N-questions</td>
<td></td>
</tr>
<tr>
<td>Ask wh-questions</td>
<td></td>
</tr>
<tr>
<td>Use clarifiers correctly</td>
<td></td>
</tr>
<tr>
<td>Use space appropriately</td>
<td></td>
</tr>
<tr>
<td>Use appropriate mouth movements</td>
<td></td>
</tr>
<tr>
<td>Use facial expression and body language to compliment signs</td>
<td></td>
</tr>
<tr>
<td>Participate in simple conversations</td>
<td></td>
</tr>
<tr>
<td>Provide directions accurately (e.g., north, west, left, right)</td>
<td></td>
</tr>
<tr>
<td>Identify pronouns</td>
<td></td>
</tr>
<tr>
<td>Arrange pronouns (their placement)</td>
<td></td>
</tr>
</tbody>
</table>

(Long, 1996).
This section is to examine the idiosyncratic or dysfluent use of sign language. Many behavior and language patterns can emulate psychotic behaviors; therefore, it is pertinent to record the observations. If any observations from the items listed below, present, check that it was observed.

<table>
<thead>
<tr>
<th>Observed behaviors or linguistic content</th>
<th>Check if observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressive ability is superior to their receptive ability</td>
<td></td>
</tr>
<tr>
<td>Receptive ability is superior to their expressive ability</td>
<td></td>
</tr>
<tr>
<td>Normally understandable expressive language contains intermittent interrupts in content/meaning</td>
<td></td>
</tr>
<tr>
<td>Normal emotive expression with normal motor use in non-linguistic related tasks but has difficulty with linguistic task</td>
<td></td>
</tr>
<tr>
<td>Fund of knowledge deficits (FOI)</td>
<td></td>
</tr>
<tr>
<td>Poor vocabulary</td>
<td></td>
</tr>
<tr>
<td>Sign features formed incorrectly</td>
<td></td>
</tr>
<tr>
<td>Aspects may be missing (topic/comment, clear referents, time indicators, grammar)</td>
<td></td>
</tr>
<tr>
<td>Repeated signs</td>
<td></td>
</tr>
<tr>
<td>Isolated signs/phrases</td>
<td></td>
</tr>
<tr>
<td>Used 3rd person</td>
<td></td>
</tr>
<tr>
<td>Inappropriate use of visual space</td>
<td></td>
</tr>
<tr>
<td>Inappropriate facial and/or emotional expression</td>
<td></td>
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<tr>
<td>Bizarre language content</td>
<td></td>
</tr>
<tr>
<td>Linguistic behaviors suggesting hallucinations</td>
<td></td>
</tr>
<tr>
<td>Guardedness and volatility evidence through language</td>
<td></td>
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<tr>
<td>Deteriorated language skills</td>
<td></td>
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<tr>
<td>Language improves with medication</td>
<td></td>
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<tr>
<td>Bizarre language usage (repeated handshape, non-linguistic element in place of sign, echoing language, inappropriate insertion of words/topics-theme)</td>
<td></td>
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<tr>
<td>Speed (unusually slow and deliberate with inappropriate pauses or rapid, nonstop, and usually hard to interrupt)</td>
<td></td>
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<tr>
<td>Frequency of a specific gesture in inappropriate contexts</td>
<td></td>
</tr>
<tr>
<td>Difficulties with discourse</td>
<td></td>
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<tr>
<td>Difficulty with metaphors, idioms, jokes, riddles</td>
<td></td>
</tr>
<tr>
<td>Difficulty with sentence assembly and/or unclear structural links</td>
<td></td>
</tr>
<tr>
<td>Difficulty with inferences, inferential reasoning tasks, figurative language, ambiguity</td>
<td></td>
</tr>
<tr>
<td>Observed behaviors or linguistic content</td>
<td>Check if observed</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Inappropriate eye contact</td>
<td></td>
</tr>
<tr>
<td>Changes in linguistic ability in regards to a specific topic or person</td>
<td></td>
</tr>
<tr>
<td>Physical disability hinders understanding</td>
<td></td>
</tr>
<tr>
<td>Signing style is inappropriate for age, race, class, gender, etc.</td>
<td></td>
</tr>
<tr>
<td>Inappropriate mouthing</td>
<td></td>
</tr>
<tr>
<td>Inappropriate 2-handed vs. 1-handed sign usage</td>
<td></td>
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</tbody>
</table>

(Communication Profile, 2008).
Additional comments or observations regarding the deaf client’s language use.

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(Long, 1996; Communication Profile, 2008).
The accompanying DVD, for this study, has six sections. They are: simple images, simple images with word(s), simple four images, simple four images with word(s), word(s) only, and ask a question.

Each DVD file contains only one plate with a Deaf Signer. A plate may consist of only one image, multiple images, English word(s), or a written English question. The Signer will sign the question while at the same time the image is being displayed. Individual files have been created as opposed to the whole assessment comprised into one file. This provides an opportunity for the clinician, sign language interpreter (SLI) or communication specialist (CS) to review the plates to ascertain which would be more appropriate for the deaf client. A situation might be, if the deaf client is color blind, then the images that contain the colors the deaf client is unable to distinguish can be avoided or not used when asking about a color or how to differentiate objects due to their color. Another situation might be if the deaf client is a sexual offender, where those images that might violate the deaf client’s parole (probation) terms and condition of agreement will not be displayed.

Simple images are where a plate will contain only one image, whether it be a picture or a drawing, in color or black and white. Examples of images are a ball, boy, girl, bicycle, airplane, or an apple. The images will start as simplistic and range to complex. The images are more concrete in nature than abstract. The objective is, the deaf client will be asked what is it (via the Signer) and the response is noted.

Simple image with word(s) is a place with a single image and a word or words corresponding to the image, just above. This plate serves a dual process. First, for the ability of the deaf client to see the image and know what it is and, secondly, to establish if the deaf client is able to read the word or words.

Simple four images are displayed while the Signer will ask a question about the images. The deaf client will respond by selecting the image that best answers the question. An example might be, “who is kicking the ball,” where one of the images has a person kicking a ball. The other images may be related to a similar type of action or a very different action.

Simple four images with words is the same as Simple four images, however, at the top of the images will be the question. The Signer will ask the deaf client to answer the question. This plate serves a dual function to determine if the deaf client can also read the English statement or question. This may look like, the Signer signing, “please answer the question,” where the English question is “who is kicking the ball” with four images to select from.
Words only are plates that contain one word or several words. They range from simplistic to complex, concrete to abstract. The Signer will ask for the deaf client to “sign what the word says.” Again, this is establishing if the deaf client can read English and also does he or she know the sign or group of signs for the English word(s) presented. It is prudent to remember, there will not always be a one-to-one correspondence of ASL sign to English word and vice-versa. Some English words may have more than one sign to represent the meaning or concept. And some ASL signs may have more than one English word to explain the meaning or concept.

The last category is Asking a Question. These are questions that will more than likely relate to the deaf client’s world or thought world. The deaf client may not know, who is the president of the United States, but may know who is the president of the local Deaf club. The questions are designed to not duplicate what was asked from the Profile. If the deaf client was asked, what is your current address, from the Profile, the Skills Inventory I will not have this question. However, if the deaf client did not answer the Profile questions, meaning a family member, friend or caregiver answered, then it is suggested to use the Profile questions here. The majority of the questions are closed-ended questions.

Some of the questions may not apply to the deaf client because he or she does not engage in that activity. These questions then can be removed from the Skills Inventory and replaced with others.

If the deaf client’s first written language is not English, some of the Skills Inventory categories may not be useful.
Simple Image Plates

1) Title of Image: _____________________________________________
   Response: _________________________________________________

2) Title of Image: _____________________________________________
   Response: _________________________________________________

3) Title of Image: _____________________________________________
   Response: _________________________________________________

4) Title of Image: _____________________________________________
   Response: _________________________________________________

5) Title of Image: _____________________________________________
   Response: _________________________________________________

6) Title of Image: _____________________________________________
   Response: _________________________________________________

7) Title of Image: _____________________________________________
   Response: _________________________________________________
Simple Image with Word(s) Plates

1) Title of Image + Words: 

Response: 

2) Title of Image + Words: 

Response: 

3) Title of Image + Words: 

Response: 

4) Title of Image + Words: 

Response: 

5) Title of Image + Words: 

Response: 

6) Title of Image + Words: 

Response: 

7) Title of Image + Words: 

Response:
Simple Four Images Plates

1) Title of Four Images: ________________________

Response: ________________________

2) Title of Four Images: ________________________

Response: ________________________

3) Title of Four Images: ________________________

Response: ________________________

4) Title of Four Images: ________________________

Response: ________________________

5) Title of Four Images: ________________________

Response: ________________________

6) Title of Four Images: ________________________

Response: ________________________

7) Title of Four Images: ________________________

Response: ________________________
Simple Four Images with Word(s) Plates

1) Title of Four Images + Words: ________________________________

Response: ________________________________

2) Title of Four Images + Words: ________________________________

Response: ________________________________

3) Title of Four Images + Words: ________________________________

Response: ________________________________

4) Title of Four Images + Words: ________________________________

Response: ________________________________

5) Title of Four Images + Words: ________________________________

Response: ________________________________

6) Title of Four Images + Words: ________________________________

Response: ________________________________

7) Title of Four Images + Words: ________________________________

Response: ________________________________
Words Only Plates

1) Words: _______________________________________________________
Response: _______________________________________________________

2) Words: _______________________________________________________
Response: _______________________________________________________

3) Words: _______________________________________________________
Response: _______________________________________________________

4) Words: _______________________________________________________
Response: _______________________________________________________

5) Words: _______________________________________________________
Response: _______________________________________________________

6) Words: _______________________________________________________
Response: _______________________________________________________

7) Words: _______________________________________________________
Response: _______________________________________________________
Asking a Question Plates

1) Question: ________________________________________________________________
   Response: __________________________________________________________________

2) Question: ________________________________________________________________
   Response: __________________________________________________________________

3) Question: ________________________________________________________________
   Response: __________________________________________________________________

4) Question: ________________________________________________________________
   Response: __________________________________________________________________

5) Question: ________________________________________________________________
   Response: __________________________________________________________________

6) Question: ________________________________________________________________
   Response: __________________________________________________________________

7) Question: ________________________________________________________________
   Response: __________________________________________________________________
Part Six: Recommendation Report

This section focuses on the report that is to be generated from an objective perspective. The report is to be presented to the mental health team, which includes the clinician, to offer what was discovered during the Communication Assessment Profile and Skills Inventory test, followed by means to suggest accommodation(s) to meet the deaf client’s communication modality. The report is to offer descriptions of the deaf client’s communication process.

When writing the report, keep in mind to provide specific observable behaviors and note if they are acceptable according to Deaf culture norms and ASL linguistic rules and structures. The deaf client may have an accent or use a dialect which needs to be reflected in the report along with examples. If a sign appears to be produced incorrectly, indicate the production of the sign in the report. The sign production may be a different accent or dialect. Or, the incorrect production could be for other reasons which needs to be addressed in the report.

The Skills Inventory section, the assessment on the DVD, needs to be included into the report of how the deaf client responded to the questions presented. The assessment is not a measuring instrument to later provide intelligence or language levels. It is only for the gathering of vocabulary to determine the deaf client’s communication modality which will later assist the mental health team in how to accommodate the deaf client, language-wise.

There will be some images on the DVD that the clinician may not want the deaf client to view. It is important to explain why certain images were not used, e.g., religious reasons, color blind, cannot read English, or contrary to parole terms and conditions of agreement. This is important to know if the deaf client has a fund of information (FOI) gap. Though the percentage of individuals who are color blind is small (roughly 5 to 8% in men and 0.5 to 1.0% in women), a statement to the color blindness needs to be added. Also, state if the deaf client is also a sexual offender or predator where the terms of his or her parole (probation) agreement might be violated if certain images are viewed.

There will be sections in which no data was collected. It is prudent to comment on the missing and/or lacking data for the section, e.g., deaf client does not know, person with information is not present or alive, or documentation is lost.

If electronic equipment was used as a communication modality, state when this process took place and under what conditions to show effectiveness or ineffectiveness. For example, the VideoPhone (VP) was proffered for some communiques between the deaf client and clinician where the deaf client in seeing the sign language interpreter (SLI) concluded he or she was “seeing people” a possible hallucination. Then this device is not recommended for use due to the deaf client not fully understanding the concept or use behind the VP. The report should indicate the non-usage of the VP and why.
There is very little information on deaf individuals having dyslexia, either in reading or in signing. There may be a possibility the deaf client has a dyslexic problem with sign production.

Errors in sign production are not the same as an accent or dialect presentation. It is more of a miscreation (mispronunciation for spoken language) problem, hereafter referred to as sign error production. It is recommended that a description of the sign error production be addressed in the report. For example, the production of SUNDAY, is a two-handed with handshape of open B for both hands, palms orientation is outward, location is in neutral space, and movement is circle hands out twice (Tennant & Brown, 1998, p. 170).

With a sign error production, the deaf client constructs SUNDAY where his or her hands have a palm orientation of inward, instead of outward. This production error must be noted. A different presentation for SUNDAY can be the hand movement is tapped out twice instead of circling; this is referred to as an accent. There are many possible reasons for this error in production, such as, but not limited to: physical difficulties or limitations, taught this is the way to produce the sign, as a child he or she made the sign but was not corrected, playing around with signs, eavesdropping on a conversation and tried to mimic the sign (unsuccessfully), or a possible brain malfunction (e.g., TBI – traumatic brain injury). The book, Signs Across America by Shroyer and Shroyer (1984) provides the various accents (sign productions) across the United States which is a good start to determining if a sign is an accent or an error in production. The SUNDAY sign selected, for the example above, is more seen in Florida, Illinois, Michigan, Missouri, New Mexico, Texas, Utah, Virginia, and Wisconsin (Shroyer & Shroyer, 1984). Shroyer and Shroyer (1984) noted that Californians have a different representation for SUNDAY. Other references are Sociolinguistic Variation in American Sign Language, by Lucas, Bayley, and Valli (2001) and The Hidden Treasure of Black ASL, by McCaskill, Lucas, Bayley, and Hill (2011). These two references show accents and dialects within the United States Deaf community.

A cultural awareness is needed in nonverbal communication, such as, pointing. Gossen's (1995) book called Diné Bizaad: Speak, Read, Write Navajo, stated that pointing with the index finger is unethical. In Mexico, a form of pointing is with the chin and for the American Indians a form of pointing is the use of lips (Carlisle, 1993). Finger pointing in certain American Indian tribes is considered accusatory and a rude behavior. Pointing in American Deaf culture is acceptable; however, it is important to know the deaf client’s cultural background.

Appendix F suggests some Do’s and Don’ts on Accommodations which has been revised to match deaf adults instead of deaf students in the K-12 setting (Guidelines for Assessment Accommodations for Student with Disabilities, 2005, p. 16). This is provided as a guideline to assist when writing up the report or while doing the data gathering.
Recommendations

(Based on SLI or CS’s report)

Comments regarding the deaf client’s treatment based on use of communication.

Consider the following:

- Environmental considerations (reduced noise, well lit, visual, etc.)
- Accessibility considerations – technology and environment (TTY, VP, pager access, captioning on TV, cochlear implant, hearing aid, amplified phone, FM system, written materials, knocking on door/privacy, intercoms, eye contact, alarms/warnings, etc.)
- Accessibility considerations or modifications for treatment related to language (one-on-one, interpreter, direct therapy, CSI, VGCS, etc.)
- Ability to use modifications or accommodations
- Audiological exam recommended? Why? (client’s desire, ambiguity, malingering, facility/agency refusing to provide services, facility were refusing to believe client has a hearing loss, or suspect a mental illness that cause client to think he or she is deaf when they are not?)
- Use of sign language? (when should or should it not be used?)
- Use of speech? (when should or should it not be used?)
- Use of speechreading? (when should or should it not be used?)
- Use of English written language? (when should or should it not be used?)
- Use of residual hearing? (when should or should it not be used?)
- Confirming information for understanding
- Additional disabilities that need consideration for treatment
- Other
Evaluator(s) Contact Information

To be included in final summary report.

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<tr>
<th>Name</th>
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## Appendix A

<table>
<thead>
<tr>
<th>Descriptors of Language Proficiency</th>
<th>Definitions</th>
</tr>
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<tbody>
<tr>
<td>Native speaker</td>
<td>Fluent, mastery of the language</td>
</tr>
<tr>
<td>Near native</td>
<td>Fluent</td>
</tr>
<tr>
<td>Excellent command</td>
<td>Highly proficient in American Sign Language (or spoken) and written English</td>
</tr>
<tr>
<td>Very good command</td>
<td>Proficient in American Sign Language (or spoken) and written English</td>
</tr>
<tr>
<td>Good command</td>
<td>Good working knowledge</td>
</tr>
<tr>
<td>Basic communication skills</td>
<td>Working knowledge</td>
</tr>
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</table>

(Describing Language Skills, n.d.)
Appendix B

Decibels (dB) are measured in degrees and the hearing loss is divided into levels based on an individual’s auditory thresholds.

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<thead>
<tr>
<th>Hearing</th>
<th>Degrees of Loss</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>0 to 25 dB</td>
<td>Hearing is considered normal</td>
</tr>
<tr>
<td>Mild</td>
<td>25 to 40 dB</td>
<td>Difficulty hearing soft speech in a noisy environment.</td>
</tr>
<tr>
<td>Moderate</td>
<td>40 to 70 dB</td>
<td>Difficulty hearing moderate speech with background noises.</td>
</tr>
<tr>
<td>Severe</td>
<td>70 to 90 dB</td>
<td>Difficulty hearing loud speech.</td>
</tr>
<tr>
<td>Profound</td>
<td>90 dB and up</td>
<td>Difficulty hearing even with amplification.</td>
</tr>
</tbody>
</table>

(Clark, 1981; Understanding Severe-to-Profound Hearing Loss, 2014).

(Advice to employers, n.d.)
Appendix C

There are many different forms of pedagogical signing systems, also known as manually coded English (MCE) (Baker-Shenk & Cokely, 1980). These systems were designed to replicate English syntax, semantics and phonemes.

Examples of these various systems that deaf individuals use to communicate, are presented here.

<table>
<thead>
<tr>
<th>Pedagogical Signing System</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.E.E. I</td>
<td>Seeing Essential English, based on root signs which others signs were affixed (Anthony, 1974).</td>
</tr>
<tr>
<td>S.E.E. II</td>
<td>Signing Exact English, the foundation is American Sign Language (ASL) with modification of the handshape by taking the first letter of the word corresponding with the English word (Gustason, Pfetzing, &amp; Zawalkow, 1972).</td>
</tr>
<tr>
<td>L.O.V.E</td>
<td>Linguistics of Visual English is a visual representation of morphemes with as much ASL employed and developed by Dennis Wampler in 1972 (Nomeland &amp; Nomeland, 2011).</td>
</tr>
<tr>
<td>Cued Speech</td>
<td>A method of teaching a spoken language through hand positions near the mouth to represent the invisible English sounds or phonemes.</td>
</tr>
<tr>
<td>Signed English</td>
<td>Visible production of English with its affixes and some semantic information.</td>
</tr>
<tr>
<td>Rochester Method or Visible English</td>
<td>Every word spoken is fully fingerspelled.</td>
</tr>
<tr>
<td>PSE</td>
<td>Pidgin Signed English is a combination of ASL and English.</td>
</tr>
<tr>
<td>MSS</td>
<td>Mainly used in Texas. The root word is signed along with an affix, e.g., re-, un-, -est, -ing, -ity, -ness, etc. MSS is literally signing all the morphemic parts of an English word.</td>
</tr>
</tbody>
</table>
Appendix D
Use of a Certified Deaf Interpreter (RID)

USE OF A CERTIFIED DEAF INTERPRETER

About the CDI
A Certified Deaf Interpreter (CDI) is an individual who is deaf or hard of hearing and has been certified by the Registry of Interpreters for the Deaf as an interpreter.

Specialized training and/or experience
In addition to excellent general 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 an extensive 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.

Meeting special communication challenges
A Certified Deaf Interpreter 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. Some 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
- have characteristics reflective of Deaf Culture not familiar to hearing interpreters.

The CDI at Work
As a team member
Often a Certified Deaf Interpreter works as a team member with a certified interpreter who is hearing. In some situations, a CDI/hearing interpreter team can communicate more effectively than a hearing interpreter alone or a team of two hearing interpreters or a CDI alone. In the CDI/hearing interpreter team situation, the CDI transmits message content between a deaf consumer and a hearing interpreter: the hearing interpreter transmits message content between the CDI and a hearing consumer. While this process resembles a message relay, it is more than that. Each interpreter receives the message in one communication mode (or language), processes it linguistically and culturally, then passes it on in the appropriate communication mode. In even more challenging situations, the CDI and hearing interpreter may work together to understand a deaf individual’s message, confer with each other to arrive at their best interpretation, then convey that interpretation to the hearing party.

For Deaf-Blind individuals
When a consumer who is deaf-blind is involved, the CDI may receive a speaker’s message visually, then relay it to the deaf-blind individual through the sense of touch or at close visual range. This process is not a simple relay in which the CDI sees the signs and copies them for the person who is deaf-blind. The CDI processes the message, then transmits it in the mode most easily understood by the individual who is deaf-blind.

Solo
The CDI sometimes works as the sole interpreter in a situation. In these instances, the CDI may use sign language or other communication modes that are effective with a particular deaf individual, and may use, with the hearing consumer, a combination of speech, speech reading, residual hearing, and written communication.

On the platform
The CDI sometimes functions as interpreter before an audience. This may involve the CDI watching a hearing interpreter and restating the message to the audience in a different sign mode. At
Appendix D - Continued
Use of a Certified Deaf Interpreter (RID)

other times, the CDI may be in front of the audience to "mirror" comments or questions from a signing member of the audience so that the rest of the audience can see them.

Benefits of using a Certified Deaf Interpreter are:

- optimal understanding by all parties
- efficient use of time and resources
- clarification of linguistic and/or cultural confusion and misunderstanding(s)
- arrival at a clear conclusion in the interpreting situation.

The Association believes that when use of a Certified Deaf Interpreter (CDI) is appropriate, the CDI and a certified interpreter who is hearing can function as a highly effective team to provide quality communication access for everyone involved.

(Use of a Certified Deaf Interpreter, 1997).
Appendix E
Interpreting in Mental Health Settings (RID)

The Registry of Interpreters for the Deaf, Inc. (RID) Standard Practice Paper (SPP) provides a framework of basic, respectable standards for RID members’ professional work and conduct with consumers. This paper also provides specific information about the practice setting. This document is intended to raise awareness, educate, guide and encourage sound basic methods of professional practice. The SPP should be considered by members in arriving at an appropriate course of action with respect to their practice and professional conduct.

It is hoped that the standards will promote commitment to the pursuit of excellence in the practice of interpreting and be used for public distribution and advocacy.

This Standard Practice Paper addresses the unique challenges faced by interpreters working in mental health settings and the skill set needed to successfully meet these challenges. The mental healthcare field is broad and includes psychiatric assessment and treatment, group and individual psychotherapy, counseling, psychological testing, substance abuse treatment and more. RID recommends that interpreters working in these settings hold a current RID certification to assure a minimum level of interpreting competence and compliance with the NAD-RID Code of Professional Conduct. It is also recommended that before working in mental health settings interpreters receive training in this area.

When communication involves two or more languages and cultures, psychiatric assessment and mental health treatment present additional complexities which must be considered and addressed by the professional team, including the interpreter. For the interpreter, these challenges can be divided into three areas: the linguistic considerations, delineated in Section A; contextual dimensions, outlined in Section B; and interpersonal dynamics, covered in Section C. Lastly, there are specific steps that an interpreter can take to improve the likelihood of success in mental healthcare work. These are addressed in Section D.

Section A – Linguistic Considerations:

Mental health professionals depend heavily on language form and content for diagnosis and treatment. Nuances in communication, including affective tone and subtleties of language structure, may be significant for diagnosis and treatment effectiveness. Further, interpreting in mental health settings frequently presents the unique challenge of working with individuals who have dysfluent or even alogiasic means of expression. Communication may be further impacted by cognitive, emotional, behavioral or social factors. Beyond these complexities associated with language form, there is a unique vocabulary as well as specialized and deliberate techniques of speaking in therapeutic relationships. Interpreters will encounter words and phrases that have a specific psychiatric meaning which is distinct from how the general public uses these same terms.

Interpreting in mental health settings requires the ability to use multiple interpreting approaches including 1st person, 3rd person, narrative, descriptive, simultaneous, consecutive, team interpreting and working with a certified deaf interpreter. Equally critical is the ability to recognize and comment on the form of language as distinct from the content of language. In addition, interpreters should be able to recognize and comment on potential exacerbating or mitigating factors affecting impaired language expression. Providing commentary on language, culture and the interpreting process is appropriate in many circumstances but should be clearly distinguished from advising or commenting on diagnosis.
Appendix E - Continued

Interpreting in Mental Health Settings (RID)

In addition to communicating with providers about relevant issues of language, culture and the interpreting process, the interpreter may also need to discuss his or her own linguistic and behavioral choices. It is of the utmost importance that issues that could lead to misunderstanding or misdiagnosis of consumers be shared with the clinical team. This may include sharing information about Deaf culture and communication norms, including dysfluency and potential deficits in a consumer’s fund of information. Interpreters should have a working knowledge of the diagnostic criteria and taxonomic structure of the current Diagnostic and Statistical Manual of Mental Disorders, due to the critical role this text plays in the field of mental healthcare. Interpreters also should be familiar with the current literature in the field of mental health interpreting.

Section B - Contextual Dimensions:

There is a wide range of mental health settings and services which are provided across the continuum of age, ethnicity and cultural identity. Settings include inpatient and outpatient settings, peer-led settings (such as AA or “self-help groups”), outreach settings (in-the-field), day programs, private clinician’s offices, clinic settings, emergency rooms, forensic and court venues, and long-term residential care settings. To perform effectively in these settings, interpreters require knowledge about the diversity of mental healthcare environments, including the goals and norms of specific settings and interventions. Interpreters should be familiar with the types of mental health professionals who are present in various settings, their roles, their communication goals and their treatment methodologies. In the most effective clinical environments, interpreters are seen as members of the mental healthcare team. An interpreter’s conduct and decision-making therefore should align with the goals and processes of the setting and the clinician(s). Working in the mental healthcare field also entails specific legal and regulatory obligations which apply to interpreters as well as clinicians. Interpreters should seek guidance and information about how applicable regulations and laws may affect them and influence their conduct.

When interpreting in emotionally-charged settings, or when in the presence of people who are experiencing instability of mood, thoughts and behaviors, interpreters must be able to remain calm, professional, attentive to their surroundings and mindful of their physical safety.

Given the importance of medications in psychiatric treatment, the interpreter should have a basic knowledge of psychopharmacology, including the medications commonly used, their indications for use and effects which may influence communication or the interpreting process.

As a member of the mental healthcare team, interpreters can also serve as a link to resources which can provide the team with information about current research, knowledge and specialists in the field of mental health with the deaf population.

Section C - Interpersonal Dynamics:

There is a long-standing recognition of the unique quality and power of the therapeutic relationship and a growing understanding of the influence of an interpreter’s presence on the development and dynamics of that relationship. This may raise distinct issues pertaining to confidentiality, vicarious trauma, transference, and countertransference. This, in turn, increases the need for self-awareness on the part of the interpreter and for strategies for managing the potential interference of one’s own biases, judgments and sensitivities in the therapeutic process.

It is essential that interpreters possess personal and psychological strengths necessary to be effective in mental health work along with the ability to consistently and critically assess one’s skills and the impact of one’s behavioral and translation decisions. These strengths include comfort amidst intense emotions, the ability to maintain professional demeanor during highly charged interactions, insight into one’s own psychological and emotional responses and utilizing resources to maintain one’s own mental health.

Mental health services are largely provided by individuals working as part of a team and in the most effective service environments, with interpreters included as members of that team. Therefore, the interpreter should be prepared to ethically and effectively function as a team member in the clinical process. This involves an understanding of the complexities of confidentiality within mental health settings and the need to form and maintain personal and professional boundaries in relationships with deaf and
Appendix E - Continued

Interpreting in Mental Health Settings (RID)

Section D – What steps can be taken to improve the potential for a successful outcome in mental health interpreting?

- Pursue opportunities for professional development in this interpreting practice specialty area. Increase your knowledge regarding therapeutic interventions, clinical terminology and psychiatric diagnoses. Stay abreast of the professional literature in the mental health interpreting field.
- Develop a relationship with a mentor who has more experience in this area.
- Develop mutual consultation relationships with mental health service providers and interpreter colleagues. It is within the context of these professional relationships that general discussions of provider goals and practice methodologies and relevant issues of language, culture and the interpreting process may be readily explored.
- Acknowledge that the presence of an interpreter will impact all aspects of mental healthcare, especially the therapeutic relationship. Develop strategies for mitigating the negative effects of that impact, such as employing pre and post-session consultations in order to more effectively align oneself with therapeutic goals.
- Continue the thoughtful development of self-awareness, including interpersonal issues, sensitivities, and biases that can unintentionally and unconsciously impact the interpreting process and mental health service outcomes.
- Reduce vulnerability to vicarious or secondary trauma by seeking a healthy balance between strong psychological boundaries, empathetic engagement and a philosophy of detachment. Incorporate a routine of self-care and develop an intellectual appreciation of the field of mental health in order to offset the negative impact of repeated exposure to the psychological and emotional pain of others.
- Collect and share resources from the mental health interpreting and mental health services and the deaf population. Among such resources are the following:
  - The Office of Deaf Services at the Alabama Department of Mental Health and Mental Retardation: [http://www.mh.aldakabama.gov/MIDS/]
  - The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals at [http://www.mnccddef.org/]
  - The Deaf Wellness Center at the University of Rochester: [http://www.urmc.rochester.edu/dwc/]
  - The Registry of Interpreters for the Deaf: [http://www.rid.org]
  - The APA PsychInfo database: [http://psychinfo.apa.org/]

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1. Dysfluent (disfluent) – A lack of proficiency in producing or understanding one’s preferred (best) language. Dysfluency can be gross or extremely subtle. It may be a result of cognitive, educational, or psychiatric difficulties. Examples include echolalia, clanging, neologisms, stuttering, and incoherence.
2. Alinguistic – Expression of spoken or signed utterances without a consistent or formal language structure.
3. Transference refers to the phenomenon of emotions, perceptions, and behaviors from past relationships biasing a client’s relationship with his or her therapist (or interpreter). Countertransference refers to the therapist’s (or interpreter’s) past relationships biasing his or her emotions, perceptions or behavior toward his or her consumer(s).
Appendix F

Do’s and Don’ts When Choosing Accommodations

<table>
<thead>
<tr>
<th>Do’s</th>
<th>Don’ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do … make accommodation decision based on the deaf individual’s needs.</td>
<td>Don’t … make accommodation decisions based on whatever is “easiest” to do (e.g., preferential seating, communication modality, etc.)</td>
</tr>
<tr>
<td>Do … document assessment accommodation(s) in the chart.</td>
<td>Don’t … use an accommodation that has not been documented in the chart.</td>
</tr>
<tr>
<td>Do … be familiar with the types of accommodations that can be used as assessment accommodations for deaf individuals.</td>
<td>Don’t … assume that all accommodations can be used for assessment.</td>
</tr>
<tr>
<td>Do … be specific about the “where, when, who, and how” accommodations will be provided.</td>
<td>Don’t … just indicate that an accommodation(s) will be provided “as appropriate” or “as necessary.”</td>
</tr>
<tr>
<td>Do … refer to state-allowable accommodations listed and understand implications of selections.</td>
<td>Don’t … check every accommodation possible as a checklist just to be “safe.”</td>
</tr>
<tr>
<td>Do … evaluate whether an assessment accommodation is used by the deaf individual.</td>
<td>Don’t … assume that the same accommodation should remain appropriate year after year.</td>
</tr>
<tr>
<td>Do … get input about accommodations from general educators, parents, and sign language interpreters.</td>
<td>Don’t … make decisions about assessment accommodations alone.</td>
</tr>
<tr>
<td>Do … mediate the type of accommodations needed for the deaf individuals at your facility.</td>
<td>Don’t … assume that an accommodation for one deaf individual can be applied to all deaf individuals. One size does not fit all.</td>
</tr>
</tbody>
</table>

(Guidelines for Assessment Accommodations for Student with Disabilities, 2005, p. 16).

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