The Nature of Deaf Culture: Implications for Speech and Hearing Professionals

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Deaf culture is a lifestyle for many individuals who are born deaf and hard-of-hearing and for other people with acquired hearing loss who have enculturated into it. It has its own history, values, traditions, folklore, and communication behaviors. Its language is American Sign Language (ASL) which gives the culturally Deaf group its identity. People who are culturally Deaf do not consider deafness a pathology or abnormality, but rather a difference and a cultural minority. Even though speech is not compatible with ASL, culturally Deaf people may be interested in spoken English because they realize they must interact with hearing people. Professionals should acknowledge and respect Deaf culture if training in English communication is to be successful. This article provides an overview of Deaf culture; its unique behavioral characteristics, values, and traditions; and suggestions of ways to improve interaction between Deaf people and communication professionals.

Most of the adult clients with hearing loss seen by speech and hearing professionals are adventitiously hard-of-hearing or late-deafened. These clients usually communicate with spoken English and are frequently interested in sensory aids to improve listening, speechreading, and speech skills. Many children with hearing impairment who are seen in speech and hearing clinics have parents whose goals for their children involve development of English language skills.

There is, however, a small group of adults who are deaf or hard-of-hearing who view their own and their children's deafness differently. These are the people who are members of **Deaf** culture. Following a convention proposed by Woodward (1972), the term *Deaf* is used in this article to denote people who identify with Deaf culture in contrast to the term *deaf* which describes the audiological

condition of the individual.

The purposes of this article are to present an overview of Deaf culture; to discuss unique behavioral characteristics, values, and traditions of Deaf culture members; and to provide suggestions of ways to improve interaction between Deaf people and communication professionals in academic, clinical, and medical settings. The information in this article is based not only on what is in the literature but also on the experience of the author, who has been an audiologist at Gallaudet University for more than 20 years. Included in the discussion are approaches used at the Gallaudet University Hearing and Speech Center for provision of evaluative and rehabilitative services to Deaf individuals. Palmer, Bement, and Kelly (1990) also describe Deaf culture and discuss approaches used at the National Technical Institute for the Deaf (NTID) to help students improve speechreading ability and use of communication strategies.

OVERVIEW OF DEAF CULTURE

The following discussion represents an overview of Deaf culture. More in-depth information can be obtained from the following sources: Crittenden (1993), Lane (1990, 1992), Padden and Humphries (1988), Paul and Quigley (1990), Van Cleve and Crouch (1989).

There is considerable diversity within Deaf culture involving competence in American Sign Language (ASL), level of education, type of education (e.g., residential or mainstream environment), type of employment, competence in English, degree of hearing loss, and age of onset. Jacobs (1974) identifies a number of categories of Deaf people, including prelingually Deaf adults from Deaf families, other prelingually Deaf adults, uneducated Deaf adults, adults from oral programs, adults from public schools, deafened adults, and adults who are hard-of-hearing. All of these people may be included in Deaf culture if they identify with its values. In addition, racial and ethnic differences exist. Padden and Humphries (1988) describe this diversity well.

Deaf culture is considered by its members as a minority culture with its own history, customs, values, social patterns, traditions, beliefs, rules of behavior, stories, and jokes (Padden, 1980). It has a distinctive gestural-visual language which is not English. This culture is transmitted through everyday social interaction and participation in special schools, church groups, social and sports clubs, and other Deaf organizations. Its members identify with and obtain most of their social experiences within the Deaf community. As Kannapell and Adams (1984) describe, culturally Deaf adults are those individuals who have chosen to use sign language as their primary means of communication and to associate primarily with others who do likewise. Such individuals find sign language to be a complete, unambiguous communication system and find a vast array of social and cultural support systems within the signing Deaf community.

Persons who belong to Deaf culture demonstrate some degree of hearing loss

which may range from moderate to profound. The type of degree or hearing loss, however, does not constitute a criterion for being Deaf (Padden, 1980). According to Padden (1980), Deaf people are often unaware of the details of their friends' hearing losses and may be surprised to find out that voice telephone use is possible for some. A person may be born into Deaf culture or may become enculturated later in life by adopting its language, values, and practices. Residential schools serve as major sources of enculturation for children from hearing families, although some deaf people educated in mainstream environments later choose to become part of Deaf culture.

LANGUAGE AND SPEECH

The language of Deaf culture is ASL, which consists of handshapes presented in specific directional and movement patterns. These handshapes, directional patterns, hand movements, and positions of the hands relative to the body all carry semantic, grammatical, and pragmatic information. Body language, gestures, facial expressions, and lip movements which typically do not represent spoken English, are also part of ASL (Klima & Bellugi, 1979; Liddell, 1980; Lucas, 1989, 1990; Stokoe, 1960; Wilbur, 1987). Although all culturally Deaf people consider ASL their primary language, they do not necessarily sign the same way. As with speech, signing has dialectical characteristics; therefore, people from different regions sign somewhat differently from each other. In addition, for many Deaf adults, ASL has been influenced by English. Therefore, sign communication tends to fall on a continuum from English-free ASL at one end to more English-based signing at the other where sign presentation corresponds to English word order. Many Deaf people, particularly when communicating with hearing people who sign, use some variant of English signing which omits function words but retains English word order. This type of signing is known as "contact signing" or "pidgin sign" English (Lucas & Valli, 1990). Many Deaf people use different types of sign language to accommodate different communication partners.

Although adults who are culturally Deaf tend to communicate comfortably with sign language and consider English as a second language, some have difficulties with the vocabulary and structure of English in either a manual or oral form (King & Quigley, 1985; Quigley & Paul, 1990). Many culturally Deaf people recognize the importance of competence in written English and may seek help. It is important that professionals not confuse English language difficulties with intellectual or cognitive deficits. Usually such individuals can communicate well in ASL.

It is not possible to speak and sign ASL at the same time because of structural differences between the languages. Although it is possible to combine speech with English signing, speech is not encouraged or considered a high priority by many Deaf adults. Many Deaf people who use some form of English signing use lip movements, but no voice. One reason given for the lack of voice is that it is

very difficult to synchronize spoken and signed language even if English word order is maintained; one language or the other suffers. Still, many Deaf people are skilled code switchers. They will use speech (if they have the capability) to communicate with hearing people when necessary for clear communication. Many Deaf people are aware of the necessity to interact with hearing people and the importance of maximizing their speech skills for that purpose.

DEAF CULTURE AND DEAF COMMUNITY

According to Kannapell and Adams (1984), ASL is more than a communication mode for Deaf people. It provides group identity, and ASL competence is a requirement for membership in the Deaf culture and community. There is a difference between Deaf culture and the deaf community. The deaf community consists of a larger and more heterogeneous group of people who share the values and goals of Deaf people, but are not necessarily culturally Deaf. Padden (1980) defines a deaf community as:

> a group of people who live in a particular location, share the common goals of its members, and in various ways, work toward achieving these goals. A deaf community may include persons who are not themselves Deaf, but who actively support the goals of the community and work with Deaf people to achieve them. (p. 92)

Although culturally Deaf people form the core of the deaf community, hearing relatives, post-lingually deaf people, hard-of-hearing members of hearing families, and hearing friends may be included. These people share the common goals of the core group and work toward achieving these goals. Hearing people may be part of the deaf community, but need to know and use ASL whenever possible. However, when Deaf or hearing people are involved in activities which include people who use English rather than ASL, Signed English is acceptable. Levine (1981), Padden (1980), and Rosen (1986) suggest that it is more appropriate to think of an array of deaf communities in different locations, varying in size, hearing status, communication systems, educational and ethnic background.

Crittenden (1993) and Padden (1980) suggest that membership in Deaf culture is more restricted than membership within the deaf community. People included in Deaf culture have some degree of hearing loss, use ASL as their primary language, generally do not use speech when communicating with others, and engage in social activities with each other. Language use is more flexible at the community level, but more restricted to ASL within the cultural group.

Hearing children of Deaf adults (CODAs) usually are fluent ASL communicators and familiar with the values and traditions of Deaf culture. Yet they are generally not considered members of Deaf culture, even though their exclusion may be painful to Deaf relatives. Padden and Humphries (1988) describe the unclear status of CODAs typified by their exclusion from Deaf organizations such as the American Athletic Association of the Deaf.

VIEWS OF DEAFNESS

Culturally Deaf people view deafness as a difference, not a pathology. They consider deafness a minority culture, not a defect, and do not consider themselves abnormal in any way. In contrast, the author has found that the Pathology model is more common among adventitiously deaf and hard-of-hearing people as well as many audiologists, speech-language pathologists, and physicians. Crittenden (1993), Lane (1990), Paul and Quigley (1990), and Wixtrom (1988) describe differences between the Pathology and Cultural models. The following discussion presents an overview of the differences.

Because deafness in the Pathology model is considered an abnormality, proponents of this model seek ways to ameliorate the effects of the disability. There is much interest in devices that enhance hearing and speech such as hearing aids, assistive listening systems, cochlear implants, tactile devices, and computer-aided speech systems. The role of the communication professional under this model is to help deaf people overcome their handicaps and live in the hearing world. There is strong emphasis on speech and speechreading. Spoken language is considered the most natural language for all persons with hearing loss, including those with profound loss, and mastery of spoken language is a central educational goal. Sign language is frequently considered inferior to spoken language and discouraged. Deaf people are encouraged to socialize with hearing people. Deaf/deaf interaction and marriages between deaf people are sometimes frowned upon. The "normal hearing person" is considered the best role model. Deaf culture is not accepted or supported (Wixtrom, 1988).

In contrast, in the Cultural model deafness is considered a natural condition which does not need to be overcome (Sacks, 1989; Van Cleve & Crouch, 1989). Deafness is openly acknowledged. There is usually little interest in using hearing aids, other listening technology, speechreading, and spoken English to become more like hearing people. There is interest, however, in communication access for Deaf people through visual devices and services such as light-signaling devices, captioning, telecommunication devices, and interpreters. Vision is considered as an alternative to audition. Sign language is considered the natural language for Deaf people and equal in importance to spoken language. Socialization within the deaf community is considered as important as socialization within the larger community. The abilities of Deaf people are stressed, with successful Deaf adults held up as positive role models for Deaf children. The primary educational goal is to teach Deaf children subject matter through sign language, rather than to focus on development of spoken language.

Most Deaf people value the development of all communication modes but feel that speech development should not be considered more important than sign communication. People who support the Cultural model regard appropriate professional involvement with Deaf people as working with them to obtain the same privileges, rights, and opportunities that hearing people enjoy. Culturally Deaf

people want hearing people to respect, value, and support their culture and language.

RELATING TO CULTURALLY DEAF PEOPLE

In order to provide services to Deaf people, it is important for communication professionals to be aware of pragmatic conventions and other behavioral communication characteristics which are different from those used by hearing people. It is also helpful to understand some of the values and traditions of Deaf culture. The following discussion presents an overview of behavioral characteristics, values, and traditions of culturally Deaf people.

Behavioral Characteristics

Deaf people tend to be visually oriented. Continuous eye contact is considered important during ASL conversations; breaking eye contact is considered rude. Facial expression is not only a way to express emotion but is also of linguistic importance in ASL. For example, raised eyebrows often accompany questions. This visual orientation can facilitate the development or improvement of speechreading skills, if that is appropriate for a Deaf client.

Communication between Deaf people tends to be more direct than between hearing people. For example, a Deaf client may ask direct questions about the qualifications and personal life of a clinician without meaning to be rude. When hearing people introduce themselves, they use their names only. When a culturally Deaf person meets another Deaf person, generally names are exchanged first and then immediately followed by the name of the residential school for the deaf the person attended. Residential schools are very important in the Deaf culture because that is where many Deaf children become enculturated into the Deaf culture. Knowledge of the individual's school quickly establishes bonds between Deaf people.

When two Deaf people part company, they sometimes find it difficult to end the conversation, and will continue to communicate as they reluctantly leave each other. This practice probably originated when conversation between Deaf people was limited to personal visits, before development of the TDD and computer communication. This behavior may carry over to clinical situations even when communication between client and clinician is clear and effective; the clinician may find it difficult to end a session. Some Deaf people may not respond to nonverbal signals signifying the end of a session such as the clinician looking at the clock or putting materials away. Clients may even be unresponsive to verbal statements such as "It's time to stop." Some phrases that may help to end a conversation are "See you later" or "Have a nice day."

Appropriate ways to get a Deaf person's attention include tapping the shoulder, waving the hands in the person's line of sight, blinking the lights, and gently banging on the table. It is inappropriate to touch the hands while a person is sign-

ing. Using voice is generally not appropriate (Padden & Humphries, 1988). Instead of expressing appreciation by clapping their hands in applause, Deaf people will hold their hands high and shake their open palms. This is called the deaf cheer, clap, or wave.

According to Ramsdell (1978), people who are adventitiously deaf or hard-of-hearing may become suspicious when they do not understand what other people are saying. They may accuse others of saying unpleasant things. It has been the experience of this author that people who are culturally Deaf may react in a similar manner to hearing people who communicate with each other in their presence without using sign language. It is accepted practice at Gallaudet University for hearing people to sign to each other in the presence of a Deaf person, even if that person is not an integral part of the conversation.

People with severe to profound hearing loss of late onset sometimes experience depression and feelings of inadequacy because subliminal auditory cues which have coupled an individual to the world of sound since birth are lost (Ramsdell, 1978). Most culturally Deaf adults, however, have never experienced the world of sound as hearing people know it and do not consider the absence of subliminal auditory cues abnormal. Some Deaf people are able to hear loud noises, such as the roar of an airplane engine or low frequency vibration (Padden & Humphries, 1988). For these individuals, restoration of hearing as a link to sound is not sufficient reason to use amplification.

Ramsdell (1978) describes problems at the warning level when sounds convey information about objects or events. People with hearing loss may miss the siren of an emergency vehicle, a fire alarm, the door bell, the telephone ringer, or the sound of footsteps. Insecurities resulting from loss at the warning level may affect culturally Deaf people as well as those who are adventitiously deaf. A vast array of electronic visual systems as well as hearing aids have been developed to deal with warning level problems. Detailed discussions of these systems can be found in Compton (1989, 1993); DiPietro, Williams, and Kaplan (1984); Kaplan (1987); and Ross (1994). Some culturally Deaf people choose to use hearing aids for purposes of hearing warning sounds.

Values and Traditions of Deaf Culture

Deaf people prize ASL and consider it beautiful. They believe that only one communicative use of the hands is acceptable (e.g., ASL) and sometimes react negatively to Cued Speech or English-based signing systems. Some Deaf people consider these manual communication systems a violation of their natural language.

Oral deaf people are accepted into Deaf culture provided they learn to communicate with ASL and de-emphasize speech. Sometimes deaf people with good spoken English skills are accused of "thinking hearing." Hearing people, even hearing children of deaf parents, and non-culturally deaf people are sometimes

excluded from Deaf clubs and other social activities.

There is a body of Deaf folklore which includes local legends about Deaf people, jokes, humorous stories, history of deaf education and individual residential schools, history of the struggle of Deaf people to achieve legal equality, and stories about the lives of famous Deaf people. Storytelling and poetry in ASL are highly valued. Deaf people take pride in the accomplishments of other Deaf people.

The cultural definition of deafness is different from the audiometric definition. Degree or type of loss are unimportant. People with hearing loss are considered Deaf if they identify with Deaf people and communicate with ASL, even when hearing loss is moderate. The cultural distinction between *deaf* and *hard-of-hearing* is different from that understood by hearing people. It is based, not on the audiogram, but on the person's communication skills. For example, two people might have the same degree of hearing loss audiometrically but one might be considered hard-of-hearing because of the ability to use the telephone and the other might be considered deaf because telephone use is not possible. The first person may be labeled "Deaf but hard-of-hearing."

Another interesting use of terminology by culturally Deaf people concerns the concept of degree of hearing loss. When hearing people use the term "a little hard-of-hearing," they generally mean a mild hearing loss or slight deviation from normal hearing. For culturally Deaf people, however, the norm is profound deafness. Therefore, a little hard-of-hearing means that the person can hear only a little. A mild hearing loss would be referred to as "very hard-of-hearing" (Padden & Humphries, 1988).

IMPLICATIONS FOR THE
COMMUNICATION PROFESSIONAL

It is important for communication professionals to understand and acknowledge the Cultural model of deafness in order to effectively provide services to culturally Deaf clients. Deaf people are generally comfortable with their deafness and do not wish to "cure" it. However, most Deaf people realize that in addition to functioning within their own culture, it is helpful for them to be able to function within the hearing world for vocational reasons, to obtain services, or to communicate with hearing family members. Many Deaf people will seek communication training so that they may function more independently in the majority culture and become better consumers. The motivation to improve English communication skills must come from the Deaf person. English probably will not be accepted if it is imposed by an external authority (e.g., university, employer) because the Deaf person may interpret that imposition as devaluation of Deaf culture and ASL (Crittenden, 1993; Meadow, 1972) At Gallaudet University, communication training is offered and widely advertised to the Deaf population, but not required.

Terminology is important. Most Deaf people wish to be called Deaf, not hearing impaired, because the latter term suggests defect or abnormality. Similarly, most Deaf people do not wish to be referred to as disabled or handicapped or as patients (Brown & Gustafson, 1995; Crittenden, 1993; Kinsella-Meier, in press; Lane, 1992; Padden & Humphries, 1988). The term *oral* is unacceptable because it suggests oral ideologies (Padden & Humphries, 1988); the terms *spoken English* or *spoken communication* are preferable. Even the professional title *speech-language pathologist* suggests allegiance to a Pathology model to some Deaf people (Brown & Gustafson, 1995). At present, speech and hearing professionals at Gallaudet University call themselves communication therapists. The term *communication therapy* is used in place of *aural rehabilitation* because many Deaf people are interested in improving aspects of communication that are not aural such as written English. The substitution of another term for *therapy,* perhaps *training,* has been discussed at Gallaudet to avoid connotations of impairment but has not been implemented.

Deaf people prefer training goals that stress development of skills that increase independence in the use of spoken and written English, rather than goals which aim to cure, eliminate, or minimize deafness. The Deaf person's self-reported needs and experiences should be considered in planning therapy. Deaf people are sometimes interested in assistive listening systems as aids to functioning in the workplace rather than as aids to making them more like hearing people (Compton, 1993; Compton & Kaplan, 1988).

During evaluation, it is more productive to define the abilities of the Deaf person rather than the disabilities. For example, many Deaf people cannot identify single syllable words such as the phonetically balanced word lists frequently used by audiologists, but do have other useful auditory skills such as pattern perception or identification of environmental sounds. At the Gallaudet University Hearing and Speech Center, a modification of the Monosyllable-Trochee-Spondee Test (MTS) (Erber, 1982) using written word lists instead of pictures is used routinely to evaluate auditory skills. Audiovisual skills are also routinely evaluated (Brunner, Devlin, Kaplan, Kleifges, & Windham, 1992).

Deaf people use vision for communication. Therefore, during evaluation and therapy, it is important to devote as much time to speechreading and written language as to hearing aids, assistive listening technology, and cochlear implants. It is equally important to use sign language for communication to the extent possible. The clinician who acknowledges the Cultural model shows respect for sign language and Deaf culture.

It is important for communication professionals who wish to work with culturally Deaf people to learn sign language; any attempt is usually appreciated. If the professional is not fluent enough to communicate directly with the Deaf client, an interpreter may be used. In that situation, the conversation should be directed to the Deaf person, not the interpreter. Direct communication, when pos-

sible, between client and clinician is always best, however.

It is unwise for conversation between hearing people to take place in the presence of a Deaf person unless the Deaf person can participate. Participation of the Deaf person may be accomplished by using sign language, written language, or by making sure the Deaf person can speechread the conversation.

THERAPY MODEL USED AT THE
GALLAUDET HEARING AND SPEECH CENTER

Communication therapy at the Gallaudet Hearing and Speech Center has been designed to meet the needs of people who are Deaf or hard of hearing who wish to function biculturally by developing greater communicative independence in situations in which they must interact with non-signing people. The model used at the Hearing and Speech Center is called the Integrated Therapy Model. It is described in detail by Horn, Mahshie, Wilson, and Bally (1983); Horn, Mahshie, Wilson, Bally, and Kaplan (1984); Wilson et al. (1990); and Wilson and Scott (in press). The following discussion presents an overview of the major principles of the model.

Therapy goals are based on the need for the Deaf client to develop functional skills so that communication will improve in those situations considered important by the client. These skills do not necessarily coincide with areas of weakness identified by traditional assessment tools which compare the client's performance to a standard norm. For example, although speech production may be found to be semi-intelligible, speech improvement will not become a therapy goal if the client plans to communicate entirely by signing and writing. The client may prefer to work on improvement of written English skills for the workplace.

The therapy process begins with an assessment of the client's motivation, attitudes, and communication skills as perceived by both the client and clinician. Procedures used for information gathering may include an interview and questionnaire to assess the client's attitudes and perceptions of his or her communication skills. The interview provides an opportunity for the clinician to evaluate speech intelligibility. Because the questionnaire requires phrase or sentence responses it provides information about written English skills. Traditional tests are used primarily to provide baseline information on the client's skills; results must be interpreted cautiously because most are not normed on a Deaf population. Use of roleplaying allows assessment of the client's communication skills in simulated real life situations.

Sometimes the client's perception of his or her communication skills and choice of goals are inconsistent with the clinician's perception of what is realistic based on the assessment results. Negotiation then occurs to help the client develop a more realistic view of his or her skills. The client and clinician together reconcile perceived differences and establish a set of therapy goals consistent

with assessment data and personal communication needs. At this point the client is ready to begin integrated therapy.

The integrated therapy approach involves development of a number of communication skills in an integrated fashion within a situationally based context as opposed to individual development of isolated communication skills typical of more traditional approaches. The situations which form the core of therapy are those which were identified as important by the client during the assessment process. The specific skill areas developed in therapy are those which were agreed upon during the negotiation process. Therapy may enhance existing skills or develop new skills. Palmer et al. (1990) integrate speechreading and strategy instruction, using roleplaying of general conversations and job interviews.

Skill areas which may be selected are speech/voice production, pronunciation rules and their application to unfamiliar vocabulary, auditory skills such as suprasegmental and segmental speech-perception and perception of non-speech sounds, audiovisual speech-perception, and speechreading training. Language skill areas include expressive and receptive vocabulary, figurative language, morphology and syntax, and pragmatics in spoken or written form. Some form of English language training is usually incorporated into most communication therapy programs.

In addition to skill development, the integrated therapy model includes three global areas which are incorporated into the therapy process as appropriate. First, training in communication strategies may include anticipatory, maintenance, and repair strategies. Anticipatory strategies are behaviors which allow an individual to avoid communication breakdown by advanced planning. An example might be predicting and practicing dialogue and vocabulary that will probably be used in a future communication event. Maintenance strategies are behaviors that allow ongoing conversation to continue. Appropriate turn taking would be considered a maintenance strategy. Repair strategies are behaviors which resolve communication breakdown when it occurs (e.g., asking the talker to repeat more slowly).

A second global area is technology such as speech production feedback systems, hearing aids, assistive listening systems, telecommunication systems, and alerting devices. Such technology, used appropriately, can support communication and is incorporated into therapy as appropriate.

The third area is informational counseling. For culturally Deaf people, informational counseling usually involves providing input about the latest technology. In addition, consumerism and advocacy are fostered. It is important that Deaf clients understand the implications of legislation, particularly the Americans with Disabilities Act (ADA). The following is an example of how appropriate global and skill areas can be incorporated into an integrated therapy plan.

Mark G. is a profoundly Deaf senior at Gallaudet University who is working part-time at an off-campus internship. He hopes to work full-time at that facility after graduation but finds telephone use difficult. His therapy goal is to improve

his telephone skills. Mark's speech is partially intelligible and can be improved. Auditory evaluation has demonstrated word recognition skills of 40% in his right ear and the ability to understand speech on the telephone with great difficulty if the talker is a familiar person. He owns a well-fitted hearing aid for his right ear which has a functioning telecoil, but he does not use it. Mark does not wish to use his hearing aid or his voice on campus, but is willing to use both on the job.

Mark and the therapist agreed that they would establish therapy goals based on communication in the workplace. Although he would be expected to use appropriate technology and his voice during therapy and at work, he would not be required to do so on campus or in off-campus social situations.

Therapy goals would include:

1. Identification of and training with appropriate telecommunication systems (e.g., telephone amplifier with the hearing aid telecoil, relay system).

2. Understanding of existing telecommunications legislation and implications for him as a Deaf communicator.

3. Understanding what is necessary to become a sophisticated telephone consumer (e.g., how to make long distance calls, how to access telephone services).

4. Developing receptive and expressive communication strategies to facilitate understanding of talkers on the telephone and their ability to understand his speech.

5. Improving speech production and pronunciation skills, focusing on the language of the workplace.

6. Improving auditory comprehension of specific telephone messages and conversations related to the workplace.

7. Refinement of language (e.g., vocabulary, figurative language, sentence structure) needed for telephone communication in the workplace.

SUMMARY

Deaf culture, with its own history, traditions, and values, is a distinct lifestyle for many deaf and hard-of-hearing people. Its language is American Sign Language. Many Deaf people are interested in functioning more effectively within the mainstream culture and will seek professional help, providing that hearing professionals respect their culture and seek ways to communicate with them. Deaf people are responsive to professionals who are interested in helping them gain access to the same rights and privileges that hearing people enjoy rather than in overcoming a handicap. This difference in attitude is important to Deaf people and may make the difference between successful and unsuccessful communication therapy. An integrated therapy approach has been found to be useful with this population. This approach is characterized by development of a number of communication skills in an integrated fashion within a situationally based context, using those situations which the client has identified as important.

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