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Treatment of Deaf Clients: Ethical Considerations for Professionals in Psychology

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Abstract

Providing therapy to deaf clients raises important ethical considerations for psychologists related to competence; multiple relationships and boundary issues; confidentiality; assessment, diagnosis, and evaluation; and communication and using interpreters. In evaluating and addressing these, psychologists must consider the APA's Ethics Code and other relevant issues (e.g., ADA) necessary to provide ethical treatment. The current article provides background, ethical considerations, principles and standards relevant to the treatment of deaf clients, and recommendations to support psychologists, training programs, and the field. Psychologists have the responsibility to guarantee that the benefits of mental health treatment are fairly and justly provided to this traditionally underserved population.

Keywords

deaf client; ethics code; treatment; mental health

Worldwide, nearly 360 million people, or 5% of the world's population, have disabling hearing loss (WHO, 2015). According to the 2010 U.S. Census Bureau about 7.6 million people (3.1%) in the United States have experienced a hearing difficulty, 1.1 million of whom had a severe difficulty hearing. Research has demonstrated a high prevalence of mental health problems among people who are deaf or hard of hearing, with only a limited number of whom actually receive mental health services (Fellinger, Holzinger, & Pollard, 2012; Glickman & Pollard, 2013). When mental health services are obtained, the services provided have often been inappropriate, from case conceptualization to diagnosis and treatment, raising a number of ethical concerns (Loera, 1994; Pollard, 1998). It is clear that the deaf population's mental health needs in the United States are severely and traditionally underserved (Corbett, 2003; Leigh & Pollard, 2003; Critchfield, 2002).

Although there exists a wealth of research that addresses providing psychotherapy to deaf clients (Glickman & Harvey, 2008; Leigh, 2010; Glickman, 2009; Williams & Abeles, 2004), Deaf culture (McCreary & Coeling, 1999; Paone & Malott, 2008; Reagan & Wilson, 1994; Corbett, 2003; Williams & Abeles, 2004), and the role of interpreters in

psychotherapy (Cornes & Napier, 2005; Paone & Malott, 2008; Halgin & McEntee, 1986; Hoyt, 1981; Gill & Fox, 2012; Glickman & Harvey, 2008; Porter, 1999), there remains a need for a more current discussion of the ethical considerations relevant to providing treatment to the deaf population. With the exception of Gutman's (2002) text, "Ethics in Mental Health and Deafness," Leigh and Gutman's (2010) chapter on the ethical dimensions of psychotherapy with deaf people, and Glickman and Harvey's (2008) brief mention of the application of ethics in mental health and deafness, the literature addressing the ethical considerations relevant to conducting psychotherapy with deaf clients is lacking and comes from nearly 20 years ago. Moreover, few address the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (hereinafter referred to as the Ethics Code) directly, something that is greatly needed for psychologists providing services to deaf clients. A more recent discussion of ethics should prove important as a guide for making ethical decisions in providing culturally competent services to deaf individuals. Therefore, ethical considerations for professionals in psychology is the main focus of the current paper.

In order to provide appropriate and ethical psychological services, the APA recognizes the need to understand culture among diverse populations (APA, 2014). Further, according to the APA's Ethics Code (2010), psychologists should aspire to "...benefit those with whom they work and take care to do no harm" (Principle A: Beneficence and Nonmaleficence; APA, 2010), maintain professional standards of conduct, clarify roles and obligations, assume accountability for their behavior and handle conflicts of interest that have the chance of leading to mistreatment or harm, and consult with, refer to, or cooperate with other professionals as necessary (Principle B: Fidelity and Responsibility; APA, 2010), acknowledge that all persons are permitted access to and benefit from the contributions of psychology, and use judgment and take precautions to ensure that their possible biases, limits of competence, and boundaries of expertise do not lead to or condone unfair practices (Principle D: Justice; APA; 2010), and "... [be] aware of and respect cultural, individual and role differences, including those based on... culture,... disability, [and] language" (Principle E: Respect for People's Rights and Dignity). In order to maintain the highest ethical ideals of the profession, psychologists should aspire to uphold these principles when treating all clients, and for the purpose of this discussion, deaf clients.

The treatment of deaf individuals presents a number of challenging ethical considerations for professionals in the field of psychology. Among these are competence to provide treatment, multiple relationships and boundary issues, confidentiality, assessment, diagnosis, and evaluation. Of special note for ethical work with this population are concerns related to communication and using interpreters. These considerations are similar to those seen in work with other diverse cultural groups; however, the deaf population also presents its own unique ethical concerns. For example, some deaf clients have significant language problems or are "minimally language skilled" which adds an additional level of complexity to communicating about assessment, diagnosis, and evaluation, even with the help of a qualified interpreter, which is discussed in more detail later (Pollard, 2014). Such concerns are compounded by the complex clinical issues related to treatment access, mistrust of mental health professionals within the deaf community, and the unique mental health

concerns among the deaf population. Practitioners require knowledge, training, and resources to be properly educated on and competent in the ethical treatment of deaf clients

The current article presents a detailed explanation of relevant background information and an evaluation of the fundamental ethical considerations that psychologists must be prepared to address in working with the deaf population. Further, the article provides recommendations for refining the current state of awareness regarding these five areas of ethical considerations and the resources available that support the related decision-making process. In evaluating and addressing these issues, psychologists must consider the APA's Ethics Code and other relevant topics (e.g., ADA) necessary to provide ethical treatment. In order to provide the reader with context, however, the current paper will first briefly address some background information, history, and cultural issues and terminology so that the ethical issues raised can be seen in context.

RELEVANT BACKGROUND INFORMATION

In order to address ethical considerations, one must first have a firm understanding of the historical and political contexts in which these issues have arisen, including the importance of Deaf culture. Being deaf can be defined in a number of ways (McCreary & Coeling, 1999). Physiologically, deafness is a "loss of hearing sufficiently severe to render an understanding of conversational speech impossible in most situations with or without a hearing aid" (Bradley, 1991, p. 26). However, some individuals define being deaf culturally. That is, the most important quality of being deaf is not the nonexistence of hearing itself, but is instead the affiliation with a culture based on American Sign Language (ASL).

As with all languages, studies of ASL have argued credibly that ASL is a language in the full linguistic sense of the word in that it has its own complex grammatical structures, vocabulary, sociolinguistic variation, and rules of discourse (Cornes & Napier, 2005). However, ASL varies considerably from English in its vocabulary, syntax, grammar, and discourse pattern (Pollard, 2014). For example, ASL places verbs at the end of sentences, uses adjectives after the words they modify, and does not have individual words for *the*, *is*, *are*, *was*, and *were*. Further, ASL uses time concepts to establish the time frame instead of referring to it multiple times, as is often the case in English, and ASL uses the space around the signer's body to convey linguistic meaning throughout the conversation. ASL is a complex language that if not fluent in, one must at least aim to understand, particularly when working with a client whose primary language is ASL (Pollard, 2014). Communication using ASL is often viewed as the principal requirement for cultural affiliation and community participation (Reagan & Wilson, 1994).

For individuals who are affiliated with the Deaf community, the word Deaf is denoted with a capital "D" (Jampel, 2010). This capitalization is an affirmation of culture, whereas deaf with a lower case "d" is simply an audiological condition characterized by a lack of hearing (McCreary & Coeling, 1999). Many Deaf individuals do not consider being deaf a disability (Corbett, 2003).

Although treatment of deaf clients may look differently based on whether they identify as a part of the Deaf culture or not, many of the same ethical issues arise. Therefore, the current paper focuses on ethical considerations with deaf clients as a whole, whether they identify with the Deaf or hearing community. Throughout this paper, issues that are relevant to both deaf and Deaf individuals will be denoted by the use of “deaf/Deaf.” When the issue is more applicable to one group over the other, this will be indicated by the use of “deaf” or “Deaf” alone. The literature on working with Deaf clients in psychotherapy is far larger than that of working with deaf clients. For this reason, it may at times seem that the majority of the paper focuses on Deaf issues; however, the author has attempted to explore the issues related to deaf clients when possible as psychologists may also treat deaf clients who do not identify as Deaf. Ethical issues are significant regardless of cultural affiliation. It is also important to note that many of these same issues may arise in working with hard-of-hearing clients (who typically identify with the hearing community) as well, however, given the focus and scope of the current paper, this will not be explored in detail. The field would benefit from future work that explores the ethical issues related to psychotherapy with hard-of-hearing clients.

Historical and Political Contexts

In order to understand the unique worldviews and experiences of potential clients, and therefore understand the relevant ethical issues, especially those related to competence, it is important to consider the historical and political contexts related to being deaf/Deaf. The deaf/Deaf community has had a lengthy history characterized by oppression, both with the language used as well as the lives led. In 1880, the second International Congress of the Deaf voted in favor of oral methods of communication, as opposed to manual methods, as the preferred means of educating deaf students (Jankowski, 1992). The lack of acceptance of signed language signified that it was not recognized as an authentic form of communication (Phillips, 1996). This resulted in the oppression of deaf/Deaf people which has persisted for centuries. Additionally, Deaf individuals were long treated as if they had a medical condition that needed a cure. Such treatment resulted in a distrust of hearing people and the medical professionals among the Deaf community, who do not believe their lack of hearing is a condition that needs to be cured (Jankowski, 1992). Such distrust persists today.

In addition to language oppression and medicalization, deaf/Deaf individuals have also experienced a history of oppression in the educational realm (McCreary & Coeling, 1999). During the nineteenth century, the majority of individuals accepted Aristotle’s judgement that because deaf people were not able to demonstrate oral language, it meant they had no intellect above that of non-humans. Therefore, education during that time focused on raising deaf children above the supposed intellectual level of non-humans by teaching them how to speak (Pollard, 1993). Although there has been progress in this educational realm with the acceptance of ASL, oppression is still a reality. Parents of deaf children often have to decide what educational philosophy to pursue. That is, should the child be enrolled in a school that focuses on developing auditory and visual senses and strives to create speech, or should the child be taught manual communication with sign and fingerspelling, or both? Additionally, parents must decide between either mainstream, residential, or day school programs. Decisions are often variable, especially when the hearing status of the parents is considered. For example, one might expect a Deaf parent to be more likely to enroll their deaf/Deaf child

into a program with a purely manual communication method, while a parent who does not understand Deaf culture might want his or her child to be mainstreamed (Corbett, 2003). Such decisions impact acculturation outcomes among deaf/Deaf children and have implications for deaf/Deaf identity (see Leigh, 2010, p. 46 for a detailed description of the types of deaf identity) and educational attainment.

Similar to deaf/Deaf individuals being viewed in the early 1900s as oddities (Pearse, 1912), deaf/Deaf individuals have continued to be viewed as lazy and ineffective by the public (Padden & Humphries, 1998). Such public perceptions have resulted in numerous negative economic outcomes including underemployment and unemployment (Barnett et al., 2011). Limited educational preparation and training, mixed with a detrimental public perception, have resulted in a massive financial burden among deaf/Deaf people, with little financial support from society (McCreary & Coeling, 1999; Critchfield, 2002).

The political agenda of the Deaf community has actively promoted the use of ASL, acknowledgment of the rights and abilities of Deaf people, and the need for a greater understanding of the rights and needs of deaf/Deaf individuals among the hearing community (Padden & Humphries, 1988). Further, there has been a large national movement towards achieving educational equality for deaf/Deaf and hard of hearing students (see The National Agenda, 2005). Political advocacy groups are typically a part of Deaf cultural clubs (described in more detail later on; McCreary & Coeling, 1999).

According to Pollard (1996), the publication of “A Dictionary of American Sign Language,” by William Stokoe and colleagues in 1976 was the catalyst for bringing deaf/Deaf students and consumers in to contact with professional psychology. This dictionary is considered a “watershed event” given its careful examination of the structural elements of ASL (Pollard, 1993), which brought legitimacy to the Deaf community in the eyes of many hearing persons, including those individuals within the mental health field (Pollard, 1996). Since the 1990s, there has been a continued growth in the number of programs offering mental health training for deaf/Deaf people alongside the hearing (Pollard, 1996). However, there has been a long history of lack of training of deaf/Deaf individuals in doctorate level psychology programs as well as a lack of acceptance of trainees into internships and the workforce. This has resulted in few doctorate-level Deaf therapists who use ASL as their primary communication method (Gutman & Pollard, 1999). To overcome this shortage, it is important for hearing therapists to acquire the knowledge necessary to ethically (i.e., fairly and justly, requiring adequate competence) serve the heterogeneous Deaf community.

Deaf Culture

Learning about the culture of deaf/Deaf people is inherently tied to learning their language (Gallaudet, n.d.). While it is not always practical for psychologists to learn ASL before providing treatment, understanding Deaf culture and learning about ASL are essential to building rapport and strengthening the therapeutic alliance. Ultimately, learning ASL should be the goal of therapists who have chosen to treat Deaf clients. It is important to point out, however, that those who are audiotically deaf but do not identify with the Deaf culture may have their own set of cultural values, separate from ASL proficiency, that the psychologists should explore.

Individuals who are involved in or affiliated with the Deaf culture do not view being deaf or the use of signed language as a disability. Instead, it is viewed as a culture (Corbett, 2003). Within the culture, being Deaf is simply viewed as a communication barrier similar to any other linguistic minority (McCreary & Coeling, 1999). Norms include the use of ASL, Deaf cultural pride, and Deaf identity. However, it would be a mistake to assume that just being audiotically deaf (i.e., having little or no functional hearing) makes one culturally Deaf. That is, to be considered a member of the Deaf community, one must accept the values of ASL and Deaf clubs as well as those of Deaf pride and identity (McCreary & Coeling, 1999).

Part of understanding Deaf culture also includes having knowledge of common group characteristics. Members of the Deaf community most often have experienced hearing loss before the age of three, obtained education in a school or program for deaf individuals, identify as Deaf and not “hard of hearing” or “hearing impaired,” and have fluency in ASL (Corbett, 2003; Cornes & Napier, 2005). Further, diversity within the Deaf community must be considered. Therapists must be aware of how factors such as racial background, hearing status, and communication mode fall under the broader identity of being Deaf (Corbett, 2003; Leigh, 2009). Such group characteristics and individuals experiences may differ based on whether the client identifies with the Deaf culture, as experiences may be different based on this identity. It is important for providers to have knowledge in this area in order to provide competent treatment, which is discussed more in depth later on (McCreary & Coeling, 1999).

Cultural Pride—Cultural pride within the Deaf culture has been explained as a “deep commitment to history and heritage of a culture that reflect the culmination of the values and life experiences of a designated culture” (Leininger, 1982, p. 141). Among the Deaf, cultural pride is just that. Being Deaf is a unifying part of the culture which infiltrates all other areas of life including one’s values and norms. Although the deaf/Deaf are still divided by normal demographic factors such as SES, education, religion, and race, Deaf pride tends to override these and act as a promoter for socialization into the larger Deaf community. This pride is so salient that Deaf parents often hope to have deaf children so that their children are more likely to be accepted into their culture (McCreary & Coeling, 1999).

Values, behaviors, and traditions of Deaf culture—Within the Deaf culture there are a number of other important values, behaviors, and traditions that are unique to this group. However, within this population there is considerable heterogeneity. Therefore, not all of the values, behaviors, and traditions will be the same across individuals. Most importantly, though, ASL is a central value, and necessary to be accepted into the culture. Likewise, Deaf people view storytelling (i.e., creative narratives that recreate experiences) as a cultural value. Deaf people also express a preference for showing versus telling or describing, use facial expression and body language as a central linguistic element to ASL, and prefer to use ASL versus speechreading (Phillips, 1996).

An especially controversial issue in the community has surrounded cochlear implants (Sparrow, 2005; Phillips, 1996). Cochlear implants are surgically implanted devices that provide electrical stimulation of sound to the auditory nerves that even a profoundly deaf/

Deaf person can learn to interpret as meaningful. According to Fellingner, Holzinger, and Pollard (2012), cochlear implantation in children has positive effects on overall psychosocial wellbeing. However, such implants have been viewed by the Deaf culture as a “standard” imposed by the hearing medical community that perceives deaf/Deaf people as having a disability in need of repair. This is in direct conflict with the value that Deaf people are a linguistic minority. Further, Deaf people have viewed implants as an attempt by the mainstream culture (i.e., the hearing) to force its language and values on them rather than adjust its institutions to better accommodate the needs of members of another culture (Sparrow, 2005). On the more extreme end, these implants have been regarded by some Deaf people as comparable to genocide, which has the ultimate aim of obliterating Deaf culture (Sparrow, 2005; Tucker, 1998). Although this topic deserves a more lengthy discussion, it is beyond the scope of the current paper which aims to address ethical considerations related to treatment.

Mental Health Needs of Deaf Individuals

As is true with any cultural or linguistic group, the mental health needs of their members vary based on their particular life experiences, values, and beliefs. It is also important to recognize that because mental illness typically impacts thought processes, the flow of communication can be jeopardized. This is a significant issue among Deaf individuals who require the ability to produce and comprehend ASL to fully participate in the Deaf community (Corbett, 2003). This, coupled with being a linguistic minority and the lack of treatment seeking behaviors, or more realistically, the lack of access to treatment and services, among Deaf people, puts this group at significantly increased risk for mental health problems (Glickman & Harvey, 2008).

Nevertheless, mental health problems in deaf/Deaf people are similar to those experienced by other minorities. Greater incidences of substance abuse, past year suicide attempt, intimate partner violence, trauma and abuse, unemployment and underemployment, isolation and segregation from others, and distrust of members in mainstream society are all common (Williams & Abeles, 2004; Rendon, 1992; Fellingner et al., 2012; Barnett et al., 2011; Sullivan, Brookhouser, & Scanlan, 2000). Low self-concept and poor identity development, denial, and fear of external environment may also be concerns (Corbett, 2003; McCreary & Coeling, 1999; Dolnick, 1993; Scheetz, 1993; Williams & Abeles, 2004). Although dated, Hoyt and colleagues (1981) interviewed 10 therapists and supervisors who had clinical experience in working with deaf clients and found differential mental health needs depending on whether the individual became deaf after (i.e., post-lingually) or before (pre-lingually) acquiring speech and language. Those who were pre-lingually deaf were found to be more likely to have more severe psychopathology and serious developmental deficits. Post-lingually deaf individuals were noted as more likely to have problems related to depression, passivity, loneliness, and relationships difficulties. Given the lack of systematic data to confirm this finding, and its date of publication, it should be interpreted with caution. However, a somewhat more recent study by de Graaf and Bijl (2002) found a greater degree of mental distress in a postlingual-onset deafness group when compared to a prelingual-onset deafness group, but only among women. The inconsistency in these findings points to

the need to consider how a deaf/Deaf individual's loss of hearing and his or her perception of being deaf/Deaf is related to his/her mental health needs.

ETHICAL CONSIDERATIONS, PRINCIPLES, AND STANDARDS

Psychologists must take responsibility to thoughtfully consider the potential ethical issues related to treating deaf/Deaf clients and take reasonable steps, which are further explained in the current paper, to ensure the Ethics Code is being upheld. There are five main areas of ethical issues that should be considered: competence to provide treatment; multiple relationships and boundary issues; confidentiality; assessment, diagnosis, and evaluation; and communication and using interpreters. Although the Ethics Code does not overtly mention those issues related to treating deaf/Deaf individuals, many of its principles and standards are applicable to the current discussion. For example, General Principle E (Respect for People's Rights and Dignity) calls psychologists to "...respect the dignity and worth of all people... [by being] aware of and [respectful of] cultural, individual and role differences, including those based on... culture...[and] disability... and consider these factors when working with members of such groups" (APA, 2010, p. 2). Similarly, Standard 3.01 (Unfair Discrimination) prohibits psychologists from discriminating based on personal characteristics such as culture or disability (APA, 2010). In providing services to deaf/Deaf clients, psychologists must look to the relevant principles and standards of the Ethics Code.

Competence to Provide Treatment

The standard of professional competence (Standard 2.01, Boundaries of Competence) has been referred to as the foundation of ethical practice (Campbell, Vasquez, Behkne, & Kinscherff, 2010). Further, Leigh and Gutman (2010) point out that ethical practices and competencies are indistinguishably intertwined. The standard of competence to provide treatment and the majority of other standards are closely tied to General Principle A, Beneficence and Nonmaleficence, which instructs psychologists to strive to benefit those with whom they work and to do no harm in their professional activities (APA, 2010). Standard 2.01(b), outlines the importance of various individual characteristics in determining competence: "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with... culture... disability, [or] language is essential for effective implementation of their services... psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services" (APA, 2010). One area in which we must be competent is when we are called to provide treatment to individuals who are from a cultural background with which we are not familiar. In that case, we are expected to understand factors associated with culture, disability, and language (among others) in providing services. When applied to working with the deaf/Deaf population, not only must we be familiar with the issues this population faces, but also be familiar with how to apply the ethics code to work with this population. The latter of these is the focus of this article.

Corbett (2003) discussed the need to understand the culture of a client as necessary to provide quality mental health services; this has been referred to as "cultural sensitivity" elsewhere in the literature (Leigh, 1999). Similarly, Leigh (2010) points out that

understanding the culture of a deaf/Deaf client should first include seeing “deaf” as a unique quality of the client that requires sensitive understanding, instead of viewing it as a weakness or disability. Further, the psychologist should have awareness of linguistic and communication processes and recognize the related issues that may arise in working with deaf/Deaf clients, as well as validate clients’ self-worth and build on their strengths (for a full discussion of the critical components of competency see Corbett, 2003). In order to competently treat deaf/Deaf clients, psychologists should have scientific or professional knowledge of the unique cultural and linguistic issues relevant to deaf/Deaf individuals, or should obtain training, experience, consultation or supervision to ensure the competence of their services. If this is impossible, which is not unlikely given the relatively small number of competent treatment providers for this population, the psychologist should consider referral to another mental health professional (Standard 2.01; APA, 2010; Leigh, 1999). At a minimum, there should be supervision of the treating psychologist by a more experienced and competent psychologist in the field. Given that these individuals are few and far between and may not be located in the same proximity, it may be necessary to employ supervision via video conferencing or weekly phone calls.

As with any cross-cultural encounter, competence is also an imperative factor in building a therapeutic alliance with the client. Competence allows the psychologist to understand common expectations and misunderstandings as well as special features of therapy with deaf/Deaf clients (Leigh, 1999; Leigh, 2010). Some deaf/Deaf individuals might come to psychotherapy with a similar uncertainty of what to expect, or with incorrect expectations based on what they have heard from others or in Deaf folklore (e.g., thinking that they are in danger of wrongful imprisonment or psychiatric hospitalization as a consequence of poor communication between themselves and the psychologist; feeling they will be completely at the mercy of hearing authorities; and believing they will be powerless to make decisions about their own care; Leigh, 2010). It is important for psychologists to clarify any misconceptions, and relate these assumptions and expectations back to the client’s own cultural norms and experiences. If not addressed openly, it is possible that distrust of the hearing psychologist will persist, which may negatively impact the therapeutic alliance. It should be noted that a deaf individual who does not identify with Deaf culture may not need these types of considerations depending on their language preference and cultural identity. However, regardless of hearing status, the therapeutic alliance is of the utmost importance. Without the competence to provide treatment to deaf/Deaf people, these important aspects of treatment may go unrecognized and may hinder the working relationship or even fail to uphold the psychologist’s duty to “do no harm” (Principle A; APA, 2010).

In considering competence to provide treatment, it is also necessary that psychologists recognize their own biases. As individuals, we bring our own set of cultural experiences, some of which, if unacknowledged, may be detrimental to the treatment of someone with a different cultural background. That is, we might unknowingly make mistakes that alienate some culturally Deaf people (Glickman & Harvey, 2008). Leininger (1994) points out that one’s own personal cultural values, beliefs, and preferences can lead to cultural clashes and conflicts with clients. For ethical and informed practice to occur, psychologists need to consider their own biases and take special caution to evaluate whether they are pathologizing their client’s cultural expressions because they are drawing on their own culture for “truths.”

Phillips (1996) would refer to this as our ethnocentric perspective, and invites clinicians to engage in self-reflection, self-scrutiny, and the process of mentalizing (i.e., holding mind in mind; Allen, 2008) when engaging in the treatment of culturally diverse clients. Given the difficulty in evaluating our own biases, psychologist should also consider supervision and ethics training (e.g., coursework and continuing education).

Mental health professionals must also be careful not to devalue the meaning of deaf/Deaf client's lives. That is, psychologists need to take caution against rewriting a client's reality based on their own cultural perspective (Phillips, 1996). Glickman and Harvey (2008) note that cultural self-awareness, or an inability to adequately assess one's personal biases, is the most difficult to teach, especially to hearing people. However, regardless of this challenge, if a psychologist is unable to adequately assess such personal biases, competence to treat deaf/Deaf individuals should be honestly questioned. Further, if there is any doubt about the ability to identify one's own biases, outside consultation or supervision may be in the psychologist's, as well as the client's, best interest. Deaf individuals are especially attuned to nonverbal cues, making therapist biases easily recognizable (Williams & Abeles, 2004). Psychologists must take special caution to attend to the potential influences of their personal biases on the therapeutic relationship and work to correct and/or minimize those biases.

Developing competence in a certain area is neither simple nor straightforward. It requires more than a simple mastery of relevant history, concerns, and problems experienced by the group. Instead, competence necessitates the acquisition of foundational, core, and specialized competencies (Kaslow, 2004). Competence requires one to be able to think critically, use analytic judgment, reflection, and self-modification. Such competence may be best obtained through graduate-level training, specialized workshops, supervision, and continuing education courses. It is imperative to remember that obtaining competence is not enough. Psychologists, according to Standard 2.03 (Maintaining Competence), must also uphold his or her competence. In this regard, psychologists must undertake ongoing efforts to develop and maintain their competence as related to the treatment of deaf/Deaf individuals (APA, 2010). For a more through discussion of assessing competence see Kaslow et al. (2007).

Multiple Relationships and Boundary Issues

According to Standard 3.05 (Multiple Relationships), "A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, [or] (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologists has a professional relationship..." (APA, 2010). If the clinician is also Deaf, this adds another level of complexity in that it may increase the chance that the psychologist will have encounters with clients outside of the clinical setting at Deaf community events, clubs, or social gatherings (Leigh, 2002). If the therapist is hearing and has multiple clients who are affiliated with the Deaf community, it is possible the therapist will treat individuals that know one another from other contexts. The Ethics Code is careful to note that multiple relationships which would not be reasonably expected to cause harm or impairment are not necessarily unethical

(Standard 3.05a). However, when these multiple relationships jeopardize the confidentiality (Standard 4.01) of the client, this becomes problematic.

Boundaries between the public and private realms of one's life become less well-defined in small communities. Since the client and clinician are highly likely to encounter one another outside of the treatment setting, the avoidance of multiple relationships all together becomes challenging. This is especially so in the case of the Deaf community, where multiple relationships are among the most troubling areas for clinicians (Gutman, 2002). Deaf community members value openness and view secrecy as antisocial; this can conflict with a therapist's professional training which values confidentiality and strongly discourages multiple relationships (Gutman, 2002). Psychologists must achieve a balance between upholding the Ethics Code to the best of their ability while at the same time considering the norms of the Deaf culture. Pope and Vasquez (2010) point out that each situation is unique and psychologists should take special effort to assess the potential effects of the boundary crossings that are likely to occur within small communities.

When making decisions about multiple relationships and boundaries, psychologists should focus on the potential for risk of exploitation, loss of therapist objectivity, and harm to the professional relationship (for a detailed discussion of decision making models see Campbell & Gordon, 2003 and Gutman, 2002). Psychologists must consider the possibility of multiple relationships when treating Deaf clients and take special precautions to protect their client's welfare. When entering into a multiple relationship or unintentionally finding oneself in a multiple relationship, special precautions may include engaging in an ethically based, risk-managed, decision making model, such as that offered by Younggren and Gottlieb (2004). This model suggests the therapist take into account the best interests of the client, any conflicts of interest, the possibility for impaired objectivity, any potential harm to or exploitation of the client that might occur, and the impact on the therapeutic relationship, while also documenting the decision making process (Younggren & Gottlieb).

Confidentiality

The Ethics Code requires psychologists to, "... take reasonable precautions to protect confidential information" (Standard 4.01, Maintaining Confidentiality; APA, 2010). Due to the small nature of the Deaf community, it is quite possible that a clinician who treats Deaf individuals will find he or she has clients who have personal relationships with one another outside of the therapeutic context. This poses a number of confidentiality concerns, especially due to the within-group belief that secrets are impossible to keep in the close-knit Deaf community (Gutman, 2002). Behnke (2004) and Gutman (2002) point to educating the public about psychology's core values and informing psychologists how to implement these values into everyday practice as the best way to protect clients and their welfare. Clients should be informed about their right to confidentiality (i.e., ethically and legally) and the limits on confidentiality within the therapeutic context. Further, the clinician and client should discuss the potential for public encounters and make a decision about how encounters will be handled. Clients might also benefit from a discussion of how much information about their own treatment to share with the community (Gutman, 2002). Such information

may be best covered during the informed consent process with the client at the outset of treatment and may serve to safeguard the client's right to confidentiality.

Psychologists should further protect themselves from an ethics violation by taking other precautions to protect their client's confidentiality. They might, for example, avoid back-to-back scheduling and opt out of sharing information with colleagues when such information may reveal the identity of the client (Gutman, 2002). Other reasonable precautions may be necessary based on a range of extraneous factors and psychologists should thoughtfully consider how they can best protect their clients.

A client who does not identify with the Deaf culture may not have the same concerns as their social circle may be much larger. Therefore, this may decrease the likelihood of having clients who have personal relationships with one another outside of the therapeutic context and may decrease the changes of public encounters. As is the case with Deaf clients, psychologists should think thoroughly about how to protect the confidentiality of their deaf clients and take reasonable precautions in order to do so.

Psychological Assessment, Diagnosis, and Evaluation

An additional area with a number of ethical considerations concerns psychological assessment, diagnosis, and evaluation. Glickman and Crump (2013) explain, "Clinicians who do not speak the consumer's language are at a huge disadvantage in assessing their strengths, weaknesses, and potential areas of psychopathology" (p.128). Further, Pollard (1996) pointed out that understanding ASL and the associated culture is a critical aspect of evaluating psychiatric presentation and symptomatology and that language "is a key element in the accessibility and effectiveness of mental health treatment..." (p. 391). Although it may not always be possible for psychologists to learn ASL, it is possible to gain a more comprehensive understanding or competence related to Deaf culture and the use of ASL in order to ensure ethical assessment, diagnosis, and evaluation. For example, without knowing the historical contexts surrounding Deaf culture, one may inaccurately conclude that a client is excessively suspicious and resistant to change when, in reality, the client is simply distrustful of mental health professionals in general due to the long history of oppression experienced by the Deaf culture (Henwood & Pope-Davis, 1994; See Phillips, 1996 for a case example). An individual who is affiliated with the Deaf culture may also have different experiences that should be taken into consideration. Obtaining competence in this area would prevent such misunderstandings from having detrimental impacts on case conceptualization and treatment. Not having this competence may cause harm to the client and, therefore, be in violation of Standard 3.04 which requires psychologists to avoid harming their clients (APA, 2010). Clinicians without an understanding of the cultural and linguistic norms of their clients should be conservative in drawing diagnostic conclusions (Glickman & Crump, 2013).

This is further complicated by the fact that some deaf/Deaf clients are language "dysfluent," meaning they are not skilled users of ASL or their preferred language (Glickman & Crump, 2013). It is important for the psychologist to recognize if the client is using language in a dysfluent fashion and evaluate why that might be the case. For example, language dysfluency may be a result of mental illness or brain damage, or that individual may have

never mastered the language. The psychologist should also pay careful attention to this concern when working with interpreters as the interpreters might “fix” the language, therefore influencing the conclusions drawn (Glickman & Crump). Additionally, Critchfield (2002) points out that the average reading level of deaf high school graduates is below the fourth grade, which may also impact testing depending on the literacy level of written materials (Pollard, 2002). Assessment, diagnostic, and evaluation conclusions should only be drawn in light of this information. For a psychologist that is not experienced in evaluating language dysfluency, further education or supervision is recommended (see Glickman & Crump, 2013 for a detailed discussion).

The Ethics Code also discusses standards for the use of assessment instruments. According to Standard 9.02, it is imperative to critically evaluate the instruments for their validity and reliability in light of the population for which they were normed. The psychologist must also use assessment methodologies that are appropriate to the client’s language preference and competence (APA, 2010). Brauer and colleagues (1998), along with a number of other researchers (e.g., Pollard, 1993), note that many of the standard tests and mental health measures designed for hearing individuals are often rendered invalid when used with deaf/Deaf individuals. That is, standard tests and mental health measures have been designed for and normed within the hearing population, yielding them potentially problematic when used with deaf/Deaf clients (Fellinger et al., 2012). Pollard (2002) points out that if deaf/Deaf and hearing subjects yield different but reliable results on a measure, this may or may not indicate a problem with the measure. However, if the measure is allowing error to invade the assessment or is leading to bias, then alternative methods may be needed.

Pollard (2002) suggests carefully evaluating five elements of the measure being used when judging the appropriateness of a given instrument. These elements include: whether the instrument’s purpose is relevant to the question at hand, the nature of the test instructions (in light of literacy issues, fund of information, etc.), the fairness of the nature of the task including the nature of test items, the response modality, and the scoring method employed. If in any of these five areas things such as English knowledge, hearing loss, fund of information, or sensory or sociocultural experiences as a deaf/Deaf or hard of hearing individual would play an undesirable role, then the instrument is questionable. However, there has been some promising progress in terms of adaptations and sign-language translations of existing instruments as well as new measures developed specifically for administration using signed language (Fellinger et al., 2012). Evaluations and diagnoses based on particular instruments should therefore be considered in light of this information.

Assessment also becomes challenging in working with deaf/Deaf clients as some may recognize an English mental health expression but might connect it with a meaning that does not accurately match the standard definition (Leigh, 2010). For example, some individuals might be able to discuss the concepts of “depression” and “addiction” knowingly in ASL but might be unfamiliar with the paralleling English terminology (Steinberg, Loew, & Sullivan, 2010). As Steinberg and colleagues point out, this can make accurately evaluating the relationship between linguistic and conceptual knowledge a challenge. For these reasons, it may be necessary to use alternative language which may then render the instrument, and potentially the evaluation or diagnosis, less valid. This would conflict with Standard 9.02 of

the Ethics Code (APA; 2010). Therefore, it is imperative to consider which assessment instruments would be most appropriate for a given client based on these factors.

Psychologists are also required to consider the characteristics of the person being assessed in their interpretation of assessment results for the above reasons (Standard 9.06; APA, 2010). For example, deaf/Deaf individuals are likely used to the experience of being assessed given the regular and routine evaluations performed in the U.S. Education System. However, they may only be used to being assessed with instruments intended for and normed on the hearing population. This should be considered in light of how it may change the instrument's reliability and validity. Although assessment can be a valuable tool in working with deaf/Deaf clients, such instruments require appropriate interpretation and evaluation because they are not usually designed or standardized for deaf/Deaf people.

Similar issues arise in obtaining informed consent for assessments. Standard 9.03 (Informed Consent in Assessment) requires psychologists to obtain informed consent from the client for assessments, evaluations, and diagnostic services using language that is reasonably understandable by the client (APA, 2010). This standard puts the weight of ensuring that the deaf/Deaf client fully understands the consent process on the shoulders of the psychologist. The psychologist must ensure that appropriate accommodations are made so that the deaf/Deaf client can make an informed decision. In the case of a Deaf client, unless the psychologist is fluent in ASL this will require the assistance of an interpreter.

Without an adequate understanding of Deaf culture and how it has influenced the client's life experiences or, in the case of those who are not a part of the culture, how it has not influenced the client's life, it is difficult to make accurate assessments, diagnoses, or evaluations. As Pollard (1996) pointed out, understanding Deaf culture, and cultural preference in general, is absolutely imperative to accurate evaluation of symptomatology and treatment decisions in therapy. Psychologists must be aware of the mandate to consider individual differences (e.g. cultural differences) in their assessments, diagnoses, and evaluations of deaf/Deaf individuals in order to prevent inaccurate conclusions.

Communication and Using Interpreters

Language discrepancy between a therapist and client has been demonstrated to negatively affect various issues related to treatment including client retention (Sue, 1991; Halgin & McEntee, 1986), accuracy of diagnosis (Bamford, 1991), strength of therapeutic alliance (Halgin & McEntee, 1986), and the type and depth of topics covered in treatment (Santiago-Rivera, 1995; Seijo, Gomez, & Freidenberg, 1991). For these reasons it is ideal that Deaf clients be treated by a therapist fluent in ASL (Hoyt, Siegelman, & Schlesinger, 1981; Leigh, 2010). However, it is rarely practical for a hearing therapist to learn ASL in order to provide competent, and therefore ethical, treatment to Deaf individuals. Additionally, many deaf/Deaf individuals who utilize mental health services have significant language problems or are "minimally language skilled" (Pollard, 2014; Glickman, 2009; Glickman & Harvey, 2008). These challenges, in addition to limited mental health care access and distrust towards organizations that fail to provide language assistance has resulted in qualified interpreters often being a requirement for treatment in therapy (Paone & Malott, 2008). In the case of a deaf client, his or her preferred communication method should also be

accommodated to ensure the best treatment outcomes. However, the decision to utilize a qualified interpreter, in comparison to learning ASL, should not rid the psychologist of the responsibility to learn about ASL and its differences from English.

Qualified interpreters are a useful tool for facilitating a sense of belonging for the client, increasing client trust in the psychologist and therapeutic process, reducing isolation by allowing clients to more accurately express complex feelings and concepts in his or her own language, and bridging the cultural gap by educating psychologists regarding Deaf culture and culturally informed behaviors (Paone & Malott, 2008). Interpreters are not only responsible for transposing between the two languages, but they are also met with the task of bridging the gap between two cultures and backgrounds, which is quite a challenging task (Dean & Pollard, 2005). Previous research has demonstrated that the presence of interpreters increases client willingness to return to therapy (Hillier, Loshak, Rahman, & Marks, 1994). The Ethics Code also supports cooperation with other professionals (Standard 3.09) when indicated and professionally appropriate for the purposes of serving clients effectively and appropriately (APA, 2010). Further, the Americans with Disabilities Act (ADA) requires businesses to provide interpreters for people who are deaf or hard of hearing (APA Practice Organization, 2012), while Section 504 of the Rehabilitation Act forbids organizations from excluding or denying individuals with disabilities an equal opportunity to participate in, and have access to, program benefits and services (U.S. Department of Health, 2006). It is clear that providing qualified interpreters is not only an important ethical consideration, but also an imperative legal consideration. Although a useful and often necessary tool, bringing an interpreter into treatment presents numerous unique ethical and treatment issues.

It is good practice for providers to only use qualified interpreters. Understanding what makes one “qualified” is vital. The ADA sets the standard for the qualifications as an interpreter as follows: “A qualified interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively... and expressively... using any necessary specialized vocabulary (U.S. Department of Justice, 2014). There are two national certifying bodies in the U.S.: the National Association of the Deaf’s Interpreter Assessment Program, and the Registry of Interpreters for the Deaf. An additional certifying body, the Certification Commission for Healthcare Interpreters, is responsible for credentialing healthcare interpreters. Further, some states have their own interpreter assessment programs that operate independently of the national certifying bodies (Critchfield, 2002). There are also a number of states that require specific, advanced training to work in mental health settings (e.g., Alabama). It is important for psychologists to know the legal requirements in their state. Some psychotherapists might find it easier to contract with an interpreting agency than try to identify individual interpreters on an as-needed basis. Further, it may be useful for psychotherapists to review the writings of Crump (n.d.) on training, standards, and certification of mental health interpreters

Thus, the first concern in working with an interpreter is finding access to a highly-skilled interpreter with experience in a psychotherapy setting. Leigh (1999) notes that although there are many competent interpreters with appropriate certification and expertise, only a minority has the skills necessary to interpret in the psychotherapy setting. Thankfully, mental health interpreting is becoming an established subspecialty in the interpreting field

(Dean & Pollard, 2001; Dean & Pollard, 2005; See the Alabama Mental Health Interpreter Training accessible at <http://www.mhit.org/> and The Deaf Wellness Center accessible at <https://www.urmc.rochester.edu/deaf-wellness-center/>), suggesting those with the skills necessary to interpret in the psychotherapy setting may increase. However, the use of an interpreter (even one that is less skilled), should be preferred over using family members. The use of family members can jeopardize the clinician's ability to diagnose and treat the client, especially if the family member edits the messages conveyed or answers the questions for the client him or herself. Further, it directly compromises the client's confidentiality, making it a serious ethical concern. Qualified interpreters should always be preferred over family members or other ad hoc interpreters (Leigh, 1999).

A second ethical, and legal, concern in working with an interpreter is related to who pays for the services provided. According to the 2011 ADA Update: A Primer for Small Businesses, it is the business's responsibility to provide a sign language, oral interpreter, or video remote interpreting service "unless doing so would result in an undue burden." "Undue burden" in this case is determined by a business's overall resources (U.S. Department of Justice, 2011). The APA Practice Organization (2012) takes the position that, in most cases, a psychologist should attain and pay for the cost of an interpreter for a deaf patient because proving "undue burden" would be a significant challenge. The APA also notes that the cost of doing so is outweighed by the risk of an ADA complaint being filed against the psychologist. Further, Gutman and Pollard (1999) have taken the stance that it is "virtually always illegal" to deny a request for an interpreter or ask the consumer to pay for the cost.

Although qualified interpreters who work in mental health settings are bound by their own set of standards of practice and code of ethics which touch on issues such as confidentiality, impartiality, and discretion (Stewart, Schein & Cartwright, 1998; see NCIHC, 2004 and NCIHC, 2005) and linguistic considerations, contextual dimensions, and interpersonal dynamics (RID, 2007), psychologists are still mandated by Standard 2.05 (Delegation of work to Others) to take reasonable steps to "...(1) avoid delegating work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity [e.g., a family member or friend]; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience...; and (3) see that such persons perform these services competently" (APA, 2010). Therefore, psychologists are responsible for ensuring that interpreters are competent and trained in the importance of the APA's ethical standards, including confidentiality, the potential for harm in multiple relationships, and informed consent (Campbell, Vasquez, Behkne, & Kinscherff, 2010). It is also important for psychologists to understand the complex task that interpreters are faced with and to participate more broadly and actively in the process of translation (see Dean & Pollard, 2005 for a more detailed discussion).

Since the Deaf community is small in size, both generally and within a given location, and the number of qualified interpreters is scarce, it is important for psychologists to consider that qualified interpreters are likely to be known to clients in other contexts. This may result in heightened anxieties and concerns among clients related to self-disclosure and confidentiality (Steinberg, 1991). It is important to assure clients that it is the psychologist's

duty to hold interpreters to the same standards of confidentiality that they themselves are held to. That is, psychologists are required by Standard 4.01 (Maintaining Confidentiality) to "...take reasonable precautions to protect confidential information obtained through or store in any medium..." (APA, 2010). This also points to the importance of only using qualified interpreters whenever possible. It may also be necessary to require interpreters to sign a contract stating they received adequate training by the psychologist and agree to uphold the confidentiality of their clients.

Although a mental health interpreter may be qualified and well versed in the Ethics Code, it is necessary for a psychologist to also consider the interpreter's mental health language competence and comfort with session content (see Standard 2.05 described above; Searight & Searight, 2009). Interpreters should be familiar with common terms and concepts used in therapy and should be comfortable with conveying this information to the client in a neutral way without inserting their own biases. Interpreters must comprehend the concepts they hear or see in a mental health context in order to translate them accordingly (Dean & Pollard, 2005). Psychologists need to be mindful of the possible ambiguity in a Deaf client's response if his or her communication or the interpretation is too literal (resulting in misunderstanding), too leading (which may shape the client's response), or incorrectly interpreted (typically through interpreter manipulation; Cornes & Napier, 2005; Paone & Malott, 2008). It becomes the responsibility of the psychologist to educate his- or her-self on the information relevant to working with qualified interpreters in treatment. Specific recommendations and resources are offered at the end of the current article.

Special attention should also be paid to linguistic alterations (i.e., accuracy). That is, according to Paone & Malott (2008), psychologists should be cognizant of the fact that interpreters may ignore information they do not understand or believe may embarrass the client or themselves, may reduce information to decrease translation execution time in favor of translating more important information, which may result in a loss of impact, may use additions, elaborations or phrase changing when they believe the information given by the therapist was incomplete or unclear, and may even substitute, condense, or alter material perceived as too challenging for clients to understand because of language difficulty, the amount of information, or possible emotional impact. Quality assurance in this regard might seem impossible given that the psychologist does not know the client's language and therefore cannot readily recognize the linguistic alterations; therefore, suggestions for doing this are offered in the "Recommendations" section of the current paper.

Although it is vital for psychologists to take responsibility in ensuring mental health language competence and comfort with session content when working with qualified interpreters, it is also important for psychologists to understand the inherent judgment that qualified interpreters must use to do their job ethically (i.e., according to their Code of Ethics) and effectively. The National Association of the Deaf (NAD) and the Registry of Interpreters for the Deaf (RID) Code of Ethics (RID, 2005) states interpreters "refrain from providing counsel, advice, or personal opinions" (p.3). Dean and Pollard (2005) believe that when this is taken in a literal context (although they were referring to the 1994 version of the RID code, it is very similar) it is erroneous and detrimental because translations often do not correspond the precise words said, translations can and often do require information to be

added or deleted (i.e., linguistic alterations), and translations are based on the interpreter's judgment of what consumers mean instead of the words they choose (Dean & Pollard, 2005). Psychologists must understand the realities of interpreting work and balance these with their requirement to safeguard their clients and do no harm.

In a related study, Miller and colleagues (2005) had fifteen therapists and interpreters working with refugees in the U.S. cite positive and negative aspects of counselor-interpreter collaboration, according to their experiences. Although there were positive aspects, some therapists reported observing inappropriate interpreter reactions to sensitive content (e.g., high levels of distress) in session. Cornes and Napier (2005) suggest that challenges with processing the emotional impact of sensitive therapeutic material will have clear consequences on the equivalence of the interpretation. Comfort with session content should ideally be addressed before the session with the psychologist in private. Psychologists must take on the responsibility to ensure mental health language competence and comfort with content are addressed prior to being brought into session with the client, whom psychologists have an ethical responsibility to safeguard.

A further ethical consideration in working with qualified interpreters is informed consent. The Ethics Code, in Standard 10.01 (Informed Consent to Therapy), requires psychologists to obtain informed consent as mentioned in Standard 3.10 (Informed Consent) and "... inform clients/patients as early as is feasible... about the nature and anticipated course of therapy, fees, involvement of third parties and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers" (APA, 2010). Informed consent is defined as "a shared decision-making process in which the professional communicates sufficient information to the other individual so that she or he may make an informed consent about participation in the professional relationship" (Barnett, Wise, Johnson-Greene, & Bucky, 2007, p. 179).

This process is complicated when using a qualified interpreter for many of the same reasons previously mentioned. Psychotherapists must be personally responsible for ensuring that information related to informed consent is adequately translated (i.e., the translation is free from errors, biases, and the other issues mentioned above) and must understand how linguistic differences may limit the client's ability to make consent truly informed (Barnett & Goncher, 2008; Pollard, 2002). It would also be ethically responsible to consider how the underlying concepts of informed consent can be influenced by cultural factors. Barnett and Goncher (2008) give the example of autonomy, or the right to self-determination (as emphasized in General Principle E: Respect for people's Rights and Dignity). Conceptualizations of autonomy may vary by culture. For example, a Deaf client may feel more comfortable including significant members from the Deaf community in his or her decision making process. Such preferences should be respected during the informed consent process (Barnett & Goncher, 2008).

Although bringing a qualified interpreter into treatment can seem like quite the undertaking, at least ethically speaking, the importance of using interpreters in serving the Deaf community has been well-documented and the ability to work skillfully with qualified interpreters has been considered a core competency (Glickman & Harvey, 2008).

Psychologists should strive to consider the plethora of relevant ethical issues, particularly those discussed in the current paper, prior to beginning treatment with a Deaf client, and should consider additional matters, such as legal factors, relevant to bringing a qualified interpreter into treatment. A discussion of all relevant considerations for working with qualified interpreters is beyond the scope of this paper. Those interested should refer to Dean and Pollard (2005), Cornes and Napier (2005), Leigh (1999), Gutman (2002), and Paone and Malott (2008).

SUMMARY

Given that there is a clear need for psychologists who are competent to treat deaf/Deaf clients, psychologists must endeavor to become familiar with the ethical considerations (i.e., obtaining and maintain competence; making ethical decisions related to multiple relationships and boundary issues; confidentiality considerations in working with deaf/Deaf clients; assessment, diagnosis, and evaluation in light of the lack of appropriate instruments for use with deaf/Deaf clients; and communication and using interpreters in therapy) relevant to working with this population. In addition to maintaining ethical standards, psychologists should strive to guarantee that all persons, regardless of hearing status or cultural affiliation, are afforded access to and benefit from the contributions of psychology and receive equal quality in the services they provide (Principle D: Justice; APA; 2010).

While it is impossible for psychologists to become competent in working with every cultural and linguistic group given our increasingly diverse culture, it is their ethical responsibility to try their best to do so. Some might argue that given the small size of this population, it is unlikely a psychologist will ever receive such a referral. However, even if the psychologist cannot take the time to become competent in working with the deaf/Deaf population, they must educate themselves on how to move forward ethically and know where to find appropriate resources for doing so.

RECOMMENDATIONS

The aims of the following recommendations are to support individual psychologists, training programs, and the field as a whole in ensuring an active approach to the ethical treatment of deaf/Deaf clients:

1. Develop and disseminate specific professional guidelines for the application of the APA Ethics Code in treating the deaf/Deaf population as well as for interpreting in mental health settings.
2. Increase competence by generating and offering training for psychologists that covers the cognitive, social, emotional, and psychological development of deaf/Deaf individuals (Cornes & Napier, 2005). Training should also consider the ethical considerations described in the current article as they are an important aspect of competence. Training must also focus on issues relevant to working with qualified interpreters, including how to identify a qualified interpreter, knowledge of potential errors qualified interpreters can make, and how to collaborate with qualified

interpreters pre- and post-session as well as within session to protect the therapeutic alliance and ensure comprehension by the client (e.g., encourage interpreter-clinician teams). Further, therapists should be trained in how to deal with assessing interpreter competence, comfort with session content, and how to navigate the informed consent process when working with a qualified interpreter. Creating a regular quality assurance program where the client can indicate satisfaction with the interpreter may be one way to protect against inaccurate interpretation and other issues that may result in ethical violations (See the Deaf Wellness Center's lecture on interpreter translation accessible at <http://www.urmc.rochester.edu/deaf-wellness-center/training-education/>). A good starting place is Robert Pollard's Mental Health and Deaf Individuals On-Line Training for Clinicians accessible at <http://training.dmh.mo.gov/clinical-training/>. Further, the Missouri Department of Mental Health offers free online trainings (<http://dmh.mo.gov/deafsvcs/training.html>).

3. Develop and encourage the use of a referral network for professional psychologists with the competence and experience necessary to treat deaf/Deaf clients. "Experience necessary" might require creating specific competency and supervision benchmarks that adequately qualify one to work with this population. Such benchmarks may be best detailed in the professional guidelines for the application of the APA Ethics Code mentioned above.
4. Deliver and pursue appropriate knowledge, skills, training, and expert consultation in order to deal with the ethical decision making common in working with deaf/Deaf clients. Required knowledge should include, but should not be limited to, familiarity with Deaf cultural values and traditions (and how they might differ from a deaf client's values and traditions), including the significance of Deaf pride and Deaf identity, an understanding of the mental health needs unique to this population, clinical skills in working with interpreters (See Glickman and Harvey, 2008 for a detailed discussion), and a general understanding of the common ethical issues related to treatment of this population (See Leigh, 1999, Figure 1 for a detailed list of training needs and Leigh, 2010 for a discussion of ethical reasoning approaches). Such knowledge, skills, and training may be best obtained through a combination of graduate courses, experience and supervision in working with deaf/Deaf clients, and continuing education. Beginning with certification programs via workshops or online courses would also be useful tools for addressing this aim more immediately given the challenges related to graduate-level training described above.
5. Educate professionals on the importance of awareness and discussion of biases, values, beliefs, difficulties, or concerns regarding treating deaf/Deaf clients or working with interpreters into training (e.g., ethics courses that explore values as a component of the course material), supervision,

literature (e.g., Glickman & Harvey, 2008 and Phillips, 1996), continuing education, and the professional culture of psychology. Graduate training program's ethics courses have the unique opportunity to increase awareness of and address values related to treating deaf/Deaf clients. The ethical issues relevant to treating deaf/Deaf clients should be added to these courses in order to increase exposure and decrease the likelihood that some well-meaning future psychologists might agree naively to see a deaf/Deaf client without considering the plethora of important ethical issues.

6. Actively work in collaboration with the Deaf community and Deaf organizations to provide information and psychoeducation to their members in order to expedite equal access to services. Content might focus on familiarizing Deaf people with psychotherapy, including the role of the therapist, the purpose of and techniques used in therapy, and the role of interpreters and families in the therapeutic process (Cornes & Napier, 2005). Clinicians should actively participate in professional organizations in the field of deaf studies (Leigh, 1999). This might increase the possibility that all persons, regardless of hearing status or cultural affiliation, are afforded access to and benefit from the contributions of psychology.
7. Encourage empirical research focused on how to be most effective in treatment and assessment when using an interpreter. Continue to build empirical knowledge, including the most effective types and modalities of treatment for treating deaf/Deaf clients. The aim of this should be to develop empirically supported treatments for use with deaf/Deaf clients. Clients should be made aware during the informed consent process that few empirically supported treatments have been tested with deaf/Deaf individuals.
8. Actively advocate for treatment providers to become more deaf/Deaf-friendly by offering interpretive services, becoming familiar with relay phone services, or offering two way pagers. Since this places financial responsibility on the provider, it would also be beneficial to advocate for funding that would give providers the economic resources necessary to achieve this goal.
9. As a field, work to make doctoral level training more accessible for Deaf trainees. The Deaf Wellness Center at the University of Rochester Medical Center has a specific program for Deaf Trainees. However, institutions such as Gallaudet University often experience challenges in placing students in internships with more general programs, even if the program has an emphasis on treating disabled clients.

Although it is unlikely that identification and resolution of ethical problems will be straightforward, it is the responsibility of the psychologist and the field of psychology as whole to uphold the standards of the Ethics Code. This will require the profession to continue to increase its understanding of working with deaf/Deaf clients through research on

the best treatments, training programs, and ethical decision making models that adequately address the deaf/Deaf population's specific mental health needs and cultural preferences. Competence is the foundation of ethical treatment with culturally diverse groups, and the deaf/Deaf population is no exception. By actively advocating for such advances and embracing the challenge of working with the deaf/Deaf population, psychologists can work towards ensuring that the benefits of treatment are fairly and justly provided to all persons (consistent with Principle D: Justice; APA, 2010).

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