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First

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A qualitative meta-synthesis on the experience of psychotherapy for deaf and hard-of-hearing people

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A review was conducted to examine the experiences that affect the therapeutic relationship when a person who is deaf or hard-of-hearing meets with a therapist. Electronic databases were searched using keywords and 10 qualitative articles were retrieved that met the inclusion criteria. A qualitative meta-synthesis was conducted on the articles, including appraisal, comparison, and synthesis of findings. The results of the synthesis highlighted seven areas where the therapeutic relationship is challenged, including issues which occur before and during psychotherapy. The findings of the review are discussed in the context of the articles' limitations. The implications of the results are discussed in terms of clinical practice, future research, and current models in psychology which are based on hearing participants.

Keywords: deaf; hard-of-hearing; sign language; therapy; qualitative

Extensive research has been conducted surrounding the issues presented when a hearing person who requires an interpreter meets a therapist within a therapeutic encounter (Tribe & Tunariu, 2009). However, sign language is unique in that it is a multidimensional, visual-gestural language which distinguishes it from verbal languages. It is estimated that in the United Kingdom about nine million people are deaf or hard-of-hearing, 50,000 of whom use British Sign Language (BSL) as their first or preferred language (Royal National Institute for the Deaf, 2006). The publication of policies and government recommendations within the United Kingdom exemplifies a move towards greater recognition of deaf or hard-of-hearing people within health services. For instance, Towards Equality and Access (Department of Health, 2004) addressed many issues surrounding mental health for people who are deaf or hard-of-hearing and contained 27 recommendations aimed at encouraging health trusts to attend to limitations, including deaf awareness training for staff and hiring interpreters. Similarly, the Disability Discrimination Act (1995) is legal legislation within the United Kingdom and refers to *reasonable adjustment* in accessibility to services for people with disabilities, including providing interpreters. This Parliamentary Act should help people who are deaf or hard-of-hearing access health services and facilitate adequate communication between the client

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and clinician. However, research has shown that people who are deaf still have difficulty accessing health services (Harris & Bamford, 2001). Furthermore, an interpreter is not always provided when they do access services and many deaf people are not aware of their legal rights (Steinberg, Barnett, Meador, Wiggins, & Zazove, 2006).

Moreover, the research into the factors which influence therapeutic outcomes for any client during psychotherapy was summarised by Lambert and Barley (2001). The authors argued that the most significant changes occur due to *extra-therapeutic techniques*, such as social support, which are not directly controlled by the therapist. However, for factors which can be influenced by therapists, *common factors,* such as the therapeutic relationship, correlate most highly with positive outcomes in therapy. Other factors which influence therapeutic outcome were *expectancy effects*, including placebo effects and *specific therapy techniques*. Despite the models apparent inclusivity, it was based solely on studies which used participants who were able to hear and it has not been applied to populations who are deaf. A review which examines how the therapeutic relationship is affected for clients who use sign language would be beneficial, as Lambert and Barley argued that it is the most significant factor that a therapist can influence.

Conversely, research conducted into mental health services for deaf and hard-of-hearing people has increased in recent years, for example in psychotherapy (Bruin & Brugmans, 2006), counselling (Munro, Philp, Lowe, & Biggs, 2005), applying specific therapeutic techniques (Glickman, 2009; Munro, Knox, & Lowe, 2008), and general therapeutic literature (Cornes & Napier, 2005). The aim of these studies vary, with some examining therapists' perspectives (Oldale, 2008), clients' perspectives (Cohen, 2003), and some examining interpreters' perspectives (Bruin & Brugmans, 2006). The range and diversity of research will be beneficial to this review as it will facilitate a comprehensive examination of the issues that affect the therapeutic relationship. It is accepted that qualitative studies can deepen understanding of clients' experiences and perspectives of healthcare (Cushing, 1994). Studies which employ qualitative methods assume the participant is the expert in their own experience, facilitating an understanding and meaning which is relevant to the participant (Smith, 2003). However, studies are often conducted in isolation and it can be difficult to make pragmatic links with previous research (Sandelowski, 1997). A qualitative meta-synthesis addresses these concerns by consolidating individual studies through a process of translation and synthesis (Zimmer, 2006). Although the debate over what constitutes a qualitative meta-synthesis continues within the literature (Paterson et al., 2009) the method outlined by Sandelowski and Barroso (2007) will be followed in this review as it provides a clear guide on the process, facilitating a consistent approach to synthesising the information.

For instance, previous attempts to consolidate the literature include a review by Scheier (2009) who examined the challenges that people who are deaf encounter whilst trying to access healthcare services. The review made recommendations relating to practical suggestions, including use of technology and medical procedures. Furthermore, a review by Barnett (2002) examined research on the communication between physicians and patients who are deaf. The review found that there can be difficulties in their communication, resulting in fear for the patient that their healthcare is substandard. The review only used studies that examined encounters with people who use American Sign Language (ASL) and excluded research which had been conducted outside of America. It also included both quantitative and qualitative research and was not explicit on the methodology used to review the data, stating only that "expert opinion helped guide discussion and recommendations" (p. 376). The lack of clarity of how the synthesis was conducted, limits the validity of the findings. The current review will only use

qualitative research studies, as advocated by Sandelowski and Barroso (2007) and will not discriminate between different types of sign language, types of psychotherapy, or therapist, to prevent the exclusion of valuable qualitative data. The reviews by Barnett (2002) and Scheier (2009) were aimed at the medical profession, accessing medical services, and interactions with medical staff. Consequently, the findings from these reviews cannot be directly applied to services and interactions with therapists, which are likely to raise different challenges, due to the different service structures and relationships with clients.

Therefore a review of the literature surrounding deaf and hard-of-hearing people in regards to meeting with mental health professionals, where a therapeutic relationship can exist, is warranted, as it may highlight issues that are specific within this population with regards to building such a relationship. The aim of this review is to examine qualitative literature to highlight factors that impact upon the therapeutic relationship between a therapist and sign language user. The review will help to identify differences in the therapeutic process for people who are deaf or hard-of-hearing, which may be directly affecting the therapeutic outcome. The author knows of no other review which examines the issues raised when a sign language user and therapist interact through the use of an interpreter.

Method

Searching for articles

Throughout various countries, there have been significant changes in governing legislation for individuals who are deaf or hard-of-hearing who access mental health services. For example, the Americans with Disabilities Act (1990), the Disability Discrimination Act (1992) in Australia, and the Disability Discrimination Act (1995) within the United Kingdom all attempted to ease access to healthcare and mental health services for individuals who are disabled. Consequently, it was felt that the experiences of individuals who are deaf or hard-of-hearing who attempt to access mental health services after such legislation could be significantly different to that of individuals who attempted to access them before the passing of such legislation. Therefore, this was accounted for in the review, due to the direct impact such legislation could have on individuals' experiences and their therapeutic relationship with the therapist. As such, studies were only accepted for this review if legislation had been passed which recognised the needs of individuals who are deaf or hard-of-hearing in accessing services and the study was conducted after the legislation had been passed. Furthermore, the review did not discriminate between types of sign language (e.g., BSL/ASL/Australian Sign Language) due to the similarities in how they are expressed and the assumption that the therapeutic experience with an interpreter would be similar regardless of type of sign language used.

Therefore, the inclusion criteria were: (a) published after relevant Disability Act relevant to country of origin; (b) qualitative empirical studies and information relevant to therapeutic process; (c) participants of any age, race, religion, nationality, culture, or gender and can include any number of three types of participants: (i) any health professional who has been involved in a therapeutic relationship with a sign language user, (ii) person who uses sign language as their first language, (iii) and sign language interpreters. "Interpreter" is defined as a person who has mediated between two people in sign language, regardless of any qualification.

The exclusion criteria were: (a) any study conducted before relevant Parliamentary Act; (b) mixed method studies, quantitative studies, mixed sample studies (e.g., participants

who don't use sign language and those who do), alternative style qualitative research presentations (e.g., auto-ethnographies), studies with no human participants, other non-research qualitative method; (c) friends or family members as participants (unless used as "interpreter") and deaf or hard-of-hearing people who do not use sign language; (d) and studies not written in English.

The following terms were used in a variety of combinations to search relevant electronic databases; *deaf, deafness, deafened, hearing (-loss/-impaired), sign language, signed language, interpreter, translator, BSL, ASL, Auslan* (common term for Australian Sign Language). The initial search took place between 27th April and 1st May, 2010, and the following databases were searched: PsycINFO, CINAHL, Web of Science, ScienceDirect, PubMed, ProQuest (Dissertations and Theses), MEDLINE, Academic Search Complete, AMED, and PsycARTICLES. In total, 1830 studies were retrieved and filtered according to the inclusion and exclusion criteria; 605 were not related to people who are deaf of hard-of-hearing, 750 were not related to healthcare, 310 were non-empirical, 19 were not written in English, 44 used quantitative methods, 5 used alternative qualitative accounts, and 48 were published before a relevant Parliamentary Act. This process left 49 potential articles from which it could not be determined by the abstract alone whether they met all inclusion criteria or any of the exclusion criteria. Once these articles had been read, 21 were removed because they were non-empirical, 14 were not relevant to the review's aim, 4 were not conducted with qualitative methods, and 1 used a mix of participants with various disabilities. Therefore, nine articles met all of the inclusion criteria (Cardoso, Rodrigues, & Bachion, 2006; Cohen, 2003; Iezzoni, O'Day, Killeen, & Harker, 2004; Munro et al., 2008; Oldale, 2008; Steinberg, Sullivan, & Loew, 1998; Steinberg, Wiggins, Barmada, & Sullivan, 2002; Steinberg et al., 2006; Thomas, Cromwell, & Miller, 2006). The recommendations by Bates (1989) in relation to "footnote chasing" and "citation searching" were conducted on the remaining nine articles and one new article was retrieved (Witte & Kuzel, 2000).

Appraising individual articles

The 10 articles were appraised using guidelines produced by Sandelowski and Barroso (2007) to assist in the evaluation of individual reports, rather than compare them. The guidelines highlight specific areas to assess the quality of the study, including the literature search, participant sampling strategy, sample size, data collection method, and data analysis method. The purpose of the appraisal tool was not to exclude studies, but to examine the limitations of the studies, which will be drawn upon in the discussion.

Comparing the articles

The use of a cross-study display for comparative appraisal was also used to compare studies, which can be seen in Table 1. This display facilitated the comparison and summary of the main characteristics of the reports, which will be utilised in the results section.

Synthesising the articles

The findings were synthesised using two techniques described by Sandelowski and Barroso (2007). The first technique was constant targeted comparison, which compares the similarities and differences between a specified target phenomenon and phenomenon not

Table 1. Cross-study display for comparative appraisal of qualitative studies that were used in meta-synthesis.

Author	Year	Place and sign language	Discipline	Method	Participant type	Analysis
Steinberg et al.	1998	America; ASL	Psychiatry	Individual and group semi-structured interviews	Client	Unclear
Witte & Kuzel	2000	Richmond, VA; ASL	Family Practice	Two focus groups of 6–8 people	Client	Unclear
Steinberg et al.	2002	America; ASL	Psychiatry	Four semi-structured focus groups of 4–8 females	Client	Thematic analysis
Cohen	2003	America; ASL	Social Work (with therapy skills)	Semi-structured interviews	Client	Grounded theory
Iezzoni et al.	2004	America; ASL	Medicine	Semi-structured group interviews	Client	Unclear
Cardoso et al.	2006	Brazil; Brazilian Sign Language	Psychiatric Nursing	Semi-structured interview	Client	Thematic analysis
Steinberg et al.	2006	America; ASL	Psychiatry	Four semi-structured focus groups of 2–21 people	Client	Unclear
Thomas et al.	2006	Britain; BSL	Community mental health teams	Eight focus groups	Therapist	Thematic analysis
Munro et al.	2008	Australia; Auslan	Psychology and counselling	Constructionist interview	Client	Constant comparative analysis
Oldale	2008	Britain; BSL	Counselling	Semi-structured interviews	Therapist	Thematic analysis – Duquesne school

Note: Articles are ordered chronologically.

addressed in the selected studies. However, due to the nature of the articles retrieved, the comparisons did not include phenomenon from external sources, as the types of participants allowed for constant targeted comparison between them (i.e., client and therapist). The second technique was reciprocal translation, which allowed for the comparison of intra-study conceptual synthesis, and it was decided that this should be based on participant type. Therefore, studies that used participants who used sign language were integrated and similarly with the studies that used therapists as participants. Consequently, this technique allowed for the integration of findings from the studies that used the same type of participant, whereas constant targeted comparison facilitated the integration and comparison of findings from studies that used different types of participants.

Results

Sample configuration

The search produced 10 articles which met the inclusion criteria and were published between the years of 1998 to 2008. The primary authors' disciplinary affiliations (not including multiple reports by the same authors) were psychology ($n=2$), psychiatry ($n=1$), counselling ($n=1$), family practice ($n=1$), social work with therapeutic training ($n=1$), medicine ($n=1$), and psychiatric nursing ($n=1$). A majority of the studies were conducted in America ($n=6$), and therefore the primary sign language used was ASL. The rest of the studies were conducted in Britain using BSL ($n=2$), Australia using Auslan ($n=1$), and Brazil using Brazilian Sign Language ($n=1$). There were only two articles which appeared to be underpinned by a specific theoretical orientation, which were by Cohen (2003) whose study was orientated by a psychodynamic perspective, and Munro et al. (2008) whose study orientated towards a social-constructionist perspective. The stated methodology of the articles were individual semi-structured interviews ($n=4$), group semi-structured interviews ($n=2$), focus groups ($n=4$), and constructionist interview ($n=1$). The analyses of the articles were thematic analysis ($n=4$), grounded theory ($n=1$), constant comparative analysis ($n=1$), and studies in which the analysis was not explicitly stated ($n=4$). The articles were unrelated to each other in terms of samples used, meaning that no bias was present regarding the opinions of participants. However, it should be noted that three of the studies had the same primary author (Steinberg et al., 1998, 2002, 2006) which may affect the overall findings. Therefore, this shall be attended to during the synthesis and discussion to avoid any assumptions or biases in Steinberg's results. The purpose of the majority of the articles was to gain the perspective of the client who uses sign language ($n=8$) whilst the remaining studies examined the perspective of hearing and deaf therapists ($n=2$). None of the articles retrieved examined interpreters' perspectives.

Profiles of samples

All the articles included demographic characteristics of the participants, except for the study by Thomas et al. (2006) which was therefore not included in the following summaries. The sample sizes of the studies ranged from 2 to 91, with a total sample size of 263 ($M=29.22$). Collectively, the sample consisted of participants who were deaf ($n=228$), hard-of-hearing ($n=29$), and hearing ($n=2$). The studies which employed participants from the perspective of the client, 94.86% used ASL, 0.79% used Auslan, and

4.35% used Brazilian Sign Language. The studies that used BSL were not used in this calculation as they examined the perspective of the therapist (Oldale, 2008; Thomas et al., 2006). The age range of the sample was 18 to 83, although this potentially was higher as Witte and Kuzel (2000) did not specify the oldest participant's age. The sample size consisted of 62.87% females and 37.97% males.

Synthesis of findings

The synthesis of the 10 reports highlighted seven concepts which may affect the therapeutic relationship. The issues are presented in a specific order, starting with those that occur before psychotherapy, followed by ones which are present during the interaction, and concludes with issues that are present when third parties become involved. The term "client" refers to a client who uses sign language.

Service issues

The first difficulties that impact upon the therapeutic relationship occur before psychotherapy begins, relating to aspects of local mental health services, and were mentioned by clients and therapists. Some clients were unable to locate accessible mental health services, relying on deaf community members instead for "informal counselling" (Steinberg et al., 1998, p. 984). This issue was also discussed by professionals who stated that they or the client had to undertake considerable travelling for appointments (Thomas et al., 2006). Such issues highlight how a client is less likely to access services, pre-empting the challenges they may encounter. Furthermore, when clients decide to access services, they are likely to have to forfeit more time and effort than a hearing person. There was concern amongst professionals that the lack of specialist services meant that it was difficult to share information which led to unclear roles (Thomas et al., 2006) and the isolation of trained professionals (Oldale, 2008). These challenges do not facilitate optimal services for clients, potentially meaning that trained professionals are expected to work with limited professional support, have more clients on their caseload, and work over large geographical areas. Consequently, the perspectives of clients and therapists are likely to be affected during any contact, with some clients deciding to not engage in services for these reasons (Oldale, 2008; Steinberg et al., 1998; Thomas et al., 2006; Witte & Kuzel, 2000).

Communication with other workers

The next challenges that a client encounters before therapy begins are related to communication with staff in the service, who are not their therapist or interpreter. For instance, three of the articles highlighted how clients had encountered difficulties whilst trying to contact the office where the therapist was employed (Iezzoni et al., 2004; Munro et al., 2008; Witte & Kuzel, 2000). This was due to the office not having appropriate equipment to facilitate communication with people who are deaf. Furthermore, Witte and Kuzel (2000) noted that this left clients relying on family members to speak to the office staff, later resulting in the office staff ringing the family members before the client, which was "disappointing" for the client (p. 18). Clients also discussed their frustration and anxiety over interacting with office staff and an example which was highlighted in three of the articles was when clients could not hear their name being called in the waiting room (Cardoso et al., 2006; Iezzoni et al., 2004; Witte & Kuzel, 2000). This was also discussed in one of the articles that examined therapists' perspectives (Thomas et al., 2006) which

found that therapists were aware, to some degree, that clients encounter difficulties due to limited resources of the service, including not having text telephones.

Therefore it appears that challenges encountered when communicating with staff in services is widespread and a familiar experience for clients. The issue was highlighted in five out of the 10 retrieved articles, indicating that it is not specific to one particular mental health service. Consequently, it is clear that the communication with staff needs addressing within services of all countries, as the client is likely to make assumptions about the service which is based on their initial communications with staff.

Communication between therapist and client

The communication between therapist and client was highlighted in all of the articles and was prominent for clients and therapists. Clients conveyed several messages, including fear of not being able to communicate adequately and anxiety about the impact of this upon their treatment (Iezzoni et al., 2004; Steinberg et al., 1998, 2002, 2006). Related to this were clients' perspectives, who thought the optimal option would be to have a therapist who could use sign language (Cardoso et al., 2006; Steinberg et al., 1998, 2002, 2006) as they would feel more comfortable communicating and there was an assumption that they would know more about deaf culture (Steinberg et al., 1998) which would make them feel healthier (Steinberg et al., 2006). Deaf culture is an overarching term used to describe the cultural norms of distinct deaf communities (Mindess, 2006) including, sign language, social beliefs, values, identity, social communities, history, and behaviours. A therapist may not understand, for instance, certain behaviours of communication, the identity of deaf individuals or common experiences of individuals who are deaf. For example, many deaf communities value the group rather than the individual, and people value their place within deaf communities. Furthermore, people who are deaf have common ways of interrupting in conversations or gaining attention, such as touching people or moving their hands in front of them. Additionally, intrinsic within the identity of deaf individuals is that deafness is not viewed as a negative trait which requires fixing. These aspects of deaf culture, as well as many others, may not be familiar to therapists who are hearing, which could cause difficulties or ruptures within the therapeutic relationship or process if they are not understood.

It was acknowledged within the articles that clients were more comfortable with clinicians who made any effort to communicate with them directly, whether this be through facial expressions and attentiveness (Cohen 2003; Steinberg et al., 2002) or allowing the client to see their face and mouth clearly so they could lip-read (Iezzoni et al., 2004; Witte & Kuzel, 2000). The main difficulty for clients was when clinicians would not attempt to explain or clarify aspects of therapy and were regardless of clients' lack of understanding (Steinberg et al., 2002, 2006). Consequently, as all types of psychotherapy rely on clients being active participants throughout the process, a lack of understanding of what the therapist is communicating is likely to result in ineffective therapy or disengagement.

Furthermore, the communication between client and therapist was also highlighted in both articles that examined therapists' perspectives and there was a general consensus that difficulties impacted negatively on clinical work (Oldale, 2008; Thomas et al., 2006). The communication difficulties led to frustration for the therapist and some disclosed that unclear communication resulted in guesswork (Thomas et al., 2006). Therapists also highlighted increased emotional response for themselves and clients, due to the fact that sign language is visual (Oldale, 2008). For example, a significant part of sign language

relies on re-enacting situations, with the signer role-playing all the people involved in the situation, as if it is happening in the present. This re-enactment of situations is different from verbally describing events in the past tense and as Oldale found, has emotional consequences for the therapist and client. Such re-enactments could be particularly emotionally provoking within psychotherapy, due to the negative content or "problem-focused" which dominates communications. Therapists do not need to understand sign language to be emotionally affected by it and professionals who are not used to such visual communication methods may find it emotionally challenging. Furthermore, Oldale found that therapists are unable to decipher if clients' signing is due to aggressiveness, mental health difficulties, or is culturally appropriate. These aspects of communication may result in challenges when forming a therapeutic relationship, and lead the therapist to be more uncertain of the work they undertake with clients.

Thus, communication appears to be of concern for both parties, with detailed explanations of how such things can have negative consequences. Such communication difficulties will have direct consequences for the therapeutic relationship, as both clients and professionals highlight how it negatively impacts on them, in terms of their feelings and the work undertaken. As this issue was discussed in all of the retrieved articles, it is not limited to difficulties in one service and needs addressing throughout all mental health services.

Lack of knowledge

This area was mentioned in six of the articles that used clients as participants and relates to various issues of knowledge. There appears to be a general feeling amongst clients of inferiority in the presence of clinicians because they use unfamiliar terms or phrases that cannot be directly translated into sign language (Iezzoni et al., 2004; Munro et al., 2008; Steinberg et al., 2002). Consequently, clients become reluctant to ask the clinician any queries they have (Steinberg et al., 2002) which highlights the challenges it poses for the therapeutic relationship. The clients also felt that they were viewed as inferior for lacking skills and knowledge in verbal language (Iezzoni et al., 2004). Such views held by clients within psychotherapy could lead to disengagement, poor therapeutic outcomes, or potentially facilitate self-esteem difficulties.

Furthermore, clients believed that therapists lacked knowledge about deaf culture, heightening the sense of a negative experience (Cohen, 2003; Iezzoni et al., 2004; Munro et al., 2008; Steinberg et al., 2006; Witte & Kuzel, 2000) and that clinicians generally viewed deafness as pathological (Witte & Kuzel, 2000). This was consistent with both articles that used therapists as participants, which showed that therapists thought they lacked knowledge in terms of deafness and mental health (Oldale, 2008; Thomas et al., 2006). However, therapists did not discuss the issue of using unfamiliar terms with clients, suggesting that therapists are unaware of the language they are using.

Therefore, lack of knowledge could impact upon the therapeutic relationship if the client feels inferior or thinks the therapist does not have knowledge about deaf culture. This is consistent with the difficulties noted in the communication between therapist and client, as each causes negative feelings to be evoked between the pair, which will consequently be detrimental to the therapeutic relationship. It should be noted that this issue was raised in two of the articles that Steinberg was involved in (Steinberg et al., 2002, 2006). However, as each of the studies focused on different aspects of the issue, it was felt that the synthesis would not be affected by including them.

How the client perceives the therapist's feelings

This concept related to how clients perceived the therapists' feelings whilst working with a patient who used sign language. This issue was highlighted in seven of the articles that examined clients' perspectives and was discussed with negative connotations. For instance, clients thought the clinician felt uncomfortable (Witte & Kuzel, 2000), had unethical and negative views towards people who were deaf (Steinberg et al., 2002, 2006), felt nervous and angry towards the client (Cardoso et al., 2006), were prejudice towards them (Steinberg et al., 1998), and thought clients who were deaf did not care about their health (Iezzoni et al., 2004). The therapists' attitude towards deafness may be the most important factor of building a therapeutic relationship according to Cohen (2003) who argued that it related to how people who are deaf experience negative attitudes from their own parents. Moreover, these issues were also discussed in both articles that studied therapists' perspectives of working with people who were deaf (Oldale, 2008; Thomas et al., 2006). Thomas et al. (2006) highlighted how the work was more complex, took twice as long, and how there was reluctance to work with them due to a lack of experience and resources.

Therefore, it appears that some of the negative feelings that therapists may experience are sensed by the client, which could cause further challenges to the therapeutic relationship. As nine of the articles discussed this difficulty, it appears to be a common problem across mental health services in various countries.

The use of an interpreter

The therapeutic relationship appeared to be significantly affected when an interpreter was involved throughout therapy, and was mentioned in all the articles that examined clients' perspectives. Although a qualified sign language interpreter was appreciated in psychotherapy (Cohen, 2003; Iezzoni et al., 2004; Munro et al., 2008; Steinberg et al., 2002; Witte & Kuzel, 2000) it also created challenges. Firstly, the participants expressed concerns which could directly impact on the content of what they discussed in psychotherapy. For instance, participants raised concerns about confidentiality, due to the small size of the deaf community (Steinberg et al., 1998) which could restrict what they are willing to discuss. Participants also expressed concern over the interpreter's competency (Steinberg et al., 1998) and fears that the interpreter would not be conveying their entire message (Witte & Kuzel, 2000). Participants also felt that they had to work harder with some interpreters, for example, when an interpreter did not understand what they were signing (Cohen, 2003; Witte & Kuzel, 2000). In the study by Witte and Kuzel (2000), participants felt they could not ask for an interpreter for various reasons, casting doubt over the strength of the therapeutic relationship and the efficacy of therapy without adequate communication. Secondly, participants also discussed difficulties which could ultimately result in them not attending therapy. For example, experiences were described of having to wait longer for psychotherapy, due the delay caused in hiring an interpreter (Steinberg et al., 2002). Furthermore, the practicalities of hiring an interpreter made clients feel uncomfortable, including payment for their services, resulting in some clients avoiding treatment (Steinberg et al., 2002; Witte & Kuzel, 2000). Finally, participants described direct negative impacts upon the therapeutic relationship due to having an interpreter present. For instance, Iezzoni et al. (2004) described how clinicians would not make eye contact with clients and instead would look at the interpreter during therapy. Steinberg et al. (2006) found that clients became frustrated when clinicians made them feel like the interpreter was only for the client's benefit, instead of benefiting both of them.

Conversely, the use of interpreters was rarely mentioned in the articles that studied therapists' perspectives. The article by Thomas et al. (2006) mentioned them in respect to the limited availability of interpreters and feeling uncomfortable relying on them to treat patients. The limited mention of these issues by therapists contrasts with clients who mentioned it frequently. This may be due to therapists not realising how interpreters affect their relationship with the client, or due to the possibility that research to date has not been appropriate to elicit therapists' thoughts on such issues. Nevertheless, collectively the studies show sufficient issues which need addressing in this area.

The role of family and friends

The final area that affected the therapeutic relationship was also due to the affect of third parties, namely friends and family. The issues that arise when friends and family are used in the process were highlighted in six of the articles from the perspectives of clients. One of the main difficulties highlighted was when family and friends were used as an interpreter during psychotherapy, which caused problems for the majority of clients. For instance, it was thought that this type of mediation was an inadequate form of interpretation (Iezzoni et al., 2004) and compromised clients' confidence that the message was relayed faithfully (Witte & Kuzel, 2000), confidentially (Steinberg et al., 2006; Witte & Kuzel, 2000), and restricted what they disclosed to the therapist (Cohen, 2003). Cases in which the client had felt isolated during the therapeutic process also existed, due to the family member being involved as the interpreter (Steinberg et al., 2006). Such difficulties are likely to affect the therapeutic relationship and may limit the efficacy of psychotherapy, especially if the client feels that they are restricted due to concerns over confidentiality. Furthermore, clients expressed that they received varied support from family and friends when they disclosed they are having therapy (Steinberg et al., 1998) which may make the client particularly sceptical to engaging in therapy when a friend or family member is involved. This view was also highlighted in one of the articles from therapists' perspective (Thomas et al., 2006) which acknowledged that they understood that relying upon family members to interpret may compromise a comprehensive and unbiased therapeutic session, as well as confidentiality. However, it was also noted that having a family member present can be supportive when helping the client fill in forms and understanding written information (Cardoso et al., 2006). This opinion only seemed relevant to the practicalities of going to therapy, rather than being beneficial to the communication.

The context of these results should be acknowledged, as two of the articles were written by Steinberg (Steinberg et al., 1998, 2006) which may have biased the results. However, the findings of both of these studies highlighted different aspects of family involvement and so it was thought that this would not affect the findings. Although this issue was not mentioned in the article by Munro et al. (2008), as this study specifically examined constructionist therapy with a reflecting team, there was no need for family or friends to be involved in the therapeutic process. As such, the difficulties of using friends and family as interpreters within the therapeutic process appear to cause universal difficulties for the therapeutic relationship. Nevertheless, the results indicate that mental health services continue to use friends and family as an inadequate substitution for qualified interpreters.

Discussion

This meta-synthesis has highlighted seven areas which challenges the formation of a therapeutic relationship including service issues, communication with other workers, communication between therapist and client, lack of knowledge, how the client perceives the therapist's feelings, the use of an interpreter, and the role of family and friends. The review is consistent with a previous review (Barnett, 2002) which concluded that difficulties in communication are present between medical professionals and clients who are deaf. For instance, this review concurred with Barnett's review on the lack of knowledge and challenges in the language used by professionals. However, the current review is aimed at the difficulties that occur when the encounter is with a therapist, which raises further issues relating to the therapeutic process. The findings by Barnett were mainly in the context of practical issues, such as eliciting information from clients and seating arrangements during the interaction. Furthermore, this review details the various stages of challenges encountered by clients who use sign language, including those encountered before therapy begins, which their assumptions of the service may be based upon.

The model by Lambert and Barley (2001) suggests that the primary influencing factor that a therapist can control is common factors, such as the therapeutic relationship. However, as this review has argued, many factors can challenge the relationship specific to deaf clients, some of which therapists acknowledge and others that they appear to be unaware of. The implications for practice are discussed below. The model also states that the most influential factor that affects outcome is extra-therapeutic factors, including social support. However, this may not be the case for some sign language users who have no choice but to involve their family or friends in the therapeutic process as their interpreter, which may consequently affect the usefulness of social support by the same people. The model by Lambert and Barley also argued that expectancy effects account for about 15% of outcome variance. However, the current review suggests that this may be not be the case for deaf and hard-of-hearing people, as part of their expectancies will be based on the experiences that occur before psychotherapy, including accessing services and communication with office staff. As their experiences of accessing services are different to people who are able to hear, their assumptions of the service may also differ. Therefore, their expectancy may be different to what Lambert and Barley suggested. As this example highlights, it should not be assumed that theories, models, and research based on hearing participants can be applied to sign language users. The model outlined by Lambert and Barley is limited in the context of this review, and exemplifies the need for the adaption of models and theories for deaf people, based on research with this population.

Moreover, this review shares similarities with systematic reviews that have studied psychotherapy mediated by verbal interpreters (Flores, 2005; Karliner, Jacobs, Chen, & Mutha, 2007). For instance, both Flores (2005) and Karliner et al. (2007) found that the use of qualified verbal interpreters improved clinical care whereas using interpreters who were not qualified, negatively impacted on care. Furthermore, studies which have used a verbal interpreter in healthcare settings have drawn attention to the disadvantage of using friends and family to mediate conversations (Phelan & Parkman, 1995). The literature on verbal interpreters highlights other similarities, including cultural effects, using technical terms, and the effectiveness of direct communication with the client (Tribe & Morrissey, 2004). However, this review highlights differences, such as the different challenges posed by accessing services. For example, research shows that immigrants who verbally communicate have difficulties knowing what services are available (e.g., Bhatia & Wallace, 2007; Uba, 1992). Conversely, sign language users seem to be aware of the services

available, but may choose not to use them due to the various challenges encountered. Another example of how the experiences differ, which may be particularly relevant to the building of a therapeutic relationship, is what is communicated in a psychotherapy session and how it is communicated. The visual element of sign language has an increased emotional impact in therapy, which is not relevant for people who speak a foreign language, which is communicated verbally. Clinicians would benefit from future research aimed at highlighting the differences more explicitly. However, this review highlights how it is not beneficial for therapists to assume the literature on psychotherapy with foreign language speakers can be adapted whilst working with deaf and hard-of-hearing clients.

Similarly, the current review has implications for practice with clients who use sign language. Therapists should enquire about and acknowledge the difficulties that clients encounter whilst accessing services and if appropriate explore the assumptions this may have created. Such an approach may help the therapist understand the client more, as well as make the client feel more appreciated. Also, being aware not to verbally call the names of clients who are deaf and using appropriate technology, including text telephones, will help ease clients' anxiety. The therapist can facilitate a therapeutic relationship further by being aware of their non-verbal communication with clients, not being distracted by the interpreter's signing, making eye contact with the client and making sure the client can see their face if they want to lip-read. These will help the client feel more involved in the therapy, rather than feeling isolated in the process. Many participants also acknowledged the benefit of a therapist who made any form of effort to communicate with them directly. Therefore, it may facilitate a good therapeutic relationship if a therapist can say "hello" or spell their name in sign language.

Furthermore, when an interpreter is involved, therapists should ensure that they are appropriate, who the client does not know, and who can be used throughout the duration of therapy. A client's friend or family should not be used as an interpreter and such issues should be organised with the client before psychotherapy begins. It is important for the therapist to feel supported, as feeling isolated creates further challenges to engagement with a client. Therefore, the therapist should seek appropriate support and be aware that supervisors may be inadequately trained for this. Therapists should also undertake training in deaf awareness, as advocated by Towards Equality and Access (Department of Health, 2004). All of the above recommendations will help in the formation of a therapeutic relationship and may help therapists with their reluctance to work with sign language users.

However, the limitations of this meta-synthesis need be taken into consideration when generalising the results. Firstly, a majority of the studies were conducted in America, which creates a bias in terms of which health system participants experienced and also the type of sign language participants used. Additionally, the studies that were conducted in Britain did not focus on clients' perspectives and the studies conducted in other countries did not take account of clinicians' perspectives. This creates a bias in the findings, in terms of who gave opinions of which mental health services. Also, as perspectives were taken from different mental health services, the results are compared on the assumption that similarities exist between the healthcare systems in different countries. As more research is conducted in this area, further reviews will able to discriminate between disciplines, county, and sign language. Furthermore, some of the studies did not state the analytical procedure that was used, limiting the quality of the study's findings and casting doubt on how reliably the findings portrayed participants' views. However, as the synthesis showed, the themes were found across several studies, which is one of the benefits of doing such

a review. As no study focused on interpreters' perspectives, future research would benefit from examining this as they play a vital part in such interactions.

Accordingly, caution should be taken in generalising the findings to any one service or client. Seven areas have been highlighted which affect the therapeutic relationship between a clinician and a sign language user. It is hoped that this review will also be used to signpost future research into these seven concepts to further our understanding of them and highlight where current research is limited.

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