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# Issues and Implications of Deaf Culture in Therapy

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In the United States, it is estimated that between 200,000 and 500,000 individuals are culturally Deaf. Deaf culture provides unique challenges that can impact standard therapeutic techniques. Issues regarding the ability of hearing therapists to effectively work with Deaf clients are addressed, and a number of guidelines are offered to assist hearing therapists in bridging language barriers and cultural gaps with Deaf clients. Additionally, concerns about the selection and inclusion of sign language interpreters are discussed.

The definition of deafness may seem straightforward to people with little exposure to the Deaf community. It is viewed in the medical community as a hearing loss, and it is legally classified as a disability. In the United States, an estimated 22 million people have some degree of hearing loss (Schirmer, 2001). Of this number, it is estimated that between 200,000 and 500,000 deaf people share American Sign Language (ASL) as a primary language and are part of a culturally distinct community, which is referred to as the Deaf (note the uppercase *D*) community (Roe & Roe, 1991; see Phillips, 1996, for a discussion of "big-D Deaf" versus "little-d deaf" individuals, pp. 138–139). Therefore, deafness is a multicultural issue that must be addressed in therapy (Henwood & Pope-Davis, 1994; Phillips, 1996). The purpose of this article is to address unique therapeutic issues involved in working with culturally Deaf clients.

As with any discussion that focuses on global characteristics of a particular group, it is important to recognize that the generalizations made below about the life experiences of members of the Deaf community may not apply to a particular Deaf individual. This article is not intended to provide a rigid template by which to judge Deaf clients. As pointed out by Clark (1998), there is no single "psychology of the Deaf," and any attempt to truly understand another individual requires an in-depth understanding of each of the elements and choice points that have brought the person to a particular place in life. Instead, the goal of this article is to provide a common language for discussion, a general framework within which clinical judgment and experience can operate to create a more complete understanding of a client.

Deaf people are likely to enter therapy with the same problems as hearing people. However, there are special circumstances that are created by Deaf clients' cultural background and position in society (Hoyt, Siegelman, & Schlesinger, 1981; Phillips, 1996). For example, the Deaf community experiences effects of oppression that mirror difficulties of other minorities, including a greater incidence of substance abuse, unemployment or underemployment, isolation/segregation from others, and distrust of members of the mainstream society (Glickman, 1996). The fact that Deaf individuals do not communicate using the dominant language of the society may further isolate them from their parents and other family members (Harvey, 1982). In this article we discuss Deaf culture and identity development in the lives of Deaf individuals and the ways in which these factors affect the therapeutic relationship and the prognosis for successful therapy. We also address issues relating to therapist competence in working with Deaf clients and issues that arise when interpreters become part of the therapeutic process. In this way, we hope to provide some insight and therapeutic tools to mental health professionals who work with Deaf clients and their families.

## Therapeutic Issues Related to Deaf Culture and ASL

Throughout history, Deaf individuals have been chastised for using ASL in their families and schools (Phillips, 1996). Therefore, Deaf clients, especially older clients, are likely to have conflicts about their language usage and cultural identity within the therapy relationship. Often significant others in a Deaf person's life have not learned sign language. More than 90% of Deaf children are born to hearing parents who have little or no previous experience with deafness and are not able to provide a language model for their children (Schirmer, 2001). Without effective language interactions, Deaf individuals may have limited ability to express themselves with others and may also struggle to label their own experiences, thoughts, and feelings (Corker, 1996; Pollard, 1998).

Given that communication is critical for all aspects of the therapeutic process, the paramount issue that arises in working with Deaf clients is the language barrier. As Kaufman (1996)

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explained, "Both the process and ultimate effectiveness of psychotherapeutic intervention are directly dependent upon language, the bridge between different experiential worlds" (p. 261). Because of the visual nature of ASL, the gulf between it and English may be especially difficult to bridge (Phillips, 1996). This is immediately evident when trying to make an accurate assessment and diagnosis of a client's situation. Until a way can be found to communicate effectively with a Deaf client, there is a high probability of misdiagnosis and inaccurate case conceptualization (Pollard, 1998). Additionally, communication problems hinder the development of a therapeutic alliance and increase the likelihood that the client will drop out of therapy (Halgin & McEntee, 1986). Of greater concern, communication breakdowns perpetuate long-established patterns of misunderstanding, isolation, and oppression in the client's life (Pollard, 1998; Schirmer, 2001).

Within the therapeutic relationship, linguistic and cultural differences will manifest themselves in a variety of ways. In the beginning stages of therapy, Deaf clients may wait for the therapist to prompt conversation and may provide short, simple responses that lack richness and content (Hoyt et al., 1981; Pollard, 1998). Furthermore, early therapeutic work may need to focus on differentiating between various emotional experiences and accurately describing and labeling affects (Corker, 1996; Kaufman, 1996). One form of language that may prove especially therapeutic with a Deaf client is the use of storytelling. Storytelling is a central value in Deaf culture, and it is perhaps the most popular form of signed entertainment (Phillips, 1996). Additionally, given that ASL is spatial and linear, therapists may find that clients are particularly open to visual and action metaphors (Freedman, 1994). Furthermore, time and sequence are important to Deaf clients, and the storytelling process is more important than the punch line or outcome of the story. Therapists who learn to adapt to these elements of ASL and Deaf culture within therapy may find that it strengthens the connection between themselves and their Deaf clients (Schirmer, 2001).

In addition to adapting therapy to take advantage of the strengths of ASL, therapists must be aware of several other cultural norms when evaluating and working with Deaf clients (Schirmer, 2001). For example, reliance on eye contact will likely differ from that of most hearing clients. While a conversation between two American hearing people may not have sustained eye contact over 1 s in duration, it is not uncommon for eye contact between two Deaf people to exceed 5 s during a conversation (Glickman, 1996). Therefore, when a hearing and a Deaf person are in conversation, the hearing person may feel uncomfortable with the intensity and duration of the Deaf person's eye gaze while the Deaf person becomes frustrated with the hearing person's apparent lack of attention to the conversation. In fact, whereas not maintaining eye contact in American hearing culture may be seen only as a sign of boredom or timidity, within the Deaf culture, it may be seen as evasive or even hostile. The act of breaking eye contact in a visually based conversation destroys the communication bridge.

In addition to the importance of eye contact, therapists must be aware of cultural differences in the use of nonverbal communication. For example, Deaf people have different ways of getting attention (waving, tapping on the shoulder, flicking lights on and off) and of greeting each other (hugs and longer salutations) than is considered normal in mainstream American culture (Phillips, 1996; Steinberg, 1991). Additionally, Deaf clients have a more fluid definition of personal space than their hearing counterparts. When they are signing with each other (and within therapy), physical closeness represents understanding and intimacy for sharing personal details (Phillips, 1996), whereas greater distance is important in order to take in all of the visual information they are receiving when processing stories or learning new concepts (Glickman, 1996). Deaf clients also tend to be highly attuned to messages delivered through facial expressions and body language when communicating with others. As Corker (1994) pointed out, 90% of communication occurs in a nonverbal way, and these unspoken conversations are vital to establishing and maintaining a therapeutic relationship with a client. In fact, this type of communication may be frightening for therapist and client alike because it involves a deeper level of response than the more removed and symbolic verbal language.

## Therapeutic Issues Related to Identity Development

When the communication barrier has been addressed, another important challenge for therapists is understanding the role that deafness plays in the identities of clients. Self-concept develops within the context of language development and the general socialization process. Deaf individuals may be viewed as deviant when they do not behave according to the expectations of the mainstream culture. Furthermore, they may or may not have access to their own minority culture while they are growing up, depending on decisions made by their parents, doctors, school personnel, and other authority figures (Gutman, 2002). Thus, a Deaf person may have internalized the repeated message that he or she is inferior, stupid, evil, or sick, often without words or explanations that can later be analyzed and refuted.

Traditionally, research related to deafness has focused on the medical model that is oriented toward deficits in functioning, on hearing loss rather than linguistic and cultural minority status (Glickman, 1996). In the general educational system, this deficit model continues, and a deaf child may be excluded from the school community, by both school professionals and peers, because they are seen as different or disabled (Scheetz, 2001). Intensive efforts are placed into work with speech therapy, attempts to optimize residual hearing with amplification devices such as hearing aids or cochlear implants, and other efforts to "overcome" deafness, which is seen as the result of "broken ears" (Corker, 1994). One result of the disability label is that Deaf people are often treated as less than human. They may be seen as incapable of making their own decisions, leading to decisions being made for them by others, either overtly and without their consent, or through the tendency of professionals to ask others around the deaf person what he or she likes rather than asking the deaf person anything directly (Corker, 1994; Gutman, 2002). Thus, Deaf people may be taught to accept others' decisions in their lives and to depend on others for access to the world, access that is typically limited in scope by the agendas of the "helpers" (Gutman, 2002). Within the mental health arena, Loera (1994) has pointed out that deaf clients' presenting problems are often caused or exacerbated by the inability to communicate with those who are supposed to treat them and that deaf people are often not consulted when devising a treatment plan.

A child that is brought up within the Deaf community has access to language and culture models. This experience with ASL and the acceptance of it by family members and the community have a substantial impact on positive identity development and the psychological health of Deaf individuals (Akamatsu, 1994; Schirmer, 2001); however, Deaf individuals face other challenges. The Deaf community is a small, closed system with a strong sense of conformity and limited access to the general media information that hearing people take for granted (Modry, 1994). Therefore, their values, stereotypes, and social dictates may be more rigid, and social changes may occur more slowly than in the mainstream hearing culture. Historically, Deaf people have also experienced discrimination in educational opportunities, employment, and social interactions (Carver & Doe, 1994). They have not had equal access to information and as a result have been vulnerable to exploitation. When they have received mental health services, these services have often been inappropriate from case conceptualization and client diagnosis to treatment (Loera, 1994; Pollard, 1998). Thus, Deaf clients may have a healthy distrust of professionals and may resist therapeutic goals of change (Henwood & Pope-Davis, 1994; Phillips, 1996).

Understanding the idiosyncratic and societal influences that have contributed to Deaf clients' current behavioral patterns will help therapists to build on clients' strengths and foster growth. Therapy involves transition and change, which can be anxiety producing for any client (Wachtel, 1993). Clients often see themselves in static terms, as incapable of change. This may be especially true for Deaf clients who have adopted the disability identity and have been surrounded by a lifetime of experiences of paternalism and helplessness (Pollard, 1998). Therapists may need to help clients recognize the existence of strengths and then notice small steps that are taken to enhance those strengths and change difficult situations. Wachtel (1993) has reminded us that people do not move from defensiveness to openness immediately, but they may make small movements in the direction of strength. These small movements should be acknowledged and encouraged.

It has been noted that clients pose tests of trust for their therapists (e.g., Corker, 1994; Teyber, 1997) and that therapists must successfully pass these tests in order for therapy to be successful. In the case of Deaf clients, certain tests have been suggested as a standard part of relationship development (Corker, 1994). One of these tests relates to support and autonomy. Deaf clients may offer their therapists the opportunity to take control as other people have done. Instead, what may be more helpful is to support decisions by clients while also encouraging clients to act on them themselves.

Deaf clients are also often concerned about confidentiality. For many of them, hearing people have talked about them and made decisions for them without their input, so they expect similar problems within therapy. This is made more difficult when an interpreter is involved in the therapy process (Halgin & McEntee, 1986; Harvey, 1982). Because of the small-community aspects of the Deaf community as well as the scarcity of certified interpreters, skilled interpreters are likely to be known to clients from other contexts. This may heighten clients' anxieties and concerns about self-disclosure and confidentiality, or alternately it may lead to clients viewing interpreters as the helpful professionals and the therapists as the outsiders (Steinberg, 1991). Skilled interpreters can be assets in solving this dilemma assuming that they are ethical professionals (an assumption that is examined further in the interpreter section below).

## Therapist Issues

Although the primary focus of this article has been the importance of clients' experiences within and outside of therapy, mental health professionals also need to consider their own cultural assumptions and concerns about competency when working with Deaf clients. Therapists are not immune to cultural biases and misconceptions about Deaf people (see Scheetz, 2001, for a discussion of common myths). These assumptions need to be confronted so that they do not hinder the therapeutic process. As Wachtel (1993) pointed out, "One's attitude is conveyed not only in one's words, but in one's tone, rhythm, posture, and so forth, and it is virtually impossible to disguise over the long run how one feels about the patient or about what he is saying" (p. 12). The fact that nonverbal messages are a central component of ASL (Corker, 1994), combined with the fact that Deaf individuals are traditionally less powerful in their relationships with members of the mainstream hearing culture and therefore may be more attuned to nonverbal cues, suggests that they will be quick to perceive therapists' anxiety or discomfort (Brunson & Lawrence, 2002; Pollard, 1998).

Therapists who have not worked with Deaf clients can be expected to feel anxious about their first encounter. They may ask themselves if they are qualified or capable to handle their clients' issues (Roe & Roe, 1991), and they may try to refer clients to "specialists" or others with more experience (Henwood & Pope-Davis, 1994). The ideal qualifications for a therapist to possess would be fluency in ASL and comfort with Deaf culture. However, as Halgin and McEntee (1986) pointed out, most psychotherapists are unlikely to undertake the rigorous training and time required to reach this level of competence. In fact, survey research suggests that the majority of those working with Deaf clients (85%) did not have a focus on deafness in their formal training (Heller, 1987). Therefore, there are not likely to be established Deafness experts in a given community, and anyone who meets these qualifications is likely to be overwhelmed by requests for services.

Given that the majority of mental health professionals do not know ASL and are not familiar with Deaf culture, it is important to ask what is minimally required to effectively work with Deaf clients. Some writers have suggested that a culturally inexperienced clinician who is open to communication options (including sign language, writing, and other forms of verbal and visual communication) and is willing to explore and work through their own anxieties offers a better alternative than no services at all (Elliott & Lee, 1987; Schirmer, 2001). However, Haley and Dowd (1988) pointed out that first impressions are important to successful therapy outcomes. In their work, they found that Deaf adolescents were more willing to see a counselor when sign language was the primary form of communication (either directly with the counselor or through the use of an interpreter). This was supported by Freeman and Conoley (1986), who suggested that while Deaf students are tolerant of inexperienced clinicians who do not sign, they express distrust and suspicion for mental health professionals who choose to continue to work with Deaf clients over time and do not learn ASL.

The debate continues over whether nonsigning clinicians can effectively work with Deaf clients. Regardless of personal opinion on this matter, the fact remains that anxiety about language proficiency can diminish a hearing therapist's ability to effectively communicate with a Deaf client (Boyarin, Burke, Evans, & Lee, 1987). Comfort with Deaf clients may come before language fluency, and Boyarin et al. (1987) have suggested visiting a place where Deaf people are interacting as a way to determine your own interest and comfort in working with Deaf people. This will also help curb a tendency to assume that the population of Deaf mental health clients generalizes to all Deaf people. Once therapists become aware of the similarities and differences between hearing and Deaf cultures, they may feel less anxious about working with Deaf clients, and this decrease in anxiety is likely to facilitate the development of a therapeutic alliance.

## The Use of Sign Language Interpreters in Therapy

In a survey of 808 service providers for deaf and hard-of-hearing students in the United States, only 30% rated their sign language skills as average or above, and half (49%) of part-time providers reported that they could not sign at all (Heller, 1987). Therefore, the majority of people who provide services to Deaf students require the assistance of a sign language interpreter to effectively serve their Deaf clientele. Note that this statement implies that an interpreter serves the needs of the hearing therapist as well as the Deaf client. Traditionally, Deaf individuals have been seen as needing a "language helper"; however, the reality is that most Deaf individuals have ample experience in communicating in less-than-ideal circumstances (Stansfield & Veltrie, 1987).

When one has made the choice to work with a sign language interpreter, several important points need to be taken into consideration. Of primary importance is the fact that not everyone who knows sign language is qualified to work as an interpreter. Westermeyer's (1990) requirements for using spoken language interpreters for assessment and treatment apply equally well to sign language interpreters: fluency in both languages being used, familiarity with assessment and care or at least general understanding of medical and/or social services, sensitivity, and ability to work as part of a treatment team. In the sign language interpreting profession, standards exist for both language competency and ethical behavior. Although some states evaluate and provide credentials for interpreters, evaluation criteria vary widely (Roe & Roe, 1991). To ensure the highest level of sign language interpreter competence, national certification is required. An interpreter who is certified by the National Registry of Interpreters for the Deaf has shown sufficient fluency in both English and ASL, the ability to move between the two languages, and an understanding of deafness and the Deaf community. Additionally, national certification demonstrates an awareness of the interpreting code of ethics, which focuses on issues of confidentiality, impartiality, discretion, and boundaries within professional situations (Stewart, Schein, & Cartwright, 1998). The high standards of national certification allow both the therapist and the Deaf client a greater sense of security in the accuracy of communication in the therapeutic process.

To create the most effective therapy environment, it is important for the therapist and interpreter to respect one another's professional standards and expertise (Westermeyer, 1990). Each needs to rely on the other in issues related to their fields; thus, the therapist is the expert in therapeutic issues, and the interpreter is the expert in communication issues (Brunson & Lawrence, 2002). If each member of the team is aware of his or her role and is sensitized to the issues involved in the merging of psychological health and communication, a sign language interpreter can serve as a bridge between the two cultures and languages of the therapist and the Deaf client.

Given the complexities of the working environment, it may be helpful for therapists and interpreters to meet prior to initial sessions with clients (Harvey, 1982; but see Roe & Roe, 1991, for a discussion of ethical concerns about extratherapeutic contact between interpreters and therapists). In this meeting, the two professionals can clarify the roles and expectations of both parties, plan the seating arrangement and other practical aspects to facilitate smooth communication, discuss the language used by the client and its implications for eye contact with the therapist and interpreter, and create a plan for clarifying the miscommunications that are likely to occur at some point in the process (Henwood & Pope-Davis, 1994; Pollard, 1998). It is important to recognize that this meeting should focus on the process of creating an effective communication environment rather than any questions you may have about the client. Interpreters are not mental health experts, nor are they secondary sources of information about the client. Even if they are aware of personal information about the client, which is not a given, they are bound by confidentiality not to share that information with others. Any questions you have about the client should be addressed to the client. This will enhance your working relationship with the interpreter as well as facilitating trust with the client.

Introducing a person who signs into the therapeutic relationship does not instantly solve communication problems; language difficulties may still occur and many relationship factors are changed with the addition of a third person. For example, the addition of a third person changes transference dynamics and alliance development (Harvey, 1982; Westermeyer, 1990). A Deaf client may either see the interpreter as an intruder or as the true helping professional, with the hearing therapist becoming the outsider. Furthermore, an interpreter will likely experience countertransference-like reactions to the client much as the therapist will. Finally, therapists and interpreters may either see each other as colleagues or compete for power within the therapy room. To address these concerns, it is important that the interpreter and the therapist both be aware of language and relationship dynamics within the therapeutic experience (Brunson & Lawrence, 2002).

## Other Practical Issues to Consider

1. Contact with clients, such as confirming or changing appointments, may need to occur by mail, fax, or E-mail (Elliott & Lee, 1987). When telephone contact is necessary or preferred, a professional relay service provides greater independence for the client than relying on hearing friends or family members. If you plan to work with Deaf clients on a regular basis, it may be helpful to own a Telecommunication Device for the Deaf (TDD) and be trained in its proper use in order to communicate directly with clients.

2. It is important to remember that qualified interpreters are scarce. Therefore, more time may be needed to coordinate the schedule of the therapist, client, and interpreter or to find a qualified substitute interpreter. Issues of confidentiality and alliance are likely to recur with substitute interpreters as well, and the substitute interpreter will not have the background information about what you have been working on with the client.

3. The referral process is often more complicated with Deaf clients. Often professionals request inappropriate services based on their own inability to assess clients' language, needs, and abilities. Given that the success of treatment is strongly affected by clients' independence and freedom of choice, it is best if clients are directly involved in setting up the initial appointments and the requests for services (Burke, Elliott, & Lee, 1987).

4. Given the complex requirements and ramifications of services under court referral, therapists not experienced with deafness should not attempt to work with court-referred Deaf clients (Burke et al., 1987).

## Conclusion

In an ideal world, Deaf clients would have the same range of options for mental health services as hearing clients. They would be able to choose someone who shares, or at the very least understands, their language and culture. For most Deaf individuals, however, this is not possible. Given the limited number of therapists who are fluent in ASL and aware of Deaf culture, a Deaf client can only hope to be able to work with a culturally affirmative therapist. To optimize therapy outcomes, therapists should educate themselves on issues that impact Deaf clients and be willing to collaborate with a certified interpreter, who can serve as a bridge between languages and cultures. In general, therapists who choose to undertake this work will find that Deaf people are open to working with professionals who genuinely try to see the world through their eyes.

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