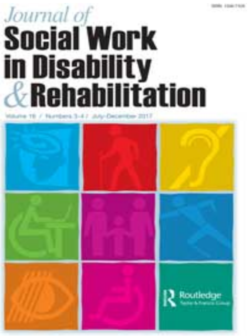

Routledge
Taylor & Francis Group

Journal of Social Work in Disability & Rehabilitation

ISSN: 1536-710X (Print) 1536-7118 (Online) Journal homepage: http://www.tandfonline.com/loi/wswd20

You’re Deaf? Breaking through Myths for Effective Therapeutic Practice

Teresa Crowe

To cite this article: Teresa Crowe (2017) You’re Deaf? Breaking through Myths for Effective Therapeutic Practice, Journal of Social Work in Disability & Rehabilitation, 16:3-4, 230-246, DOI: 10.1080/1536710X.2017.1372239

To link to this article: https://doi.org/10.1080/1536710X.2017.1372239

Accepted author version posted online: 06 Sep 2017.
Published online: 08 Nov 2017.

Submit your article to this journal

Article views: 58

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
http://www.tandfonline.com/action/journalInformation?journalCode=wswd20

Download by: [107.72.164.51] **Date:** 12 January 2018, At: 17:10

JOURNAL OF SOCIAL WORK IN DISABILITY & REHABILITATION
2017, VOL. 16, NOS. 3–4, 230–246
https://doi.org/10.1080/1536710X.2017.1372239

Routledge
Taylor & Francis Group

Check for updates

You're Deaf? Breaking through Myths for Effective Therapeutic Practice

Teresa Crowe

Department of Social Work, Gallaudet University, Washington, DC, USA

ABSTRACT
Most mental health practitioners provide services to hearing clients and might be unprepared when a deaf individual requests services. The purpose of this article is to explore commonly held stereotypes and myths about deaf people and to provide guidance to clinicians who encounter deaf clients in their practices. Myths and stereotypes can affect the way clinicians perceive their clients' needs. This can lead to miscommunication, misunderstanding, and misinformation, which can harm the therapeutic relationship, thus making effective therapy unattainable. Clinicians should reframe these beliefs and overcome barriers to make way for the therapeutic process to begin.

KEYWORDS
Access; accommodations; advocacy; culture; deaf; deaf myths; disability frameworks; hard of hearing; therapeutic practice

Downloaded by [107.72.164.51] at 17:10 12 January 2018

> Imagine that you are a clinician at a busy mental health clinic. You see on your schedule that a 60-minute assessment is scheduled in 2 days with a new client. In the notes, the administrative assistant typed the words *hearing impaired*. You have never worked with someone like this. Your schedule is tight, which makes you feel stressed about working with an unfamiliar client. You hope the individual will bring an interpreter. If not, you're not sure what to do.

As busy clinicians, we might not take the time we need to fully understand the needs of a client who is a member of a racially, ethnically, or linguistically diverse group. In the age of fee-for-service care, our employers expect us to maximize the number of sessions we see clients, thus increasing revenue for the agency. As a result, many agencies take steps to assist us with maintaining consistent revenue. They might have a centralized scheduling system or assessment team who will manage the individual clinicians' schedules. Our jobs are to see our clients regularly and on time. Our supervisors expect us to deliver effective interventions that demonstrate progress toward clients' goals. We are expected to complete paperwork associated with these sessions in a timely fashion to ensure that third-party payers will reimburse the agency for these sessions. What happens, though, when a client with a different

---

CONTACT Teresa Crowe, PhD, LCSWC, Professor ✉ teresa.crowe@gallaudet.edu 📪 Department of Social Work, Gallaudet University, 800 Florida Avenue NE, Washington, DC 20002, USA.

© 2017 Taylor & Francis

Downloaded by [107.72.164.51] at 17:10 12 January 2018

background comes to see us for services? If that client uses a different language or requires accommodations, how do we adapt? Do we adapt?

The purpose of this article is to provide guidance to clinicians who encounter deaf clients in their practices. This is not to serve as an exhaustive guide, but rather to offer ideas about how to handle situations that can occur when deaf clients seek services from hearing professionals. The structure of this article begins with the often hidden myths and stereotypes people, including clinicians, might hold about deaf people. I suggest ways to correct and reframe these beliefs to make way for the therapeutic process. This article is a quick and easy way to identify important issues that can impede the therapeutic process and interfere with effective practice with deaf individuals. Finally, I suggest ways in which practitioners can address barriers to effective practice and provide services that are culturally sensitive.

Stereotypes and myths

In general, stereotypes are systems of beliefs about particular social groups (Hamilton & Mackie, 2014). These beliefs can affect the perceptions of others and their interactions with them. Stereotypes are more than just descriptions of individuals who are considered to be members of an outgroup. Rather they are cognitive structures that influence perceptions, attention, and memory, and can lead to prejudice, and unconscious or conscious bias (Dovidio & Gaertner, 2014; Northern, 2009).

Legitimizing myths are created through socially constructed hierarchies that determine which individuals are in the ingroup and which are in the outgroup (Caraballo, 2014). They are beliefs (stereotypes) and attitudes (prejudices) about the way society works (Caraballo, 2014; Quist & Resendez, 2002). They serve as vehicles to maintain and justify the hierarchies where one group is considered the majority ingroup and the other, more inferior group, is considered to be the minority outgroup.

Audism, prejudice toward those who cannot hear, can affect if and how a clinician works with a client who is deaf (Hauser, O'Hearn, McKee, Steider, & Thew, 2010; Kattari, 2015; Kiger, 1997; Nomeland & Nomeland, 2012). Hearing clinicians might have unconscious biases that can affect their decisions when working with deaf clients. Their decisions can have a great impact on the individuals they serve. They might resist providing an interpreter if they deem the deaf individual as being able to speak. They might view the deaf individuals as unintelligent or struggling with being deaf. When decision makers are prejudiced, whether intentionally or unintentionally, they often judge others less favorably (i.e., outgroup members) and subsequently allocate fewer resources to those individuals (Sommers & Norton, 2008).

The concepts of *ableism*, the preference for people without disabilities (i.e., discrimination against those with disabilities), and *audism*,

Downloaded by [107.72.164.51] at 17:10 12 January 2018

discrimination against those who cannot hear, imply a hierarchy that values able-bodied and hearing individuals within the dominant culture. For deaf individuals, audism stems from a legitimizing myth of deficit and medical pathology (Hauser et al., 2010). In the United States, disability is defined in broad terms that describe an individual in terms of impairment, activity limitations, and participation restrictions (Brault, 2012). In this regard, the larger society often defines deaf people through a deficit-oriented lens. Despite the fact that many deaf individuals do not view themselves through a disability-focused lens, some hearing individuals view them as less intelligent and less capable (Hauser et al., 2010). Deaf clients can feel inferior or disconnected from their therapists who are unfamiliar with Deaf culture (Gill & Fox, 2012). Because many deaf individuals might have experienced prejudice and stereotyping from hearing individuals, they could be especially sensitive to clinicians who hold negative views about being deaf or who feel nervous, anxious, or angry around deaf people (Gill & Fox, 2012).

Breaking through myths about deaf people

Myths about deaf people are commonly held beliefs about who they are and what they need. Practitioners might hold these beliefs because of limited exposure to deaf individuals. They might believe these myths because of portrayals from media, including books, movies, and television shows. They might hold misconceptions because of anecdotal experiences or what others have told them. Some clinicians might never even consider what a deaf person needs because they have never had a deaf client. However, one might not know when a deaf client will request services. The number of deaf people is fewer than hearing people, but they live all over the world. In the United States, approximately two to three children out of 1,000 are born with hearing loss (Centers for Disease Control and Prevention, 2010). The vast majority, approximately 90%, are born to parents who are hearing (Mitchell & Karchmer, 2004). Approximately 37.5 million adults (15% of the population) report having some degree of hearing loss (Blackwell, Lucas, & Clarke, 2014). However, the exact number of people who affiliate with Deaf culture is not known. Although the U.S. Census collects information about hearing loss, it does not ask questions about cultural membership or the use of American Sign Language (ASL).

To provide culturally and linguistically sensitive services, practitioners should be aware of commonly held myths, know the truth, and take steps toward building a therapeutic relationship with their deaf clients. A therapeutic relationship between a therapist and a client is a key factor in positive mental health outcomes (Barth, 2014). In this type of relationship, a client wants to feel understood by the therapist, thus creating a safe space in which to disclose personal information. Clients might hide information,

Downloaded by [107.72.164.51] at 17:10 12 January 2018

such as compulsions or addictions, from clinicians until they feel safe in the relationship (Barth, 2014). During the initial sessions, clients assess the clinicians just as the clinicians assess them. Clients might focus on the therapist's demeanor, communication patterns, and underlying values of nonjudgment, openness, and authenticity to determine how much information may be safely disclosed (Barth, 2014). For deaf individuals, past experiences of audism and ableism might make them especially concerned about the therapist's views and beliefs about deaf people.

Hearing therapists might be unaware of their "hearing identity" and could feel puzzled or resistant if a client mentions this (Leigh, 2009). Deaf people understand a hearing world to mean an environment where the ability to hear and speak are cultural and social norms. So, a hearing clinician who is unaware of the underlying facets of being hearing (i.e., speaking, hearing, deemphasis on facial expressions and gestures) might develop beliefs about those who are deaf and display behaviors such as an emphasis on facial expressions, gestures, body language, and physical touch (Barnett, 2002; Gill & Fox, 2012; Kiger, 1997; Leigh, 2009).

Although some literature exists about attitudes toward deaf individuals by hearing people (Cumming & Rodda, 1989; Kiger, 1997), such as feelings of inferiority by deaf clients when hearing therapists are unfamiliar with Deaf culture (Gill & Fox, 2012), experiences of oppression, discrimination, and prejudice by deaf individuals (Lane, 2005; Leigh, 2009; Vernon & Leigh, 2007), and stigmatization of deaf individuals (Leigh, 2009), research on specific stereotypes and myths is sparse. Because the relationship between the therapist and client is a key factor in improving therapeutic outcomes, it is important that a client feel understood by the therapist (Barth, 2014).

Unconscious or conscious bias toward a client can negatively affect the relationship in a multitude of ways. An Internet search of stereotypes and myths, although not necessarily data-driven, produced much anecdotal and lived-experience documentation (Disability Unit, 2015; Finch, 2016a, 2016b; If My Hands Could Speak, 2016; Kish, 2016). The myths and stereotypes listed here incorporate this information into a general list of stereotypes and myths that many deaf people report. It serves as a skeleton on which to flesh out truths and nontruths, which can impinge on the establishment of a therapeutic relationship.

Myth 1: Deaf culture is a myth

Some, not all, deaf people identify with Deaf culture

Most individuals who have hearing loss do not consider themselves as members of Deaf culture. Deaf and hard of hearing individuals who consider themselves part of the culture espouse its traditions and values

Downloaded by [107.72.164.51] at 17:10 12 January 2018

(Wilson & Schild, 2014). When writing about those who do not consider themselves culturally Deaf, a lowercase d sometimes is used; an uppercase D is often used to identify those who belong to the cultural group. In this article, a lowercase d is used for consistency and inclusion of all individuals who are deaf and hard of hearing except when specifically referring to the cultural membership.

A hallmark of membership in Deaf culture is the use of ASL as a primary language. Estimates of ASL users in the United States vary widely from 250,000 to 500,000 (Mitchell, Young, Bellamie, & Karchmer, 2006). Membership in Deaf culture today has evolved. In recent decades, two primary delineations of cultural membership were attendance at residential schools and participation in Deaf clubs (Gertz & Boudreault, 2016). The numbers of residential schools and Deaf clubs are declining, thus causing Deaf individuals to find other ways for gathering as a group. Although avenues for cultural participation are changing, the role of cultural transmission continues to focus on passing down ways for effective living in an environment where most people hear (Gertz & Boudreault, 2016). Its goals are to provide Deaf individuals with healthy identity formation, self-determination, information sharing, and effective communication.

During the assessment phase, a clinician can ask the deaf client about his or her affiliation or nonaffiliation with Deaf culture. The practitioner can ask whether there are other family members who are deaf, whether the individual participates in activities in the Deaf community, and whether the client identifies with Deaf culture. A client might report no affiliation with Deaf culture, but rather connection to and involvement with hard of hearing or hearing individuals (i.e., hearing culture). During an assessment, the clinician's focus should not favor one affiliation over another. Rather, understanding the client's frame of reference and support systems should take priority. Asking questions and listening to answers, although seemingly a basic foundation of all clinical practice, is especially important when working with deaf and hard of hearing individuals. Putting aside assumptions and proscribed recommendations that cast all deaf people in the same light is an important step in establishing therapeutic rapport. Without bias, the practitioner gathers this information as part of the process to understand the surrounding support system.

Myth 2: Deaf people like being called hearing impaired

The term hearing impaired *is controversial*

Historically, the term *hearing impaired* replaced the older terms of *deaf mute* and *deaf and dumb* (Gertz & Boudreault, 2016). These older labels referenced physiological disease and malfunction, namely an inability to hear, learn, and speak. None of these assumptions is necessarily true for all deaf individuals. Hearing impairment, considered politically correct in the 1970s, continues to frame deaf people in terms of loss, deficit, and dysfunction (Gill & Fox, 2012; Leigh, 2009; Nomeland & Nomeland, 2012). These attitudes toward deaf people continue to be reflected in the language used to describe them (Hauser et al., 2010; Kiger, 1997). Culturally sensitive terms are *deaf* and *hard of hearing* (Finch, 2016b; Gertz & Boudreault, 2016; Lane, 2005; Leigh, 2009).

A culturally sensitive clinician needs to understand how use of language and labels conveys implicit meaning (Beukeboom & Finkenauer, 2010). Using a term that can be offensive could prevent therapeutic rapport from developing. A practitioner should ask the client for the best term to use. The practitioner might ask, “Do you consider yourself Deaf or hard of hearing?” or “Are you active in the Deaf community?” In that way, the clinician conveys two things: (a) he or she is familiar with the appropriate terminology, and (b) he or she is allowing the clients to identify themselves with their own language.

Downloaded by [107.72.164.51] at 17:10 12 January 2018

Myth 3: All deaf people use sign language

Not all deaf people use sign language

The group of deaf individuals who use ASL is a small subset of a larger group who report having difficulty hearing (Blackwell et al., 2014). Thus, not all deaf people use sign language. Those who identify as culturally Deaf typically use ASL as their primary language. Hard of hearing individuals, depending on the degree of hearing loss, might or might not use sign language and might or might not use speech. Devices, such as hearing aids and cochlear implants, could help improve hearing and might affect whether a deaf or hard of hearing person uses primarily speech or sign language (Finch, 2016a). In addition, an individual might choose a particular communication modality (e.g., ASL, signed English, spoken English) depending on with whom the person is conversing.

Clinicians might have difficulties discerning when communication difficulties result from poor language skills that are secondary to severe mental illness or to inadequate sign language fluency on the part of the client or the clinician. Interpreters who are trained to work with clinicians and deaf individuals with psychiatric illnesses can help clarify problems with language dysfluency; that is, problems that arise when deaf individuals lack skill in their own sign language (Glickman & Crump, 2013). In these cases, an interpreter can assist a clinician in understanding how a particular deaf client is using language. The interpreter can offer an assessment of whether the issue is with sign language translation (e.g., communication ability) or whether a client’s language is impaired by cognitive disruptions that occur as a result of a mental illness.

Downloaded by [107.72.164.51] at 17:10 12 January 2018

A clinician should assess communication skills when working with a deaf client. A practitioner can ask the interpreter for feedback or guidance if there is a breakdown in communication with the client. The clinician might also ask for clarification from the client or interpreter during the session. In some cases, a certified deaf interpreter might be helpful, especially in cases when deaf individuals exhibit language dysfluency (Glickman & Crump, 2013). In an assessment, the service provider should identify the communication modality the client uses. An interpreter generally is not used for treatment plan development or clinical interventions. Rather, the interpreter is used as a tool for communication, not clinical assessment. It is appropriate for a practitioner to indicate in a written report when an interpreter is used and how he or she was used. For example, the clinician can indicate, "The consumer used American Sign Language for communication, which was translated by an interpreter," or "The client communicated using sign language with minimal use of speech," or "The person served primarily used speech with supportive sign language for communication." In cases when the client uses speech, the clinician can write, "The deaf client communicated primarily using speech with some gestures to facilitate understanding."

Myth 4: All deaf people can read lips

Not all deaf people can read lips

Lip reading, or sometimes called speech reading, is the process by which spoken language is read on the lips rather than heard by the ears. This skill is used by some deaf and hard of hearing individuals to communicate with someone who speaks. Lip reading is difficult because many of the consonant sounds are made by the tongue inside the mouth and cannot be seen on the lips (Campbell & Mohammed, 2010). For this reason, only approximately 30% of speech can be accurately read on the lips (Campbell & Mohammed, 2010; Finch, 2016a; Kish, 2016; National Institute on Deafness and Other Communication Disorders [NIDCD], 2014). The degree to which speech can be read on the lips depends on many factors, including distance, facial views, lighting, individual differences, use of visual cues, age of exposure, and use of assistive devices (Campbell & Mohammed, 2010; E-Michigan Deaf and Hard of Hearing People, 2002; Mantokoudis et al., 2013). Some deaf individuals identify themselves as "oral deaf"; that is, they use primarily spoken English (Leigh, 2009). Although many oral deaf individuals socialize primarily in a spoken environment, they might also feel a connection with their culturally Deaf peers.

A clinician should always ask the client about communication preferences. Expecting a client to read lips during a session is inappropriate. The potential for misunderstanding is great given that most of the English language cannot

Downloaded by [107.72.164.51] at 17:10 12 January 2018

be discerned by speech reading. In addition, it puts the burden of communication onto the client at a time when he or she is seeking help. Asking a client to read a clinician's speech adds frustration and fatigue to the process. Unless a client specifically directs a clinician to use speech for communication, the practitioner should use another mode of communication, in particular, an interpreter if possible.

Myth 5: Writing to a deaf person is just as good as using a sign language interpreter

Writing might not be the best method for clear communication

The first step in this process should be a conversation between the clinician and the client. The amount of understanding through verbal communication will vary by individual (Barnett, 2002). Often the best method of communicating with a culturally Deaf person is directly using sign language (National Association of the Deaf, 2017). If that is not possible, using a certified and competent sign language interpreter is appropriate. The goal is to ensure effective communication that reflects cultural sensitivity and awareness of the complex dynamics that occur during interpersonal exchanges.

ASL is different from English. ASL has no written form; it is entirely visual. It is a complete language that has its own syntax, semantics, and structure, and is expressed using hands, facial expressions, and body language (Finch, 2016a; NIDCD, 2014). Because deaf and hard of hearing individuals rely more on visual information, such as cues, periphery, motion, and surroundings, ASL in its visual nature is a natural language for many deaf and hard of hearing people (Hauser et al., 2010; NIDCD, 2014). For many deaf and hard of hearing people, ASL is the primary language of choice. Because of this, English is a second language. As such, writing with a deaf individual might not be an effective means of communication.

Some deaf individuals lag behind hearing individuals in English proficiency (Seessel, 2013). Childhood factors, such as high parental expectations, enjoyment of reading and writing, good communication with family members, a positive self- image, and demanding school performance are predictors of success in mastering the English language. ASL differs from English in its use of tense markers, names, word order, prepositions, articles, conjunctions, and verbs (Seessel, 2013). Because of these differences, writing is not the best method of communication with a deaf person, especially in situations of high stress or crisis.

Clinicians should also be prepared to adapt communication strategies and settings for deaf individuals who communicate primarily through oral means. For some, using alternative methods, such as writing, oral communication, or assistive devices might be effective.

The following tips can be helpful to aid in oral communication (Barnett, 2002):

- Minimize background noise.
- Ensure adequate lighting.
- Establish eye contact.
- Make sure the mouth is not obscured.
- Ask the client for periodic summaries to ensure comprehension.

Writing could be helpful for short, necessary communication, such as when a deaf individual makes an impromptu visit to an agency for an appointment. Rather than speaking, which requires that the deaf person read lips, writing short notes can help clarify information or next steps. Giving a deaf person an appointment date in writing or asking him or her to sit in the lobby to wait for the provider would be appropriate use of written communication if an interpreter is not present.

Myth 6: Deaf people want to have a miracle cure to become hearing

Not all deaf people want to become hearing

Deaf identities are complex and multidimensional (Ferndale, Munro, & Watson, 2016; Kemmery & Compton, 2014; Power, 2005; Young, 1999). The medical or pathological view of hearing loss emphasizes auditory dysfunction, deficit, and disability. The sociocultural view of being deaf espouses a cultural identity and belonging. Deaf and hard of hearing individuals could view themselves as members of either group or as parts of each (Kemmery & Compton, 2014; Leigh, 2009). There are deaf individuals who seek to improve their residual hearing by use of assistive devices, such as hearing aids and cochlear implants, yet do not view themselves as disabled per se (Kemmery & Compton, 2014). There are other deaf individuals who admonish the use of assistive technology because they prefer to embrace their sociocultural identity and distance themselves from the hearing community (Gertz & Boudreault, 2016). Other deaf individuals view themselves as disabled and seek resources that are designed to help them integrate into a hearing society.

It is important for practitioners to refrain from making assumptions about deaf people and their views about their own deafness. Understanding how deaf individuals identify themselves with others is critical to understanding identity (Kemmery & Compton, 2014). In a clinical environment, a deaf person might feel very strongly about his or her Deaf identity. Another person could see being deaf as a disability and a struggle through life. Others might consider their identity as fluid, depending on interactions with others, settings, and contexts (Kemmery & Compton, 2014). During the assessment, the clinician can ask about how the individual became deaf and his or her feelings about it, but should not automatically assume that the client is seeking services to resolve internal conflicts about being deaf.

Downloaded by [107.72.164.51] at 17:10 12 January 2018

Myth 7: Hearing aids and cochlear implants can make all deaf people hear normally

Hearing aids and cochlear implants can help some deaf individuals hear better, but have some limitations and might not be effective with all deaf people

A hearing aid is an electronic device that is worn in and behind the ear and makes sound louder. A cochlear implant is a device that is surgically implanted in the cochlea of an individual. Today some professionals consider cochlear implants to be medical marvels for individuals who have severe to profound sensorineural hearing loss (Asker-Arnason, Wass, Gustfsson, & Sahlen, 2015; Rubinstein, 2012; Sarant, Harris, & Bennet, 2015). Much of the research indicates that those who use cochlear implants find their hearing improved. Negative factors that can affect the individual are poor hearing quality due to environmental sounds, surgical risks of implantation, interference by static electricity, and problems with receiving medical tests that use magnetic resonance (NIDCD, 2014).

When communicating, a clinician should look directly at a client who is deaf, whether the client is using a hearing aid, cochlear implant, or no assistive devices. It might be necessary to move to a room without environmental noises or motion distractions. If a practitioner is chewing gum or eating, this can interfere with understanding. A beard or mustache that covers the lips can also hinder communication. Communication should be attempted in a well-lighted room that is free from distractions.

Downloaded by [107.72.164.51] at 17:10 12 January 2018

Myth 8: Deaf people are less intelligent than hearing people

Deaf people are just as intelligent as hearing people

As with hearing people, deaf individuals are diverse. Some hearing people are college-educated and hold professional jobs; the same is true for deaf people. Some hearing individuals are undereducated and lack resources; the same holds for deaf people. Historically, IQ testing of deaf individuals indicated that deaf people have lower intelligence than hearing people (Lane, 2002; Marschark, 2006; Vernon & Leigh, 2007). However, improper testing methods, lack of communication during testing, and unstandardized tests yielded inaccurate and misleading results (Vernon, 2005). When tested using appropriate methods, deaf and hard of hearing individuals perform similarly to their hearing counterparts.

Some clinicians might assume that a deaf person is less intelligent if he or she demonstrates limited English skills. This assumption is wrong given that many deaf individuals communicate using ASL, a completely different language than English (Gill & Fox, 2012; Glickman & Crump, 2013; Leigh, 2009; Vernon & Leigh, 2007). English literacy as a second language varies among deaf individuals. Practitioners should not assume that an inability to use English fluently is an indication of limited intelligence. Similarly, clinicians should interpret with caution the results of old psychological tests with deaf individuals. They should consider the findings in relation to how old the tests are, who conducted the tests, and whether standardized measures were used with deaf and hard of hearing individuals.

Myth 9: Anyone who can sign can be an interpreter

Competent sign language interpreters have specialized training and are often certified

Not every person who is hearing and who signs can be an interpreter. Interpreters who are specially trained to work in mental health settings are important vehicles for providing culturally sensitive and professionally appropriate care (Barnett, 2002; Gill & Fox, 2012; Glickman & Crump, 2013; National Association of the Deaf, 2017). The National Association of the Deaf (2017) recommends that referrals to specialist interpreters should be guided by consumer choice. If this is not possible, clinicians should work collaboratively with sign language interpreters who have experience working in mental health settings. Because mental health professionals depend largely on a client's language for assessment, diagnosis, and treatment, it is important that the appropriate type of interpreter be obtained (Glickman & Crump, 2013).

Not all interpreters are able to work effectively with deaf individuals seeking mental health services. Interpreters must (a) understand specific mental health terminology, (b) understand the complex interpersonal dynamics arising from mental health issues, (c) understand interpersonal awareness and boundaries, (d) have expertise in language and culture, (e) have fluency in receptive and expressive ASL skills, and (f) have specialized mental health training (Glickman & Crump, 2013; National Association of the Deaf, 2017). Providers must understand that minor adjustments should be made to accommodate a deaf client when using an interpreter. Sessions could be longer. The clinician might need to pause on occasion to allow the interpreter to catch up to what is being said. Questions might need to be reframed for the client to understand what is being asked. The clinician, interpreter, and client should work collaboratively to make sure that everyone understands the expectations, process, and substance of the sessions.

During an assessment with a hearing client, the practitioner should pay attention to the way a client communicates his or her thoughts. With a deaf client, it is important that the interpreting process not mask mental health

Downloaded by [107.72.164.51] at 17:10 12 January 2018

nuances in the language, especially with those who have serious mental illness (Glickman & Crump, 2013; National Association of the Deaf, 2017). The job of the interpreter is to act as a vehicle for effective communication, but at times, it might be necessary for the interpreter to interpret exactly what a deaf person signs word-for-word to better understand symptomology. In this regard, providers and interpreters act as members of a collaborative team to appropriately assess, diagnose, and treat deaf individuals.

Myth 10: The more deaf a person is, the higher the chance of mental illness

The degree of hearing loss does not predict mental illness

The literature indicates that deaf individuals might have higher rates of mental illness compared to their hearing counterparts, but it is not related to the degree of deafness (Bridgman et al., 2000; Fellinger et al., 2005; Fellinger, Holzinger, & Pollard, 2012; Fellinger, Holzinger, Sattel, Laucht, & Goldberg, 2009; Hindley, 2000; Kvam, Loeb, & Tambs, 2007). Many deaf individuals face barriers and experience disparities in accessing and receiving mental health care, thus exacerbating mental health issues. The results of much research indicate that there are medical and mental health disparities between deaf and hearing people (Behl & Kahn, 2015; Blaiser, Behl, Callow-Heusser, & White, 2013; Wilson & Schild, 2014). Researchers estimate that approximately 80% to 90% of deaf and hard of hearing individuals who need mental health services do not access them. Challenges include poor understanding of written medical literature, including instructions, medications, side effects, and dosages. Service providers who are fluent in ASL and understand Deaf culture are few. Deaf individuals face numerous and often insurmountable communication barriers with service providers, including lack of competent interpreters, lack of deaf-relevant interventions, lack of supports that allow family members to be included in sessions, and lack of professionals who are familiar with Deaf culture.

An individual's deafness does not automatically mean that his or her mental health problems are worse. Clinicians need to be aware of the barriers deaf individuals face even before they begin treatment. Many providers do not know how to work with a deaf person and might inadvertently offend, ignore, or dismiss the individual's unique needs. An understanding of the barriers is a first step toward effectively serving deaf individuals. By knowing what challenges exist, the provider can begin a dialogue with the client to create an environment that will support him or her in achieving goals. These first steps toward building a therapeutic alliance will enhance the effectiveness of any treatment regime.

Downloaded by [107.72.164.51] at 17:10 12 January 2018

Building a therapeutic alliance with a deaf person

A strong therapeutic alliance between a practitioner and a client contributes to positive treatment outcomes (Barth, 2014; Falkenstrom, Granstrom, & Holmqvist, 2013; Sharf, Primavera, & Diener, 2010; Simpson & Reid, 2014). Just as a clinician can assess a client's readiness for change, so too, the client can assess the clinician's degree of authenticity, openness, and nonjudgmental attitude (Barth, 2014). If clients do not trust or feel safe with the practitioner, they might hide compulsions, addictions, or problematic thoughts and behaviors. Deaf and hard of hearing clients might initially distrust hearing professionals because of experiences of oppression, discrimination, and prejudice (Cumming & Rodda, 1989; Gill & Fox, 2012; Kiger, 1997; Lane, 2005; Vernon & Leigh, 2007).

The therapeutic alliance between a hearing provider and a deaf consumer will require consideration and planning to optimize effectiveness. Breaking through myths and internal preconceptions of what it means to be deaf are important steps toward developing an effective therapeutic alliance. Practitioners who take concrete steps toward establishing therapeutic rapport with deaf clients demonstrate their willingness and openness in understanding the client and his or her needs. In summary, the following recommendations could help to build and strengthen rapport between a provider and deaf client and make way for effective treatment (Barnett, 2002; Cornes & Napier, 2005; Gill & Fox, 2012; Glickman & Crump, 2013; Wright & Reese, 2015).

Downloaded by [107.72.164.51] at 17:10 12 January 2018

Ensure effective communication

A clinician should discuss communication needs with the client first to determine the best approach for establishing rapport and ensuring a good start toward implementing effective clinical practice. If indicated, a therapist should obtain a trained interpreter. The practitioner should avoid using family and friends as interpreters. The therapist should refrain from using jargon or technical terminology without adequate explanation. The clinician might need to increase nonverbal expressiveness, such as maintaining direct eye contact throughout the discussion or using physical touch to get the client's attention. The practitioner should take note of the physical environment for the sessions and minimize distractions.

Demonstrate cultural sensitivity

A clinician should understand that eye contact with deaf individuals is not only an essential component of communication, but also a sign of respect for their culture. Terms such as deaf-mute, deaf and dumb, and hearing impaired could be considered offensive by some deaf individuals. The

Downloaded by [107.72.164.51] at 17:10 12 January 2018

practitioner should recognize the collectivist nature of Deaf culture (e.g., the Deaf client might want to include a Deaf friend in the session or might be worried about the perceptions of other Deaf people). Clinicians should understand that a client might be highly descriptive or graphic because of the nature of ASL.

Behave in ways that are respectful of deaf or hard of hearing individuals

When using an interpreter during sessions, a practitioner should not maintain eye contact with the interpreter, but rather look directly at the deaf individual. Understand that when an interpreter is present, everything the practitioner says will be interpreted to the individual. A clinician should ask the individual about cultural affiliation and not assume the person wants to be hearing or use hearing devices (e.g., hearing aids or cochlear implants).

Recognizing underlying assumptions, stereotypes, and prejudices is an important component of establishing a therapeutic relationship with any client. Many hearing practitioners never worked with a deaf individual before and assume that they are like their other hearing clients. However, some deaf people are culturally Deaf, which requires understanding and sensitivity by the provider to offer culturally sensitive services. Practitioners need to follow ethical practice guidelines when working with clients, especially those who are from diverse racial, ethnic, and linguistic backgrounds. Many deaf individuals will recognize when a provider is trying to be culturally sensitive and appreciate the effort. In this way, clinicians and their deaf clients can partner to create an environment where healing and health can occur.

References

Asker-Arnason, L., Wass, M., Gustfsson, F., & Sahlen, B. (2015). Reading comprehension and working memory capacity in children with hearing loss and cochlear implants or hearing aids. *The Volta Review*, *115*, 35–65.

Barnett, S. (2002). Communication with deaf and hard of hearing people: A guide for medical education. *Academic Medicine*, *77*, 694–700. doi:10.1097/00001888-200207000-00009

Barth, D. (2014). *Integrative clinical social work practice*. New York, NY: Springer.

Behl, D., & Kahn, G. (2015). Provider perspectives on telepractice for serving families of children who are deaf or hard of hearing. *International Journal of Telerehabilitation*, *7*(1), 1–12.

Beukeboom, C., & Finkenauer, C. (2010). The negation bias: When negations signal stereotypic expectancies. *Journal of Personality and Social Psychology*, *99*, 978–992. doi:10.1037/a0020861

Blackwell, D., Lucas, J., & Clarke, T. (2014). Summary health statistics for U.S. adults: National Health Interview Survey, 2012. National Center for Health Statistics. *Vital Health Statistics*, *10*(260). Retrieved from https://www.cdc.gov/nchs/data/series/sr_10/sr10_260.pdf

Blaiser, K., Behl, D., Callow-Heusser, C., & White, K. (2013). Measuring costs and outcomes of tele-intervention when serving families of children who are deaf/hard of hearing. *International Journal of Telerehabilitation*, *5*(2), 3–10. doi:10.5195/ijt.2013.6129

Brault, M. (2012). *Americans with disabilities: 2010*. Retrieved from www.census.gov/prod/2012pubs/p70-131.pdf

Bridgman, G., Macpherson, B., Rako, M., Campbell, J., Manning, V., & Norman-Kelly, T. (2000). A national epidemiological survey of mental illness in the New Zealand deaf community. In T. Hjortso, L. von der Lieth, & C. Carlsen (Eds.), *Mental health services for deaf people: A worldwide perspective* (pp. 216–234). Devon, UK: European Society for Mental Health and Deafness.

Campbell, R., & Mohammed, T. (2010). *Speech reading for information gathering: A survey of scientific sources*. London, UK: University College London.

Caraballo, A. (2014). *Benevolent sexism is not benign*. Retrieved from https://sites.psu.edu/aspsy/2014/10/04/benevolent-sexism-is-not-benign/

Centers for Disease Control and Prevention. (2010). *Identifying infants with hearing loss: United States—1999 to 2007*. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5908a2.htm

Cornes, A., & Napier, J. (2005). Challenges of mental health interpreting when working with deaf patients. *Australian Psychiatry*, *13*, 403–407. doi:10.1080/j.1440-1665.2005.02218.x

Cumming, C., & Rodda, M. (1989). Advocacy, prejudice, and role modeling in the deaf community. *The Journal of Social Psychology*, *129*(1), 5–12. doi:10.1080/00224545.1989.9711693

Disability Unit. (2015). *Myths and misconceptions about deaf people*. Retrieved from http://www.cput.ac.za/blogs/disability/disability-awareness/deaf-hearing-impairment-info/myths-and-misconceptions-about-deaf-people/

Dovidio, J., & Gaertner, S. (2014). Stereotypes and evaluative intergroup bias. In D. Hamilton & D. Mackie (Eds.), *Affect, cognition, and stereotyping* (pp. 167–193). San Diego, CA: Academic.

E-Michigan Deaf & Hard of Hearing People. (2002). *Speech reading (lip-reading)*. Retrieved from www.michdhh.org/assistive_devices/speechreading.html

Falkenstrom, F., Granstrom, F., & Holmqvist, R. (2013). Therapeutic alliance predicts symptomatic improvement session by session. *Journal of Counseling Psychology*, *60*, 317–328. doi:10.1037/a0032258

Fellinger, J., Holzinger, D., Dobner, U., Gerich, J., Lehner, R., Lenz, G., & Goldberg, D. (2005). Mental distress and quality of life in a deaf population. *Social Psychiatry & Psychiatric Epidemiology*, *40*, 737–742. doi:10.1007/s00127-005-0936-8

Fellinger, J., Holzinger, D., & Pollard, R. (2012). Mental health of deaf people. *The Lancet*, *379*, 1037–1044. doi:10.1016/s0140-6736(11)61143-4

Fellinger, J., Holzinger, D., Sattel, H., Laucht, M., & Goldberg, D. (2009). Correlates of mental health disorders among children with hearing impairments. *Developmental Medicine & Child Neurology*, *51*, 635–641. doi:10.1111/j.1469-8749.2008.03218.x

Ferndale, D., Munro, L., & Watson, B. (2016). A discourse of "abnormality": Exploring discussions of people living in Australia with deafness or hearing loss. *American Annals of the Deaf*, *160*, 483–495. doi:10.1353/aad.2016.0001

Finch, C. (2016a). *Common myths about sign language*. Retrieved from https://healdove.com/disabilities/Myths-and-Misconceptions-About-Deaf-People

Finch, C. (2016b). *Myths and misconceptions about deaf people*. Retrieved from https://healdove.com/disabilities/Myths-and-Misconceptions-About-Deaf-People

Gertz, G., & Boudreault, P. (2016). *The Sage deaf studies encyclopedia*. Los Angeles, CA: Sage.

Gill, I., & Fox, J., (2012). A qualitative meta-synthesis on the experience of psychotherapy for deaf and hard of hearing people. *Mental Health, Religion, and Culture*, *15*, 637–651. doi:10.1080/13674676.2011.609161

Downloaded by [107.72.164.51] at 17:10 12 January 2018

Glickman, N., & Crump, C. (2013). Sign language dysfluency in some deaf persons: Implications for interpreters and clinicians working in mental health settings. In N. Glickman (Ed.), *Deaf mental health care* (pp. 107–137). New York, NY: Routledge.

Hamilton, D., & Mackie, D. (2014). *Affect, cognition, and stereotyping*. San Diego, CA: Academic.

Hauser, P., O'Hearn, A., McKee, M., Steider, A., & Thew, D. (2010). Deaf epistemology: Deafhood and deafness. *American Annals of the Deaf*, *154*, 486–492. doi:10.1353/aad.0.0120

Hindley, P. (2000). Child and adolescent psychiatry. In P. Hindley & N. Kitson (Eds.), *Mental health and deafness* (pp. 42–74). London, UK: Whurr.

If My Hands Could Speak. (2016). *Myths about deaf people (and the truth)*. Retrieved from https://ifmyhandscouldspeak.wordpress.com/common-myths-about-deaf-people-and-the-truth/

Kattari, S. (2015). Examining ableism in higher education through social dominance theory and social learning theory. *Innovative Higher Education*, *40*, 275–386.

Kemmery, M., & Compton, M. (2014). Are you deaf or hard of hearing? Which do you go by: Perceptions of identity in families of students with hearing loss. *The Volta Review*, *114*, 157–192.

Kiger, G. (1997). The structure of attitudes towards person who are deaf: Emotions, values, and stereotypes. *The Journal of Psychology*, *131*, 554–560. doi:10.1080/00223989709603544

Kish, M. (2016). *Stereotypes and misconceptions about deaf people*. Retrieved from http://deaf-educationworldwide.weebly.com/stereotypes-and-misconceptions-about-deaf-people.html

Kvam, M., Loeb, M., & Tambs, K. (2007). Mental health in deaf adults: Symptoms of anxiety and depression among hearing and deaf individuals. *Journal of Deaf Studies and Deaf Education*, *12*(1), 1–7. doi:10.1093/deafed/enl015

Lane, H. (2002). Do deaf people have a disability? *Sign Language Studies*, *2*, 356–379. doi:10.1353/sls.2002.0019

Lane, H. (2005). Ethnicity, ethics, and the deaf-world. *Journal of Deaf Studies and Deaf Education*, *10*, 291–310. doi:10.1093/deafed/eni030

Leigh, I. (2009). *A lens on deaf identities*. New York, NY: Oxford University Press.

Mantokoudis, G., Dahler, C., Dubach, P., Kompis, M., Caversaccio, M., & Senn, P. (2013). Internet telephony allows speech reading by deaf individuals and improves speech perception by cochlear implant users. *PLoS ONE*, *8*(1), e54770. doi:10.1371/journal.pone.0054770

Marschark, M. (2006). Intellectual functioning of deaf adults and children: Questions and answers. *European Journal of Cognitive Psychology*, *18*(1), 70–89. doi:10.1080/09541440500216028

Mitchell, R., & Karchmer, M. (2004). Chasing the mythical ten percent: Parental hearing status of deaf and hard of hearing students in the United States. *Sign Language Studies*, *4*, 138–163. doi:10.1353/sls.2004.0005

Mitchell, R., Young, T., Bellamie, B., & Karchmer, M. (2006). How many people in the United States use ASL? *Sign Language Studies*, *6*, 306–335. doi:10.1353/sls.2006.0019

National Association of the Deaf. (2017). *Position statement on mental health interpreting services with people who are deaf*. Retrieved from nad.org/issues/health-care/mental-health-services/position-statement-mental-health-interpreting-services.peo

National Institute on Deafness and Other Communication Disorders. (2014). *American Sign Language fact sheet*. Bethesda, MD: National Institute of Health.

National Institute on Deafness and Other Communication Disordersx. (2017). *Hearing and amplification: Cochlear implants*. Retrieved from http://www.babyhearing.org/hearingamplification/cochlear/LimitationsRisks.pdf

Nomeland, R., & Nomeland, M. (2012). *The deaf community in America*. Jefferson, NC: McFarland.

Downloaded by [107.72.164.51] at 17:10 12 January 2018

Northern, S. (2009). Ask the difficult questions. *Nursing Standard*, *24*(12), 20–21.

Power, D. (2005). Models of deafness: Cochlear implants in Australian daily press. *Journal of Deaf Studies and Deaf Education*, *10*, 451–459. doi:10.1093/deafed/eni042

Quist, R., & Resendez, M. (2002). Social dominance threat: Examining social dominance theory's explanation of prejudice as legitimizing myths. *Basic & Applied Social Psychology*, *24*, 287–293. doi:10.1207/s15324834basp2404_4

Rubinstein, J. (2012). Cochlear implants: The hazards of unexpected success. *Canadian Medical Association Journal*, *184*, 1343–1344. doi:10.1503/cmaj.111743

Sarant, J., Harris, D., & Bennet, L. (2015). Academic outcomes for school-aged children with severe-profound hearing loss and early unilateral and bilateral cochlear implants. *Journal of Speech, Language, and Hearing Research*, *58*, 1017–1032.

Seessel, J. (2013). Listening for silenced voices: Teaching writing to deaf students and what it can teach us about composition studies. *Teaching English in the Two Year College*, *40*, 399–415.

Sharf, J., Primavera, L., & Diener, M. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy*, *47*, 637–645. doi:10.1037/a0021175

Simpson, S., & Reid, C. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *Australian Journal of Rural Health*, *22*, 280–299. doi:10.1111/ajr.12149

Sommers, S., & Norton, M. (2008). Race and jury selection: Psychological perspectives on the peremptory challenge debate. *American Psychologist*, *63*, 527–539. doi:10.1037/0003-066x.63.6.527

Vernon, M. (2005). Fifty years of research on the intelligence of deaf and hard of hearing children: A review of literature and discussion implications. *Journal of Deaf Studies and Deaf Education*, *10*, 225–231. doi:10.1093/deafed/eni024

Vernon, M., & Leigh, I. (2007). Mental health services for people who are deaf. *American Annals of the Deaf*, *152*, 374–381. doi:10.1353/aad.2008.0005

Wilson, J., & Schild, S. (2014). Provision of mental health care services to deaf individuals using telehealth. *Professional Psychology: Research and Practice*, *45*, 324–331. doi:10.1037/a0036811

Wright, G., & Reese, R. (2015). Strengthening cultural sensitivity in mental health counseling for deaf clients. *Journal of Multicultural Counseling and Development*, *43*, 275–287. doi:10.1002/jmcd.12021

Young, A. (1999). Hearing parents' adjustment to a deaf child—The impact of a cultural-linguistic model of deafness. *Journal of Social Work Practice*, *13*, 157–173.

Downloaded by [107.72.164.51] at 17:10 12 January 2018