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Psychotherapy with Deaf adults: The Development of a Clinical Specialization

Abstract

This article summarizes the developing clinical specialization of psychotherapy with deaf adults. A review of relevant literature from the United States and Great Britain is presented. Special attention is given to the development of “culturally affirmative” approaches to psychotherapy with deaf persons and what this means for the preparation of counselors. Because most deaf people still work with non-signing clinicians who collaborate with interpreters, a case example of family therapy where a sign language interpreter was used is presented with a discussion of principles guiding this collaboration. This is followed by discussions of psychotherapy with two deaf clients at very different functional levels. One is a client who is “language and learning challenged,” from the group usually referred to as traditionally underserved deaf persons. The second is of a bilingual (ASL-English), psychologically sophisticated deaf client. The literature and these cases suggest that while psychologically sophisticated deaf persons can benefit from all credible models of psychotherapy, as long as they are conducted by counselors with specialized training in work with deaf people, deaf clients who are language and learning challenged may benefit most from a modified approach to cognitive behavioral therapy where the emphasis is placed upon “pre-treatment” strategies for engaging these clients and then the development of psychosocial skills.

Psychotherapy with Deaf adults: The Development of a Clinical Specialization

Introduction

At the end of the Twentieth Century, it became possible to ask good questions about the conduct of psychotherapy with deaf people.

For instance, what special skills are required to do this work? What knowledge base must the clinician acquire? How might various kinds of cultural identity, including the clinician's "hearingness", impact his or her work? How might a client's cultural identity and perception of their own deafness, on a continuum from medical disability to cultural identity, influence their use of the mental health field? Are their common ways in which psychotherapy must be adapted for culturally Deaf people? Are their "best practices" to use when working with deaf people or with some subsets of deaf people?

These are much better questions than "do deaf people benefit from psychotherapy?" and "how do we help deaf people cope with being deaf?"

This article is devoted to a study of what is special or unique about the practice of psychotherapy with deaf adults. The great heterogeneity among deaf persons can make generalizations difficult. Psychotherapy with linguistically competent, employed, deaf persons, who have a range of relationship ties, but who may have marital problems or struggle with non-disabling depression or anxiety, may not be that different than psychotherapy with their hearing counterparts. All the works reviewed below argue that clinicians need special training and skills, but many argue that, given such training and skills, the process of psychotherapy per se is similar. On the other hand, when one considers the group of least functional deaf persons, the challenges to effective psychotherapy are formidable indeed and definitely require a great deal of specialized

training. It is with this group of “lower functioning” deaf persons, usually labeled “traditionally underserved,” that psychological problems unique to the experience of deafness in a hearing world are most evident. Glickman (2008) argues that traditional insight oriented psychotherapy tends to be ineffective with these persons, but that a modified form of cognitive behavioral therapy, which he describes, can work quite successfully.

With a few exceptions, an informed literature on this subject only began to appear in the 1980’s. In this article, we will address the issue of what is special or different about psychotherapy with deaf adults (as compared to hearing adults) by examining the cultural self-awareness, specialized knowledge base and unique skills that mental health specialists who work with deaf people must acquire. The deaf persons discussed will be primarily those who became deaf at birth or in their first few years and who rely upon some kind of sign language for communication. However, even among these deaf consumers, there is a wide variety of life experiences and functional abilities.

The chapter begins with a review of relevant literature from the United States and Great Britain. Around 1980, the linguistic revolution sparked by the work of William Stokoe, in which American Sign Language was recognized as a real language , and in which the Deaf Community was recognized as a linguistic sub-culture, began to influence counselors (Stokoe, Casterline, & Croneberg, 1976). It became increasingly difficult to assume a connection between deafness and psychopathology (Leigh & Pollard, 2003). The older medical-pathological model of deafness was challenged by the newer cultural model (Baker & Cokely, 1980). This forced a broadening of the discussion away from a narrow focus on helping deaf people cope with their deafness and adjust to a hearing

world to a new appreciation of how deafness can be normative and even a positive value. The cultural model posited the need for clinicians to show special linguistic and clinical competencies even while recognizing serious psychopathology that individual deaf persons may develop (Glickman, 1996). We will review some of the key ideas that emerged once mental health clinicians began to adopt the cultural model of deafness.

The scarcity of mental health professionals who sign competently and specialize in working with deaf people means that most deaf people receive mental health care through the provision of sign language interpreters (Leigh and Pollard, 2003). Indeed, even deafness mental health specialists may elect to work with interpreters for a variety of reasons. Whether one is a deafness mental health specialist or not, the ability to work skillfully with interpreters is a core competency. We will therefore review some key themes that emerge when mental health clinicians collaborate with interpreters.

We then move to a more detailed examination of the issues involved in psychotherapy with deaf persons with “language and learning challenges,” the group that has also been referred to as “low functioning” or “traditionally underserved.” We discuss the difficulties of providing mental health care with these persons and present a case example. We contrast this with a case study of a clinician working with an educated, literate, culturally Deaf person. The special skills required of the clinician here are reflected in the internal dialogue of the clinician as he seeks to work in a manner attuned to the “thought world” of his client. As we will see, his knowledge of psychosocial and cultural aspects of deafness enables him to avoid mistakes emerging out of unexamined beliefs and prejudices and to ask culturally informed questions. His

language and other skills enable him not only to communicate easily but to modify his communication style for clinical purposes.

Literature Review

Prior to the 1970's, the small literature that existed on mental health care of deaf people worked exclusively the medical-pathological model of deafness. Deafness was understood only as a medical disability. Deaf people were presumed to be disabled and psychological evaluations began with the assumption of deafness as abnormality.

In the first half of the twentieth century, the main research into psychology and deafness was published by Rudolf Pintner and associates. Reflecting the interest in newly developing intelligence tests, they published over 80 papers comparing deaf and hearing samples on intelligence and personality. Using highly biased measures such as written English tests, they found, not surprisingly, lower intelligence and more psychopathology in the deaf samples (Vernon, 1995). Pintner's conclusions on the relative intellectual inferiority of deaf people were reinforced later by Helmer Myklebust, whose own studies of deaf people using English based personality tests such as the MMPI concluded that deaf people showed greater psychopathology (Pollard, 1992).

In the 1950's and early 1960's, 5 specialty mental health programs for deaf persons were established. The first was the mental health project for the deaf established at the New York State Psychiatric Institute by Franz Kallman, John Rainer and Ken Altshuler. This was followed by the St. Elizabeth Hospital unit in Washington D.C. founded by Luther Robinson; a program at the Michael Reese Hospital in Chicago founded by Roy Grinker, McCay Vernon and Eugene Mindel; the University of California San Francisco's Center on Deafness founded by Hilde Schlesinger and Kay

Meadow, and a psychiatric inpatient program for the deaf in England, established by John Denmark. These programs all focused on the most severely disturbed deaf people. The researchers tended to generalize conclusions about deaf persons based on these highly skewed samples. (Pollard, 1992). These programs provided the first contexts in which psychotherapy with deaf adults was discussed.

Sussman and Brauer (1999) note how deaf people were excluded from the burgeoning of psychotherapies that occurred in the 1960's and 1970's. Part of the reason was the lack of qualified clinicians, but this

“slow progress....was further exacerbated by negative attitudes of mental health professionals and avowed experts in deafness regarding the ability of deaf individuals to benefit from psychotherapy. The prevailing attitude at the time was that deaf people, due to their traditionally imputed deficiencies such as language difficulties, communication problems, lack of English skills, inability to reason on the abstract level, and personality issues, were not appropriate or feasible candidates for in-depth insight-developing, affectively oriented, psychoanalytically oriented, and cognitively oriented psychotherapies. It was believed that only the highly educated, the highly verbal, post-lingually deafened individuals could benefit from such forms of therapy.” (p. 3)

In the 1970's and 1980's, coincident with the recognition of American Sign Language (ASL) as a genuine language and the Deaf Community as a subculture, a number of mental health clinicians, many of whom were Deaf, pioneered new “culturally affirmative” approaches to psychotherapy with deaf persons. They challenged the

stereotypes about deaf people being incapable of insight oriented psychotherapies as well as the presumed connection between deafness and psychopathology. The first text on counseling deaf people was a small monograph with that name edited by two pioneering Deaf psychologists, Allen Sussman and Larry Stewart (Sussman & Stewart, 1971). This text contained chapters describing the social and psychological problems of deaf people, the then current status and principles of counseling with deaf people, the role and function of the counselor, and counselor preparation. Patterson and Stewart, in their chapter on principles of counseling with deaf people, argued that ...”the nature and principles of counseling with deaf people are no different than those that characterize counseling with other people. Rather, it is their implementation that differs.” (p. 55). They argued that for counseling to be successful with deaf people, “the counselor must 1. understand certain facts about deaf people; 2. be aware of the special problems experienced by the deaf; 3. know the impact of these problems so that their impact on the counseling relationship may be minimized; 4. be able to communicate with deaf people in their language; and 5. be aware of ways that deaf clients can be helped to better express themselves.” (p. 56.) Each of these points was elaborated upon.

Counseling with Deaf people was the first book to address such basic questions as whether deaf people face unique problems, what qualifies counselors to work with deaf people, whether standard methods of psychotherapy could be applied with deaf clients, and how one trains counselors to work with deaf people. At the end of their preface, the editors hoped that “this book will be the first of many on the subject of counseling the deaf.” (p.9.)

Also in 1971, Eugene Mindel and McCay Vernon published, *They grow in silence*. (Mindel & Vernon, 1971). This was followed one year later by Hildle Schlesinger and Kathryn Meadow's, *Sound and sign* (Schlesinger & Meadow, 1972). Both of these books had profound influence over the fields of education, rehabilitation and mental health care with deaf people. These three books can be considered the first "Deaf affirmative" psychology books published in the United States.

Chapter 1 of *They grow in silence*, is provocatively titled "the hearing man's bias." The authors write, "one who reads literature about deafness discovers that many prescriptions for deaf persons serve not them but the people serving the deaf. Teachers of the deaf often use their own projected feelings in attempting to understand the plight of their deaf students: facts are ignored." (p. 1) Even today, well into the 21st Century, the notion that hearing teachers, educators and other professionals are not objective benefactors of deaf people but rather are likely to be people working from deep rooted and unconscious prejudices may be very threatening. Yet uncomfortable as it may be, this is precisely the kind of perspective that hearing people seeking to work effectively with deaf people must grapple with. This challenge was articulated even more powerfully two decades later by Lane (1992). Mindel and Vernon went on to document studies showing unequivocally the failures of oral deaf education and the superiority of programs that use sign language. They cited research demonstrating the relationship between the communication isolation fostered by oralism and the difficulties these persons faced in making use of psychotherapy and rehabilitation. They also found higher instances of depression in deaf persons raised orally.

Schlesinger and Meadows' *Sound and sign* reinforced the importance of sign language in deaf education. Schlesinger and Meadow presented research showing that almost five times as many deaf as hearing students displayed severe behavioral problems. They described numerous deaf individuals who received psychotherapy services in their specialized deafness outpatient mental health program. They also made the then radical claim that,

staff members working in such a (deafness mental health) program need special training in order to understand the language and the special needs of the deaf community. Professionals working with deaf individuals need to acquaint themselves with the manual sign language of the deaf, with the cultural factors, the conflicts, and the developmental stresses to which deaf individuals are subjected. They need also to understand, and be ready to try to reduce, the stigma attached to deafness by persons with normal hearing. (p. 230.)

It was another decade before the next book on this subject, an edited volume called *Deafness and mental health* (Stein, Mindel, & Jabaley, 1981) appeared. This book contains a frequently cited chapter on *Insight oriented psychotherapy with the Deaf*. (Levine, 1981). This chapter made the then groundbreaking claim that “psychoanalytically oriented psychotherapy may be the treatment of choice for the intelligent deaf adult with emotional problems.” (p. 113). While this certainly represented an advance over the early stereotypes about the alleged inability of deaf people to do insight oriented treatment, the authors of the chapter still make assumptions suggesting they have not yet moved beyond a hearing, ethnocentric viewpoint. For

instance, a new deaf patient, in a waiting room with a receptionist who did not sign, about to meet a therapist who is also a novice signer, is described like this: “An incipient paranoia exploded in the waiting room, where she frightened the receptionist by signing with the fury of a boxer throwing punches.” (p. 117). The notion of deaf people being paranoid is evoked here along with the suggestion that use of sign language reflects hostility. Was this client truly paranoid or did she have legitimate reasons to be concerned about the nature of the treatment she would receive?

In a second case, the psychiatrist interprets a deaf patient with excellent speech dropping his voicing as an attempt to make the psychiatrist feel “awkward and helpless. This led me to an appreciation of how helpless and awkward (he) felt in relation to the hearing world.” (p. 118.) When the psychiatrist finally commented on the patients’ tendency to drop his voice, “his anger at being deaf emerged. Thereafter, he resorted much less often to lowering his voice, but the helpless rage at being deaf that had been touched upon scared him greatly and could not be contained by the therapeutic alliance. We met for yet another 6 months, dealing at times with his frustration at being deaf. He terminated treatment with only a vague plan to start again with me ‘later.’ And without ever fully working through the fear of his rage or the helplessness behind it.” (p. 118-119).

The bias implicit in these and other cases is that the deaf client must accommodate to the communication needs of the clinician and that failure to do so represents some pathology on the clients’ part. Another bias is that that clinical interpretations revolve around presumed feelings of loss and rage at being deaf and about the need for clients to mourn the loss of hearing (as opposed to, for instance, anger

against the therapist for being unable to communicate well in the clients own language.) The abrupt termination by the client of his therapy is presumed to be due to his inability or unwillingness to work through these negative feelings about his deafness and not, for instance, at his frustration with his therapists' inability to understand him.

A more successful chapter was written by Larry Stewart, co-editor of the 1971 volume referenced above.(Stewart, 1981). Stewart was the first person to demonstrate that non-directive counseling could be done with “traditionally underserved” deaf clients. Stewart, like fellow pioneer Allen Sussman argued that, “many deaf clients experience no difficulty in participating in the counseling process exactly as a hearing client of comparable abilities would, provided the counselor possesses the communication skills and empathy level necessary for effective interaction with the client.” (p. 136). Stewart provides transcripts of sessions demonstrating counseling (primarily client centered and reality therapy) with deaf clients with very different language and functional abilities. His most striking examples are of his work with clients who have limited language abilities.

The next significant publication was an edited monograph published by the Arkansas Rehabilitation and Training Center on Deafness and Hearing Impairment (Anderson & Rosten, 1985; Anderson & Watson, 1985). This monograph included one of the first discussions of cross-cultural variables in counseling with deaf people (Anderson & Rosten, 1985). The chapters on how to apply psychodynamic psychotherapy (Rayson, 1985), Adlerian counseling (Farrugia, 1985), Reality therapy (McCrone, 1985), Structural family therapy (Scott & Dooley, 1985) and structured group therapy (Danek, 1985) review basic principals of these treatment approaches and

describe their applicability with deaf consumers. This monograph, along with *Deafness and mental health* (Stein et al., 1981), brought consideration of deaf people into the world of rapidly expanding psychotherapies. The main theme was that deaf people could be worked with successfully in many styles of psychotherapy.

In the 1980's, coincident with the explosion of interest in Deaf Culture, the first articles on "cross cultural" psychotherapy with deaf persons appeared (Anderson & Rosten, 1985; Glickman, 1983, 1986; Sussman, 1988). These were followed in the 1990's and early 2000's by other articles on this topic (Freedman, 1994) as well as books taking an explicitly "culturally affirmative" view of counseling and mental health care of deaf persons (Glickman & Gulati, 2003; Glickman & Harvey, 1996; Leigh, 1999).

The psychotherapy with deaf persons literature of this time consisted overwhelmingly of theoretical arguments and case studies, not empirical research. (Leigh & Pollard, 2003).

A representative article (Peterson & Gough, 1995) discusses the principals of Gestalt Therapy such as the goal of creating greater self-awareness. Some Gestalt techniques are reviewed and then an account of a Gestalt therapy session with a deaf client is presented. No research is cited; just a theoretical argument and case example.

The late 1980's saw the publication of the first book addressing systemic and family therapy interventions with deaf persons (Harvey, 1989). This text provided a conceptualization of functional and dysfunctional behaviors that individual deaf people showed as located, not within the deaf individual, but rather within patterns of interaction between them and people in their family, personal and professional networks.

Accordingly, several systemic interventions were described. As with the new emphasis on culturally affirmative treatment, Harvey's text moved the perspective clinician's view

when treating deaf persons away from the presumed connection between deafness and psychopathology. Harvey argued that deafness has no inherent meaning, *but the meaning that people assign to deafness has great psychological impact*. Deaf people could not be understood apart from how they were understood and treated in their families, schools, jobs, network of professional helpers, and the larger society's cultural influence. Therefore, Harvey demonstrated, it was often most useful to intervene with family, school, and professional helpers; to change their interaction with the deaf "identified patient," than to sit with the lone deaf person in the relative isolation of the therapy office.

Harvey went on to produce two more books on psychotherapy with deaf persons, particularly non-culturally deaf persons and those with acquired hearing loss.(Harvey, 1998, 2001). Unlike his book on systemic and family therapy, both of these books were written in a layperson's narrative, also appropriate for consumers. They consisted of case studies about deaf persons from diverse walks of life going through the psychotherapy process. Countertransference factors were also illustrated

Culturally affirmative psychotherapy with deaf persons

The nature of psychotherapy with deaf persons is dependent upon the model of deafness that one adopts. Glickman (1996) argued that shifting from the medical-pathological model of deafness to the cultural model resulted in a radically different set of concerns being raised. He drew upon an influential position paper on multicultural counseling developed by a task force of the American Psychological Association (Sue, Arredondo, & McDavis, 1992; Sue et

al., 1982) to lay out a framework for culturally affirmative psychotherapy with deaf persons.

This framework calls upon counselors who work with deaf people to master three domains. First, they must become culturally and personally self-aware so they are not defensively working from unexamined prejudices against deaf people. Secondly, they must develop a great deal of specialized knowledge about deaf people. Thirdly, they must acquire an array of new skills, with sign language skills being only the most obvious.

Of these three domains, the cultural self-awareness dimension is the most difficult to teach. It can be particularly difficult to teach hearing people to become self-aware of the perspective and biases that emerge from the social experience of being hearing because the dominant definition of deafness is that it is a medical disability, not a cultural difference. Mental health settings are often medical settings where the medical-pathological model is assumed. Effectively challenging those clinicians who hold this viewpoint can be especially difficult.

This self-awareness dimension of multi-cultural work refers to the development of a non-defensive appreciation that, for majority member clinicians, *you and your group* have enormous social advantages vis-à-vis the minority group, and *that by virtue of the power that comes from your social position you are likely to have unconscious, ingrained attitudes, beliefs and behavior patterns that people in minority groups find oppressive, whatever your intentions*. This is the challenge, for instance, of helping well intended White persons appreciate their unconscious biases towards racial minorities or helping

men come to terms with how they have been socialized into particular expressions of masculinity.

What does a hearing bias against deaf people look like? Glickman argued that it begins with this medical-pathological assumption that deafness is a tragic disability. Certainly, individual deaf people may look at their deafness this way, but this view of deafness is a social construction, very analogous to the idea that homosexuality represents mental illness. To associate with Deaf people who live fully within the belief that deafness is both normative and positive is to appreciate how arbitrary this view of deafness is. Deafness can be understood to be a huge social disadvantage in a non-deaf world, but this is a byproduct of how deafness is conceptualized and deaf people are treated. Again, changing social views of homosexuality underscore how core social beliefs about a condition can change; and how these changing beliefs, from a pathological to a normative model, create new possibilities for mental health in the minority community. Changing social views of homosexuality have had such effect that organizations like the American Psychological Association now actively promote the normative model of homosexuality and bisexuality. Psychologists working with the older view of homosexuality and bisexuality as mental illnesses risk being viewed as unethical or even of engaging in malpractice ("Guidelines for psychotherapy with lesbian, gay and bisexual clients," 2003) Glickman recommended a similar paradigm shift with regard to our understanding of deaf persons as an essential element in the creation of a more respectful, affirming and empowering psychotherapy.

The medical-pathological model of deafness fosters the idea that deaf people are inherently broken, and that mental health specialists are tasked with helping deaf people

cope or adjust to this tragic flaw. This model also presupposes a value system in which hearing is considered superior to not-hearing, speech to signing, English to American Sign Language, integration to cultural distinctness, and in which medical interventions such as hearing aids and cochlear implants are promoted unself-consciously. This is a value system in which mainstreaming of deaf children in non-specialized school placements is assumed to constitute the least restrict environment, and in which the creation of Deaf-centric rehabilitation and mental health programs is considered unnecessary at best and inappropriately ghettoizing at worst. The assumption of deafness as pathology can also feed other unconscious biases against deaf people, making it relatively easy for hearing clinicians to perceive paranoia or narcissism in deaf people complaining of inaccessible and insensitive treatment. It can make it easy for clinicians to assume that the language dysfluency they see in deaf clients is due to mental illness and not, for instance, the language deprivation (an issue that the uninformed clinician will not likely know about.)(Glickman, 2007).

How does cultural self awareness apply to hearing people? Is there, as Lane, (H. Lane, 1996), and Hoffmeister and Harvey (1996) suggest, a psychology of hearing people. Hoffmeister and Harvey discuss a variety of common “relational postures” that hearing people assume with regards to deaf people. These postures include:

- a. the freedom fighter posture or the person who champions the cause of fighting deaf oppression.
- b. the pathological posture or the person who seeks to help deaf people but who conceives of deaf people as disabled, sick, morally depraved or generally less fortunate

- c. the blame the victim posture in which hearing people blame deaf people for their own difficulties as when deaf people are faulted for not being able to communicate well with hearing people.
- d. the idealization and betrayal posture in which deaf people and deafness is romanticized. New sign language students are often inclined to this posture.
- e. the cognitive dissonance posture in which people struggle to reconcile conflicting beliefs about deaf people (for instance, deaf people should appreciate me because of my efforts to learn sign and help them yet some call me an oppressor.)

The hearing clinician who is uninformed or naïve about these cultural dimensions of psychotherapy is very likely to make mistakes that alienate more culturally Deaf people. This happens frequently among medical professionals or audiologists who only understand deafness to be a disability that needs remediation and who have no experience with culturally Deaf people outside the medical setting ((Gulati, 2003). Counselors asked to work with a deaf person for the first time, but lacking any training or preparation, will bring their unexamined biases about deafness to the work.

The second dimension cited by Sue et al (1982) is knowledge. There is a great deal of special knowledge to acquire about the common life experiences, strengths and problems of deaf people (Glickman, 1996.) For instance, clinicians need to be familiar with these common experiences of deaf persons growing up in hearing families:

- a. Deaf children in these families commonly receive late or inadequate exposure to sign language, setting them up to become language dysfluent their entire lives (Gulati, 2003; Pajmans, 2007)

- b. Poor communication in the family yields an endless stream of stories of perceived neglect and abuse. The story of poor communication at the dinner table is so widely told that it becomes a metaphor for the whole deaf experience.
- c. Because parents lack verbal (signed or oral) means of communicating with their deaf child, they often rely more upon authoritarian limit setting and use of force. This can set up a dynamic that gradually gravitates towards physical abuse (i.e., the child, frustrated and unable to communicate verbally with his parents, responds to these limits with behavioral aggression, and the parents, frustrated and unable to communicate with the child, become increasingly aggressive themselves). It also means the child grows up without the skills of using language for problem solving and with an expectation that authorities work through physical force or rules, not through negotiation.(Glickman, 2008; Schlesinger & Meadow, 1972).
- d. Hearing parents often grieve when they learn their child is deaf. Their grieving and the communication difficulties can interfere with child-parent bonding, setting the stage for attachment difficulties and personality disorders as the child grows (Schlesinger & Meadow, 1972; Vernon & Andrews, 1990).
- e. There is a high incidence of trauma and abuse in deaf children (Sullivan, Brookhouser, & Scanlan, 2000.) As mentioned, physical abuse often grows out of a context where communication is poor. Deaf children can be very vulnerable to sexual abuse because they don't have the language skills to make sense of, much less report, this abuse. Experiencing abuse without a

language to make sense of it sets the stage for profound trauma reactions.

Indeed, communication isolation is itself a form of severe trauma, and any therapeutic situation where communication is poor is easily experienced as re-traumatization (Harvey, 1996; (DeVinney, 2003; Sullivan, Brookhouser, & Scanlan, 2000).

- f. Deaf children often continue to experience isolation in mainstreamed school settings where communication inclusion is often done badly (Greenberg, 2000). They may have difficulty making friends and may be vulnerable to bullying.(Olivia, 2004)
- g. In non-Deaf settings, deaf people typically receive negative messages about their disability, limitations, inadequacy, and inferiority. These messages can become core aspects of a persons' self concept and certainly contribute to problems with depression, anxiety and anger (Vernon & Andrews, 1990)

These are some common experiences of deaf children in hearing families and contexts, but deafness occurs in multiple, overlapping cultural contexts (for instance, a deaf child in a recently immigrating poor and uneducated hearing Hispanic or African family who have themselves been victims of other kinds of trauma.) A text contributing a great deal towards our knowledge of how to do psychotherapy with deaf people “from diverse groups” was edited by (Leigh, 1999). This is the first mental health text to deal with cultural diversity within the Deaf Community.

Within this text, Steinberg, Lowe and Sullivan (1999) present research revealing common deaf person's knowledge, attitudes, and beliefs about mental health and mental health services. They discuss, for instance, the common view among deaf people that

“mental problems....typically arose from external factors, such as upbringing, poor communication, or family problems.” (p. 25) Communication problems in particular provided the most salient explanation for mental health difficulties. The therapist who only works within an intra-psychic model of treatment may be handicapped from the start in forming alliances with some culturally Deaf clients who attribute problems to communicate or other external factors.

Another important finding from Steinberg et. al study is the negative view of mental health providers that is common among deaf people. Psychiatric hospitals, for instance, are “a place to be feared, a place where people are taken and abandoned, a place where a hapless, unsuspecting deaf person might be sent if misunderstood. For many deaf individuals, these images of institutionalization and insanity are the only images the expression “mental health” conjures up.” (p. 32) Stereotypical images of mental hospitals, and mistrust of hearing mental health providers are not just the product of ignorance and irrationality. They reflect historical experiences so common for deaf people as to have become institutionalized in Deaf folklore. The implications of this are that mental health providers and institutions need to do very culturally sensitive outreach before deaf people will see them as resources for healing.

Also present in this text are informative discussions about psychotherapy with deaf women (Wax, 1999), deaf lesbians, gay men and bisexual men and women (Gutman, 1999), deaf African Americans (Corbett, 1999), deaf Native Americans (Eldredge, 1999), deaf Asian Americans (Wu & Grant, 1999), and deaf Latino adolescent immigrants (Hernandez, 1999). Other highly specialized content areas discussed are the particular issues for deaf clinicians (Leigh & Lewis, 1999), deaf people with HIV/AIDS

(Langholtz & Ruth, 1999), deaf survivors of sexual abuse (Burke, Gutman, & Dobosh, 1999), deaf people with Usher Syndrome (Miner, 1999), traditionally underserved deaf persons (Duffy, 1999) and deaf substance abusers (Guthmann, Sandberg, & Dickinson, 1999).

As an example of specialized knowledge required to work with one diverse deaf group, we can examine some of the issues raised by Gutman (1999) in her discussion of treatment with deaf lesbians, gay men and bisexuals. She notes that deaf gay people struggle to overcome two negative identities and that coming out as gay can make it more difficult to find social acceptance among Deaf people. The small size of the Deaf community can make it difficult to find partners within it, yet finding a hearing partner means confronting the social prejudices against deaf people that gay hearing people can also hold as well as, of course, the communication difficulties. Coming out to one's family is often difficult enough but coming out to hearing parents with whom one has never communicated well poses even more formidable challenges. Hearing, heterosexual parents who grieved when learning that their child was deaf may grieve again when learning that their child is gay and may feel that there is yet another barrier between them and their children. Deaf gay and lesbian persons may be reluctant to come out to their parents for fear of disappointing them yet again. Deaf children of deaf parents, who share the same small Deaf community with their parents, may find that their parents learn about their sexual orientation long before they are prepared to tell them. Deaf parents may also have more difficulty accessing support groups like Parents and Friends of Lesbians and Gays which do not usually have interpreters. Deaf gay people coming out may need to find therapists who are both gay and Deaf affirmative. If there is

only one signing therapist nearby, they can only hope that this person is also knowledgeable and skilled in working with gay and lesbian issues. As with work with deaf people, there is much more to work with gay, lesbian, bisexual and transgender people. The same dimensions of self-awareness, knowledge and skills apply.

Another huge content area of specialty knowledge has to do with the application of ethics in mental health and deafness. The complexity of this topic is well covered in a recent volume devoted to it (Gutman, 2002). One issue discussed there is whether clinicians without specialized training who work with deaf persons are violating ethical standards of their discipline. For instance, Standard 2.01, Boundaries of Competence, of the 2002 American Psychological Association Ethical Principles of Psychologists and Code of Conduct states that *psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.*(American Psychological Association, 2002) Furthermore, it becomes crucial to consider what constitutes adequate competence to work with deaf people and who should be the judge of this competence. As the specialty of clinical work with deaf people becomes established, it will inevitably lead to discussions of a process for credentialing clinicians to do this work

Another ethical issue is how to how to handle confidentiality in what is essentially a small community where people know each other and word travels fast. This is a daily concern in Deaf treatment programs where clients may well have long histories with each other and where client concerns about confidentiality may trump concerns such as

communication competence. A deaf person needing hospitalization may refuse to go to the Deaf inpatient program because of concerns about confidentiality.

The positive aspects of deafness, the ways in which the Deaf community and culture can provide resources for deaf individuals, are equally important to understand. The difficulty deaf people may have with spoken languages is often balanced by the joy, delight and effective communication they can experience in sign. People who are very dysfluent in English may be articulate masters of American Sign Language. Alienation that is sometimes experienced in hearing settings may be balanced by comfort and a sense of home within Deaf settings. (Padden & Humphries, 1988, 2005; Schein, 1989) Preliminary research on cultural identity development in deaf people has found that culturally Deaf and bicultural (simultaneously Deaf and “hearing”) identity affiliations are associated with higher self-esteem and satisfaction with life (Bat-Chava, 2000; Leigh & Pollard, 2003; Maxwell-McCaw, 2001).

The third dimension of culturally affirmative mental health work is specialized skills. Glickman (1996) discusses these culturally specific skills for deafness specialists:

1. Cross-cultural communication skills including skill in the variations of sign language and skills in non-verbal communication particular to deaf people.
2. Skill in working with interpreters
3. Skills in expanding and flexing clinical roles
4. Skills in collaboration with indigenous helpers
5. Skills in selecting and designing culturally syntonic treatment interventions

Almost every discussion of psychotherapy with deaf people addresses the need for the clinician to either develop sign language skills or work skillfully with interpreters.

Developing communication skills to work well with deaf people means developing skills across the sign language continuum, from ASL to more English-like signing, as well as the ability to communicate effectively with the significant numbers of language dysfluent deaf persons. For non-native signers, this challenge may involve a lifetime of training. To non-signing persons, however, all signing can look the same.

Mental health and deafness literature from Great Britain

The literature review thus far has focused on the United States but there has also been a growth of specialty programs and literature in Europe, especially in Great Britain. The chief pioneer of Deaf mental health programs in Britain was John Denmark. As the son of a headmaster of a school for the deaf children, he grew up knowing British Sign Language. He later established the first psychiatric unit for deaf persons (Denmark & Warren, 1972) and wrote an important book called *Deafness and mental health* (Denmark, 1994)

In *Deafness and mental health*, Denmark provides a broad overview of the psychological, sociological and cultural aspects of deafness. He also reviews the specialized knowledge base and skills clinicians must have. At first the only signing clinician in his specialty deaf unit, he had a deep understanding of the importance for clinicians of being able to assess and treat using sign language themselves. He described how varying forms of mental disorder interact with deafness and how easy it is for non-specialist clinicians to misjudge communication problems and attribute them to mental illness.

While Denmark advocated for the development of more specialized programs for deaf consumers, he said relatively little about psychotherapy per se. His primary concerns were that clinicians be properly trained, that they could sign competently themselves or at least work well with interpreters, that they understood the problems and abilities of deaf people and made appropriate assessments.

Three recent British edited texts have included chapters addressing aspects of psychotherapy with deaf persons. Two of these texts, *Mental health and deafness* (Hindley & Kitson, 2000) and *Deafness in mind* (Austen & Crocker, 2004) contain chapters on psychodynamic therapies, family therapy, behavioral and cognitive approaches. We'll consider the complementary chapters in each text simultaneously.

In the first chapter on psychodynamic psychotherapy, (Kitson, Fernando, & Douglas, 2000) argue that there are no fundamental differences in psychodynamic treatment with deaf persons provided the patients has the abilities to make use of such treatment. The therapist should be able to not only provide a linguistic match, but should be skilled enough in his/her own signing abilities to be able to point out to the deaf patient how resistance may be manifest in the patient's signing (i.e., signing rapidly or unclearly.)

It takes a confident hearing therapist to challenge a Deaf person over his own language. The therapist, who is likely to need the respect of the Deaf community to be effective, may feel unable to challenge Deaf people's use of language as a defense. Some Deaf patients will use Deaf pride as a defense against, or an attack on, particularly hearing therapists in a way

that hides their own anger and attributes it to the oppressed Deaf community. This is the harder to challenge as the hearing community has undoubtedly oppressed the Deaf community (p. 351.)

They discuss transference dynamics that can occur between deaf and hearing persons. For instance, a hearing therapist can become a transference object not only for key parental figures but for hearing people in general. It thus helps for the clinician to be familiar with common life experiences of deaf people and common Deaf/hearing relationship dynamics. With this knowledge and the needed communication skills, the process of treatment, they argue, is essentially the same.

The second author, Jane Fernando, contributes another chapter on “psychodynamic considerations in working with people who are deaf,” in the second text, *Deafness in mind* (Fernando, 2004) Here she writes that there are three main issues that arise in dynamic psychotherapy with deaf persons. The first is anger related to not being understood. The second is the high incidence of sexual abuse. The third is personal identity. She says that the therapist must possess strong cultural knowledge of deafness, awareness of his/her own prejudices and provide a good linguistic match. Clients must have “psychological mindedness,” and for those who don’t she recommends art or movement therapies.

Both book chapters on family therapy with families of deaf persons (Crocker, 2004; Warner, 2000) draw heavily upon earlier work by Harvey (Harvey, 2003). Both focus upon how the inclusion of interpreters can influence the communication dynamics of the family by, for instance, exposing how poor the family communication is and

revealing how substantive conversations with the deaf member are possible. Warner discusses the scapegoating of deaf family members (often the “identified patient,”) and notes common structural dynamics.

Therefore in D:H (deaf children in hearing families) there is likely to be less authoritative parenting and more parentification of children, whereas in H:D (deaf children in hearing families) there are likely to be infantilized children and overcontrolling parents. This is not true for all families with deaf members but is certainly so in clinical populations (p. 372.)

Crocker also addresses common family therapy forms of questions which require such cognitive and linguistic skills as thinking probabilistically (i.e., if you do this, how will your father feel) and perspective taking. She cautions that some linguistically dysfluent deaf persons will not be able to respond to these forms of questions.

O’Rourke (2000) and Austen (2004) contribute chapters on cognitive behavioral approaches to therapy with deaf persons. O’Rourke argues for a “Deaf-centered approach” to treatment that goes beyond adapting existing models. She says an approach can be Deaf-centered if 1) it recognizes that the presentation of a disorder may be different in a deaf person (for instance, the cognitive themes in a deaf depressed person may relate to his/her deafness) and 2) specific therapeutic tools may need to be modified. With regard to the latter, she advocates for less reliance upon written tools and more use of videotape and visual aids. She also argues that DBT approaches that target skill deficits are made to order for deaf people who have developmentally based deficits in the acquisition of psychosocial skills. This line of reasoning anticipates the cognitive

behavioral therapy approach to work with “deaf and hearing persons with language and learning challenges” developed later by Glickman (2008.)

Finally, Austen contributes a chapter on “cognitive behavioral models in deafness and audiology” in which she describes common cognitive distortions among deaf people such as jumping to conclusions, all-or-nothing thinking and over-generalizations. Austen provides a few case examples showing how she challenged these cognitive distortions in particular deaf clients.

Another recent British volume, *Deafness and challenging behavior (Austen & Jeffery, 2007)* is the first book to focus on the problem of helping deaf persons with severe behavior problems. The problems are understood from varying viewpoints (neurological, psychodynamic, developmental, and linguistic) and varying techniques and approaches to managing them are discussed. A brief chapter on social skills improvement comes closest to being a psychotherapy intervention (Eernisse & Warren, 2007). The connection between language deprivation and behavioral problems is well explored in this book.

Young deaf children, in whose language there has been insufficient investment and whose challenging behavior is not immediately addressed, will become adults who have challenging behavior that is more entrenched and harder to manage. (Preface, p. xiii)

Working skillfully in therapy by collaborating with interpreters

There have been a growing number of articles which describe the practice of a psychotherapist providing individual and family treatment with an interpreter. Harvey (Harvey, 1984a, 1984b, 1985, 1986; Harvey, 2003) described the utilization of an interpreter to modify intra-familial linguistic and systemic transactions when providing family therapy for a deaf-member family in which there is a verbal communication barrier. Including an interpreter in treatment has also been described by Gulati (2003), Dean & Pollard (2001, 2005), Sussman and Brauer (1999), Pollard (1998), (MacEachin, 1982; Stansfield, 1981; Taff-Watson, 1984), (DeMatteo, Veltri, & Lee, 1986; Sluzki, 1984). Mental health interpreting is itself becoming an established subspecialty in the interpreting field (Dean & Pollard, 2001; Dean & Pollard, 2005; Pollard, 1998) Pre and post meetings between the interpreter and the therapist has become recommended practice in order to foster a collaborative relationship between interpreter and therapist.

That collaboration is deceptively simple. It necessarily depends, in part, on the idiosyncratic characteristics and personalities of the therapist and interpreter and on the context in which those individuals find themselves. The interpreter and therapist are both physically and therefore *affectively present* for the gamut of intimate human disclosures which typically characterize the process of therapy. When two people collaborate in this kind of intimate process, particularly if over a period of time, a bond inevitably develops.

This section describe some specific psychological "nuts and bolts" of the evolving relationship between the interpreter and therapist from the perspective of a hearing family therapist who is able to sign for himself and who has experience in the field of deafness.¹ It delineates how the interpersonal dynamics between an interpreter and therapist

¹ This section is an adapted version from Harvey, 1997.

influence the progress that an individual or family make in treatment; and how those client(s), in turn, influences these dynamics.

Exchange of information

The interpreter has relevant information to share with the therapist. For example, presumably the interpreter, prior to the session, has a sense of the deaf client's language proficiency. The interpreter needs to inform the therapist of his/her needs during the session, such as seating arrangements, people talking one at a time, etc. After the session, the interpreter has important information regarding what was the quality of linguistic communication of the Deaf family member, of the therapist, of the family? Did the Deaf member understand the discourse? Why or why not? What was being communicated subtly, nonverbally or cross-culturally? What communication was the interpreter unable to interpret?

Similarly, the therapist has information that the interpreter needs. Prior to the session, it would be important to clarify what the therapist needs and expects from the interpreter. Following the session, the therapist has important information regarding what was the theoretical basis for certain questions. What was the therapist trying to get at? Did the therapist necessary expect that all of the family members, including the Deaf member, understand completely what s/he was saying to another family member?

The degree of mutual trust, risk taking, and non-defensiveness between the interpreter and therapist will directly influence the quantity and quality of information which they must necessarily share during the pre and post sessions. For example, the interpreter will be free to admit that s/he might not have been "with it" during a particular session and therefore interpretation was inadequate, possibly influencing the quality of

the sessions. This is obviously vital for the therapist to know. Or the therapist can admit to the interpreter feelings of defensiveness in front of him/her during the treatment session. Or the therapist can admit to the interpreter that s/he was trying to accomplish certain goals during the session and succeeded or failed. These acts of self disclosure markedly decreases both persons' anxiety and thus would be expected to facilitate optimal functioning and creativity during the session.

Initial Defensiveness of Therapist:

It is one thing for me (MH) to select portions of my videotaped clinical work for presentations in front of colleagues. It is quite another thing to work "live" in the presence of another professional who is privy to both the therapeutic "magic moments" as well as to those moments during which I make the therapeutic blunders which I would rather pretend never happen. Such "countertransference" factors are easier to write about than to experience.

As an example, I recall once finding myself feeling a bit insecure in front of an interpreter about seemingly "doing nothing" and therefore trying to executive particularly clever therapeutic interpretations, clever reframes, and especially clear signing. Although I theoretically knew that it was necessary to wait for the proper time and situation to implement particular interventions, I unwittingly found myself intervening prematurely. This, in turn, understandably precipitated more resistance from the family, which precipitated more defensiveness, anxiety, and embarrassment from me. In the midst of this cycle, I asked myself:

"Does the interpreter think I'm inept?"

"Does the interpreter think I'm a lousy signer?"

Etc.

Dealing with these countertransference issues allowed me to understand the origins of my reactions more fully. In contrast to how our relationship had begun, I soon not only felt quite relaxed during the sessions but also missed the interpreter when she could not attend a meeting. This milestone also made it possible for the interpreter and I to work together in a variety of creative ways, as described in the rest of this section.

Modeling Dyadic Interaction for Families:

A comfortable interaction between interpreter and therapist also inevitably "spills over" to positively affect the interaction among all members of the session and vice versa. For example, I recall attempting to ask a Deaf adolescent a "circular question" (Palazzoli, Cecchin, & Prata, 1980): ie., "if you felt sad, who in your family would be the first to notice?" I signed it twice but noticed that I was not making myself clear. The interpreter let out what I perceived to be a mock sigh and said to me "let me do it" while shaking her head. At the same time, she smiled and made eye contact with me in a warmhearted way. I laughed as did the family. I then said to the interpreter in mock indignation "Ok, you try!" After she signed it successfully, the Deaf adolescent teasingly said to me "Oh, that's what you meant!" and laughed. I then shrugged my shoulders.

The affinity between the interpreter and me made this interchange fun and helpful in that it provided a bit of necessary respite for the whole family during what was otherwise a fairly intense session. However, it is apparent that the above interchange could easily have made an intense session more tense and less productive, had the interpreter and I not enjoyed and respected each other. Moreover, soon after this

exchange, other family members began to mimic the observed camaraderie between the interpreter and me.

Working Through Ego Defensive Reactions by Family Members:

A positive relationship is essential towards helping particular family members work through ego defense mechanisms, such as projection and transference, which are often inadvertently elicited by the mere presence of an interpreter. As has been described in previous publications (Harvey, 1982, 1984a, 1984b; Harvey, 1989; Harvey, 2003), family members often project, displace or transfer reactions that they unconsciously experience towards their Deaf sibling on to the interpreter.

For example, one father manifested extreme anger towards the interpreter while experiencing an altercation with his Deaf son who had just smashed the family car. The father did not appear angry at his son but was quick to yell at the interpreter for being two minutes late for the session and "for making faces" (in this case, facial expressions associated with American Sign Language). He also emphatically inquired of me whether the interpreter was "doing a good job translating everything I am saying to him (son)" and then asked whether "the interpreter is intimidated by me."

The father's conscious feelings of anger towards the interpreter (a transference reaction to mask his own unacknowledged anger towards his son) and wondering whether the interpreter was intimidated by him (a projection reaction to mask father's own feelings of intimidation in front of his son and/or the interpreter) were openly discussed in the presence of the interpreter who did not volunteer personal sentiments. I maintained intermittent eye contact with the interpreter during this piece of therapeutic work in order to convey that this is a necessary therapeutic procedure. The psychodynamic factors soon

became apparent to the father: that he harbored identical feelings of anger and helplessness with his son, and that the interpreter merely served as a catalyst for these feelings to become conscious. In a psychological sense, the father reacted to the interpreter as if she was his son.

Clearly, in order for our nonverbal eye-contact during the session to have been useful, it was vital for the interpreter and I to have already discussed the concept of transference and my therapeutic plan with this family, namely, in this case, to *utilize* the transference reactions of father to therapeutic advantage. Specifically, it had to be quite clear to everyone that the interpreter would not be expected to answer the father's queries about "is she angry at or intimidated by me?"; and there had to be sufficient trust between the interpreter and me for her to know that I would not put her on the spot by asking her to reveal personal sentiments.

Therapeutic Enactment

Let me continue with this clinical example in order to illustrate how the interpreter-therapist relationship affects, and is affected by, the therapist executing an intervention technique called "enactment" (Minuchin, 1974). A few sessions following the interventions described above, I instructed the father and son to discuss this new information concerning the transference directly with each other, but, unlike previous times, I asked the interpreter not to interpret any dialogue between them.² As each party openly acknowledged their hostility, helplessness and frustration in regards to

² The purpose of this technique is to enact communication barriers and other interactions which "naturally" occur at home without an interpreter. Although detailed elaboration of this technique is beyond the scope of this article, it is important to note that this was agreeable to the Deaf member; he understood the purpose of this technique. In the context of our positive working relationship, he did not feel exploited by it, but, in fact, appreciated it. This technique is elaborated by Harvey (2003).

communicating with each other, they began to effectively discuss vital but heretofore taboo topics associated with their relationship. Subsequently, in order to facilitate more information easily becoming accessible to both parties- ie how the father felt about generational "communication breakdowns" with his own father- I asked the interpreter to again interpret their dialogue during their interchange.

This technique of requesting that an interpreter only intermittently interpret a particular dialogue between Deaf and hearing family members- an example of "enactment"- may spark positive change in their interactional patterns. As the purpose of this kind of enactment was not known by the particular interpreter, we were sure to discuss it during our pre and post meeting sessions, prior to when I actually employed the intervention. Thus, the interpreter felt on solid ground during this therapeutic sequence.

My therapeutic "conducting" via requesting that the interpreter stop and start interpreting could not have successfully occurred unless the interpreter and I were in sync with each other, and were clear about each other's goals. Again, it becomes apparent that *the interpreter needs to have a clear idea of the therapeutic intent and have trust in the therapist in order to interpret correctly, comfortably, and ethically.*

Fluid Balancing of Roles

As my relationship with the interpreter continued to evolve towards furthering "mutual trust", certain linguistic interventions which the interpreter and I had overtly structured became markedly less dependent on my verbal cues and more fluid. For example, as I continued to implement the technique of enactment with several different families but with the same interpreter, the interpreter began to be able to predict what therapeutic interventions I would use with certain kinds of interpersonal transactions.

She had developed a gut sense about what I was trying to do, became adept at reading my subtle nonverbal body cues, and thus independently initiated regulating the ease of communication (and therefore affective intensity between persons) by only intermittently interpreting their interactions.

However, an important clarification must be emphasized at this point. The interpreter is *not* a co-therapist. The therapist has ultimate responsibility for the direction of treatment. As an example, during a particular treatment session, there occurred a poignant moment when a hearing sister finally acknowledged linguistic difficulties between herself and her Deaf brother and was struggling to make herself clear via mime and gesture, as opposed to her previous strategy of using exaggerated mouth movements. The interpreter, having worked with me for several hundred hours, sensed that I would consider it therapeutically helpful for interpretation to temporarily cease. She therefore stopped interpreting. However, the interpreter maintained frequent eye contact with me which I knew, from our long history of pre and post session discussions, meant "is this okay?" As I assessed the interpreter's linguistic intervention to be in the best therapeutic interests of the Deaf and hearing members, I responded with a slight grin and wink which the interpreter knew meant "go for it". However, I might have nonverbally or verbally responded to the interpreter's query by requesting that s/he continue interpreting. And we would have rehashed our nonverbal/verbal communications during the post-session meeting.

Let us consider another common therapeutic technique. Varying the physical placement of the interpreter affects the degree and frequency of eye contact between any two persons and thus affects the probability of affiliations. As family therapists and

interpreters well know, with eye contact comes a host of possibilities for non-verbal communication, frequently at an implicit level. Maximizing the frequency of eye contact between two persons increases the probability that more affective exchanges will occur. Indeed, this is the rationale for interpreters traditionally sitting slightly to the side and in back of the non-signing, hearing person: so that the Deaf person can obtain maximum visual exposure to the hearing person's facial expression.

Therapists can also vary the position of the interpreter to demarcate boundaries. Much like the standard moves of structural family therapists who may, for example, move people around the room to increase and decrease the ease of interaction among other members, here, the position of the interpreter has the same function. For example, in a hearing family in which the mother and son are enmeshed (too psychologically close) and father and family are disengaged (too psychologically distant), the mother might sit quite close to her son and to the interpreter while the father sits quite far from the family. The therapist might implement a standard structural move by asking the interpreter to move away from mother and towards father in order to "pull in the father" and increase the boundary between son and mother. The degree and frequency of eye contact with the father would be increased.³

³ Very important and complex issues are raised here, namely for whom is the interpreter working: the Deaf member, therapist, or family? What if the Deaf member objects? From the family therapy perspective, I can only say that this technique, as with all techniques, must be implemented in the context of a mutually respectful relationship and a clear therapy contract with the Deaf member as well as with his/her family. Thus, the situation of the Deaf member objecting to the interpreter moving around the room has never come up in my experience thus far; the purpose and goal of this intervention has been clearly understood and condoned by all family members as part of treatment. However, I am well aware of many Deaf client's "learned helplessness" in terms of asserting themselves; what if the Deaf member agreeing to this technique is one example

As with the technique of enactment, in the early stages of my relationship with the interpreter, I quite explicitly cued the interpreter to shift positions in the session in order to influence alliance and boundary factors in accordance to what I judged to be most therapeutically helpful at any given time. However, at a later stage in our evolution, this too became more fluid. I recall an example when a relationship with one particular interpreter evolved into a comfortable, trusting and fluid "dance"; at some point the interpreter and I nonverbally orchestrated the therapeutic scenario. I alternately distanced and involved myself in the exchanges among family members while the interpreter herself initiated positional changes. It was a very effective session for the family and was personally satisfying for both the interpreter and myself.

Spontaneity Between Interpreter and Therapist:

Spontaneity, creativity, and flexibility between interpreter and therapist is important and is imperative in order to provide optimal services for families. In my case, although I usually have a more or less specific sense of what I want to have happen during a given session and how I want to linguistically communicate, it may not happen as I plan it. The family may come in with a different and more useful agenda, I spontaneously may think of a new and better direction, and/or my original plan may not work.

In this regard, I recall explicitly informing one interpreter during the pre-session that I would sign ASL without voice to the Deaf member and asked the interpreter to voice for me. However, when the time came, the plan did not fit, as I judged it important to simultaneously maintain eye contact with the Deaf child and his parents. Since the

of many instances when s/he maintains a passive stance towards the environment? These issues merit further discussion.

child easily understood Pidgen Sign English, I changed my plan and used simultaneous communication with the Deaf family member and only much later did I code switch to ASL. The particular interpreter, by this time, knew that I could not totally be trusted to predict what I would do during sessions; for presenting situations often would countermand what I planned. Thus, the interpreter very comfortably "went with the flow" in a different direction. While reviewing the videotape of the session, we both marveled at how smooth and easy it appeared. More importantly, we noted how the interpreter was able to participate in a cogent, helpful, and ethical manner and in accordance with our sharing of the therapeutic goals.

This unique "dance" between the interpreter and myself, our creative balancing of roles, was a direct result, not only of much hard work, but also of our positive rapport and our qualifications. As with any relationship, it could not have worked with all therapists, nor with all interpreters, nor with all therapist-interpreter dyads.

Psychotherapy with deaf persons with language and learning challenges

Throughout the literature on mental health and deafness, one finds references to the cohort of deaf persons with severe language, emotional and behavioral problems. Within the Deaf community, these persons are commonly called "low functioning deaf," a pejorative term which nonetheless accurately references their lower levels of psychosocial functioning. Other labels that have been used include "severely disabled," "underachieving," "minimal language skilled," "multiply handicapped," "traditionally underserved" (Dew, 1999) as well as "psychologically unsophisticated" (Glickman, 2003). The term "traditionally underserved" has been widely adopted because it implies that their problems are due to their lack of services rather than some psychological trait.

According to the comprehensive report of the Institute on Rehabilitation Issues Prime Study Group on Serving Individuals Who Are Low Functioning Deaf (LFD) (Dew, 1999), Rehabilitation Services Administration (RSA) research between 1963 and 1998 produced consensus on six characteristics that seem to describe persons who are low functioning deaf (LFD).

1. Inadequate communication skills due to inadequate education and limited family support.
2. Vocational deficiencies due to inadequate educational training experiences during the developmental years and changes in personal and work situations during adulthood.
3. Deficiencies in behavioral, emotional, and social adjustment.
4. Independent living skills deficiencies.
5. Educational and transitional deficiencies.
6. Health, mental, and physical limitations

Similar criteria have been developed by (Long, Long, & Ouellette, 1993).

Population estimates for this group of persons are 125,000 to 165,000 (Bowe, 2004).

Hard numbers are not available in part because the federal government has not funded specialized programming for them long enough to establish consistent, clear criteria for identifying them or to complete program evaluations and establish best practices (Harmon, Carr, & Johnson, (1998)).

The literature on psychiatric inpatient treatment of deaf persons also includes many references to a cohort of deaf persons who are low functioning, have severe language dysfluency and behavioral disorders. This group of persons usually do not

have major psychotic disorders like schizophrenia yet they are well represented in any inpatient sample of deaf persons. Many clinician/researchers have commented on their difficulty making diagnoses of these persons (Daigle, 1994; Denmark, 1994; Pollard, 1994), and they have speculated as to whether they had a syndrome unique to the population of persons born deaf. This proposed syndrome has been named *surdophrenia* (Basilier, 1964), *primitive personality disorder* (Rainer & Altshuler, 1966), *borderline syndrome* (Grinker et al., 1969) and more recently *language dysfluency with deficiencies of behavior, emotion and social adjustment* (Glickman, 2008). Denmark (Denmark, 1994) described groups of deaf patients hospitalized in England as having *communication disorders and problems related to deafness*. He noted that a majority of the deaf patients in his study presented with behavior and adjustment problems “which in the majority of instances were due to maturational delay.” He goes on to comment that “It is difficult to know whether preverbally deaf people who present with problems of behavior and adjustment have a personality disorder per se or whether those problems are the result of immaturity consequent upon deprivation of language and experience.” (p. 97).

Black and Glickman (Black, 2005; Black & Glickman, 2005; Glickman, 2008) presented a new study of 96 deaf patients treated on a specialty deaf inpatient unit over a 7 year period. They present evidence for the prevalence of language dysfluency and they argue that the traditionally underserved group is heavily represented in specialized deafness mental health, rehabilitation and educational programs. Black and Glickman (2008) note, “These persons will be mental health patients in one setting, rehabilitation clients in another, difficult to serve students in another; and in all these settings staff will

exert great effort to adapt assessment and intervention approaches. Inevitably, these are the clients that we spend most of our time struggling to find means to help.”

Psychotherapy with these traditionally underserved deaf persons presents challenges that clinicians working outside the deafness field rarely encounter. The language limitations of these persons, along with the other developmental deficits influenced or caused by language deprivation, can make them particularly difficult to engage in a primarily verbal medium such as psychotherapy.

Duffy (1999), working primarily from the Self-Psychology model of Kohut (Kohut, 1984), describes the obstacles to seeking to engage traditionally underserved deaf persons in insight oriented therapy. She notes that poor language skills and capacity for insight make these clients appear to be poor candidates for psychodynamic therapy. Working with two languages, and with persons who are not skilled in any language, increases the chances there will be empathic failures on the part of the therapist. Counselors who can not expertly match the communication skills of their clients will have great difficulties “mirroring” the experience of their clients, and staying empathically attuned to them, increasing the likelihood of rupture in the therapeutic alliance. Nonetheless, Duffy provides examples of successful clinical case management and psychotherapy with traditionally underserved deaf persons who are motivated for the treatment.

Glickman (2008) presents a model for how to adapt best practices in cognitive behavior therapy to deaf and hearing persons whom he calls “language and learning challenged (LLC)” This group roughly corresponds to the group of “traditionally underserved deaf” but would include hearing persons with their own language and

learning challenges. It refers generally to people whose language and cognitive problems make them poor candidates for traditional insight oriented psychotherapy but who nonetheless have severe emotional and behavioral problems putting them in need of mental health intervention. While they are only a subset of deaf persons, most clinicians who treat deaf persons encounter them often. They are often viewed as the toughest deaf clients to engage in meaningful mental health or rehabilitation work.

Glickman's cognitive behavioral therapy (CBT) model places great emphasis upon what he calls the "pre-treatment" challenge. Pre-treatment refers to the process of educating and motivating clients so that they can collaborate effectively in the treatment process. Glickman culls from the psychotherapy literature 9 strategies that he has found useful with this clientele. The four key strategies are these:

- a. The persons need to be given a simple, compelling "language" for the treatment process. Glickman finds this language in the world of cognitive behavior therapy with its emphasis upon psychosocial skills. These skills includes coping skills, which can be defined as skills for dealing with one's "inner world," and social skills, which can be defined as skills for dealing with one's "outer world," especially other people. Examples of coping skills are sensory strategies like deep breathing. petting a dog, or rocking in a chair (Trikakis, Curci, & Strom, 2003); cognitive strategies like the ability to coach oneself through a challenge (Meichenbaum, 1977a, 1977b), religious strategies like prayer or rituals, and distraction and diversion strategies. Social skills include communication, problem solving, conflict resolution, assertiveness and helping or influencing other people. Other kinds of psychosocial skills are skills for managing, anticipating and avoiding reoccurrences of symptoms and skills for keeping one's body

and environment clean and safe. A focus upon skills demystifies the therapy process, making it concrete, understandable and useful.

b. The skills must be conceptualized developmentally. That is, very simple, everyday activities (e.g., petting a dog) are construed as skills. Complex social skills, such as negotiation and compromise, are broken down into their developmental precursors (e.g., listening, turn taking, flipping a coin), and pictures are provided for many of these skills to use with clients who can't read. Discussions with clients about skills is usually about the very simple skills that children develop first.

c. Enormous emphasis is then placed upon finding evidence of skills these persons already have. These skills are named and praised, and conversations are devoted to exploring how these persons came to already use these skills. This is a form of strength-based work that further demystifies the counseling process (i.e., it's about developing skills) and makes it a positive experience (i.e, the counselor is interested in what I'm already doing well.)

d. Because the pre-treatment orientation places the emphasis upon establishing meaningful collaboration, problems are addressed by *inviting* clients, using a "one-down stance,"⁴ to examine the effectiveness of their own behaviors. Clients are asked questions that encourage them to consider the advantages to them of becoming even more skillful. They are helped to self-monitor and self-evaluate, often with pictorial forms.

Once they agree that they want to develop their skills further, the formal treatment process begins. This treatment consists primarily of cognitive behavioral therapy,

⁴ In a one-down stance, the clinician attempts to give power and authority to the client. Clinicians may express wonder, concern or confusion. They convey that they do not know the answers and need the client's help.

appropriately adapted, with a particular focus upon coping, conflict resolution and relapse prevention skills.

An example of the initial pre-treatment work with an 16 year old deaf male with severe language and learning challenges follows.

Like most persons admitted to the Deaf Unit at Westborough State Hospital ⁵, Luis was referred because of severe behavioral problems. He had been through numerous schools and residential placements. Unlike most of our patients, Luis was English dominant, but his English skills were very poor. He was functionally severely hard of hearing. He had rudimentary sign language skills which we also tried to help him develop. Communication with him required very simple English, spoken clearly to his best ear, and supported by sign. In previous placements, Luis was sometimes thought to be displaying severe mood and thought disorders, but on the Deaf Unit, staff saw no evidence of hallucinations, delusions, grossly disorganized thinking or symptoms suggestive of clinical depression or mania. Staff saw a person whose fund of information about the world was so small that he could appear delusional. For instance, he frequently misconstrued teenage girls to be his girlfriends. While this might represent a delusional belief system, we felt it was more likely to reflect his very poor understanding of social conventions and his complete inability to read non-verbal social cues.

The Deaf Unit's clinical team's first task was to engage him by 1) introducing the simple skill vocabulary and 2) identifying skills and strengths he already had. We would also minimize limit setting to the extent possible. That meant being flexible about

⁵ The Deaf Unit is an acute psychiatric inpatient program for deaf persons located in a state hospital, Westborough State Hospital, in Massachusetts. The work of the unit is presented in detail in Glickman (2003, 2008).

arbitrary rules (e.g., you can't go into the kitchen now because it's not snack time) but maintaining natural limits (e.g., you do have to be in the hospital right now, and before you can visit with your family, you must show safe behavior.) When the first natural limits were set, Luis responded by throwing a chair, trying to bang down the unit front door, making menacing posturing towards staff, and then walking down the hall to his room. When he came out of his room, staff congratulated him on the skill of noticing he was angry and going to his room. They did not address, for the time being, his aggressive behaviors. They also commented that he managed to avoid hitting anyone. How did he do that, they asked?

There were a few times when he stayed in control in response to minor limit setting. For instance, his schedule had to be changed and, though annoyed, he remained safe. Staff approached him after that and asked him what skill he used to stay in control. He responded that he wanted to go out later, and he knew if he blew up, he couldn't go out. Staff smiled and told him he used his "thinking skills." He noticed he was angry, but then he thought that if he blew up, he couldn't go out. He used "notice your feelings" skills and "thinking" skills. Awesome! Staff continued this theme of looking for evidence of (primitive) skills he already had and labeling these for him as skills.

After another incident in which he became angry, knocked over the refrigerator, and then stormed off to his room, staff processed the incident by commenting first on the skills he used to avoid hitting anyone. They focused on the skills of "noticing you are angry," "making a decision to go to your room," and "going to your room." Luis may have expected to be bawled out after his negative behaviors, so this initial positive focus

enabled us to engage him in a conversation. We could then ask him how he could have shown even more skill. Like most of our patients, he had no trouble answering. He said, “don’t push over the refrigerator,” and “talk to staff.” This is exactly what we would have told him, but it’s much more useful coming from him. Our patients almost always know what good behavior looks like, and they will tell us if we approach them in the right way.

We had another incident in which staff told he could not go outside at that moment. He tolerated this “no” by distracting himself with the play station. Staff then pointed out to him his demonstrated ability to cope with a limit and to use skills like “accepting no” and “play station.” As much as we could, we set up a program where we were constantly commenting on skills he was using, even in the midst of some pretty bad behaviors, and then soliciting his own evaluations of his negative behaviors. We were also using simple notions of skills, consistent with how we might discuss them with a young child.

The result here and in most instances where we have used this approach was a slow reduction in aggressive behaviors and concomitant increase in treatment engagement in which we were having regular conversations about skills. The focus on skills he was already using established an atmosphere of positive support, fostered productive relationships between him and us, and created the possibilities of having “meetings” in which we talked about skills. We would not call these meetings “counseling” until he is much more engaged in the process.

A typical “meeting” went like this:

One day Luis observed a staff person using her cell phone/pager and demanded to use it himself. The staff person would not give it to him, explaining that it was her personal possession. He then threw a box of toilet supplies across the nursing desk. He pushed a staff person and then marched down to his room. A few moments later, he came out of his room, and strut down the hall, puffed up and posturing aggressively, towards staff. One staff person was able to redirect him into the “comfort room.” When I (NG) arrived, he was sitting in that room, talking with the staff person, and settling down. Communication was strained but he was listening and watching.

First asking his permission to enter the room, I began by discussing with him what he did well (i.e., going into the comfort room, calming himself down, talking with staff.) I encouraged him to do some slow deep breathing, and modeled this for him. Watching his body language for signs of calming, I asked him what happened. Although he blamed the staff person for being “mean,” he acknowledged pushing someone, and said that was “bad.” With a little encouragement, he was able to meet with that person and apologize for pushing her. That gave me the opportunity to notice and label his skills in talking, listening and saying he was sorry.

After some time, he said he was calm and ready to go off the unit on a planned trip. We were not going to allow that immediately after this aggression, and I told him we wanted him to stay on the unit for the remainder of the day. He then started to puff up again, and appeared likely to again become aggressive. I reminded him of his skill in “thinking,” and helped him think this through. If he stayed in control now, he’d be able to go outside tomorrow. If he wants a pass with his family, he has to stay in control. I then distracted him by asking him to teach me how to use a videogame he was very

skilled at. While he wasn't able to really teach me (as much due to my limitations as his), he did settle down by playing the videogame. Then he watched TV and had a snack. When this was over, we then talked about how he used play station, television and snack skills to calm down.

Even though we sought to minimize limit setting, there were many instances where natural limits, especially around safety, had to be set, and there were two incidents when his behavior was so dangerous that he had to be restrained. This limit setting was done, however, in a context in which staff were constantly searching tenaciously for skills and strengths; and in which most conversations were about skills he was using. Just as importantly, staff were giving him the vocabulary for what doing well looked like. That is, doing well meant using any of the simple skills we discussed, pictures of which were posted everywhere. Where limits had to be set, staff would first ask him what he did and pull out of him the consequences for such dangerous behaviors.

This work so far is really pre-treatment, designed to engage him in a meaningful treatment plan. The treatment work didn't begin until he agreed to learn and practice his skills further. As his engagement and our rapport developed, we asked him more questions that promoted self-evaluation. Did he use his skills in this situation? If he had used more skills, what would that have looked like? Would he be willing to practice that now? How would he rate his own skills today? What does he want to have happen? Is he satisfied with the progress he is making? If he used these particular skills more often, would he reach his goal sooner?

One day, after he had gotten into an argument with a peer and had a mild blow up, he told me that he couldn't control himself. I responded that he could control himself,

gave him evidence of that even in this instance where he was able to avoid physical assault and calm himself down, and just suggested he needed to “practice skills” some more. His response was, “Well then, let’s go do it!” This moment reflected a psychological movement from pre-treatment to treatment.

At a later point, when we were in a coping skills groups, and he was practicing using “shield” and “thinking skills” (Glickman, 2008) in response to role played provocation, he announced that he was bored with these skills and wanted to learn new ones. This was music to my ears, exactly what I hoped he’d say. I then directed him to pictures we had of many other skills and asked him which ones he was willing to learn. He selected “breathing” and “decide yes-no” (decision making) skills, and we practiced these.

In about four months on the Deaf Unit, Luis’s behavior improved dramatically. Just as importantly, he had learned a “language” for therapy, and he was easy to engage in discussions around skills. As this happened, and as his rapport and relationship with staff developed, he relaxed enough that we could begin to have discussions that went beyond skills. He began to talk about his life in a way that resembles what people usually think occurs in psychotherapy. At this point, he was discharged from the unit to a school, but our recommendation was that this strength based framework of skills continue to be used with him because it gave him a user-friendly map of the process of therapy and development.

Although Luis was English dominant (and language dysfluent) this was exactly the same approach used on this unit with most of our patients, who are sign dominant (and language dysfluent.) Our ability to have these therapeutic treatment

conversations depends, of course, on both his language skills and ours. With severely linguistically deprived signing deaf persons, even simple conversations about skills may be impossible. But we have found that there is a large cohort of these language and learning challenged clients that have enough sign language to engage in meaningful therapeutic conversations about skills provided the treatment providers can match their language and thought world.

These conversations about skills and eventual practice of simple coping and social skills were Luis's psychotherapy at this time. It is possible that later in his life, he will seek out psychotherapy to talk about concerns that he identifies on his own. At the time we saw him, he was a long way from being prepared to do that.

It is certainly easier to do such strength based, psychosocial skill training in Deaf mental health, rehabilitation or educational programs where the communication resources are more likely to be found. Commonly, however, such programs are not available and deaf language and learning challenged clients may be lucky to have even one signing therapist in the community. This therapist, considered the local "deafness expert" may be asked to be all things to all deaf people, and to make up for a lack of the continuum of mental health services (inpatient, partial hospital, day treatment, residential treatment, substance abuse treatment, emergency services and outpatient therapy and psychiatry) that are usually available to hearing persons from the majority culture. (Glickman, 2003). The burdens on these lone "deafness experts," often working without knowledgeable supervision, are enormous, and burnout is a predictable occupational hazard. The expectations on this deafness expert to make up for the lack of a continuum of therapeutic care, to serve well any deaf person who comes along regardless of age, clinical problem,

communication abilities, and cognitive resources, are unfair and unrealistic. Nonetheless, this simplified, strength based CBT, consistent with the emphasis upon psychosocial skill development that one finds in psychiatric rehabilitation, can help bridge the huge gaps in thought worlds between deaf language and learning challenged clients and mental health clinicians. It provides the outlines of a map for successful treatment with this difficult to serve group of persons.

A case study of psychotherapy with a language and learning proficient Deaf adult

In the following case study, a hearing psychologist (MH) with extensive experience with deaf people works with a deaf client who is language and learning proficient. Both client and counselor sign well and a linguistic match is easily made. The client solicited psychotherapy from the counselor and has strong motivation to use it to address some personal problems. He is intelligent and easily capable of showing insight into himself. He comes to psychotherapy already seeing the counselor as a credible helper and valuing the process of “talk” as a means of getting insight and solving problems. He is what is sometimes called a YAVIS client (young, attractive, verbal, intelligent and successful) who is deaf and prefers to communicate in sign language. In addition to his signing skills, the psychologist draws upon a wealth of knowledge about common themes in the lives of deaf people. He uses this knowledge as a basis for making culturally and clinically informed questions and interventions.

When I (MH) consider the issues of hearing therapists providing psychological treatment for deaf people, I often recall when a deaf client named Mark parenthetically

asked me when daylight savings time began. It was by all appearances an innocuous question; he asked it after our session had ended while putting on his coat. My immediate instinct was to answer (truthfully) that I didn't know – and I probably would have spontaneously responded as such if he were a hearing client. But here I hesitated. Why? As I *deconstructed* or *contextualized* that moment with that *deaf* client, I became aware of asking myself several questions:

- How, if at all, did my hearing and Mark's deaf status influence him to ask me that question?
- Why might he have thought that I, as a *hearing* person, would have the answer?
- What, if anything, did his question to me have to do with the dimensions of power, stature or authority between us?
- What, if anything, did the fact that his hearing family didn't sign have on him asking me that question?
- Why did he choose a hearing therapist?
- Was I analyzing this too much?

My final question seemed the easiest. If I were working with a language and learning challenged (LLC) client, my answer would probably have been that I was, in fact, analyzing this too much; that my pondering, contextualizing, deconstructing, mapping the interpersonal cross-cultural dynamics of Mark's question – while it might serve as a useful heuristic for a book chapter and/or a distraction, a coping skill, for when I get anxious during airplane turbulence – really wasn't that relevant to treatment. With a language and learning challenged client, I might simply have answered the daylight

savings time question or provide education on the steps to find the answer – a version of parents telling their children, “look it up.”

As it turned out, I answered Mark’s question with “Sometime in the Spring, I think” and he responded “Yeah” and we confirmed our next appointment. A simple, uneventful exchange.

The complexity would come later when he discussed the conversational isolation and his lack of access to incidental information in his family of origin (e.g., “Spring/Forward, Fall/Back”) and in a hearing mainstream setting among his hearing peer group. In an earlier publication (Harvey, 1996), I described such isolation and denigration as the quintessential trauma for many of the deaf clients we see in psychotherapy and therefore that it is often an essential focus of therapeutic discourse. Mark and I often referred to his daylight savings time question as a metaphor for how he had felt “rejected as an outsider” as a child in his family and similarly how he has continued to feel, in his words, “ostracized as an outsider in the hearing world.”

Mark’s experience exemplifies a common cultural narrative among deaf people (Glickman & Gulati, 2003; Pollard, 1998;(H. Lane, Hoffmeister, R., & Behan, B., 1996).) Sussman and Brauer (1999), referencing Williams and Sussman (Williams & Sussman, 1971) noted the “oft-quoted statement by deaf people to the effect that rather than the hearing disability per se, the attitudes of society toward deaf people is the handicapping factor. As Sussman and Brauer (1999) stated, “Deafness seen as a handicap that is akin to racism, sexism, and other ‘isms’ associated with minority groups . . . It is generated, operated, and perpetuated by the non-deaf community and its institutions. Even in this day of enlightenment, Deaf people endure daily insults, often from early childhood.”

This phenomenon has important implications for treatment of deaf clients. It is essential to inquire about and validate client's experiences of "daily insults, often from early childhood" (Sussman & Brauer, 1999) and then to determine whether they have become internalized. When one endures such denigration, there is an increased likelihood of believing that those negative statements are true. In Mark's case, the remnants from these handicapping experiences appeared to mold his sense of self as defective and to be important factors for causing his depression. This formulation is consistent with his reason for choosing a hearing therapist: "You're better educated" and, as he sarcastically added, "And I would become a worthy member of the hearing club."

I wasn't his first therapist, however. He had previously worked with a few therapists – all hearing. I was sure to ask him to describe in some detail the nature of his relationship with each therapist with particular attention to what was and was not helpful. This is my usual line of questioning with any client, often in the first session. But I am routinely sure to ask more detailed questions in this regard with deaf clients, in particular, as previous helping professionals – often hearing – are often perpetrators of "handicapping experiences." Accordingly, deaf clients are more likely to be hypervigilant for recurring oppression in the face of a new helper.

It is important to ensure that this "traumatic transference" does not impede treatment (Harvey, 2003) The process of inquiring about and validating a deaf client's negative experiences with previous helpers facilitates the differentiation of that therapist from the oppressive context. Accordingly, I took some time to ask Mark what he did and did not appreciate about his previous therapists, and did my best to convey my understanding and compassion for his sentiments. I strived to become a collaborator with

Mark; not one of many hearing authority figures who seemingly had all the answers and power.

Stated in narrative therapy terms, I strived to achieve a relational stance of “appreciative ally” (Madsen, 1999). This stance, while a cornerstone of all psychotherapy, is particularly important with cross-cultural work with deaf persons. It obligates the therapist not only to learn about Deaf culture and the Deaf community, but also practice a “therapeutic naiveté” (i.e., not to assume a priori knowledge about a particular deaf client) (Harvey, 1993). Rather, after having studied about Deaf culture/community, a therapist gains the privilege to ask well-informed questions. For example, “I have learned something about Deaf culture, but please help me understand how it applies to you.”

As I reflect on issues of providing psychological treatment for deaf people, I am often struck by what I typically do *not* first think about: communication, the most basic parameter! My initial “knee-jerk” recollection of Mark was his daylight savings time question – how or if it related to transference factors, perhaps idealization of the therapist as if I – as a hearing therapist – must know the answer. But the importance of full communication between the therapist and deaf client cannot be overstated. I do not know exactly why this most basic factor usually doesn’t enter my mind at the outset; perhaps because its importance seems obvious and is frequently emphasized. But without linguistic matching (Harvey, 2003) between therapist and client, treatment cannot succeed and may, in fact, do significant harm.

So let’s go back to the beginning. Immediately after escorting Mark to my office for the first time, I asked him via sign language what mode of communication he

preferred (e.g., ASL, PSE, simultaneous communication, oral). He replied that he was bilingual in ASL and signed English and that either was fine. I noticed that he signed primarily in an English format so I followed suit. But, as with many deaf clients, I wondered who was accommodating who? Was he more comfortable with ASL but was accommodating my relative comfort with English? Or did he prefer English-based signing? This internal therapist dialogue is an important facet of providing treatment with clients who may use a different language.

It was when Mark recounted what he had learned from previous psychotherapy that I became acutely aware of his impressive English proficiency. In an English-based signing format, he recited a well-rehearsed, almost pedagogic, discourse of the etiology of his depression: that his idealization of hearing people, including his family and previous therapists, and feelings of rejection have contributed to his devaluing of himself. His PSE signing was very clear, as was his fingerspelling of psychological terms, such as “idealization” and “etiology.” Mark was not a language and learned challenged client. He was “language and learning proficient!”

At some point in our conversation, I abruptly asked him in American Sign Language if he had been bothered more lately by depression. It was a curious moment. Why did I code switch from English to ASL? In addition to my struggle with “Who is accommodating who?”, I wondered whether code switching to ASL would disrupt Mark’s over-intellectualized, psychodynamic, English-based treatise of his depression which was certain, in my judgment, to get him nowhere except more imbedded. Perhaps his use of English served as an internalized defense and/or as a distance regulator in our relationship?

All important questions -- and ones that are often pondered when working with deaf clients – but they would have to wait until later. For now, my goal was to investigate more fully Mark’s “relationship” with his depression, and ASL is “tailor made” for that endeavor. As Freedman (1994) noted, American Sign Language is particularly well suited to visually externalizing abstract concepts, such as depression, in a space away from the client: “In ASL we not only have the ability to place as a separate entity, outside of the client, but we can also show him, quite clearly, how (the emotion) is capable of moving towards or away from him.” (p. 19) (author’s insert).

One mode of inquiry that elucidates one’s relationships with problems is a narrative therapy approach, specifically “externalizing conversations” (Madsen, 1999; White, 1995, 2007; White & Epston, 1990). With “language and learning proficient” deaf clients, in particular, the narrative therapy approach lends itself to more clearly changing one’s internalizing language (e.g., “I am depressed”) to externalizing language (e.g., “The depression affects me.”). The person is not the problem, the problem is the problem; and the essential task is to elucidate and modify one’s relationship with the externalized problem.

An important caveat: the implication is *not* that narrative therapy is the best, or only, approach to use with deaf clients. There is no one set of psychotherapeutic interventions that are appropriate or inappropriate for all deaf clients. A deaf client’s developmental level, including language and cognitive development are determining factors (Glickman, 2008). Mark was bright, verbal (in ASL and English) and insightful, albeit over-intellectualized. I could therefore choose from a potpourri of clinical interventions.

When using a narrative therapy approach with hearing clients, I often spatialize a problem, such as depression, as situated on a chair but with Mark, I had more creative options. To illustrate, the following is an ASL gloss of my question to Mark, “Have you been bothered more lately by depression?”⁶

UP-UNTIL-NOW, DEPRESSION INDEX (the depression is located by pointing onto the palm, away from Mark’s body), ITSELF BOTHER-YOU, BOTHER-YOU, BOTHER-YOU, YOU, DECLINE-IN-HEALTH, FEEL WORSE?
FINISH EXPERIENCE YOU? RECENTLY?

We then engaged in an in-depth discussion about the depression’s character and behavior. I asked Mark to role play and become the depression. Not surprisingly, “the depression” fired several rounds of verbal assaults at Mark – “Can’t you lip-read?”; “What he was saying wasn’t important”; “Deaf and dumb,” etc. It wouldn’t stop. The depression showed its true colors as a “perpetrator of handicapping experiences.” I then asked Mark to be himself, and then be the depression, then himself, then the depression, etc. Back and forth. Soon other influences became evident and were externalized and represented in the space around my office: e.g., his ex-boss firing him because he was deaf, hearing kids ridiculing him in school. Suddenly a phantom crowd had gathered in my office! The act of spatializing Mark as separate from those visual representations of handicapping influences catalyzed an important psychological shift for him. He came to experience and appreciate his personhood as separate from, although influenced by, the multi-leveled, oppressive context of his ecology.

⁶ ASL glossed text is an English representation of sign concepts. It cannot capture the complexity, riches, or beauty of ASL in signed form (Freedman, 1994).

In this manner, I assisted Mark to understand his depression as something different than himself and to separate his own identity from the negative messages he received about himself as a deaf person. As someone who specializes in psychotherapy with deaf persons, I am aided by what I hope is sufficient cultural self-awareness as a hearing person (so that I'm not vulnerable to joining Mark's negative beliefs about deafness as disability), familiarity with common life experiences of deaf people (the many ways, for instance, in which he picked up negative messages about his deafness), and specialized skills, including the ability to adjust my signing for communication and clinical purposes. While Mark is verbal and bright enough to make use of many different approaches to psychotherapy, a non-deafness specialist would be handicapped by the lack of cultural self-awareness, specialized knowledge and skills that distinguishes clinicians doing culturally affirmative psychotherapy with deaf persons.

Conclusions

In 2008, when this chapter is written, we are certainly well past the days when the literature was marked by clinicians asking naïve questions about whether deaf people could benefit from psychotherapy. The growing number of deafness mental health specialists appreciate diversity among deaf people, and they approach psychotherapy from any number of orientations. Of course, many deaf people benefit from psychotherapy, appropriately conducted, but the key word here is "appropriately." At some point, this clinical specialty will probably develop a credentialing process. At that point, the people developing the credentialing test will need to base it on a consensus understanding of the body of knowledge and skills that deafness mental health specialists are expected to have. They'll need to define operationally what "appropriately" means.

Beyond “knowledge of sign language and Deaf Culture,” the vague tag often attached to job descriptions for deafness specialists, this consensus understanding hasn’t yet formed. Certainly, clinicians with no training in deafness, who bring in an interpreter and assume that everything else is business as usual, are highly vulnerable to making significant errors. They may even unknowingly behave unethically. When there is no local specialist or specialty program, it is ethically justifiable to serve a client from a minority group with whom one has no experience provided one seeks out guidance. Unlike with other linguistic minorities, however, the danger with non-specialists working with deaf clients is that they don’t realize they are involved in a cross-cultural encounter. They don’t realize the complex interaction of medical, disability, psychological, social, and cultural dynamics at play, and they assume they needn’t even try to locate appropriate resources. They don’t know what they don’t know.

Thus, we can find, for instance, deaf people served poorly even when appropriate resources are nearby. Insurance companies may insist that deaf members go to non-specialists on their selected panel even when they are specialists, off the panel, nearby. People administering mental health, rehabilitation and substance abuse programs and agencies may resist the call to develop specialized resources by arguing that non-specialized resources can be accessed through an interpreter (even when there aren’t sufficient interpreters.) They may refuse to fund placing a deaf client in a specialized Deaf program that exists in a neighboring area, arguing that they can serve the person well in a hearing program. Alternatively, they may create the appearance of inclusion by hiring some hearing signers, or providing sign language classes for existing staff, bypassing qualified deaf applicants desperately looking for employment.

Psychologists and psychiatrists doing forensic assessments, which can influence whether or not someone goes to jail or is committed to a psychiatric hospital long term, may not even consider whether they are qualified to do the job and may not even try to make appropriate referrals, even when the resources exist. This is especially problematic when they are doing assessments on language dysfluent deaf persons who may be incompetent for linguistic reasons (Vernon & Miller, 2001, 2005; Vernon & Raifman, 1997).

On the one hand, the deafness mental health field continues to need development so that we can reach genuine consensus about what constitutes this specialization. On the other hand, we are far enough along that there can no longer be doubt that people who do this work need special training. There is a process of self-awareness, attitude and identity development that clinicians must experience before they are competent to treat deaf people. There is a body of literature and a variety of complex skills to master. We can point towards the pervading ethnocentrism of our culture as causing mental health crises for deaf patients as it has for other marginalized groups. There is a great need for the mental health field to assist in the repair. We can do that, but we must first overcome the hearing ethnocentrism that has for so long made us part of the problem.

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