Counselling Deaf Clients: Politics, Practice and Process

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Abstract

The Deaf community in Australia comprises a small but diverse group of people with a rich, distinctive culture, unified by a common language and history. In recent times, there has been an increasing awareness among 'hearing' counsellors of the importance of understanding deafness and Deaf culture in order to more appropriately meet the needs of this client group. This paper will address political, practice, and research issues relevant to the improvement of counselling services provided by hearing therapists for clients from the Deaf community. Firstly, in regard to politics, the paper will highlight some of the tensions between medical and cultural models of deafness and how these frameworks can impact upon the understanding of deafness. Secondly, it will be proposed that constructionist counselling approaches, and narrative therapy in particular, may provide a more culturally and linguistically relevant approach for practice with both clients and interpreters. Lastly, some of the dilemmas of counselling research specific to this client group will be discussed, together with the author's own work in these areas. The paper will benefit therapists working in cross-cultural settings, or working with interpreters, and those interested in the dilemmas of counselling research.

Note: It is conventional in writing to use the lower case d (deaf) to describe audiological experiences of deafness, hearing loss and/or hearing impairment and the capital D in reference to Deafness as a cultural term and for Deaf people who identify as members of a Deaf community. The term d/Deaf encompasses both phenomena (Senghas & Monaghan, 2002).

Keywords: Deaf, Constructionist, Research.

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A review of Australian and international literature reveals little research into the counselling experiences of Deaf people. In Australia, some attention has been given to Deaf peoples' experiences with the public mental health system (Briffa, 1999; Briffa, 2001; VicDeaf, 2001). However, specific research into the development of therapeutic alliance between hearing counsellors and Deaf clients in Australia is lacking.

In the broad domain of counselling literature a growing body of recent research emphasises the role that therapeutic alliance plays in predicting outcomes for clients (Bohart & Tallman, 1999; Duncan & Miller, 2000; Miller, Duncan, & Hubble, 1997). The purpose of this paper is to hypothesise about therapeutic alliance in the counselling context for hearing therapists working with Deaf clients, a situation that is gaining recognition as a "cross-cultural" conversation (Barnett, 2002; Leigh, Corbett, Gutman, & Morere, 1996; Napier & Cornes, 2004; Pollard, 1992; Pollard, 1996). Napier and Cornes (2004) state, "Cross-cultural counselling encompasses any counselling situation that involves two or more participants being culturally different. Variables may include language, values, beliefs, customs, ethnicity, gender, sexuality, religion, disability and socio-economic status" (p. 161).

This paper argues that constructionist counselling frameworks may be particularly appropriate for hearing therapists and Deaf clients when the counselling relationship is viewed as cross-cultural. Additionally, guidelines are presented for hearing therapists on how to avoid common mistakes when working with Deaf people. It is proposed that the interventions reviewed in this paper will promote a positive therapeutic alliance between hearing therapists and Deaf clients. Lastly, some of the dilemmas in testing these hypotheses

will be discussed, particularly situated against a background that acknowledges the politics of deafness and tensions between cultural and medical models of deafness.

A Political Appreciation of Deafness

Most people can recount a brief exchange with a Deaf person, but few hearing people experience the privilege of knowing and experiencing the richness of Deaf culture. Furthermore, the notion of Deafness as a cultural phenomenon is often an unfamiliar concept to hearing people who assume that d/Deafness is a disability.

The term “cultural Deafness” has been adopted by the Deaf community to describe a group of people who use Auslan (Australian Sign Language) as their first language and identify as being part of a Deaf community with a common language, and a shared history and social life (Austen & Coleman, 2004; Dawkins, 1991; Power, 1996). For Deaf people, the measurement of hearing capacity is not a criterion for membership to the Deaf community but rather is subordinate to family, social and language affiliations (Padden, 1996) .

In contrast, the traditional medical model of deafness emphasises the measurement of hearing loss or deficit in order to diagnose deafness based on scores obtained through audiological testing (Padden, 1996). These frameworks for understanding deafness are poles apart. The cultural model endeavours to promote and celebrate the culture of Deafness whereas the medical model is motivated towards the restoration of hearing, which is presented as the ideal state (Senghas & Monaghan, 2002). Both frameworks carry a myriad of assumptions that can potentially burden or liberate those to whom these assumptions are applied (Corker, 1998). Furthermore there is a range of terminology and identities between these two positions that includes the hearing impaired, hard-of hearing, severely deaf, profoundly deaf, oral/deaf, cochlear recipient, disabled, and so on.

Hearing people may be aware of the medical model of deafness but may not be aware of the alternative, 'cultural' model (Robinson & Adam, 2003). The Australian Association of the Deaf is the national peak organisation for Deaf people in Australia. The AAD web page distinguishes between cultural and medical models stating;

> *"Culturally Deaf people do not like the term 'hearing-impaired', perceiving it as negative and clinical. Hearing-impaired people do not like being identified by the terms 'Deaf' or 'deaf'…. Deaf people are rarely unhappy about being deaf, though they may feel frustrated by discrimination and obstruction. Hearing-impaired people, especially those who have recently lost their hearing, may be unhappy about their condition, but this should never be assumed…"* (Australian Association of the Deaf, 2004)

Post modern constructionist counselling frameworks provide a way of working with people that explicitly addresses the dangers of making assumptions with regard to how people define or describe themselves and their world (Biever, Bobele, & North, 1998).

Professional Practice Issues

In counselling and clinical settings, Deaf people have indicated a preference for therapy in their first language (Barnett, 2002; Steinberg, Sullivan, & Loew, 1998). Ideally, this means Deaf clients would see counsellors who are also Deaf or fluent in sign language. In Australia, there are very few Deaf therapists or hearing therapists who are fluent in sign language (Napier & Cornes, 2004). Additionally, because the Deaf community is very small, some Deaf clients have expressed a preference for therapy with professionals outside of their own social or professional community (personal communication with staff from the Queensland Deaf Society). The combination of these two factors has contributed to the need for Deaf people to present to hearing therapists for access to counselling services.

One of the common mistakes made by hearing therapists unfamiliar with Deaf culture and sign language, is to assume that Deaf people can use English and lip-read to communicate. For many Deaf people English is a second language and English literacy in the Deaf community is often low (Power & Leigh, 2000). Leigh et al.(1996) state "Use of written communication to interact with deaf clients is tedious and frustrating. It can also lead to errors in communication that may, in turn, influence diagnostic errors" (p. 367). English and Auslan are different languages and Deaf people experience similar difficulties with written English as other groups from non-English speaking backgrounds.

Barnett (2002) reports that only 30-40% of speech sounds are visible on the lips. Furthermore, there is no oral or written form of sign language, with Auslan being expressed through visual/spatial modalities and English in the oral /auditory modalities making them even more distinct than different spoken languages (Temple & Young, 2004). For these reasons, lip-reading and written English are not acceptable forms of communication in a therapeutic setting and non-signing therapists must use a sign language interpreter.

While some clients may wish to bring a signing family member to counselling for support, it is not appropriate for these people to act as interpreters. Porter (1999) states, interpreter-related distortions are more likely to occur when relatives interpret; for example, relatives may either minimize or emphasize psychopathology, especially when the topic is a sensitive one, like sex, substance use, or suicide" (p 170). Further, independent qualified sign language interpreters are bound by a professional code of ethics (Napier & Cornes, 2004).

Ideally, therapists should meet with a sign language interpreter before the session to discuss seating arrangements, lighting requirements, and the setup of the counselling room to ensure it is visually appropriate for working in sign language (Porter, 1999). During the counselling session it is imperative for the therapist to maintain eye contact with the Deaf person and to speak to the client directly even though they will be watching the interpreter

while the therapist is speaking. Porter (1999) also cautions against asking the interpreter to address the Deaf client as in "Ask him/her…". From personal experience, Deaf people also appreciate hearing therapists who take the time to learn basic greeting signs and to be able to finger-spell their name during introductions.

For the past year the Queensland University of Technology Family Therapy and Counselling Clinic has been providing counselling services to Deaf people and their families, with sign language interpreters. The QUT Clinic operates as a teaching clinic using constructionist approaches with a reflecting team. Students from the QUT Masters of Counselling Program work in the Clinic for 10 months under the supervision of experienced counselling staff and psychologists. Since 2004, the Clinic has accepted referrals for Deaf people seeking counselling as part of this author's PhD research investigating the therapeutic alliance between hearing therapists and Deaf clients.

The Research Process

Pollard (1996) describes the interface between psychology and d/Deaf people as an emerging discipline in its own right. To date however, the vast majority of the literature on deafness is devoted to medical and disability models. Outside of rehabilitation psychology, research into cross-cultural counselling and therapeutic alliance with Deaf people is limited and therefore constitutes a timely addition to an emerging discipline. Predictably, the literature on the use of various counselling frameworks with Deaf people is diverse (see Austen & Crocker, 2004; Glickman & Harvey, 1996; Hindley & Kitson, 2000). Other authors suggest some interventions are particularly appropriate for working with Deaf clients. Freedman (1994) recommends the use of "linguistically sensitive" counselling interventions, such as narrative therapy. Isenberg (1996) recommends the use of story-telling and culturally appropriate metaphors, and Hindley, Dettman, and Beeson, (1998) report success with reflecting teams of Deaf and hearing professionals in a family therapy setting. Many of these

ideas are based on the cultural aspects of being Deaf and appeal to the visual modality and story-telling practices that are essential components of Deaf culture and Deaf history.

The experiences of Deafness vary widely (Corker, 1998) and post-structural approaches acknowledge the uniqueness of an individual's experience and identity. Additionally, constructionist approaches to therapy have been found to be very appropriate in cross-cultural contexts (Lee, 2003; Semmler & Williams, 2000) because they are discourse sensitive and explicitly acknowledge the dimensions and roles of power in the counselling context (Besley, 2002). Further, the use of a reflecting team in counselling settings may provide a forum for validation and acknowledgment of the effects of marginalisation that many Deaf people report. In their work with Deaf families in the United Kingdom, Hindley et al, (1998) describe the reflecting team "as both a technique and a process" that assists in equalizing power gradients between clients and therapists by inviting the client/s and the therapist to observe the team as it discusses the therapeutic session. A reflecting team might also ameliorate the impact of miscommunication and /or misunderstanding that, as suggested by Raval and Smith (2003) sometimes impedes cross-cultural communication.

Recent literature on counselling outcomes identifies the therapeutic alliance between clients and counsellors as being a better predictor for successful outcomes than comparisons between frameworks (Duncan & Miller, 2000). Furthermore, it is now widely reported that it is the client's assessment of the therapeutic alliance which often shows the strongest correlations with outcome (Horvath, 2001). However, Horvath also suggests that "…different helping contexts, types of therapy offered, the goals of the process interact to generate unique alliances" (p. 175). While acknowledging that there is no consensus on the definition of therapeutic relationship, Bachelor and Horvath (1999) report that "there is general agreement that the working alliance, emphasizing the collaboration of client and therapist in the work of therapy, is a crucial ingredient" (p.137)

Research into the therapeutic alliance between Deaf clients and hearing therapists faces a number of unique dilemmas which probably contribute to the paucity of information in this area. Firstly, the cost of undertaking cross-cultural research is increased by the need to employ interpreters to be present for all contact with Deaf participants. In most cross-cultural research, information and communication can be translated into the relevant language and distributed to wide sectors of the community in written form and native speakers can make telephone contact. These are often unsuitable methods of contact in the Deaf community thus increasing the number of interpreter hours and face-to-face meetings with participants or potential participants. All written material, for example, information for recruitment or consent forms, also needs to be interpreted fact-to-face. This also impacts on the dissemination of information, slows the recruitment of participants to the research and makes large sample sizes more difficult to achieve.

Low literacy levels and the lack of norms for quantitative measures widely used in hearing groups, drastically limit the feasibility of using quantitative scales with Deaf people. A review of the literature reveals that no measures of therapeutic alliance have been interpreted into sign language for use with Deaf clients. As a result, qualitative techniques are often more suitable for smaller sample sizes and when norms are not required for data analysis. In addition, qualitative phenomenological techniques are more philosophically aligned with constructionist approaches and may more adequately address some of the ethical considerations that emerge in cross-cultural research regarding power gradients, the opportunity for collaboration, and the impact of the research process on the host community. Despite these strengths, qualitative research with Deaf people requires that interviews be interpreted from a visual language into a verbal language and then transcribed. This process raises a number of epistemological dilemmas related to the role of the translator, the

researcher and the impact of translation on the data and its analysis. (These dilemmas are more fully discussed in Temple & Young, 2004).

Conclusion

Against this background, a number of research questions emerge for hearing therapists working with Deaf client groups. Firstly, do some frameworks provide more scope for linguistically sensitive counselling interventions for Deaf people seeking counselling from hearing therapists? Secondly, what types of interventions assist in developing successful cross-cultural therapeutic alliances between Deaf people and hearing therapists? Lastly, how can hearing therapists assess the efficacy of their work cross-culturally with Deaf people, and how can Deaf people can have a voice to be the arbiters of what constitutes successful or culturally relevant therapy?

In an effort to address these questions and with regard to the specific research dilemmas, this author is undertaking a doctoral project aimed at building a model of cross-cultural therapy based on constructionist interventions with a reflecting team of Deaf and hearing professionals. In addition, a measure of therapeutic alliance will be translated into Auslan so that Deaf clients can evaluate their experiences of cross-cultural therapy in a standardised format. Finally, the model will be evaluated using a qualitative constructionist methodology that is appropriate for cross-cultural counselling research.

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