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NEGOTIATING THE GRAY AREAS OF ETHICAL DECISION MAKING: DEAF THERAPISTS WORKING IN THE DEAF COMMUNITY

by

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Bachelor of Arts, College of St. Mary, 2004
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A Dissertation

submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Grand Forks, North Dakota
May

2010

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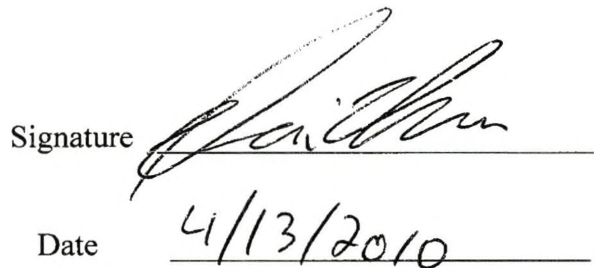
Signature 

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TABLE OF CONTENTS

LIST OF FIGURES vii

LIST OF TABLES viii

ACKNOWLEDGMENTS ix

ABSTRACT xii

CHAPTER

I. INTRODUCTION 1

Deaf vs. Deaf and American Sign Language (ASL) 2

Purpose of the Present Study 4

Definition of Multiple Relationships – U.S. Perspective 7

Historical Background of Multiple Relationships 9

Ethical Principles Regarding Dual Relationships/Ethical Guidelines and Codes 13

Changes in Ethical Guidelines 15

Reality of Small Communities 15

Dual Relationship Dilemmas for Therapists in Small Communities 18

Therapists' Professional Obligation Regarding Dual Relationships in Small Communities 20

Small Town and Dual Relationships 24

Previous Decision-Making Models – General and Small Communities 29

Deaf Culture and Deaf Community Distrust of Hearing People 39

Small World Hazards (Deaf Community) 44

Deaf and Dual Relationships 46

Connecting the Dots 47

Research Questions........ 50

II. METHOD 53

Research Design 53

Researcher as Instrument........ 55

Participants 58

Procedure/Data Collection........ 61

Setting........ 62

Data Analysis........ 62

III. RESULTS........ 65

Overview of the Conceptual Framework........ 66

Multiple Relationship Experiences........ 69

Examples of Multiple Relationships........ 72

Identity Development 74

Professional and Personal Self 82

Modeling Behaviors 85

Deaf Culture vs. Professional Role........ 86

Strategies 91

Conclusion 96

IV. DISCUSSION 97

Significance of Findings 97

Importance of Culture 98

Multiple Relationships in Small Communities 100

Identity Development 103

Professional and Personal Self 107

Strategies 112

Limitations of the Study 119

Research Implications 120

Clinical Implications 122

Conclusions 123

APPENDICES 127

REFERENCES 136

LIST OF FIGURES

Figure | Page

1. Interactions of Deaf Culture and Code of Ethics within the Professional and Personal Role 89

2. Strategies to Negotiate Roles 93

3. Multi-level Interactions of Deaf Therapists and Multiple Relationships 95

4. Proposed Decision-Making Model for Deaf Therapists who work in the DHH Community 118

LIST OF TABLES

Table | Page

1. Categories and Themes 66

2. List of Themes and Subthemes by Participants 67

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Picture me now standing with my arms up high in the air, at the top of a tall mountainous peak with the University of North Dakota flag firmly planted nearby. See the flag flying proudly in the wind. Now, see me as I wave, with two hands high in the air, wildly and enthusiastically! I'm saying to all of you: Thank You for helping me to *reach another summit*!

This dissertation is dedicated to one of the most extraordinary individual in my life, my dearest grandmother, Alice Thew, who has been my strength through life. I am proud to carry her name and many of her finest qualities – compassion, ambition, energy, adventurousness, enthusiasm, perseverance, strength, and spirit.

ABSTRACT

Deaf and Hard-of-Hearing psychologists, who provide services to the Deaf and Hard-of-Hearing community, face unique dilemmas when dealing with overlapping relationships. Similar to psychologists from other small or rural communities, dual relationships are generally unavoidable. The ethical guidelines for psychologists do not provide for the exceptional struggles that many Deaf therapists face in this regard.

This study was conducted to explore the decision-making patterns that Deaf therapists have used in negotiating nonsexual, multiple relationships with clients. Ten taped interviews were conducted to collect preliminary data on the overlapping relationship dilemmas of participants who are Deaf, licensed therapists and have been providing therapy in the Deaf community for at least a year. Grounded theory qualitative research approach was used when analyzing the data to identify themes and categories in an effort to identify primary topic areas for future research, further our understanding of ethical decision-making theory, and propose a model for ethical decision-making.

CHAPTER I

INTRODUCTION

This research explored the significant dilemma that many Deaf therapists encounter when providing services to the Deaf community. Due to the fact that the Deaf population is small, and the Deaf culture is considered a collectivist in nature, it is unrealistic to expect Deaf therapist to avoid any outside encounters with their past or current Deaf patients. When addressing multiple relationship dilemmas, the professional codes of ethics create more predicaments for many Deaf therapists. In order to best understand the context of the Deaf culture, including how one works and lives, it is necessary to make use of the kaleidoscope metaphor. Studying the history, and examining the evolution, of the Deaf culture is best achieved through the lens of the kaleidoscope. When using the kaleidoscope, the viewer looks in one end while the light enters the other end, reflecting off the mirrors, which presents varying colors and patterns while the tube is being rotated. The color represents the variables collected in this study, while the mirror represents how we perceive the variables to see the whole picture. As a standalone, the variables are meaningless. The mirrors are manipulated which allows different perspectives on the patterns and colors (variables). The kaleidoscope makes order out of little pieces of data. This kaleidoscopic approach allows us to weave many variables as we probe the historical past and this research data more deeply as we ask new questions and discover new evidence.

Deaf vs. Deaf and American Sign Language (ASL)

First, it is necessary to address two major concepts or definition of terms. The first is the differentiation between Deaf individuals and deaf individuals. The distinction indicated by the established convention of using "capital-D," or "big-D," to refer to a person who is a part of the Deaf culture and the "little-d" or "lower-case d" to refer to a person who is deaf by audiological measures only (Woodward, 1972; Lane, 1992; Phillips, 1996). "Big-D" or Deaf people describe themselves as a linguistic minority who share a common culture, not a medical condition, or a disability group. Many—not all—deaf people refer themselves as "Deaf" to illustrate their identity, identify with the "Deaf Culture," and affiliate with members of the "Deaf Community" (Padden & Humphries, 1988, Leigh et al., 1996; Gutman, 2002). American Sign Language (ASL) is the primary language for Deaf people and competency in ASL is a defining characteristic of those considered to be in the Deaf community. This study is about Deaf psychologists working and living in the Deaf community.

The second concept to note relates to American Sign Language and Translation (ASL to English and English to ASL). As an independent language in its own right, American Sign Language (ASL) consists of its own grammar and syntax, idioms and metaphors, jokes and poems. It has *no* written form and can only be mastered through extensive contact with those who are fluent in ASL (Sacks, 1989; Lane, 1992; Meador, 1994). It is imperative to clarify that ASL or other sign languages are not manual translations of spoken languages. The signs of ASL are not simple gestures or pictures, but abstract symbols with a complex inner structure composed of three independent parts - namely, location, hand-shape, and movement – that are analogous to the phonemes of

speech. In contrast to speech, which is linear, sequential and makes use of a single dimension, sign languages such as ASL makes use of four dimensions (three spatial dimensions as well as time) and therefore is capable of expressing multiple elements simultaneously (Sacks, 1989).

Glickman (2003) made an important point that the use of an interpreter provides an *illusion of inclusion* for D/deaf clients receiving mental health services. Furthermore, there is an illusion of inclusion in deaf education as well, where the educators and parents believe that deaf children are achieving full access to language (Hauser et al., 2009). Many research studies show otherwise. For example, both deaf children and adults typically comprehend and understand less than 50% of what an individual verbalizes through lip-reading alone (Commission on Education of the Deaf, 1988; Hauser et al., 2009). Other research by Tevenal and Villanueva (2008) discovered that if the hearing adult uses sign in addition to speech (simultaneous communication), deaf individuals again typically still understand less than 50% of what is said. The situation is not much better when educational interpreters are used, as Schick (2008) discovered that they interpret less than 50% of what was conveyed in the classroom (Hauser et al., 2009). These discoveries are believed to be similar in the mental health setting between the deaf patients and hearing therapists.

Lastly, having a simple knowledge of ASL is not the same as having the ability to interpret. Introducing a person who signs into the therapeutic relationship does not instantly solve communication problems; language difficulties may still occur and many relationship factors are changed with the addition of a third person. As Westermeyer

(1990) pointed out, the addition of a third person changes transference dynamics and alliance development.

Purpose of the Present Study

The United States is a country with a diverse population. One of the fundamentals to successfully building robust relationships across cultures is recognizing what are acceptable and expected behaviors or customs across each culture. Cultural traditions strongly influence different styles of interacting, ways of negotiating differences and even perception of what is acceptable or ethical. Understanding these differences may improve negotiations and relationships between different cultures such as the dominant hearing population, and the Deaf and Hard-of-Hearing community (DHH), along with numerous other small communities (gay, lesbian, bisexual and transgender [GLBT], Native American, Asian American, Veteran, rural, etc). This multicultural perspective may help establish a basis for developing standards for ethical behaviors in small, sometimes insular, communities that could be translated and used by therapists from many cultures (Leigh, 2002; Corbett, 2002; Zitter, 1996).

The practice of psychotherapy is influenced by cultural traditions, so it is expected that with diverse cultural values, ideas about effective and ethical psychological practice would differ between several small communities (Schank & Skovolt, 2006; Gonzalex et al, (1994); Kessler & Waehler, 2005). For example, in the Deaf culture there is a greater emphasis on the importance of relationships in all social interactions, including the therapeutic relationship, than in the dominant hearing culture. Many Deaf individuals prefer to communicate with people they know and people who share a

common language, American Sign Language (ASL) (Guthman and Sandberg, 2002). Particularly in therapy, there are many advantages to sharing a common language.

Using White and Heterosexual privilege as a framework, one important issue that has received little attention in literature or among the general mainstream society is that of *Hearing Privilege.* Sue (2003) in his book, *Overcoming our Racism – The Journey to Liberation*, described *White Privilege* as the unearned advantages and benefits that accrue to White people by virtue of a system normed on the experiences, values, and perceptions of their group. One individual, Arden Neisser, is quoted in *Towards a Psychology of Deafness* (Paul & Jackson, 1993):

> The hearing world is deeply biased toward its own oral language, and always prefers to deal with deaf people who can speak. But speech is always difficult for the deaf, never natural, never automatic, never without stress. It violates their integrity: They have a deep biological basis for the language of signs (p. 216).

According to Gerber (1979) and McEntee (1995), one of the most obvious and overpowering reasons that many D/deaf people may avoid hearing professionals is the communication barrier characteristic of most encounters with the hearing.

Sharing certain baseline cultural values or worldviews, such as big D Deaf identity, can also profoundly influence the therapeutic relationship. Similarly, GLBT clients often choose therapists from within GLBT communities to avoid working with a therapist who may be homophobic, heterosexist, or ignorant of issues specific to GLBT individuals (Dworkin, 1992). These cultural values would be expected to influence the nature of the relationship between therapists and clients and the understandings of ethical and unethical behavior. For instance, the ethical guidelines of professional associations in

the United States (American Counseling Association, 1995; American Psychological Association, 2003; American Association for Marriage and Family Therapy, 2001; and National Association of Social Workers, 1996) prohibit or caution against therapists assuming more than one role with their clients. This poses some challenges for many therapists who work in small communities.

The United States continues to experience growth in several minority groups and different minority groups may ascribe different meanings to daily experiences. Mental health professionals, regardless of their theory, will modify their work so that interventions can be more applicable to the population that they work with. Researchers have posed many questions about ethics, theoretical approaches and different treatment modalities in treating minority populations (Bernak & Chung, 2002; Cooper & Denner, 1998; Kessler & Waehler, 2005). Many similar questions have risen when exploring effective treatment approaches and applying ethics when working with the DHH population (Gutman, 2002; Guthman & Sandberg, 2002).

Ethical problems encountered by mental health practitioners working with Deaf clients are often complex and involve issues that may not be fully addressed in professional codes of ethics (Gutman, 2002; 2005). No guidelines exist for Deaf professionals when providing services to the Deaf community. No studies have yet been published to inform the establishment of such practice guidelines. Using previous studies of psychologists who provide services in rural communities as a framework, the objective of this research is to explore and propose a decision-making process for ethical reasoning in thinking through complex problems when Deaf psychologists work with the Deaf community. A preliminary ethical decision-making model will be derived from

interviewing current Deaf licensed therapists and analyzing their responses to questions about how they deal with nonsexual multiple relationships in their work.

Definition of Multiple Relationships – U.S. Perspective

Specific definitions of multiple relationships can vary considerably by discipline. According to The Ethical Principles and Code of Conduct of the American Psychological Association (APA, 2002a), a multiple relationship is when a psychologist is in a professional role with a person in addition to another role with the same person, or is in a relationship with a person closely associated with the person, or promises to enter into a future role with the person.

Multiple relationships in psychotherapy have been often cited as easier to define than to recognize (Pope & Vasquex, 1998; Anderson & Kitchener, 1996; Lazarus & Zur, 2002). This has allowed several authors the opportunity to challenge interpretations of how to acknowledge what is sometimes called dual, multiple and overlapping relationships. Herlihy and Corey (1992) described that dual relationships occur "when professionals assume two roles simultaneously or sequentially with a person seeking help" (p. 3). Furthermore, dual relationships include situations such as a therapist-client relationship taking place concurrently with a friendship or business relationship, and when a therapist's former schoolmates, colleagues, or friends enter into a therapeutic relationship with him or her (Lamb et al., 2004; Faulkner & Faulkner, 1997; Schank & Skovolt, 2005).

Biaggio and Greene (1985) described in detail that overlapping relationships are often based on some common interest or activity outside of therapy – such as a political, religious, or social endeavor. Another similar definition was proposed by Pope (1991)

who described a multiple or dual relationship as a therapeutic relationship with a client as well as a significantly different relationship such as a social, financial, or professional role, with that client.

Kitchner (1988) stated that multiple relationships occur when, in addition to a professional relationship, there exists another relationship with clear boundaries (such as friend, employer, and business partner). Multiple relationships are generally assumed by professional organizations to be implicitly harmful to the well being of students, clients, and patients, when there is a possible potential for exploitation or conflict in the roles.

Plaut (1997) proposed two categories of multiple relationships: those relationships in which the professional serves two roles (i.e. teacher and therapist, therapist and business partner) and relationships in which a professional role includes personal elements (i.e. traveling with a client; disclosing personal problems to a client; touching a client). Plaut illustrated two key ideas: (a) multiple relationships are not necessarily harmful, and (b) judging whether or not particular types of multiple relationships are likely to be harmful is usually left to the provider.

Differentiating multiple relationships into sexual and non-sexual has been addressed in research. Both sexual and non-sexual multiple relationships have created ethical dilemmas in the eyes of mental health associations and professionals in the United States (Biaggio & Greene, 1995). For the purpose of this research, only nonsexual multiple relationships in the Deaf community will be addressed. The terminology – multiple, dual, and overlapping relationships may have slightly different meanings, and each of these meaning will be addressed as the data is examined closely. For some readers and past authors, these words are used interchangeably, while for others, the

concepts are interpreted differently. These terminologies will be addressed through the manuscript and in the discussion section.

Historical Background of Multiple Relationships

Multiple relationships have only recently become viewed as problematic in the United States. Historically, some of the early pioneers of psychotherapy were in multiple relationships with their clients that could be considered questionable today. Many of our theoretical legacies were developed through participation in multiple relationships, such as the tolerance of "incestuous" involvements between analysts, student, and patients during the early years of the psychoanalytic movement (Gutheil & Gabbard, 1993; Roazen, 1969). Roazen (1969) and Langs (1984) pointed out that Freud repeatedly ignored his own advice regarding treatment boundaries. Epstein (1994) provided an example of Freud, who treated his own daughter, Anna, had given some of his patients gifts, and even had meals and walks with Sandor Ferenczi while he was analyzing him simultaneously. Many of these post-treatment relationships between training analysts and their former analysands often became intimate and sometimes led to marriage.

However, blurring of therapeutic boundaries was not limited to the disciples of Freud. For instance, during the late 1960s and early 1970s, Maslow's (1968) useful concept of "self-actualization" was misinterpreted as a license to "do your own thing." Treatments modeled after "self-actualizing" encounter groups often espoused limitless pleasure seeking. Though helpful to many, these methods also produced many "casualties." (Yalom & Lieberman, 1971). Moreover, Piaget's (1952) work was a direct product of observing his own children, which could be interpreted to some as multiple relationships.

A primary concern for the client's well being began with a proscription against sexual involvement with clients and expanded to other multiple relationships (Elbert, 1997; Epstein, 1994). Apparently the foundations for the protective policies that professional organizations, legislators, and consumer protection agencies use for prohibiting therapist-client sexual relationships are to prevent client exploitation. To support these protective policies for clients, most professional mental health organizations' ethical codes address multiple relationships (Biaggio & Greene, 1995; Schank and Skovolt, 2006; Pope, 1991). Ethical codes, however, have been modified over the years to reflect the ever-changing understandings and perceptions of the field and reflect evolving theories such as humanistic, feminist, family systems, behavioral and cognitive therapies (Lazarus & Zur, 2005).

Codes in the mid-twentieth century (APA, 1953) and subsequent decades focused on promoting the client's general welfare and deterring the abuse of power by therapists. The 1953 APA document did not include incidents or elaborations and focused instead on a summary of ethical principles and subprinciples in 19 pages. The ethics codes continued to be revised and evolve over 40 years that also included changes in content regarding sexual misconduct, dual relationships, advertising, and research (Pope & Vasquez, 1998). The late 1980's reflected a period where professionals began to recognize that some multiple relationships were inevitable in situations such as rural communities, the military, inclusive communities such as Deaf, GLBT, linguistic and other minorities (Schank and Skovolt 2006).

The 1992 Ethics Code (APA, 1992) was a dramatic change from previous codes, including distinctions between ideals of practice and minimal standard of conduct "with

as much specificity as possible" (Carter et al., 1994, p.21). The 1992 Ethics Code was a shift from the previous code by addressing the dilemmas inherent in daily practice, which was a direct response to the need for a more practical approach in meeting the increasingly broader and more complex "knowledge base and scope of practice" within the profession of psychology (Gottlieb, 1994, p. 288).

A standard-by-standard comparison on the 1992 and 2002 Ethics Codes is available on the APA Website (www.apa.org) and makes clear precisely what was changed, added, and deleted in formulating the Ethics Code (Schank & Shovolt, 2006). An example to illustrate some of the changes from the 1992 to 2002 Ethics Codes regarding multiple relationships:

> 1.17 Multiple Relationships.
>
> (a) In many communities and situations, it may not be feasible or reasonable for psychologists to avoid social or other nonprofessional contacts with persons such as patients, clients, students, supervisees, or research participants. Psychologists must always be sensitive to the potential harmful effects of other contacts on their work and on those persons with whom they deal. A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship reasonably might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party.
>
> (c) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist attempts to resolve it with due

regard for the best interests of the affected person and maximal compliance with the Ethics Code. (p. 1601)

3.05 Multiple Relationships.

(a) A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person.

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists. Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

(b) If a psychologist finds that, due to unforeseen factors, a potentially harmful multiple relationship has arisen, the psychologist takes reasonable steps to resolve it with due regard for the best interests of the affected person and maximal compliance with the Ethics Code. (p.1065)

Presently many of the major professional organizations {such as the American Psychological Association, (APA); American Counseling Association, (ACA); American Association of Marriage and Family Therapists, (AAMFT); and National Association of Social Workers, (NASW) have revised sections of their ethical codes that deal with

multiple relationships. These revised ethics codes acknowledge the fact that multiple relationships are not always avoidable and not always unethical (Schank & Skovolt, 2006; Epstein, 1994). Unlike previous versions of the ethical codes, there are no comprehensive bans on non-sexual multiple relationships. The codes still caution against involvement in multiple relationships. Furthermore, they do not acknowledge that, in some cases, multiple relationships may be therapeutically beneficial for the client.

Ethical Principles Regarding Dual Relationships/ Ethical Guidelines and Codes

According to Thompson (1990), ethics represent the ideal standards set by professionals the basic purpose of which is to promote or further the welfare of the client. In other words, ethics are the beliefs, standards, and values that are adhered to by an individual, a group, or a society, which reflect a system of moral principles (Kitchener, 1984).

Most, if not all, major professional mental health organizations' ethical codes address and acknowledge multiple relationships: American Psychological Association (2002), National Association of Social Workers (1999), The American Counseling Association (1995), and the American Association of Marriage and Family Therapists (2001), to name a few. Furthermore, their codes also advise caution for unavoidable multiple relationships.

As Pope (1991) noted, multiple relationships can jeopardize the patient's welfare, therapist's personal judgment, and the process of therapy itself. Pope and Vasquez (1991) summarized the problems that may arise when therapists engage in multiple relationships:

1. Engaging in multiple relationships can alter the nature of the therapeutic relationship. This relationship is protected within a set of boundaries, which both client and therapist can rely on. Participating in multiple relationships compromises this relationship.
2. A conflict of interest may arise and thus compromise professional judgment.
3. Multiple relationships may affect the cognitive processes that research has shown to play a role in the beneficial effect of therapy and which help the patient to maintain the benefits of therapy after termination,
4. Any business relationships after the termination of therapy are not on equal grounds (the therapist is considered to have an upper hand because of personal nature of the therapeutic relationship and the nature of the conversations).
5. The nature of the psychotherapeutic relationship would change in such a way that might be secondary to therapy (business, financial, social, etc.). (p.116)

Furthermore, Schank and Skovolt (1997) indentified and outlined four common dilemmas involving professional boundaries that may arise from multiple relationships. Two dilemmas involved overlapping social relationships, and business and professional relationships. A third dilemma identified the effects of overlapping relationships on members of psychologists' families. Lastly, rural psychologists reported that having to work with multiple members of a family or others in the community who have significant connections with current clients created boundary dilemmas.

Changes in Ethical Guidelines

Schank and Skovholt (2006) emphasized, "one of the most significant statements in the 1992 APA Ethics Code, carried forward in the 2002 Ethics Code, is the attention given to the pervasive nature of multiple relationships in many small communities" (p.35).

Schank and Skovholt (2006) noted that the 2002 APA Ethics Code (APA, 2002a) is the first iteration of the code to explicitly define multiple relationships. This code also clarifies that not all multiple relationships are unethical if such relationships are not prohibited by the rule. Fisher (2003; as cited in Schank and Skovholt, 2006, p.33) elaborated that "incidental encounters and some social contacts are not considered unethical unless these contacts or relationships could reasonably be expected to impair the psychologist's objectivity or harm the client." According to Fisher (2003 p.65, as cited in Schank and Skovholt, 2006), the clarification with the APA Ethics Code (APA, 2002a) recognizes that "individual psychologists may perform a variety of roles."

Reality of Small Communities

In many small communities the possibility of less access to a wide range of professional services and service providers often means that psychologists must consider almost every person in the community a prospective client (Faulkner & Faulner, 1997). Even if every person in a small community is not a prospective client, it is still possible that clients or potential clients are connected to others through business, social, or familial relationships. In rural or small communities, relationships can occur simultaneously when psychologists have other connections with clients in addition to the therapist-client/patient relationships (Schank & Skovholt, 2006; Campbell & Gordon,

2003). Examples include a therapist who is also the business partner of a client, a supervisor who is also the therapist of a supervisee, and a therapist who has previously been a longtime friend of a client or client's family (Welfel, 1998).

Several surveys of rural practitioners indicated that they are more likely to engage in multiple relationships than their urban counterparts. Borys and Pope (1989) surveyed a large national sample of psychologists, psychiatrists, and social workers and found that the respondents who lived in the same small town as their clients were significantly more likely to have social and financial involvement with their clients. Also, rural practitioners rated multiple professional roles as significantly more ethical than other practitioners.

Another study examined the dual relationship dilemma that rural psychologists face: Horst (1989) surveyed Minnesota psychologists and found that rural practitioners "reported significantly more out-of-session contact with clients than psychologists who practice in larger communities" (p.15). However, rural psychologists appear to differentiate between casual contact and relationships that are potentially harmful or conflicted. Horst (1989) stated, "while it may be difficult for rural psychologists to control the amount of outside contact they have with clients, they do seem to manage to exert control over the form the outside contact will take" (p.23).

Rural psychologists are not the only population who struggles with ongoing dual relationship dilemmas. Morrow (2000) reviewed studies suggesting that up to 95% of LGBT therapists encountered clients socially in LGBT communities. She advised that it is therefore especially important for LGBT therapists to consider the implications of engaging in multiple relationships with clients.

In terms of providing services to the Deaf Community, Guthman and Sandberg (2002) pointed out those practitioners who refuse treatment to members of Deaf communities on the basis that they already know each other may be denying these individuals their only culturally accessible means of receiving treatment. In other words, Deaf individuals may not have access to other providers due to communication barriers.

Kertesz (2002) shared his perspective on multiple relationships as he described how he incorporated his Argentinean culture and years of practicing as a physician and psychologist throughout Latin America. He stated that Latin American cultures emphasize stronger family and community bonds than the dominant U.S. culture and that multiple relationships between health service providers and clients are seen as the norm rather than exception. He argued that mental health practitioners are often seen as both healers and community leaders in Latin cultures and therefore are expected to be actively involved in community activities and to serve as a role model. He warned that a therapist's strict avoidance of multiple relationships might be most likely to be viewed by community members as rude, distant, and aloof.

Overall, Campbell and Gordon (2003), Guthman and Sandberg (2002), Kertesz (2002), and Dworkin (1992) established that the tight-knit nature of small communities (LGBT, Deaf, and rural communities) could create an atmosphere where multiple relationships are often unavoidable. Kertesz (2002) suggested that therapists keep an open mind to the possibility of engaging in multiple relationships and consider cultural norms in their decisions, paying close attention to their own and the client's motivations for desiring the multiple relationships, and the potential for harm. Furthermore, avoiding

multiple relationships altogether is often impossible and unrealistic when providing professional services in rural and small communities.

Dual Relationship Dilemmas for Therapists in Small Communities

Some may ask what makes multiple relationships problematic. Schank and Skovholt (2006) pointed out several critical factors of multiple relationships such as 1) they are pervasive, 2) they are difficult to recognize, 3) they sometimes are unavoidable, 4) they are the subject of limited advice, 5) they are potentially harmful, 6) they involve risk to clients and to psychologists, 7) they have effects on other consumers, other professionals, the profession, and society (p. 36-42).

It may be relatively easy to define multiple relationships conceptually; however, practitioners suggested that it might be more difficult to recognize potential multiple relationship dilemmas as they develop. Many psychologists may not be aware of the client's relationships within the small community. This can be especially difficult for psychologists who relocate to a small community where the community members are established and are more familiar with extended family relationships and with patterns of allegiances, alienations, and friendships (Schank & Skovholt, 2006).

Several potential overlapping roles may occur in many small communities, and psychologists still have the responsibility to guard against impaired objectivity even when the Ethics Code does not prohibit a relationship. Even if some overlapping relationships do not raise ethical questions, Haas and Malouf (1989, p.57) pointed out that they may "provide fertile ground for the development of problematic situations and, therefore, caution is in order." Haas and Malouf (1989) described some of the professional issues of psychologists in small rural towns, such as being realistic about the

possibility of not being able to maintain the simultaneous roles of friend and therapist, especially as the process of therapy usually prevents a truly equal social relationship. When there is a post therapy social relationship, the client may be prohibited from ever returning to the original therapeutic relationship.

It is believed that small community psychologists are more likely than their traditional urban counterparts to face difficult dilemmas and therefore, must continually be aware of such potential conflicts. Steinman, Richardson, and McEnroe (1998) outlined a set of traps that many helping professionals may fall into when trying to make ethical decisions:

1) confusion among ethical codes, personal values and standards, and religious convictions

2) the belief that ethical questions do not have right or wrong answers because "the circumstances under which they occur (rather than the behavior itself) must be taken into consideration in making the decision" (p.7), and

3) the difficulty of "taking sides from among two or more conflicting interests" (p.9).

Many small community psychologists have argued that multiple relationships are unavoidable (Schank & Skovholt, 2006). This belief may be perceived as a lack of careful consideration of alternatives, which can lead to the mistake of widespread acceptance of any and all multiple relationships. Pope (1991, as cited in Schank & Skovholt, 2006, p.38) stated that psychologists "who view multiple relationships as unavoidable in small communities risk the unfortunate mindset that they have little control over situations and therefore have no responsibility to maintain appropriate

professional relationships." It can be too easy for the conversation during a therapy session to shift to a more casual and mutual level if the distinction between a friendship and a professional therapy relationship has not been clearly defined (Herlihy and Corey, 1992).

Therapists' Professional Obligation Regarding Dual Relationships in Small Communities

A commonly held belief about traditional therapy is that therapists should avoid multiple relationships with clients. There are clinical, ethical and legal justifications for discouraging such interaction. According to this belief, familiarity damages the therapeutic process. This belief holds that it is imperative that the client be blind to the therapist's flaws, because such knowledge would negatively impact the therapeutic process and interfere with the necessary hierarchical relationship (Lazarus & Zur, 2002; Pope & Vasquez, 1998).

It is difficult for therapists and their clients to maintain clear and strict boundaries in small, close-knit geographical communities in the United States. The social norms in these small geographic communities and social networks support participation in multiple relationships because it is almost impossible and certainly impractical to avoid interactions outside of therapy. Familiarity is an important factor in these small close-knit geographical communities. Familiarity, whether it is an out of office experience, or having something in common, has been strongly linked with valuable and effective therapeutic relationships (Lazarus & Zur, 2002). Factors that greatly contribute to positive outcomes in therapy across cultures are: prior knowledge, compatible lifestyles, values and common beliefs (Faulkner & Faulkner, 1997).

In contrast to close-knit communities that are geographically close, the Deaf community is considered a close-knit community, even across large geographical distance (Guthman and Sandberg, 2002). They argued that many Deaf clients would seek out therapists they know from Deaf communities to ease communication and comfort within the therapeutic dyad.

Furthermore, extra-therapeutic encounters could also give the client a glimpse of the therapist's human qualities and could enhance the therapeutic outcome. These encounters occur, at times, because clients or therapists have many roles in the community such as therapist-scout leader, therapist-teacher, or client-store owner. Lazarus and Zur (2002) proposed that these out-of-office encounters could be managed by discussing the potential dilemmas with the client and implement some problem solving strategies from the very beginning of therapy. Several authors (Schank and Skovolt 2006; Pope &Vasquez, 1998; Lazarus and Zur, 2002) encourage the importance of consulting with colleagues when in doubt regarding how to deal with the above-mentioned issues.

Many authors agree that multiple relationships are sometimes an inevitable part of the therapist-client relationship (Lazarus & Zur, 2005). This is particularly true in certain settings (i.e. rural towns), and may often be appropriate as long as the client is not exploited and the therapist-client relationship is not otherwise compromised. For the rural practitioner, completely avoiding multiple relationships may be an unrealistic option because of the limited alternatives for mental health services and the interrelationships that are involved in a small community (Brownlee, 1996). Although APA's Ethical Principles of Psychologists and Code of Conduct (2002) addresses this dilemma in

Section 1.17a, it does not explain the relationship characteristics that should be taken into consideration. Hence, appropriate ethical decision-making is left to the therapist.

While there are no easy and straightforward answers that can be applied to decisions regarding the advisability of multiple relationships, psychologists should be aware of professional boundaries when the therapist-client roles have terminated (Anderson & Kitchener, 1998; Schank & Skovholt, 2006). Anderson and Kitchener (1998, p.98) emphasized "psychologists are not relieved from acting morally toward a person just because the person is no longer a client."

Several factors should be taken into consideration when evaluating nonsexual overlapping relationships: context, history, current status of the relationship, the client's reaction, and the psychologist's explanation of the purpose of the boundary-crossing within the context of therapeutic goals. Conversely, it is important to note the ambiguity of determining whether a particular action is likely to cause impairment, exploitation, or harm (Lamb, Catanzara, & Moorman, 2004).

While the APA Ethics Code (2002) offers some broad and relevant principles, specific guidelines on dealing with nonsexual post-therapy relationships with former clients are not listed out or provided. Disagreements have arisen on over how the ethics codes should be interpreted and whether they serve as guidelines or as rigid prohibitions. It is widely expected or encouraged that psychologists avoid nonsexual post therapy relationships that may create a risk for harm, including the possibility of harm that may not be accurately predicted, even if dual relationships are not specifically prohibited (Schank & Skovholt, 2006). However, Herlihy and Corey (1992) argued that all ethics codes for the helping professions warn against dual relationships.

Some professions may not perceive multiple relationships as being abusive or exploitive; however the potential is heightened by the existence of a second relationship (Herlihy & Corey, 1992; Pearson & Piazza, 1997). The power differential between professional and client creates potential harm. Borys (1994, p. 271) addressed the potential dilemmas of dual relationships by providing the following example: "a therapist who attends a client's wedding as a gesture of support but observes new and maladaptive aspects of the patient's own behavior or a significant other's, which the clinician realizes the patient has been avoiding or otherwise defending against in the treatment." The therapist is left with the conflict of bringing up the wedding observations in therapy or keeping them private. Either choice could be damaging to the client. Kitchener and Harding (1990) suggested that psychologists should not enter dual relationships unless the risks of harm are small and the potential benefits are great. They identified three factors to consider: 1) incompatible expectations, 2) divergent responsibilities, and 3) the power and prestige of the psychologist. They also pointed out that divided loyalties, loss of objectivity, and vulnerability of clients are possible obstacles and that it is our responsibility as trained professionals to make sure that the client is not harmed or injured.

Some clients may feel exploited by dual relationships; they may feel confused, hurt, angry, and betrayed. This may have long-lasting consequences such as the clients not seeking help from other psychologists. In contrast, some clients may feel trapped and dependent on the relationship, despite feeling angry and confused (Herlihy & Corey, 1992). Even after termination, some clients may continue to have strong feelings about their therapy or the psychologist. Pipes (1999) pointed out that former clients may request

records or court testimony from the psychologist and argued that a psychologist's objectivity may be impaired by the occurrence of a nonsexual post-therapy relationship.

Furthermore, Koocher and Keith-Spiegel (1998) stated that multiple relationships that are injurious to or exploitative of clients are prohibited by all codes of ethics due to the probability that the therapist may have interests that are not focused on the welfare of the client. Professional judgment may be compromised and standards for professional behavior may become blurred. The client may not feel free to clearly express wishes contrary to those of the therapist. Consequently, the burden of proof of the benign nature of the relationship will be placed on the therapist; the code of ethics assumes that dual relationships involve heightened risk of harm to clients.

Small Towns and Dual Relationships

In urban practices, both the clients and professionals expect a separation between the personal and the professional, while in rural practices, personal and professional roles can easily become unintentionally blurred (Rich, 1990). Out-of-therapy contacts between rural psychologists and clients are commonplace. Faulkner and Faulkner (1997, p.226-227) pointed out that forming any relationships with others in the community "may mean that psychologists may be in the position of limiting the delivery of already scarce psychological services to a small number of inhabitants." Furthermore, Faulkner & Faulkner, (1997, p227) explained, "Cultural, social, and local norms in a small, rural community tend to produce an ambience where 'everybody knows everybody' and if they do not, they soon will."

Hence, psychologists in rural towns need to find ways to be accepted into the community and be trusted by the people within the community. One way to establish this

community acceptance and trust is through community involvement (Horst, 1989; Schank & Skovholt, 2006). Having role flexibility and being visible within the community leaves many rural psychologists "vulnerable to political and community involvement" (Murray & Keller, 1991, p.227). The negative stigma about mental health services, along with the perceptions that providers do not understand the issues of rural and agricultural people may prevent some rural people from getting the services that they need (Gamm, Hutchinson, Dabney & Dorsey, 2003; Schank & Skovholt, 2006). In other words, people in rural areas tend to see psychologists as outsiders and may be reluctant to request services, especially from a stranger.

One of the requirements of rural psychologists is to be a generalist and have the ability to work with diverse problems and cope with a relative lack of other resources in the community (Schank & Skovholt, 2006). Several authors identified additional responsibilities and possible conflicts for rural psychologists' role as generalists, such as the possibility of being involved in the role of advocacy, public relations, grant and proposal writing, participation in community organizations and other roles outside of direct treatment that put the psychologist in a variety of contexts within the community (Dunbar, 1982; Schank & Skovholt, 2006).

Rich (1990) stated that prevailing standards and codes of ethics cannot be applied in automatic ways for therapists who provide services in many rural settings. Schank & Skovholt (1997) elucidated that it can be difficult or impossible for many psychologists or counselors in rural communities to isolate themselves from clients and former clients, which results in many psychologists and counselors restructuring the relationships within

the context of the community and maintaining a balance between professional and community identification.

In many small community practices, nonsexual overlapping or dual relationships are not a matter of "if" as much as "when" and "the anonymity which facilitates boundary delineation does not exist" (Catalano, 1997, p.24). Denying help to a potential client because of preexisting relationship could mean that the person may get no help at all due to limited local resources and options for referral (Smith & Fitzpatrick, 1995; Schank & Skovholt, 2006).

Dittmann (2003) explained that out-of-therapy contacts with current and former clients might be more uncomfortable for psychologists than for the clients since many rural residents are used to running into their doctors and other professionals during their daily life in a small community. Furthermore, Helbok (2003) affirmed that bumping into clients in the stores is not similar to serving together on committees because both the psychologist and client's roles must change outside of therapy. It is the potential for harm that may be problematic rather than the overlapping relationship in and of itself. This equation can be further complicated by the rural resident's expectations of community involvements (Helbok, 2003; Schank & Skovholt, 2006).

A qualitative research study of several rural and small-community psychologists described "boundary dilemmas they faced in their daily practice, how various relevant factors are weighted in dealing with dilemmas, and how decisions are made when providing psychological services to clients in small communities" (Schank & Skovholt, 2006, p.78). The participants' responses identified several areas of concern that are described by the following themes:

1) the reality of overlapping social relationships

2) the reality of overlapping business or professional relationships

3) the effects of overlapping relationships on members of the psychologist's own family

4) seeing more than one family member, or seeing people who have friendships with each other as individual clients

5) getting unsolicited out-of-therapy information about clients

6) high visibility and lack of privacy

7) collecting unpaid bills from clients

8) bartering

Rural psychologists are encouraged to discuss with their clients the possibility of meeting each other in the community. Schank & Skovholt (2006) suggested that rural psychologists make it clear to the clients that they will respect client privacy by waiting to see if clients want to acknowledge or greet them. This discussion can help to open up and clarify the potential overlapping relationships and the importance of staying in appropriate roles. Schank (1994) provided an example of the importance of having an open discussion about role clarification with the client:

> It is always establishing boundaries. I live on a very busy street in town and was doing some landscaping and working out in the front yard. One of my clients must have seen me and later said, "Oh, is that where you live? I saw you." I said yes, and she said, "Well, I noticed that the house next to you is for sale. Wouldn't that be cool? You know, my parents are thinking of helping me buy a house." I said, "No, that would not be cool because you are my client – you are not a friend.

> If you moved in next door to me, it would be extremely uncomfortable. I know what you are saying – I listen to you, I care about you – but friends know about one another. You don't come in, and I sit and tell you about my problems and my life. I don't call you when I am hurting or need a friend for support." She said, "Oh, yeah. I didn't even think about that." And so it's continually having to establish boundaries with a number of clients. (p. 94)

In many small communities, psychologists may be perceived as an outsider or the community residents may feel offended if the psychologist chooses to take all of her or his business out of town. The degree of involvement is probably the primary factor to consider in overlapping relationships. For example, avoiding business interactions with clients in a local store may be impossible; however entering a business partnership with a client or client's family is unwise and potentially harmful (Schank & Skovholt, 2006). The decision-making equation can be more complex when trying to deal with the ambiguity and confusion that comes with overlapping business and therapeutic contacts. Schank & Skovholt (2006; Schank, 1994) provided several examples of this complication:

> If something went wrong with a piece of equipment, I just wouldn't make an issue out of it. If it was just a general return policy, then that is what I would follow. If it was something that would create an argument or something, I just wouldn't do it. Maybe you make it up as you go, but what I have always tried to do is put those boundary pieces in terms of my clients' needs absolutely foremost (Schank,1994, p.51)

When you do have business dealings with someone, I find it really hard. I won't bargain with them. Recently someone [who was a former client] worked on my car, and I thought the price was little high. I trust the guy, but I feel awkward in asking him what the charges were for. If it was someone else, I would have no problem asking (p.51).

We have a nice, isolated building here in a beautiful, quiet place. So professionals many times will come here. Now, I have seen a lot of professionals in town [as clients], either for personal counseling or for their children. Then I refer [clients] to [those same professionals] because there is no one else. If you read the rules about dual relationships, that is not allowed (p.51).

Previous Decision-Making Models – General and Small Communities

Being able to distinguish between benign, unavoidable overlapping relationships and those that are harmful and unethical can be difficult for many professionals working and living in a small community. Several ways to assess the risks of overlapping relationships have been proposed. When dealing with ethical dilemmas in rural or small communities, it will be useful to have several frameworks listed out so several ethical decision-making approaches will be highlighted here.

One of the most critical aspects of the Ethics Code is the Principles. Kitchener (1984) and Thompson (1990) suggest that psychologists should turn to the following principles to guide their ethical decision-making: 1) Autonomy; This principle implies that we should aim for "the maximization" of an individual's ability to choose freely and competently how to conduct his or her life (Thompson, 1990, p.13; Kitchener, 1994), 2) Fidelity; The principle addresses the therapeutic contract and involves loyalty,

faithfulness, and promise keeping, 3) Justice; This principle implies fairness and equality within the treatment we provide (Kitchener, 1994; Thompson, 1990), 4) Beneficence (or doing good for others). This core principle is central to all professional codes of conduct, which underlies the actions of all helping professions towards clients (Kitchener, 1994; Thompson, 1990), 5) Nonmaleficence; This principle can be paraphrased as "above all, do not harm" to others including both not inflicting intentional harm nor engaging in actions which risk harming others (Kitchener 1994, p. 47; Thompson, 1990). Thompson (1990) described the last principle, Self-Interest, as reflecting the moral and ethical responsibility of self-knowledge, self-improvement, self-protection, and self-care.

Kitchner (1984) was one of the pioneers in developing the procedure and foundation of ethical decision-making when addressing some ethical dilemmas. The following model of ethical decision-making builds upon the work of Kitchener (1984) and provides the step-by-step method that some professionals may use while evaluating ethical issues: 1) become sensitive to the moral dimensions of counseling, 2) identify the type of dilemma and the alternative courses of action, 3) refer to the American Psychological Association (APA, 2002) Code of Ethics and associated professional guidelines, 4) examine relevant regulations and laws, 5) seek and obtain relevant ethics literature, 6) apply fundamental ethical principles and theories to the situation, 7) consult with colleagues about the dilemma, 8) deliberate alone, 9) inform the appropriate people and implement the final decision, and 10) reflect on the actions that the professional has chosen to take. While this is a good decision-making model, it may not be the most effective guideline to apply when evaluating Deaf therapists' roles within the Deaf community. For example, in step 4, there are no laws or relevant regulations that have

been specifically designed to deal with the unique roles that many professionals are faced with in rural or Deaf communities. Also, in step 5, there is a lack of relevant ethics literature and research in this area.

Welfel's (1998) book, Ethics in Counseling and Psychotherapy, one of the most recent developments in decision-making, outlined a practical model for ethical decision-making. Her nine-step protocol involves:

1. *Develop ethical sensitivity.* Take courses and workshops that focus not only on ethical standards but also on how to follow a moral decision-making process. Continue to educate yourself throughout your career. Discuss dilemmas with other psychologist and seek out the objective feedback of others. Examine your own values and motivations for being a psychologist. Recognize that we face what Welfel described as "the commonness, complexity, and subtleties of ethical dilemmas" in everyday practice. Establish methods of assessing the ethical dimensions of each case, possibly on the intake form or in case notes.
2. *Define the dilemma and the options.* Carefully examine possible dilemmas and responses.
3. *Refer to professional standards.* See how standards and codes apply to a particular dilemma. Become so familiar with applicable standards that you can locate relevant sections quickly and easily. Refer to pertinent state and federal laws.
4. *Search out ethics scholarship.* Look for books and articles that address the same ethical issues that are of concern to you. Benefit from the perspective of

experts and become more aware of aspects of an ethical dilemma that you may not have yet considered

5. *Apply ethical principles to the situation.* Welfel pointed out that the professional literature may narrow and clarify the options, but it rarely points to a single path. Look to the underlying principles that form the foundation of ethics codes. If applicable ethical principles conflict in a particular dilemma, keep client welfare uppermost in your concerns as you weigh conflicting principles to come to the best final decision..
6. *Consult your supervisor and respected colleagues.* Obtain objective feedback from others to get additional information or points of view. Reduce emotional isolation by turning to trusted colleagues.
7. *Deliberate and decide.* After gaining the perspectives of others, and after seeking out the additional information that you need, the responsibility rests with you to weigh all the factors and come to an ethical decision. Even if the choice and consequences cause you discomfort, you are upholding the standards of the profession and adding to your confidence in making difficult ethical decisions.
8. *Inform your supervisor; implement and document your actions.* Communicate first with your supervisor and then with others who need to know of your decision, rationale, and course of action. Document those factors in your case notes or other necessary records.

9. *Reflect on the experience.* Once the immediate emotionality and pressure have lifted, take the time to think back on how and what you decide, along with how you many want to deal with similar situation in the future.

Other authors have developed a seven-step model that stressed the importance of thorough examination of alternatives, choices, and actions, along with the necessity of input from and consultation with others to ensure that complicated decisions are based on ethical principles. Steinman, Richardson, and McEnroe (1998) suggested the following steps in their Ethical Decision-Making manual for Helping Professionals: 1) identify the ethical standard involved, 2) determine ethical trap possibilities, 3) frame a preliminary response, 4) consider the consequences, 5) prepare ethical resolution, 6) get feedback, and 7) take action (p. 18-20).

A third model, developed by Koocher and Keith-Spiegel (1998), consists of eight-steps. This model moves from consideration of issues, to alternatives, and to a final decision. The steps are:

1. Determine that the matter is an ethical one
2. Consult the guidelines already available that might apply to a specific identification and possible mechanism for resolution
3. Consider, as well as possible, all the sources that might influence the kind of decisions you will make.
4. Locate a trusted colleague whom you can consult
5. Evaluate the rights, responsibilities, and vulnerability of all affected parties
6. Generate alternative decisions

7. Enumerate the consequences of making each decision

8. Make the decision

Schank & Skovholt (2006) used the above decision-making models as a foundation for their development of a model of ethical decision-making to specifically apply to small-communities. Their protocol involves 16 strategies:

1. Recognize that ethics codes or standards are necessary but not sufficient. Such codes cannot cover every dilemma that psychologists struggle with, especially in small or rural communities. Instead, psychologists are required to be knowledgeable of relevant standards and must also be able to apply them to psychological situations that are ambiguous.
2. Know relevant codes, regulations, and laws. Keeping up to date with professional guidelines and standards and with state and national laws is mandated since there is no excuse to be ignorant of the law.
3. Obtain informed consent. Obtaining informed consent is an ethically important first step that sets the tone of the professional relationship through an open, complete discussion of expectations, boundaries, and risks involved in therapy. D. Smith (2003) suggested the following points for discussion: 1) limits of confidentiality, 2) how records are kept, 3) your expertise, experience, and training, 4) alternative treatment approaches, 5) fees and billing practices, 6) emergency contacts, 7) the client's right to terminate, and 8) what services you will and will not provide. It will be critical to have an open discussion with the client to ensure that he or she understands the

reasoning for trying to minimize a potentially problematic dual relationship and the possibility for a referral instead of entering into a therapy relationship.

4. Involve prospective clients in decision making. Bring out into the open any concerns the therapists might have when discussing with the client the implications of any overlapping social or business relationships. Discuss with the client several other possible options and work together to decide if entering into a therapy relationship may be the best alternative. Document all this in case notes.
5. Talk directly with clients about the likelihood of out-of-therapy contact. Instead of waiting for a potential uncomfortable encounter in the community, discuss with the client the high potential of out-of-therapy contact with the client at the beginning. Also, set clear limits and boundaries with clients about the inappropriateness of discussing therapy outside of the office.
6. Consider the type and severity of the client's presenting problems. Before considering seeing a client, psychologists are encouraged to consider how the client's specific problems may complicate the situation, such as dealing with clients who are depressed is not same as dealing with a personality disorder. However; take into consideration that there may be no referral option available.
7. Set clear expectations. Discuss with client what expectations the psychologists may have regarding to the varying roles that one may play in the community. This also includes clarifying role obligations and expectations and address problems as they arise.

8. Set clear boundaries, both within yourself and with clients. Limitations and boundaries should be clearly defined and communicated clearly to the client at the beginning of the counseling relationship. Clearly defined boundaries generally strengthen the relationship and develop a foundation of trust.
9. Be scrupulous about documentation. Rigorous documentation protects the psychologist and also provide the opportunity to reexamine complicated events and issues in therapy.
10. Be especially aware of issues of confidentiality. In many small or rural communities, even general discussions can be misinterpreted as being about specific clients. It is common for psychologist to forget where they heard personal news due to the overlapping issues in small communities, so they need to be careful in conversations. It will be critical to explain to the client at the beginning of therapy what is included in their records and how their records are safely stored.
11. Be aware of broader community standards. Personal or professional behaviors that differ from the norms of the community may go unnoticed or unquestioned in larger communities; however, they may readily become issues that reduce credibility and effectiveness in a small community. The possibility of rumors and criticism are elevated for small-community psychologists if their personal behaviors differs from the norms of the community. As a result, small-community psychologists will need to decide for themselves how to strike a balance among personal choices, integrity and overall community standards.

12. Maintain a hierarchy of values. The client's needs should always come first and decisions should be made on that basis. When assessing the potential risks of dual relationships, it may be helpful to consider frequency and duration of out-of-therapy contact, setting and context. In particularly ambiguous situations, no matter how honorable your intentions, the behavior could potentially be viewed as unethical.
13. Know yourself. Understanding oneself, as well as monitoring one's own personal and professional needs, and be aware of how you may influence the lives of others. Additionally, it will be critical to work on your own blind spots, weaknesses, and prejudices and to be honest with ourselves.
14. Participate in ongoing consultation and discussion. Consultation is essential for good practice and helps to build community among colleagues. It is also important to consult with colleagues who may hold divergent views and who can challenge us to examine and learn from ethical challenges. Building networks and resources, attending conferences and workshops, and consulting with others can help you identify weaknesses or rationalizations. Also, seeking consultations immediately when entering into an overlapping relationship, when practicing outside of your competency level, or when the maintenances of appropriate boundaries may be difficult.
15. Continue to educate yourself. Receiving training on ethical issues in small-community practice during graduate course work or internship is rare, so it will be important to remain current on professional issues and on relevant research literature.

16. Know when to stop. The chance of the therapy contract becoming unclear usually occurs in overlapping relationships. It may be wise for psychologists to refer the client elsewhere or terminate therapy early instead of keeping a client in therapy too long. This may be necessary if the fine line between personal and professional relationships starts to blur during therapy sessions.

These above decision-making principles are lengthy and do not provide a clear or defined outline for where the client may be included in the discussion. It is critical for the client or patient to be part of the decision-making process. Since multiple relationship issues will be unavoidable for Deaf therapists, a more relevant ethical decision-making model needs to be developed for this special population. A proposed decision-making model for Deaf therapists must be straightforward and concise. Another crucial element for the proposed decision-making model should include a requirement for the Deaf therapist to consult with a licensed DHH supervisor who has had experiences in navigating these types of dilemmas. Due to the nature that many DHH individuals rely on visual tools, a diagram of the decision-making model will be helpful to allow the DHH therapist to analyze the matter that is potentially an ethical dilemma. A decision-making diagram may increase the opportunity for a positive and collaborative discussion between the Deaf therapist and Deaf clients or patients. Inclusive and open communication is critical for the Deaf individual, especially when it comes to working with a professional who occupies a position of power. While the client's needs should generally come first, as Schank and Skovolt (2006) pointed out in step 12 in the abovementioned decision-making model, when determining the hierarchy of values, the Deaf therapist's needs as a Deaf individual should be met as well, in order to maintain an overall positive well-being

as an individual. Hypothetically, if the Deaf therapist does not have a positive self-image and satisfaction with her/his own identities, such as Deaf and Hard of Hearing, then it might create a challenge for the Deaf therapist to continue to provide the rare and specialization service for this underserved population. The key is how to balance the gray areas so that both parties feel contented and that the basic needs of the core values are met. In order for this to occur, a transparent and succinct model with visual options needs to be produced.

Deaf Culture and Deaf Community

Unlike other minority groups for whom English is not the native language, Deaf people are "disabled" *only* when they mingle with the majority culture (hearing individuals who do not know sign language). In other words, Deaf people believe that if everyone used sign language, communication barriers that have historically disabled the Deaf community would be eliminated (Dolnick, 1993; Groce, 1985; Lane, 1992).

There is only one American Deaf culture, even though there are many different Deaf communities across the United States. The concept of American Deaf culture is embedded in the concept of common language practice, nonverbal behaviors, norms, patterns, traditions, and values, which shape the beliefs and behaviors and are central to the culture of Deaf people. This knowledge and foundation of their own culture enables its members to move from one geographic location to another and to negotiate the differences of a new community (Jankowski, 1991; Phillips, 1996).

Every culture has a center or a standpoint from which the people who comprise a culture see themselves and view the world around them. In the book *Deaf in America: Voices from a Culture*, the authors, Padden and Humphries (1988), demonstrate the

concept of perspective-taking from the differing centers where hearing and Deaf people make meaning of the world. For example,

> In both American Sign Language (ASL) and the English translation, the meaning of the sign HEARING is "can hear." Although for hearing people, to hear is at the center of one's sensory experience, for Deaf people, it is the opposite. In ASL as in English, to be HARD-OF-HEARING is a deviation from the norm. From a hearing person's perspective, someone who is a little hard of hearing deviates only slightly from this norm (hearing), in contrast with someone who is very hard of hearing. From the Deaf perspective, it is the other way around. Someone who is A LITTLE HARD-OF-HEARING deviates slightly from the (Deaf) norm and is considered to be close to Deaf, as compared with someone who is VERY HARD-OF-HEARING and is viewed as being almost hearing (p.26).

Padden & Humphries (1988) stated that ASL and English share the same conceptual basis from a cognitive perspective, and that the conceptual basis determines the different meaning for the same term. For Deaf individuals, the greatest deviation is to be HEARING, while for hearing individuals, the greatest deviation is to be deaf. The surrender of opposite meanings from the same conceptual basis is the direct result of the process of meaning making that originates from a different center or point from which one deviates.

Deafness is often referred to as a "hidden disability" because it does not become evident until the communication takes place. Schein and Delk (1974) explained that relational difficulties are common in families with a deaf member because 90% of deaf children have hearing parents who do not communicate effectively with their children.

Additionally, many Deaf people grow up in families and attend schools where their language isolates them from the normal information flow. "Deaf people have been isolated from the steady immersion in incidental information to which hearing people are exposed, and may not know about available mental health and social agencies" (Porter, 1999, p. 169).

In the Hauser et al (2009) article, the notion *dinner table syndrome* was presented when discussing the relationship between incidental learning and how the lack of access to minimal information have a negative impact on many Deaf individual's overall knowledge of physical and mental health.

> Many Deaf and Hard of Hearing children and adults have experienced the *dinner table syndrome*, where they have experienced years at the dinner table watching close hearing family members and friends converse with each other but are unable to decipher what is being said. Some deaf individuals also experience this at school if they attend a mainstream program where there are few if any other deaf individuals. This is especially common during the school recess times and lunchtimes. When hearing individuals talk to each other without making their conversation accessible to deaf individuals (whereas a hearing bystander would be able to follow the conversation easily), deaf individuals are deprived of incidental learning opportunities. An enormous amount of incidental learning is lost to deaf individuals while hearing children and adults have full access to this information. Deaf children who do not have full access to everyday communication often do not see how adults express their thoughts and feelings, how they negotiate disagreements, and how they cope with stressors (p.8).

This lack of access and fewer incidental learning opportunities may have a negative impact on deaf individuals' *physical health* (Mann, Li Zhou, McKee, & McDermott, 2007), *mental health* (Hindley, Hill, McGuigan, & Kitson, 1994) and *academic achievement* (Traxler, 2000). According to Mann et al (2007), the rates of presentation for injury in emergency room visits by deaf children were more than twice that of hearing children even after adjusting for age, race, sex, and the number of hospital or emergency department encounters for treatment of non–injury-related conditions (Mann et al., 2007). Typically, parents verbally pre-instruct or immediately warn children of dangers as they grow up and then the children learn about risks and dangers by being directly instructed or by passively listening to conversations of others. Theoretically, the absence of incidental learning about possible dangers may be one cause for the above findings because deaf children might not be aware of risks and dangers.

To further illustrate the relationship between improvised communication access and health, the lack of incidental learning at home can also have a negative impact on the Deaf individual's knowledge of family history, health literacy and mental health information. According to Hauser et al., (2009), "health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (p.9). To demonstrate how this process occurs:

> Imagine a typical family Thanksgiving or Holiday gathering with several family members conversing about family events that may have happened over the past few months. An uncle may mention that he needs to be careful with his food choices since his doctor told him that his cholesterol was too high. A grandmother

may respond back adding that he needs to be careful since her deceased husband followed a poor diet and eventually succumbed to a heart attack at age 51. While the above conversation may be short in length, it is rich in details that will likely be missed by a deaf family member. The deaf individual is therefore less likely to benefit from aggressive screening procedures or interventions since they cannot provide a full family health history to their physician (p.9).

Several surveys confirmed the seriousness of how lack of access to information can be dangerous when it comes to identifying mental health or physical symptoms. One study discovered that 40.4% of the Deaf individuals were not able to identify one symptom of a heart attack (Margellos-Anast, Estarziau, & Kaufman, 2006) while 90% of hearing adults in another survey were able to identify one (Geoff et al., 1998). Similarly, 62.6% Deaf adults were not able to identify one symptom of a stroke while 70% of hearing adults in another survey could list a symptom (Reeves, Hogan, & Rafferty, 2002). It will be safe to assume that many Deaf individuals will have trouble identifying some basic and treatable mental health symptoms such as depression and anxiety.

One critical aspect of Deaf culture is the value placed on eye contact that may differ than the mainstream. According to Glickman (1996), a typical conversation between two American hearing people may not maintain eye contact for more than a duration of 1 second. Between two Deaf individuals, it is common that the eye contact duration is more than 5 seconds. Consequently, when a conversation between a hearing and a Deaf person occurs, the hearing person may feel uncomfortable with the intensity and duration of the Deaf person's eye gaze while the Deaf person becomes frustrated with the apparent lack of attention from the hearing person during the conversation. In

fact, in the American hearing culture, not maintaining eye contact may be seen only as a sign of boredom or timidity, however; in the Deaf culture, it may be seen as being evasive or even hostile. As a result, the act of breaking eye contact in a visually based conversation can destroy the communication bridge (Glickman, 1996; Porter, 1999).

Another important aspect of Deaf culture is the use of nonverbal communication. Deaf individuals have different ways of getting attention (e.g. waving, tapping on the shoulder, flicking lights on and off), and of greeting each other (hugs and longer salutations), than is considered the norm in the mainstream American culture (Phillips, 1996; Steinberg, 1991). Nonverbal communication cues are critical in the mental health field when it comes to determining the most appropriate diagnosis or treatment plan for the Deaf individual.

When Deaf individuals communicate with others, the majority of messages are conveyed through facial expression and body language. In fact, 90% of communication occurs in a nonverbal way and these unspoken conversations are vital to establishing and maintaining a therapeutic relationship with a client (Corker, 1994). This type of communication involves a deeper level of responses than the more removed and symbolic verbal language, which may be uncomfortable or frightening for hearing therapist and client alike (Porter, 1999).

Distrust of Hearing People

Many Deaf individuals have a longstanding distrust of hearing people in general and, especially, the medical professional. Lane (1992) stated that the distrust is based on the medicalization of Deaf people by the medical profession. This approach contrasts to Deaf people's perspective, which is a cultural model. In other words, many Deaf people

have been viewed throughout history from an infirmity model; they have been viewed as having a medical condition in need of a cure.

Many Deaf people respond to being marginalized by maintaining a wary stance toward outsiders. Lane (1992) has written extensively on the model of infirmity that was perpetrated by health care professionals. Beginning in childhood, the lives of Deaf people have been punctuated with diagnoses from an array of hearing professionals, including physicians, audiologists, otologists, speech and language pathologists, psychotherapists, and surgeons. Of these numbers of professionals serving Deaf people, few can communicate with their patients directly, and most have little or no awareness of Deaf culture or knowledge of the Deaf community. The tendency of the medical professional is to evaluate and diagnose Deaf and Hard of Hearing people from an ethnocentric perspective, which perpetrates the perspective that Deaf people are disabled, handicapped, or impaired.

Gutman (2005) stated that withholding information could be interpreted as "snobbery or lack of trust in the [Deaf] community" (p. 176). Many Deaf people have had experiences where hearing people share information with each other but refuse to tell the Deaf individual what was going on. Furthermore, Gutman (2005) pointed out that many Deaf people "can remember a professional - perhaps a counselor, teacher, or supervisor - who told their parents or co-workers information that was meant to be confidential" (p. 176). Also, many Deaf individuals can recall situations where hearing people (eg. parents, teachers, medical professionals, etc) have made decisions for them without their input (Halgin & McEntee, 1986). This can lead to lowered expectation of privacy and trust in a clinician to keep the information confidential.

Small World Hazards (Deaf Community)

According to Gutman (2002), a formal set of practice guidelines for working with the Deaf and Hard of Hearing population has not been established. Not surprising, specific ethical issues in Deafness have not been systematically addressed to date. One critical variable that therapists face within a small community is that the therapist is highly visible, so mistakes as well as successes can be readily perceived and may influence the willingness of others to seek services.

Guthmann and Sandberg (2002) pointed out that "in small communities, such as Deaf communities, dual relationships are more likely to be the rule than the exception. And although often perceived in negative terms, dual relationships are not inherently problematic or unethical" (p.290). In other words, dual relationships in Deaf communities are often unavoidable due to the "tight-knit" nature of the Deaf community. It will be common for therapists in Deaf communities to have known their patients in a nontherapeutic context beforehand, as a teacher, peer, colleague, acquaintance, teammate, friend, coach, or in many other roles. Gutman (2005) stated that the norms of the Deaf community typically support sharing information and providing support for each other. Additionally, Deaf therapists are often faced with the expectation that they will engage in multiple overlapping relationships, especially if they participate as active and respected community members (Leigh, 2002; Leigh & Lewis, 1999; Gutman, 2005).

Sobel (1992) provided an analogue on the similarity of limited mental health service access between the Deaf community and many rural communities. In the Deaf community, access to mainstream mental health services is usually curtailed by communication barriers. Parallel to residents of rural towns, Deaf consumers have

relatively few treatment options. Service providers are likely to be known and familiar from other settings since both may be members of the Deaf community. In both the Deaf Community and in rural settings, the population may be geographically distant but psychologically in close contact and interdependent upon each other. Another commonality between these two communities is the contact networks that are defined by factors other than choices, such as place of residence in the case of rural communities, or having a hearing loss in the case of the Deaf community.

Deaf and Dual Relationships

The difficulties in providing psychological services to the Deaf community are similar to the struggles faced by professionals to maintain several roles in rural areas, where tacking on several roles may be unavoidable and being able to maintain clear boundaries may be more difficult than for many professionals who practice in more suburban or urban areas (Guthmann, 1999; Rich 1990; Schank & Shovhlt, 1997).

The Deaf community is one of several small communities that require addressing the dilemmas involving professional boundaries. Many Deaf psychologists who have specialized expertise to work with Deaf and Hard of Hearing individuals may have a difficult time finding a competent replacement if he or she takes time off for continuing education, family emergencies, or vacation. According to Schank & Skovholt (2006, p.172):

> Deaf psychologists may have a particularly difficult time, because much of their socializing is often within the Deaf community in which their lives cross paths with those of their clients. They may also have a great deal of unsolicited out-of-therapy information about clients and others within the Deaf community –

information that they might wish they did not know and about which they may have to keep careful track. Because there are few Deaf psychologists, they may find themselves having to make decisions about what constitutes the best interests of a client and about the wisdom of seeing several members of a family for individual therapy.

Many professionals who provide therapy to the Deaf community face similar dilemmas as these professionals in rural settings. It is not considered unusual for professionals to bump into their past or current clients while attending Deaf social events (reunions, Deaf club events, fund-raising events, open-captioned movie night), conferences or Expo on DHH issues, committee meetings, homecomings at a Deaf-institute, home parties (such as Pampered Chef, birthday party of a friend's child in the same circle of friends that wasn't previously known). The above-mentioned circumstances may leave many psychologists vulnerable to conflicts between personal and professional roles, and some therapists may feel isolated in the community.

Zitter (1996) "distinguishes boundaries (fixed and immutable positions necessary for therapy to work) from parameters (which may change depending upon the particular client's situation)" when assessing overlapping relationships in the Deaf community (p 222-223). Furthermore, she stated that the boundaries and parameters might vary between therapists. Common dual roles such as when therapist and client are both involved in advocacy or volunteer work for Deaf services in the community may be unavoidable. Zitter (1996) stresses the importance of involving the client in a discussion of the implications of the dual roles, both before and after it occurs, which includes both the client's and therapist's view in a joint decision-making effort.

Guthmann & Sandberg (2002) stated that Deaf communities present a unique environment for mental health professionals who work in them. Professionals who work with Deaf individuals frequently encounter their clients or colleagues outside of the work environment, serve in more than one professional capacity, or share common history. Such dual relationships are often unavoidable in the Deaf community. Furthermore, Guthmann & Sandberg (2002) believe that social dual relationships are a vital part of Deaf communities, which are inherently highly interdependent and close due to the language barriers.

Since many situations in Deafness fall outside of the ethical principles and guidelines, Gutman (2002) suggested, “an alternative approach is to emphasize an ethical decision-making process relying on ethical principles rather than specific rules and codes in making choices” (p.29). Eberlein’s (1987) approach to dealing with ethical dilemmas is a “problem-solving” approach as opposed to finding a “correct answer.”

Guthmann (2006) discussed a decision-making approach that may be more user-friendly for professionals who provide services in the Deaf communities. Her ethical decisions involves the following strategy: 1) identify the problem, such as gather information in a comprehensive manner, including ambiguity; 2) identify potential issues that might be involved, retaining the critical issues and discarding the irrelevant ones; 3) review relevant ethical guidelines, and ask the question “do the guidelines, standards, or principles of your organization or professional offer a possible solution? Consider whether your own values and ethics are considered or in conflict with relevant guidelines, and ask yourself for a rationale if in conflict; 4) obtain consultation because objectivity can be difficult when on your own and allowing feedback regarding to your own

justifications; 5) consider possible and probable courses of action, including brainstorming, enumerating the consequences of various decisions, and pondering the implications; 6) decide the best course of action and avoid second guessing (Guthman, 2006).

While the abovementioned approach was designed specifically for working with Deaf or Hard-of-Hearing clients, several critical components are absent. The decision-making model was not formed based on empirical studies, nor has it been evaluated for effectiveness scientifically. Also, the decision-making model did not clearly outline the DHH client's involvement in the decision-making, which should be considered critical to avoid creating the possibility of developing "distrust of mental health professionals." Hearing therapists who provide services to the DHH community have greater chance of being able to separate their personal life from their work, while it may be almost impossible for Deaf therapists. In other words, many Deaf therapists have a greater struggle establishing friendship outside of the Deaf community due to language barriers.

Connecting the Dots

The APA Ethics Code has evolved from nine different versions, starting with a temporary Committee on Scientific and Professional Ethics in 1938 until the most recent 2002 version. Ethical codes are by nature temporary, "since they need timely revisions which reflects changes in the culture, society and developments within the field" (Green & Hansen, 1989, p.150. This illustrates that the general ethics code are dynamic rather than static.

In several respects, some of the cultural realities and values of rural, LGBT, and Deaf communities, such as interdependences and preference for "insiders," have been

pointed out by several authors (Schank and Skovholt, 2006; Guthman Sandberg, 2002; Kessler and Waehler, 2005). Because of the tight-knit nature of rural and small communities, multiple relationships are often stated as being unavoidable.

Guthmann, Heines and Kolvitz (2000) mailed over 200 surveys to hearing members of the American Deafness and Rehabilitation Association, which is an organization for professionals who work with DHH individuals. The survey asked questions related to ethical challenges that hearing professionals face in their work with Deaf patients. The outcome of the survey suggested that refusing counseling services to individuals with whom one has another relationship would prevent people from receiving assistance and that to deny therapeutic services in order to avoid dual relationship on principle is unethical.

Past studies have portrayed the unique struggles that many therapists in rural communities have to address that many urban therapists do not need to face. While one study (Guthmann et al., 2000) did address the struggle working with Deaf community, having only hearing participants weakened the research. While hearing therapists who provide services to the Deaf community may experience dual relationship dilemmas; Deaf therapists have additional obstacles due to communication method. In other words, hearing therapists have the option to interact with a different circle of hearing friends that are not connected to the Deaf community, can attend any performance events, watch movies at any theatres, and attend many events without communication obstacles. Deaf therapists will have narrower options because of communication barriers. For example, if Deaf people want to attend performances or movies, they can only attend on a specific

date and time when an interpreter has been arranged or when the movie has captioning, thus increasing the chance of bumping into current or former Deaf clients.

Differences between urban and small community practice may contribute to the professional isolation of rural and small community psychologists. More open discussion of the issues can lessen the potential danger that rural and small-community psychologists may become isolated. Schank and Skovholt (1997) stated, “If fear of retribution from professional licensing boards in helping professions, ethics committees, and professional organizations diminishes the opportunities for frank conversations about the realities of rural and small-community practice, this retreat into professional isolation may lead to individual rural and small-community psychologists becoming the sole arbiters in their practices of ethical decision making” (p. 49).

Research Questions

The main questions guiding the research were:

(1) How do Deaf therapists define overlapping or dual relationships if they experience it?

(2) How do Deaf therapist perceive their identity development as a DHH person?

(3) How does being a Deaf Therapist for the Deaf Community change the way they interact with others in the Deaf community?

(4) How do Deaf Therapists negotiate multiple relationships and what strategies have been employed?

(5) How do Deaf Therapists maintain a professional and personal life in the Deaf Community?

CHAPTER II

METHOD

Research Design

A qualitative approach was selected for the present study to allow "for discovery, unplanned back looping, and decisions to change course" in an effort to contribute to theory building and theory testing (Hoshmand, 1989, p.14; Schank & Skovholt, 1997). Qualitative analysis is guided not by hypotheses but by questions, issues, and a search for patterns. Additionally, the elemental goal of qualitative method can be stated in several ways, all of which indicate the importance of hearing what respondents have to say and interpreting their statements within context. The goal is not to suggest causal relationships or identify external analytic schemes but rather to describe the context of meaning and the procedures by which persons create their own behavior and understand and deal with the behavior of others (Patton, 1991).

Prior to this research, there has not been any empirical or scientific study to explore how Deaf therapists address multiple relationships or any other ethical issues in the Deaf community. Due to the small number of Deaf therapists and the fact that there haven't been past studies designed specifically for Deaf therapists as participants, a qualitative method seems to be the most appropriate groundbreaking approach. Furthermore, the fact that many Deaf therapists appear to be constantly in the "spotlight"

will provide rich data regarding which of their professional decisions (including dual relationship issues) will be noticed by the Deaf community.

For the purposes of this study, grounded theory was selected to generate a conceptual model or framework and creating a theory that was grounded in the data. This approach is most applicable when little is known about the phenomenon of study, when researchers seek to understand individual experiences of the phenomenon, and when details of the phenomenon are difficult to identify quantitatively (Strauss & Corbin, 1998; 1990; Veith, Sherman, Pellino & Yasui, 2006, Patton, 2002). Grounded theory was originally developed by two sociologists, Barney Glaser and Anselm Strauss, who came from different backgrounds and influences but shared comparable goals (Glaser & Strauss, 1967; Strauss & Corbin, 1998). One of these similar goals both shared was the belief of the importance of empirical research in developing a well-rounded, integrated theory that emerged from qualitative data. Strauss & Corbin (1998) outlined these defining concepts that led to the development of this method:

(a) the need to get out into the field to discover what is really going on
(b) the relevance of theory, grounded in data, to the development of a discipline and as a basis for social action
(c) the complexity and variability of phenomena and of human action
(d) the belief that persons are actors who take an active role in responding to problematic situations
(e) the realization that persons act on the basis of meaning
(f) the understanding that meaning is defined and redefined through interaction
(g) a sensitivity to the evolving and unfolding nature of events (process)

(h) an awareness of the interrelationships among conditions (structure), action (process) and consequences (p.9-10).

In other words, the researcher is the primary data collector and data analyzer, and therefore has to be aware of subtle meanings in the data. The primary researcher has to rely on her insight and understanding in order to interpret the collected data (Strauss & Corbin, 1990).

Grounded theory can also be described as the constant comparative method by means of generating a theory systematically through coding and data analysis in order to develop emerging codes and categories that will be continually compared with one another to ensure that the emerging conceptual framework reflects the data and stays as close as possible to the participants' words. Patton (2002) explained that grounded theory starts with using induction and then later involves a more deductive analysis through the constant comparative process. Furthermore, Patton (2002) described that this is more of a recursive process rather than purely inductive, "connecting induction and deduction through the constant comparative method" (p.125).

Researcher as Instrument

One critical aspect of being a qualitative researcher is to become a connected knower. As a qualitative researcher, I need to be aware that there is no way that I will be able to perceive a phenomenon objectively since we generally tend to have our own lenses when we frame and understand life experiences. One way to be able to manage subjectivity and capture the participants' meaning as accurately as possible when analyzing and conceptualizing the data is to keep a self-reflection journal throughout the research process. Having a self-reflection will require that the researcher, such as myself,

be conscious of their own assumptions, personal backgrounds, life experiences, and how these may color and bias the findings of the study. I will describe in the following paragraph how I, as the instrument of the research, strive to pursue "a holistic comprehension of reality as mutually evolving" (Heshusius, 1994, p.20).

My personal experiences within the Deaf Community as a Deaf individual, and my professional background and experiences of providing services to the Deaf community, and how I have previously handled multiple relationships, brought certain assumptions and biases to the study. Throughout my personal, academic and professional development pathway as a student, therapist, researcher, teacher, supervisee, and supervisor, I have formed my own lens and expectations on how multiple relationships should be handled. Furthermore, many of my Deaf colleagues and supervisors have shared their experiences through dialogues.

Since this process is discovery focused, it is important to look at ideas that will be presented without allowing preconceived notions or expectations. One of the main factors that may hinder this research is that the primary researcher is Deaf and has certain biases. 1) I have struggled with nonsexual dual relationship dilemmas during practicum placements and have some expectation that many other Deaf therapists will have similar experiences. 2) I have the bias that becoming a therapist to serve the Deaf community is a life changing experience for many Deaf therapists. 3) I believe that some Deaf therapists who choose not to socialize within the Deaf community will have difficulties in having an adequate (or satisfactory) personal life.

Alternatively, having a Deaf primary investigator, who has shared similar experiences that other Deaf participant may have, can facilitate the research process. One

of the beneficial elements will be the primary investigator's advanced knowledge of the Deaf culture and the structure of American Sign Language. Also, the primary investigator is a bicultural individual who tries to balance her professional and personal lives between the Hearing and Deaf worlds. These experiences and knowledge can assist the primary investigator to detect some valuable information that a hearing investigator might have overlooked during the interview and the analysis process.

To manage my biases and assumptions, I attempted to process through them through a self-reflective journal, throughout the data collection, analysis and during the writing process. Some of my journal reflections will be reported and discussed in the discussion section. I openly discussed my feelings, biases, and ideas, and worked collaboratively, with the chair of my dissertation committee, in addition to trusted colleagues and peers. Since I left North Dakota for my internship, my chair and I have made the effort to continue our collaborative work by email correspondence. I also took my construction of the findings back to the participants of the study for feedback and further elaboration.

The primary investigator, who is a bilingual, transcribed and translated all of the interviews. The translation and data were verified for accuracy by a researcher who is also bilingual. The primary researcher and an auditor did the coding for themes and categories individually. A hearing colleague with some knowledge about the Deaf culture audited the transcription to verify the accuracy of themes and categories. This was done to recognize key excerpts. Repeated themes and patterns among the participants were closely monitored.

Participants

Ten Deaf and Hard-of-Hearing licensed psychologists or therapists (e.g. licensed social worker, marriage and family therapist, etc.) who have been practicing for at least one year, located in several communities around North America, were selected for this study. The participants were solicited via a Deaf and Hard-of-Hearing Professional listserv posting and professional network.

A snowball sampling technique (Berg, 1998) was also used in addition to the professional network; the participants identified other therapists who might be interested in taking part of the study. The participant contacted this indentified therapist to obtain permission to pass me the newly identified individual's contact information. I followed up with these identified therapists and screened each of them to determine whether they would be appropriate participants for this study, i.e., met the criteria for inclusion. When considering the criteria for inclusion, the participants must have at least 40 db hearing loss, a license in the field of mental health, fluency in ASL, and must provide services to predominately DHH clients/patients. In terms of exclusion criteria, anyone not meeting all 4 of the above criteria were excluded. Also excluded were late deafened therapists since they have had equal access to the spoken language growing up and were more likely to develop a solid English language acquisition. The rationale for the abovementioned exclusion was because this study will explore the DHH therapist's process when dealing with dual relationship issues while also living in the Deaf Community. Late deafened individuals are generally not part of the Deaf culture since they generally strive to preserve their hearing status and their placement in the Hearing world. Each interested participant was given a demographic questionnaire to determine

his or her appropriateness for the study and to collect contact information. Participation was voluntary and no monetary compensation was given. After ten interviews were conducted and preliminarily analyzed, it was determined that saturation had been reached since similar meaning units to form categories were repetitive after numerous readings of the transcripts. Numerous studies support the utility of similar sample sizes in qualitative research (Chapin & Kewman, 2001; Hill, Thompson, & Williams, 1997; McReynolds, 2001, Sullivan, 2004; Veith et al., 2006).

The participants ranged in age from twenty-nine to fifty-eight. All ten participants are licensed Deaf therapists who are fluent in ASL and who have provided clinical work in the United States for at least a year. The names of the participants have been changed to protect their identity.

Nicholas had been in practice for at least seven years and had recently switched to an administrative position just prior to our interview. When he was a therapist, he allocated a hundred percent of his clinical practice to Deaf and Hard-of-Hearing clients. He had experienced multiple relationships as a therapist, since he attends Deaf events frequently. He was born Deaf to a Deaf family and has been fluent in ASL since early childhood.

Molly spent more than 25 years of her career as a therapist. While she is profoundly deaf since the age of one, she did not learn ASL until she was in her mid-twenties and now is a fluent ASL signer. She allocates approximately 80 percent of her clinical practice to serve the DHH population and keeps a low profile within the Deaf community.

Noelle had been practicing for more than ten years and allocates 99 percent of her work with the DHH population. While she lost her hearing progressively until the age of 8, she did not learn ASL until she was 17. She is now fluent in ASL and rarely attends Deaf related events in the community.

Sally has been deaf since the age of 3 and learned ASL when she was 20. She has been providing therapy to the DHH population for over 22 years and attempts to attend Deaf related events at least three times each month.

Larissa had been a practicing therapist for the last 18 years, was born Deaf and used ASL since birth. Many members of her family are Deaf and she allocates at least 95 percent of her clinical work with the DHH individuals and the remaining 5 percent with children of Deaf adults (CODA). She is an extremely active member and large presence in the Deaf community and frequently attends Deaf related events.

Katie has been fluent in ASL since the age of 9 and has been a therapist entirely for the DHH community for the past 8 years. She tries to limit her interaction at Deaf related events by not attending events more than once every few months.

Peter had progressive hearing loss, and then lost his entire hearing at the age of 19. He became fluent in ASL at the age of 21. He had recently changed his career setting from school to a medical setting. At the school environment, he served primarily the DHH population, while at his current medical setting he serves approximately 10 percent DHH individuals. He attends Deaf related events several times each year.

Tammy who has been deaf since birth has been a therapist for the DHH community for the past six years. She allocates approximately 70 percent of her work with DHH individuals and attends Deaf related events once or twice each month.

Donna had been a practicing therapist for over 20 years and has been fluent in ASL since the age of 18. She lost her hearing at the age of 2. While her caseload is predominantly with the DHH community, she stated that she rarely attends any Deaf related events.

Mary provided clinical services to predominantly the DHH population for the past 11 years. She was born deaf and became fluent in ASL since the age of seven. She attends Deaf related events as much as she can.

Procedures/Data Collection

Participants were asked to identify themselves as a DHH licensed therapist, and whether or not they currently provide services to the DHH community. The participants answered several demographics questions to determine that they meet the criteria for this research by email. In addition to being currently licensed, the participants were required to have adequate hearing loss (greater than 40 db hearing loss), serve primarily DHH clients, and be fluent in ASL.

Those who endorse these conditions signed the hard copy interview consent form and then faxed the signed copy (Appendix A). The interview began with a discussion of the informed consent. I explained the participant's rights and purpose of the study. I provided each participant a copy of the informed consent. I also explained to each participant that the information they provided will be coded to protect their identities and that the tapes would be destroyed after the transcription was developed. Each of these participants was interviewed one-on-one by videophone, which was recorded. Additional demographic information such as ethnicity, hearing loss backgrounds, etc., was collected at that time.

Each participant was interviewed once in ASL between 40 to 60 minutes. The interviews were semi-structured to allow me the opportunity to approach the participant's viewpoint through their own lens and to allow opportunities for possible new worldviews to emerge (Berg, 1998). The interview questions (see Appendix D) were open-ended and flexible. The questions from the pilot study were modified and refined for the current study to make them more understandable to the participant, after multiple discussions held with my advisor and colleagues with qualitative research experiences. The final format was designed to allow participants to elaborate on their stories and experiences.

Setting

Interviews for this study were conducted by the videophone at each of the participant's office around United States. This approach was used because it was not logistically possible for the interviewer to travel to participants who reside throughout the country. The interview length varied due the responsiveness level of each participant, which were between 40 to 60 minutes. Every interview, video-recording, transcribing, and ASL to English translation was conducted by the primary investigator, Denise Thew. I also consulted with colleagues who were fluent in ASL for transcription accuracy and data analysis. One colleague who is fluent in ASL reviewed the videotapes and compared them with my typed transcription to ensure accuracy. Another colleague who is also fluent in ASL audited my transcriptions and we compared categories and themes.

Data Analysis

I used a grounded theory approach to analyze the interview data about the participant's reflections on their experiences of participating in non-sexual multiple relationships with DHH clients. In grounded theory research, theory emerges from the

data collected. Grounded theory analysis consists of 1) entering the fieldwork phase without a hypothesis; 2) providing a description of the observations; and 3) based on the observations, formulating explanations(s) about why the phenomena occurs (Glaser & Strauss, 1967).

Strauss and Corbin (1994) described the three stages of analysis, which was combined with the open step of the Grounded Theory (GT) methodology. During the first stage, the primary researcher independently read all of the responses of the participants and identified themes in these responses. In addition, an auditor reviewed the transcript and analyses of categories and core ideas to ensure accuracy. In order to avoid experimenter bias and to allow for unexpected findings, the open step of the grounded theory approach uses categories drawn from respondents themselves and tends to focus on making implicit belief systems explicit.

I transcribed the signed interviews into the original language, ASL, since this was the language that was used to interview the participants. Paragraph numbers were inserted in the left margin of the manuscript to provide an effective way of identifying each line and paragraph. I am proficient in ASL, and I engaged a colleague who was also proficient to verify the accuracy of the transcription. Although the interviews were conducted in ASL, all coding was done in English for all the transcripts. This was done because the final product must be in English and it also provided consistency throughout the data. I began the first level of the coding process by doing a line-by-line analysis of the transcripts and created meaning units. Meaning units serve to break down data into manageable units to be further built upon. Next, I typed the meaning units in a separate document. This allowed for all the similar meaning units to be grouped together.

Categories continued to be formed until saturation had occurred. The list of categories is presented in Table one in the result section. Saturation was achieved through numerous readings of the transcripts and combining similar meaning units to form categories.

The next step, parsimony, focused on the relationships between the categories. I reviewed the list of categories gathered from each separate transcript, and combined similar categories. As mentioned in the verification section, a colleague reviewed the categories and her suggestions were incorporated into the final coding. When all the like categories were placed together in their respective groupings, I created a theme for each grouping that described the data provided in the categories. The list of the themes is located in Table 2 (Chapter III).

CHAPTER III

RESULTS

This study generated a rich collection of descriptions of experiences of a small sample of licensed Deaf or Hard-of-Hearing therapists who reported to encounter non-sexual multiple relationships with their DHH clients. This chapter presents codes, categories, and themes that were extracted from the existing data to build a conceptual model. The quotes and statements in this section have been translated from ASL into English with caution to retain the key concepts that were captured during the interview. During the first level of coding, several meaning units emerged that were combined to form fourteen categories (see table 1). From these categories, five themes emerged (see table 1). These identified themes are: a) identifying and recognizing multiple relationships (dual and/or overlapping) when providing services to the Deaf and Hard-of-Hearing community, b) how the therapist perceived their own Deaf or Hard-of-Hearing identity development and how their identity development affects their interaction with the Deaf Community c) Deaf Therapists' awareness of their own personal and professional roles, and their concerns of maintaining a positive image in the (Deaf) community, d) prioritizing the Deaf culture norms and the Code of Ethics when they are difficult to blend or clash, and e) strategies employed by therapists and clients or patients to negotiate the boundaries of their various roles with each other. Following is an examination of the results of each of the five themes.

Table 1: Categories and Themes.

Categories	Themes
Perspectives on definition of overlapping relationship and dual relationship Importance of gaining awareness on overlapping or dual relationships Identifying dual or overlapping relationships	Identifying and recognizing multiple and/or dual relationships – Dual and/or Overlapping
Therapist's education background Therapist's family background Therapist's background and exposure to DHH culture Therapist's evolving experience during lifespan to DHH culture	Therapists' DHH identity development and their interaction with the DHH community
Therapist's professional and personal self How therapist protect their personal and professional roles Therapist's support system	Therapists' awareness of professional and personal roles and concerns of maintaining positive image in the Deaf community
Cultural norms/values in the Deaf community may lend themselves more to the participation in a multiple relationship Deaf therapist may struggle with maintaining professional ethics code while maintaining some Deaf cultural values	Deaf Cultural values and professional ethics code can sometimes clash or be difficult to blend
Therapist's multiple relationship experiences Negotiating involvement in a multiple relationship How therapist manages the multiple relationship	Strategies employed by therapists to negotiate the boundaries of their various roles

Overview of the Conceptual Framework

From the perspective of participants in this study, Table 2 presents the key themes and subthemes that were found as integral to the nonsexual multiple relationship overviews. Major themes, including multiple relationships definition, identity

development, personal and professional self, Deaf culture vs. Code of ethics, and strategies employed by Deaf therapists, were broken down into subthemes to identify some commonality.

Table 2. List of Themes and Subthemes by Participant.

	Participants									
Themes/subthemes	NW	MP	NF	SM	LD	KS	PC	TT	DW	MJ
Multiple Relationships										
Overlapping (recognize and experience)	X	X	X		X	X	X	X	X	X
Dual (recognize and experience)	X	X	X	X	X	X	X		X	X
Perceived as same definition						X	X			
Perceived as different definition	X	X	X	X	X			X	X	X
Identity Development										
Deaf (self identified)	X	X			X	X	X	X		X
Deaf (self identified)		X	X	X					X	
Hard-of-Hearing (self identified)		X	X							
ASL user (self identified)	X	X	X	X	X	X	X	X	X	X
Attended deaf school-institute	X				X	X				
Attended deaf college	X	X		X				X	X	X
Deaf with "hearing-mind" (perceived and labeled from other Deaf individuals)		X					X	X		

Table 1. cont.

Themes/Subthemes	NW	MP	NF	SM	LD	KS	PC	TT	DW	MJ
	Participants									
Professional and Personal Self										
Lifestyle choice (e.g. common interests values, background)	X	X	X	X	X	X	X	X	X	X
Awareness of how one is perceived by others (increased compared to before entering the field)	X	X	X	X	X	X	X	X	X	X
Became more selective of client types or friends	X		X		X	X	X	X	X	X
Concerns about how one is perceived by others, even when in personal role (off duty)	X	X	X	X	X	X	X	X	X	X
Culture vs. Ethics										
Awareness of maintaining ethical standard and Deaf culture	X	X	X	X	X	X	X	X	X	X
Awkwardness (when Deaf culture values clash with Code of ethics)	X	X	X	X	X	X	X	X	X	X
Admits being a Deaf therapist can be Difficult/challenging	X	X	X	X	X	X	X	X	X	X
Strategies										
Has a selected primary theoretical foundation		X		X						

Table 1. cont.

Themes/Subthemes	NW	MP	NF	SM	LD	KS	PC	TT	DW	MJ
	Participants									
Uses role play technique with clients during therapy		X		X	X	X		X		
Dialogues with clients/ patients during initial meeting to establish clear boundaries		X	X	X	X	X	X	X		X
Structures own life to avoid or reduce outside encounter	X	X	X		X	X	X	X	X	X

Following is a close examination of each of the themes and some of the participants translated quotes. Furthermore, several diagrams were developed to capture and represent the overall pattern that the majority of the participants experienced when dealing with nonsexual multiple relationships with Deaf patients.

Multiple Relationship Experiences

One of the most significant themes in this study from all ten participants was defining and identifying dual and overlapping relationships. Several participants provided some examples to illustrate the possible differentiation between dual and overlapping relationships when providing professional services to the Deaf community. Every participant in this study reported to experience multiple relationships and shared some of their strategies that they have developed over the years to help them to navigate their roles. Upon further examination on the participant's perspectives on the definition of overlapping and dual relationships, it was observed that six out of ten of the participants

stated that the concepts of dual and overlapping relationships were two separate notions, while only two out of ten participants used these two terminologies interchangeably.

Furthermore, one of the participant have never heard of the term "overlapping" and one another was familiar with the word "overlapping" but not "dual." *Nicholas Wolf*:

> I want explain two separate things - overlapping and dual relationship. I experience a lot of overlapping, because I am Deaf and the Deaf community is small, which means I experience a lot of overlapping. However; dual relationship is something that I avoid. Based on code of ethics, dual relationship is a big no-no [unacceptable] in the mental health field. I tend to avoid dual relationships as much as I can. Overlapping means that if I happen to see a client within the same member of association or in Deaf events. We saw each other but did not talk to each other. Dual relationship means that I have relationship with this person as a therapist and outside of session. If I already have relationship with them [as therapist-client], I avoid dual relationship.

Nicholas Wolf clarified his discrimination on overlapping relationship from dual relationship with the following example:

> Overlapping is more minor, such as just happened to be at the same event – such as just happened to attend the same church that large numbers of deaf people attend and I noticed that my former client was sitting over there.
>
> *Noelle Frosty* described dual relationship: I set firm boundaries and just don't have relationships with my clients outside of work. If I see an invitation, such as an e-invite and I see a client on the list then I tend to decline attending this event.

This can put limitations on my fun sometimes. I do have my circle of friends and we do things together and they sometimes are mindful and try to keep things with whom they know. I also describe overlapping relationship as crossing paths and the client and I meet in daily life one way or another. For example, going to a church and then I see my client at this church. I do have a client who goes to my church and it just happened that we both attended this same church. I've been fortunate that this person who is also my client acts normal and chats with everyone else at the church. This client is very open and says hello to me - like we don't know each other at the church. I just go with it and chat. For some other family, I wonder if they won't understand how to maintain boundaries but this family at this church is very respectful. That is what I conceptualize as overlapping relationship. Dual relationship means friends, and the "infamous" sexual relationship that many therapists get sued for, and this is where I draw a thick line.

Larissa Doe also described overlapping by providing the following example of her role as a mother and a contract therapist at her children's school:

> Many kids figure it out when I show up at the school as a mother because I do not use a badge or I dress differently, or when I show up with a badge then they know I showed up as a counselor. I don't tell them but they figure it out, so that is overlapping. Dual role means that I have two roles at the same time, such as working with deaf children as a therapist and as a deaf interpreter. Sometimes the deaf child may not understand what the interpreter interpreted for hearing parents so I have to ask myself should I take over and expand the concept or interpret to

> meet the deaf children's communication mode or level of comprehension. Some interpreters may not be qualified or skilled to interpret at the specific communication mode of that deaf child. This is sometimes a struggle as a dual role, which I believe is more challenging than overlapping relationships. Dual role means more than one role happening at the same time.

Two participants either did not perceive the distinction between the overlapping and dual concepts, and for one of the participants, the term overlapping was a novel term.

Sally Moore:

> Dual role, I perceive as having two different roles inside and outside of therapy such as having a social friendship basis as opposed to remaining professional. As for overlapping, I haven't really thought about it, and it is not a term that I am familiar with or use right now.

Sally Moore described dual relationship, as "being in a power or superior position that you need to be careful not to abuse because you might know too much information."

Katie Smith and *Peter Caine* both perceived dual and overlapping relationships as a parallel concept; that is, meeting with deaf patients at work as a therapist and then seeing them out in the community outside of the office. As *Peter Caine* stated, "Overlapping is dual relationship" when pointing out that these two definitions are used interchangeably.

Examples of Multiple Relationships

Several participants shared some examples of overlapping or dual relationships during various stages of their career span, as a novice therapist to an experienced

therapist. *Nicholas Wolfe* recalled an incident in which he managed to avoid some potential awkwardness:

> During early in my career as an intern, I had a client who was high functioning, which means he had a reliable job and was also very involved with the Deaf community. He came to see me because he was struggling with depression and I thought that as a therapist, I should encourage him to be more involved in the Deaf community by visiting some friends at their homes so that he can get himself out of the house. I was staying at a house with few roommates and one day I was looking outside the window and saw my client driving up and approaching the house. I realized that my client was a friend with one of my roommates so I panicked and took off because I didn't want to take the chance for us to bump into each others at the house. This was my first experience and I felt really awkward and freaked out. I learned from that experience and I would handle the situation more calmly if it happened again. Another situation I had encountered was that a former client and I ended up being employed with the same employer a few years after termination. The Deaf community is very small even if we scatter across the country geographically. We are still connected.

Numerous participants described some of their ongoing dilemma to navigate unavoidable multiple relationships due to limited resources in the Deaf community. *Molly Paraffin* described her multiple roles as a head of psychology services at a Deaf college:

> I often had to be really careful about what I talk about with whom because there is greater chance that I may see a client at a party or Deaf event. As one of the

> former heads of the psychology services at a college, many of my classroom students come to our counseling center as well. I also see them around the campus so I became really "paranoid" about confidentiality.

Tammy Thomas disclosed that as a sole therapist within the 100-mile radius, she often sees her clients out in the Deaf community. She feels that the best solution to reduce the awkwardness and dilemma is to reduce her interaction in the Deaf community. In other words, she stated that she has reduced her interaction from the Deaf community from 60% down to 30%.

> Right now I am more focused on myself. In the past I have taken care of everyone else, so I feel that it is my turn to focus on my own overall well-being and do de-stressing because it is very difficult to do my job. It is almost impossible to avoid overlapping relationships if I want to participate in the Deaf community in my area.

Identity Development

Participants reported a variety of Deaf or Hard-of-Hearing identity development experiences and stages. For some of them, their identity development is ongoing, while for others, their identity was transparent since birth. *Nicholas Wolf* reported to come from a Deaf family so his deaf identity was never an issue for him growing up. Many of his barriers were addressed early in his life and then he became confident with himself during college at Gallaudet. He described his identity development in terms of the model created by Dr. Alan Sussenman – his model of a well-adjusted Deaf individual – because he sees many of his own personal characteristics in the model of the well-adjusted Deaf individual. For example, he reports having a positive self-concept and self-esteem as a

deaf person. Also, he has a positive psychological acceptance of deafness, since he made it clear that he is proud to be Deaf, and classified himself as a capital D, Deaf.

> *Molly Paraffin*: "I grew up as a Hard-of-Hearing person or "hearing-impaired." I knew nothing about deaf culture or the deaf community. I mainstreamed (only deaf child in the entire school) and I consider myself a "deaf with hearing mind" person; Hard-of-Hearing but "hearing-minded."

Her first exposure to deaf culture and a signing interpreter was when she entered the Masters in Social Work program that had grants to support deaf and Hard-of-Hearing students to enroll into this particular program. Prior to this Masters program, she did not consider herself deaf but then her identity evolved after some exposure with the Deaf community:

> Right now, I consider myself as Deaf (big D) and immersed in the Deaf world, but because I grew up in the mainstream setting, many Deaf people look at me and ask who I am. So, I have ongoing struggles with that. I'm not really DEAF (as in being a Deaf militant). I didn't go to a Deaf-institute, and I didn't sign fluently growing up. However, I learned ASL and got involved in the Deaf culture, and then I worked at Gallaudet College, and I got myself immersed into Deaf culture. Generally, my world moves back and forth from hearing, Hard-of-Hearing, small d deaf, big D deaf. I have been involved in various Deaf groups and then I realized that I am small d deaf. However, I also don't want to be stuck or trapped in only the Deaf culture. I have hearing friends and I want to keep all of my options open. Now I have learned to accept that my self will not fit perfectly in any one particular world; just that I'm comfortable with myself."

For *Molly Paraffin*, her identity continues to change after she recently received the cochlear implant surgery –

> It has been interesting to see that many of my friends who were considered a "strong" member of the Deaf community with a big "D", Deaf, also received the cochlear implant! The whole Deaf community identity is changing. Also, the whole meaning of Deaf identity is changing too."

Noelle Frosty affirmed that she identified herself as Noelle rather than as a D/deaf or Hard-of-Hearing individual -

> "I see myself as [Noelle] first. That's who I am and that is whom I identify as first. Then, if I have to look at the deaf or hearing labels then obviously I'm a deaf (small d) person. I also consider myself Hard-of-Hearing when I'm with people who can talk. I can see myself as Hard-of-Hearing but still identify myself as deaf, which means I mainstream into the Deaf community. The entire Deaf culture is a whole other philosophy and perspective."

Furthermore, Noelle disclosed that she didn't learn sign language until she was seventeen, so therefore she considered herself as "very Hard-of-Hearing" growing up. She continued to explain that her identity changed after age 17 and throughout her adult years. Currently she identifies herself as a "big D deaf" with further clarification and emphasis that she does not consider herself as "a strong Deaf power type" (such as deaf militant), and wanted to make it clear that her primary identity is Noelle, not "deaf or Deaf."

> *Sally Moore:* I have progressive hearing loss. My brother is deaf (small d) and we both went to oral school for a brief time, then to mainstream. I was deaf, but

medically deaf, by age 15 when I lost all of my residential hearing and then couldn't benefit from a hearing aid anymore. My identity back then was mixed because I didn't know. I was sitting on the fence because I didn't have any deaf or Hard-of-Hearing role models growing up. I didn't become enculturated until I moved to Minnesota during the 1970's and Minnesota was where I met many well-educated deaf people. It was during this time when I learned sign language. After this experience, I decided to go to Gallaudet College in 1977. In terms of deaf identity development, that's where it all happened, at Gallaudet.

Currently, *Sally* identifies herself as Deaf first.

I don't have any issues about my identity now. I think my identity development was completed by the time I graduated from Gallaudet. My preference for socialization will be deaf people similar to me. Back then when I interacted with many hearing people, I was not able to follow what was happening during the conversation and this is something that I cannot tolerate anymore. I don't have patience for that type of interaction anymore.

Another participant, *Larissa Doe*, came from a Deaf family. She described that back in her generation, there was no such thing as a label of "Hard-of-Hearing." She stated that while growing up, the label was as simple as black or white. The label was either "deaf or hearing, so it was easy to pick which label" was accurate. Despite coming from a Deaf family, she attended a school program that emphasized the oralism philosophy.

Many people in the Deaf community were shocked that I went to a school with an oral program because I had Deaf parents. My parents wanted to give the oral

program an opportunity, and I was still labeled deaf. Back then, the label of oral was not a clear label and was considered a blurred label. The oral label became clearer when sign language was added into the mainstream education system. Also back then there weren't any sign language interpreters in mainstream classes. That term, mainstream, was also not a clear term in the past. I think that during my time, there was a lot less label available -I was simply labeled as deaf. As for identity development, I looked back and explored some of my identities. I saw myself not as deaf first but as Larissa first then as a girl, etc. Deaf was last on my list because that label was simple black and white, so the deaf label was not a priority one for me. I saw myself as a whole person and the deaf label was last on my list. That is how I believe that my parents also perceived me. Maybe it was because everyone in my family was deaf and I never felt any different when I'm at home.

Katie Smith: I became deaf when I was 26-28 months old from spinal meningitis. In terms of my family upbringing, I attended an oral program so I really struggled (referring to communication barriers) with my immediate family until I went to a Deaf-institute. While at the Deaf-institute, I noticed sign language and learned the language. This was when I identified myself as a deaf individual. I was about 9 when I identified myself as deaf and then I grew from there. I graduated from a Deaf-institute so during college I became more aware of my own Deaf identity and since then have identified myself as Deaf. I am more like the big D and at the same time, not that big D such as a strong political type but at the same time not too small of a "d." I'm more of between the big "D" and the small "d." If I'm with

hearing people who can sign then I'm ok with that as well. I don't interact with hearing people who can't sign because I have already had enough experience getting through that.

Peter Caine reported to identify himself as hard-of-hearing since he was about 19 and then he suffered from a rapid progressive hearing loss.

As a result of my sudden hearing loss, I realized that sign language needed to be acquired quickly. I also had to learn how to cope with my sudden hearing loss quickly because I was in the middle of college. I don't know exactly how I arrived to my current situation. My wife is Deaf, my daughter is Hard-of-Hearing, and my current circle of friends are 50/50 Deaf and hearing so there is some mixture when it comes to my identity as a Deaf individual because I do a lot of things with both deaf and hearing individuals. In the mental health field and my job as the Deaf psychologist on my team, I feel that my identity is dynamic.

Peter Caine stated that he generally identifies himself as a "very big D" because he sees a lot of cases and situations based on the perspective of the Deaf culture.

I am not big with implants for Deaf children, and often do not wear hearing aids. I only wear it in some situations but my ability to process sound has declined a lot. It is hard for me to use the phone – I can use it sometimes but I don't always understand what I hear and I really need to focus hard. On the phone, I can't use any visual cues. So, yes, my identity is the big D because I also tend to function this way at employment.

Tammy Thomas grew up having a deaf brother and they both attended a mainstream program at their neighbor school.

> We did have some Deaf culture exposure from attending Deaf events and meeting other Deaf people so I was "deaf" (small d) but then when I arrived at Gallaudet College for graduate school the Deaf students there called me "deaf with hearing mind" because I was not what they consider full Deaf such as "Deaf radical." I'm not like that at all. I interact with both Deaf and hearing communities. Both of my parents signed so it was fine growing up with my family. Unfortunately, some people (at Gallaudet) have a "hard mind."

While Tammy believes in the concept of "ally" by being friends with "everyone", she still considers herself as a Deaf individual with a big "D".

Donna Waine reported that there is some ambivalence whether or not she was born hearing.

> My parents knew for sure when I was 2 when I had a high fever and I wasn't responding to sounds. I wore hearing aids and went to an oral program growing up and then I learned sign language at the age of 18. When I was younger, I didn't know who I was. I attended hearing high school and did not have any Deaf peers until my junior year, when a Deaf boy joined, and then there were just two of us. He was very different from me because he had a different personality, especially because he was a male and I really wanted female friends during that time frame. I think that my identity became positive when I was enrolled in the social work program at NTID (National Technology Institute for the Deaf), and that was when I felt really proud being Deaf. The identity was there but growing up, I never knew where I fit in.

Furthermore, Donna explained that she does not want to be perceived as a "radical Deaf " and enjoys interacting with Deaf, Hard-of-Hearing, and hearing individuals.

> Although, I feel most comfortable with other deaf people like me but I'm not the kind of person who is radical, such as supporting the "ASL only" movement and all that. I want to make sure that deaf people have equal access to whatever their preference is.

Mary Jane stated that her identity development "spiked" during her undergraduate years at California State University.

> Even though I grew up in the oral system during the 70's, my parents have always put me as a person first. I was Mary first, then girl, then soccer player, then bookworm, and the list goes on. The Deaf label was last on the list. My parents always made sure that I was involved in the family but I often felt very isolated outside of my immediate family, such as relatives or hearing friends. I suppressed a lot and kept on a smile face. I had tremendous growth when I attended Gallaudet College. Many other people would identify me as Hard-of-Hearing because I could speak well even though I couldn't talk on the phone nor understand much when in a group of hearing people. I was confused with my Hard-of-Hearing label. I also was confused with my hearing aid label, speaking label, etc. When I take off my hearing aid, I am deaf and cannot hear anything at all, so I decided that I am Deaf! Gallaudet was a tough experience because many others at the college would label me as "deaf with hearing mind" because I could talk and lip-read. This label made me really frustrated and made me fight for my identity.

Currently Mary considers herself as a "big D, Deaf." She also elaborated that her identity will continue to evolve as she continues to encounter new life experiences and opportunities.

Professional and Personal Self

Many of the participants in this study disclosed some of their struggle as they try to separate their roles in their professional and personal life, and this is another theme identified in this study. For many of the participants, maintaining their professional image in the Deaf community has been a constant struggle. However, many of them have reported that this is something that comes with the territory of being a Deaf therapist for Deaf individuals.

Nicholas Wolf reported that a large percentage of his work and personal life are in the Deaf community.

> I work with Deaf clients, Deaf co-workers and in the past have had a Deaf boss. My entire family is Deaf – Deaf parents, sister, brother, and 2 aunts. My wife is Deaf and I go to Deaf events. I attended a Deaf-institute and then a Deaf university. I really am immersed in the Deaf culture and the majority of my work continues to be with the Deaf community. I notice that the more experience I have, the more careful I become. When I attend Deaf events, I wonder in the back of my mind if I will see any of my clients there. Then, when I go to the Deaf event and didn't see any clients, I often feel relieved.

Since *Nicholas Wolf* has a deaf wife who is also in the mental health field within the Deaf community, he has established a code word to cue for a potential ethical dilemma with her.

> She is a very social person and has many friends. When I see a client of mine at an event, I use the code word "client" and she will know that she should not interact with this particular person such as being friends or exchange information such as address or email. She will know to avoid that. I don't discuss cases, names, problems with her – just the code word "client" and she knows what to avoid. When we arrive to the event, I look around the location for any deaf clients and if I don't see any then I don't say anything. However, if I see one over there then I will turn to my wife in private and say something like, 'that person over there with red hair, blue shirt,' and then my wife and I would make eye contact and shake our head to show that we understood and then move forward. Sometimes I sign the word "client" but my wife and I have reached the point where we can understand each other.

Molly Paraffin pointed out that it is not so much about the notion of how much one interacts within the deaf or the hearing world, instead it is more of a lifestyle choice the individual makes.

> Currently, I feel more involved with the hearing world because my husband is hearing. My friends at work are mostly hearing and I spend more time with them now than before with deaf individuals. Many of my Deaf friends are single now. It's not about deaf vs hearing. It's the lifestyle. Singles hang out with each other. Some who are married have children. My husband and I don't have children and we are older. Those with children are younger.

This notion brings up the concept of addressing identities beyond the scheme of the Deaf vs deaf labels. The complex identity framework has been elaborated and discussed in the discussion section.

Noelle Frosty explained that staying aloof and reserved is one of the outcomes of having to maintain a professional image in the Deaf community, even while off duty. She felt that maintaining a professional image is critical in this field of professional because she believes that judgments from the Deaf community members are powerful and can impact the dynamics with current and potential clients. She described professional image such as maintaining similar demeanor that she portrays while in the office, while out in the general community to prepare for the possibility of out of therapy encounters. This includes how she dresses, how she behaves, whether she treat people with respect and so on. She admitted that she became less relaxed in the general and Deaf community since she chose this field of profession.

> One of my close friends have told me that I need to relax and go out doing things based on her observation of me. I feel that I can't just really relax and go to different Deaf events. I am a very conservative person and this experience (becoming a therapist for the Deaf community) has made me more conservative and stand back more. I only hang out with my close friends. When I go to a food store, I feel that I cannot just go in my hat on a Saturday morning because I think about the possibility of bumping into a client and then they see me with my sloppy appearance with a hat on. I feel that I have to shower, look clean and nice and then go out.

This can be comparable with a hearing person who described herself as very conservative, however for a Deaf individual who chose to provide personal services such as therapy for a close-knit community (eg. Deaf), Deaf therapists seem to believe the Deaf community expects those around-the-clock professional images, even while the Deaf therapists are off duty. Many other participants feel that their outside of office demeanors will impact their potential caseload if they do not maintain a certain appearance. In other words, unlike hearing therapists who tend to be conservative by choice, many Deaf therapists in this study feel that being conservative or reserved is an expectation rather than a choice.

Modeling Behaviors

Many participants believe that modeling behaviors for clients outside of therapy is essential and anticipated from therapists. *Molly Paraffin* disclosed:

> I feel that I need to be more neutral when out in the public. For example, I cannot go to a party and put on a lampshade hat. I must be polite and quiet in my behavior. It is like having some kind of a distance between me and other people. Furthermore, I cannot afford to be drunk. I look at my own behaviors more and want to be a role model for others in the Deaf community.

Noelle Frosty stated that despite the reality check that her friends tell her that most clients know that therapists are human beings.

> I still feel that I have to maintain my image. I must have a certain demeanor and professionalism when I interact with people in the Deaf community because of the fact that many could be my potential clients.

Sally Moore divulged that since being in this profession, she has taken a position to not reflect negatively on her professional role and this consists of being more careful with her social behaviors and how she presents herself.

> I am probably more careful about what I say, and probably will not drink too much because I feel strongly that we represent this mental health agency. The Deaf community is such a small community. If all of us go out and get drunk, we won't look very good in the Deaf community, so we are careful about what we say, what we do, and what we eat and drink. We must be on our best behavior so that we don't reflect on this program negatively.

Deaf Culture vs. Professional Role

Molly Paraffin described how she learned to navigate between the mental health culture and the deaf culture during her career:

> Early in my career, during the 1980's, it was difficult because the Deaf culture was very strong and many people in general were resistant or defensive about the mental health schema. Many people were suspicious about those who worked as therapists. The idea of venting personal information and not being sure what the therapist would do with the information caused many to be paranoid. There was a conflict between the mental health culture and Deaf culture. One of my favorite examples from my early days was when I was an intern, studying to become social worker. I attended a party at a Deaf club during the night I was assigned the emergency on-call duty. When I arrived at this party, my pager went off and I had to call to find out what the emergency was. You know, in Deaf culture, it is required to inform and share with everyone in the room when you use a TTY.

> You must explain to everyone about what you talked about and whom you talked to on the phone. I couldn't do that because of confidentiality so this is one example of how the Deaf culture can conflict with the mental health culture. At this time I lied by saying that I talked with my mother or friends just to cover it all up. I learned from this experience and the next time I attended a party at the Deaf club, I explained my role right away and that I was on-call that night. This time I walked in and informed everyone that if I had to make a phone call, I couldn't share anything because of confidentiality, not because I wanted to keep it a secret. They understood and accepted my upfront explanation. This helped me to learn how to negotiate or navigate between these two cultures, Deaf and mental health.

Molly's approach also allowed everyone at the party to know that if they needed her services, she would keep their information confidential as well.

Sally Moore believes in the need of being present in the Deaf community in order to earn credibility as a professional.

> There were times back when I first began in this field that there was a lot of awkwardness; but with maturity and being in this field for a long time, it becomes easier. One of the disadvantages of the Deaf community is that if you isolate yourself too much, you won't have a lot of creditability from Deaf community members. So, when they see you out in the Deaf community and supporting Deaf events, you will have more credibility.

Sally Moore described one of the norms of the Deaf culture, which is hugging and touching, and how she used good judgment when it comes to establishing boundaries on hugging with patients or clients.

There are many clients I don't hug and I try to teach the handshake. Except for those few times with clients who were very clear with boundaries and once in while when they are doing so well, I would give them a hug because that is part of the Deaf culture. Or, if I terminate a client because he or she has been doing really well and is ready to move on then I might give this client a hug. I'm comfortable with that limitation.

She made it clear that she would never initiate hugging with a client and that it is the client who would initiate the first move and then she would respond by using appropriate judgment.

According to *Katie Smith*, sometimes other people's behaviors affects the therapist's own behavior. "Sometimes I think it is not fair that I have to make sure my husband behaves when we are out in the Deaf community because of my profession. It is not fair to him."

Furthermore, some other participants reported that their interaction with family members, friends, and significant others can impact how they are perceived by the Deaf community. Additionally, the behaviors of these individuals the therapist interacts with can have an impact as well, positively or negatively.

Below is a diagram (Figure 1) that illustrates how the interactions of the Deaf culture, values, and norms, and the Code of Ethics are vital parts of both the Deaf therapist's professional and personal roles. According to most of the participants in this study, this interaction between professional and personal roles is an expected part of the territory that comes with being a Deaf therapist in the Deaf community. Professional role is described as the therapist's on-the-job role such as being a therapist, advocate, teacher,

researcher, advisor, chairperson, to name a few. Personal role is described as the therapist's life outside of work or while off-duty.

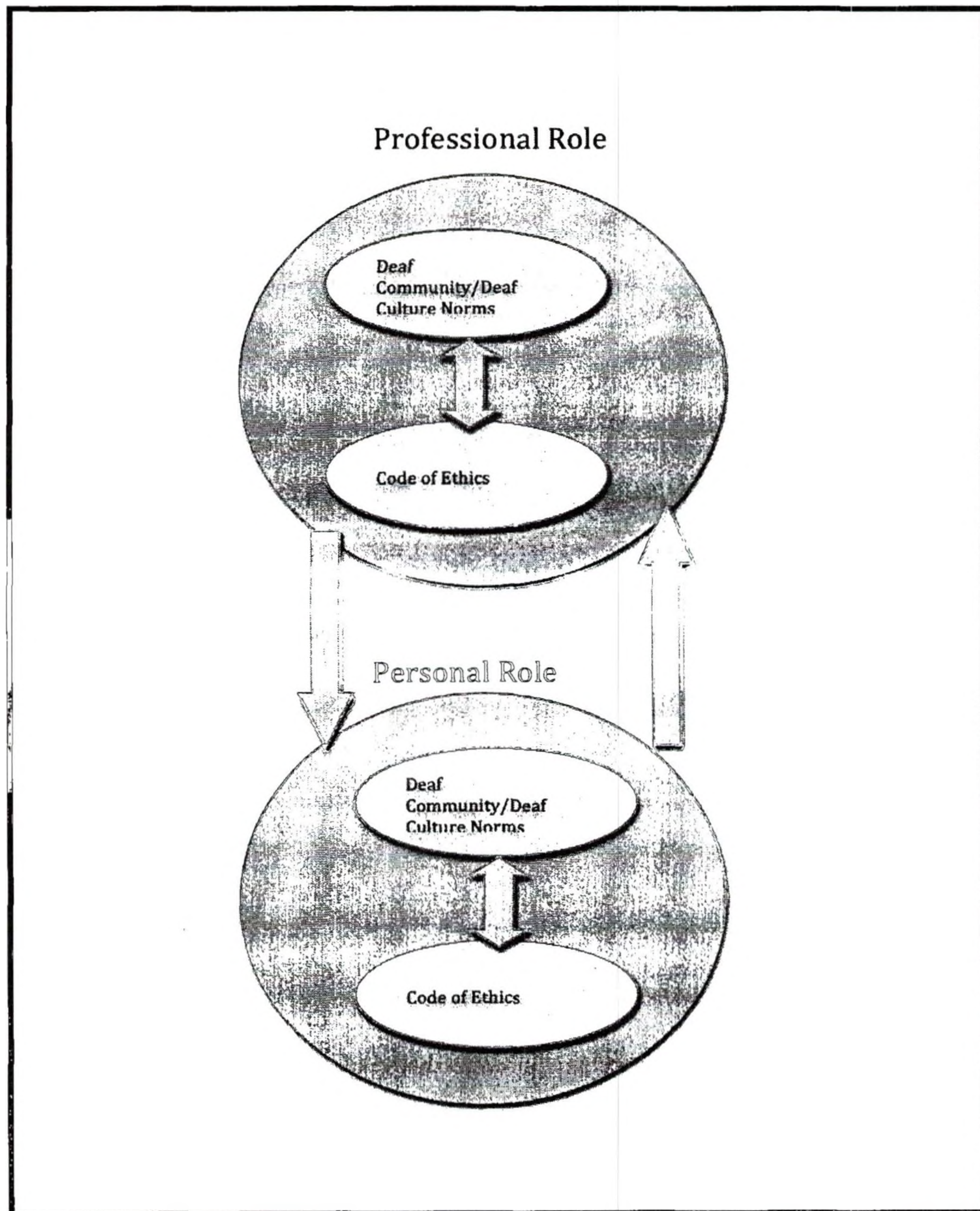

Figure 1. Interactions of Deaf Culture and Code of Ethics within the Professional and Personal Role.

Many participants reported that the challenges of trying to incorporate both the Code of Ethics and Deaf culture could be difficult in both personal and professional roles. Also reported was the difficulty in separating the professional from the personal roles while in the Deaf Community because many Deaf or Hard-of-Hearing community members perceive the therapist as a therapist even while off-duty. The Deaf or Hard-of-Hearing community members might have certain expectations of how the therapist should behave even while off duty. Some Deaf community members might expect the therapist to set aside the Code of Ethics and demonstrate more Deaf cultural values, while some others might expect the therapist to maintain a rigid Code of Ethics while interacting in the Deaf community.

Many participants reported that they still feel that they need to maintain a certain consciousness of the Code of Ethics while off duty during their personal roles, especially when interacting at a Deaf social event. This can cause some inner struggle with the self and trying to create a balance to respect both roles and values, the Deaf culture and the Code of Ethics, while trying to maintain both Professional and Personal roles. The diagram below indicates an interaction of all these components, the interaction of both the Deaf culture values and Code of Ethics, while in both Professional and Personal roles, and the interaction of both the Professional and Personal roles. In other words, the diagram shows that each of these variables are interwoven with each other and can be difficult to separate out with a clear boundary and outline. The majority of the participants in this study experience the overlap of both professional and personal roles, in which the two large arrows outside the two large circles in the diagram illustrates. Hence, it is difficult, if not impossible, to separate the professional and personal roles

while in the Deaf community (as a Deaf individual or as a Deaf professional), and it is a never-ending challenge to avoid blending the ethics with the Deaf culture norms in both of these roles. One of the goals for a proposed decision-making model for Deaf therapists is to allow these two large circles to become combined as much as possible, so that the Deaf therapist can be comfortable in their own overall well-being and identities consciously, while the ethics codes are not questioned.

Strategies

The strategies employed by therapists and clients to negotiate the boundaries of various roles with each other is another theme that was identified in this study. These strategies included clearly defining the relationship, boundaries, and roles, dialoguing/processing during therapy, role-play, checking in with the client and therapist periodically about comfort levels, and bringing this to supervision and colleagues. Many therapists also found that having a strategy of establishing boundaries at the beginning allows them to work through some of the awkwardness that could arise.

> *Molly Paraffin:* Early in our meeting in my office, I bring up the possibility that we may see each other outside of the office. We discuss how we can handle it if such an encounter occurs. I would ask them if they would like me to ignore them or say hello and whether they would like me to talk briefly, etc. I also discuss what such an encounter could look like. This helps us to set up clear guidelines on how to act outside of the office. Most times now I prevent problems ahead of time by establishing that guideline during the first few sessions of therapy.
>
> *Noelle Frosty:* With all of my clients, I explain to them at the beginning that I will go with whatever they prefer when they see me outside of the office. I will

tell them that to let me know if they want me to say hi they will need to do it first. If they don't initiate the first move then I will act as if I don't know the person.

Sally Moore stated that she discusses with clients about her seeing them out in the community, and how they can handle that during their first session.

> I let the client decide if they want to acknowledge that they recognize me and then want come up to me for a chat. That's fine with me, and I tell them that I don't want to talk about their problems out in the community. I tell them that I have a right to a break too. They really do get it, and they have been really good about it so it was never a big issue.

> *Larissa Doe*: I always make it clear at the beginning appointment, such as during the intake, that we might by chance meet out in the Deaf community and I explain to them during that time what my role is when I am at the Deaf events. We discuss how we can respond if they see me out there, and we discuss how the client wants me to respond if they see me there. I also explain that I don't talk about their personal issues outside of therapy or appointment time.

Peter Caine explains to his clients prior to the experience about what might happen and tells them how he will handle out of session encounters by giving his clients the option of making the first move.

> I tend to be upfront if it is someone that I could bump into. I will say to them that if we bump into each other, I will pretend that I don't know the person unless the person comes up to me. That will be fine with me and is their right but I will still not say anything about the type of our relationship. I will just say nothing and if

that person says that I am their therapist then it is their right but I will not say anything.

The following diagram (Figure 2) represents the strategies that many of the participants pursue.

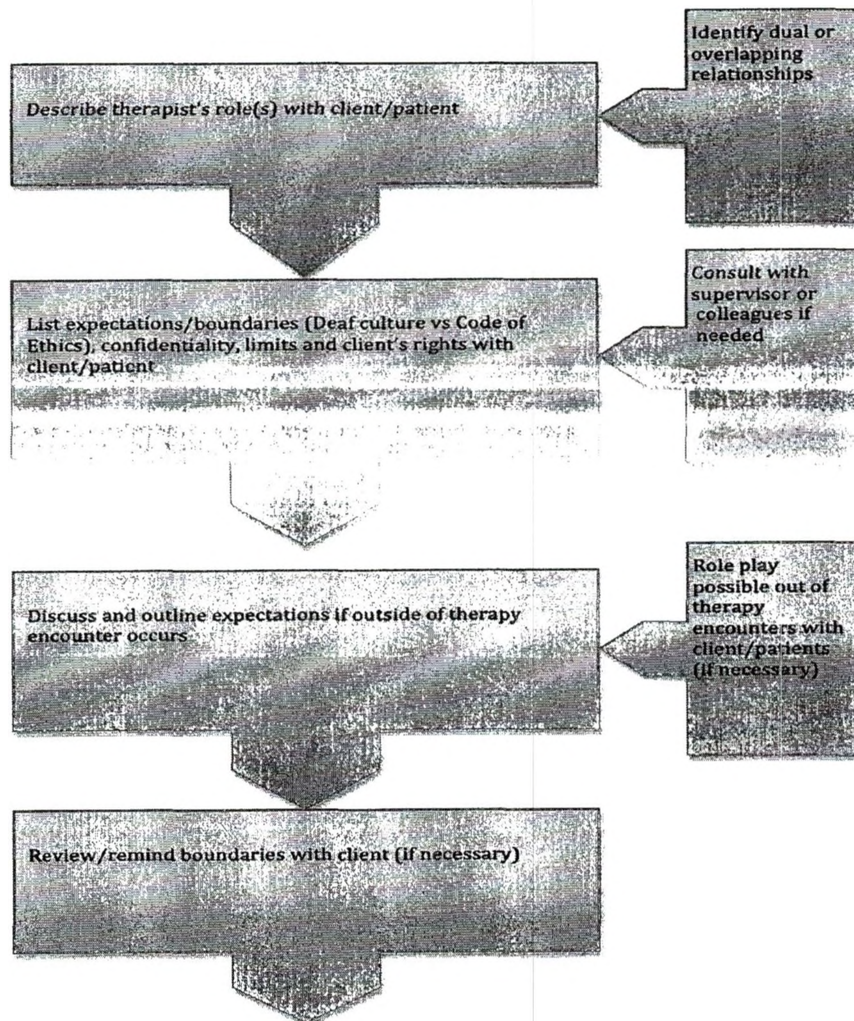

Figure 2. Strategies to Negotiate Roles.

Like many therapists, *Tammy Thomas* and *Donna Waine* clarify their roles and list out their expectations during the first session because both feel that they sometimes do not have any privacy outside of the office. Donna Waine tries to limit outside encounters to simple greetings and then discuss their encounters during therapy. She wants to establish boundaries at the beginning so that she can teach her patients to respect her personal time outside of her office.

Specifically, the overall process and approach to dealing with nonsexual multiple relationships that were shaped by Deaf therapists' overall framework that interplayed with several themes is displayed in Figure 3. The following diagram (figure 3) illustrates the overall interplay of experiences that Deaf therapists in this study encountered. The themes and subthemes where a majority of the participants have identified in this study are within the two large circles. As the two major circles overlaps each other, the participants in this study emphasized the significance of possessing the overall awareness of self, and recognizing the challenges and the importance of working through much of the awkwardness that comes with the territory of this profession. In the first circle located on the top, the four factors such as lifestyle choice, identity development, personal self and professional self all interplay with each other. The second circle below demonstrates some complexities when trying to determine the most appropriate strategies. In the second circle below, two of the themes – code of ethics and Deaf culture interplay with each other as the therapist tries to blend these two values as one of the component of trying to navigating through strategies. Identifying and/or discriminating between the overlapping and dual relationship concepts was another theme that many participants struggled with when trying to plot a route.

Many participants seem to agree that becoming a Deaf therapist for the Deaf community is a life changing experience that includes numerous challenges and awkward moments. Furthermore, many believed that building awareness is critical when it comes to provide professional services to the Deaf community. The three keywords – challenge, awkwardness, and awareness – occur when the two large circles in Figure 3 are combined to exemplify the complication of the overall interactions.

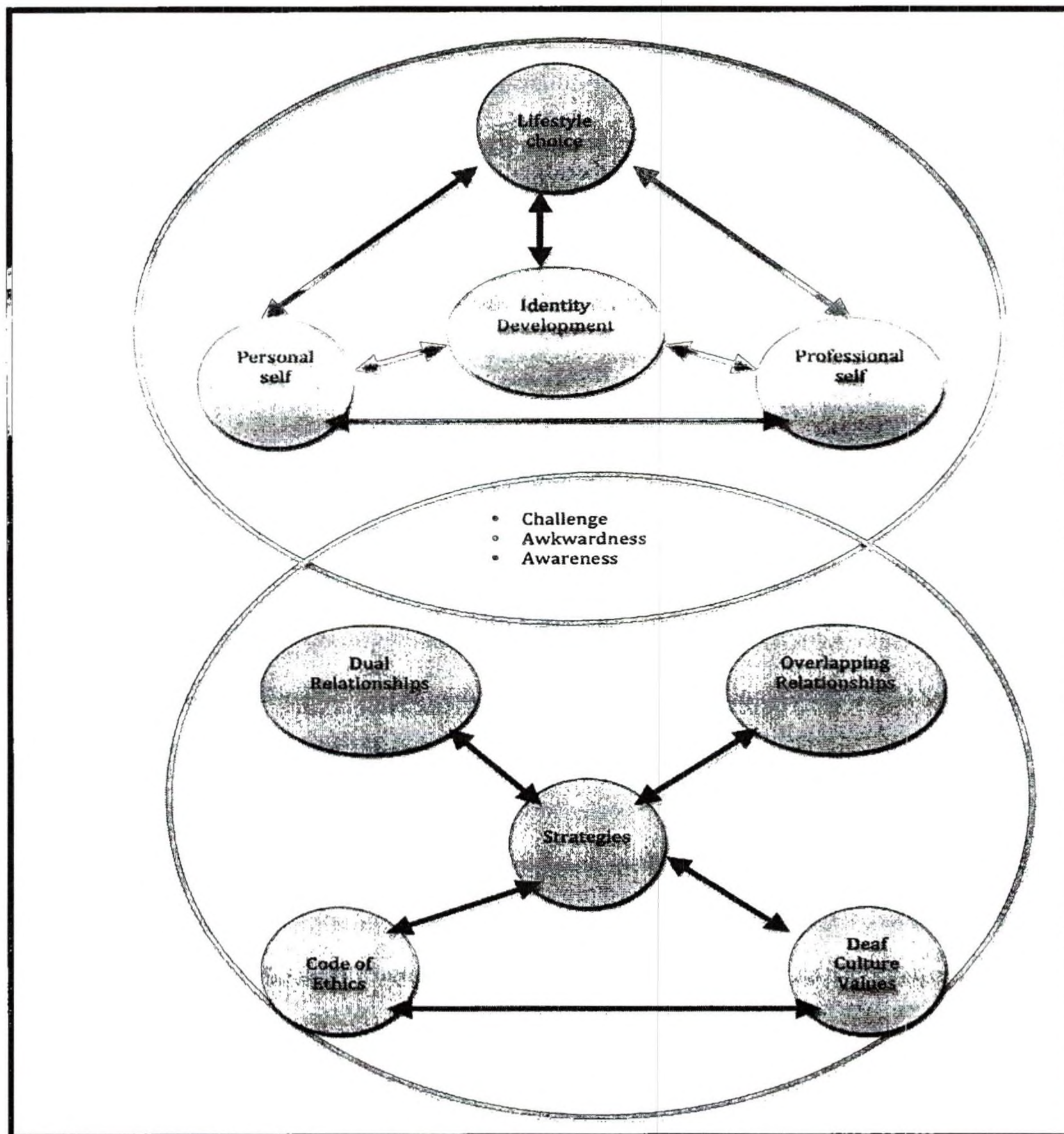

Figure 3. Multi-level Interactions of Deaf Therapists and Multiple Relationships.

Conclusion

The participants in this study described how they identify and deal with both avoidable and unavoidable nonsexual multiple relationships when working with Deaf clients. Several common themes and factors that have been identified by a majority of the participants have been outlined: 1) defining overlapping and dual relationships and whether these terms are used interchangeably or conceptualized separately, 2) lifespan of identity development, 3) maintaining professional and personal self interactively or separately, 4) how to integrate Deaf cultural values while maintaining the standard of ethics, and 5) some strategies that have been attempted and employed. Many variables that were common among every participant in this study are that Deaf therapists will experience awkwardness and that it can be a challenging profession. Every participant mentioned the importance of being aware of self, hence, awareness of how one is perceived in the Deaf community. Every participant in this study affirmed that being a Deaf therapist in the Deaf community is a life changing experience that should require proper training, supervision and guidance.

CHAPTER IV

DISCUSSION

Significance of Findings

This study examined many experiences that Deaf therapists face when involved in non-sexual multiple relationships in the United States. Several salient issues emerged from the interviews concerning involvement in multiple relationships and the impact it had on the Deaf therapists. The results of this study indicate that Deaf therapists who participated in this study commonly engage in non-sexual multiple or overlapping relationships, and many of them see this as inevitable and unavoidable. All of the participants emphasized the importance of establishing clear boundaries and developing strategies on how to navigate potential dilemmas prior to the circumstances.

Ten Deaf licensed therapists participated in this study. Themes from their individual interviews, and feedback from my peer group were analyzed and integrated into a conceptual framework. Themes were analyzed, reanalyzed and audited to fully capture and represent different perspectives of the participants.

Overall, the participants in this study described how they identify non-sexual multiple or overlapping relationships, and how a number of factors such as Deaf culture, identity development, strategies and lifestyle choice shaped them in this chosen profession.

Importance of Culture

Culture is a complex component that includes the individual's identity, group identity, beliefs, values, language, cognition, communication and behavioral patterns. In other words, culture consists of public standardized values of a group representing specific meaning, beliefs, and practices that guide social institutions, the creation of social products and individual development (Triandis, 1996; Leigh, 2009). These factors shape the individual's worldview. An individual can also have multiple group memberships determined by ethnicity, acculturation level, gender, socioeconomic status, religion, sexual orientation, language, etc. (Ponterotto, 1993; Sue & Sue, 1990). Furthermore, culture assists individuals in defining and attributing meaning to events, or encounters, experienced in that culture. Within an individual's worldview, one can identify a purpose and role in the community, which provides clear understanding of socially accepted behaviors. Marbuez, (2005) elaborated that these cultural norms provide guidance about socially accepted behaviors so that cultural patterns can be recognized and assist individuals with ascribing meaning to social interactions. It is important for therapists or service providers, to identify these distinct cultural norms and to assign meaning to interactions based on the context in which it occurs.

One of the finding of this study addressed how cultural values in the Deaf community lend to more participation in multiple relationships. Participants in this study reported multiple and overlapping relationship experiences, as well as strategies for dealing with them, and their own overall quality of life personally and professionally. Faulker and Faulker (1997) found that factors such as prior knowledge, compatible lifestyles, values and common beliefs, between therapists and clients contributed to

positive outcomes in therapy. This study is one of the first that examined the fusion of Deaf culture and Codes of Ethics that Deaf therapists encounter when providing services to the Deaf Community. This study also adds to the limited literature concerning non-sexual multiple relationships in psychotherapeutic practice.

Unlike the mainstream culture, which emphasizes individualism, the Deaf community is perceived as a collective culture due to our tight-knit nature. Communication in ASL is obviously one of the most valuable cultural values in the Deaf community and the Deaf community works collectively to achieve common goals such as striving for equal access to information shown on TV or internet (eg, having closed caption on every show and video clip), and to have interpreters provided at various locations. Another Deaf cultural value is the expectation of full self-disclosure (such as hometown, school history, amount of hearing loss, how many hearing or deaf family members, which communication mode was used while growing up, etc) when introducing one to another initially, and any sensation that some information was intentionally withheld can raise a red flag among Deaf community members and most likely harm that new individual's attempt to gain credibility within that particular Deaf community.

Negotiating privacy such as maintaining confidentiality and having a personal life within the Deaf community is difficult and challenging as illustrated in Figure 1 in the previous chapter. One reason for this challenge is the expectation of sharing information with everyone in the room. Currently, many Deaf individuals use Telecommunication Device for the Deaf (TDD), videophone, or texting on the cell phone to communicate. For example, if a Deaf individual placed or received a phone call, the person who is

involved in the phone conversation is expected to share their conversation with everyone else in the room. This is comparable with hearing bystanders who have the option of learning some of the phone conversation context between two hearing individuals by eavesdropping on the phone conversation while being present in the same room. However, as an individualistic culture, if the hearing phone user whispers, talks softly, or walks to another room with the cell phone, a hearing bystander will likely interpret this behavior as communicating that this phone call is a private matter and might adapt their behavior to respect this privacy by stepping away from the phone user or engage in a conversation with someone else in the room. In the Deaf culture, action such as covering up the videophone, moving the equipment, or withholding information from another conversation can be considered rude, hostile, or suspicious. These cultural norms might create a barrier for the Deaf therapist to earn creditability among members of the Deaf community. This is one of many scenarios to illustrate the ongoing challenges of trying to blend Deaf cultural values and the Code of Ethics, and how the Deaf therapist must constantly navigate for the most appropriate strategies while in both the professional and personal roles. As Leigh (2009) pointed out, culture has a powerful influence on how individuals organize their lives, and cultural identity is constructed through contact with particular groups that reinforce a sense of belongingness. Deaf therapists who provide services to the Deaf community might not be able to maintain a steady caseload if they have not gained acceptance and credibility by the Deaf community.

Multiple Relationships in Small Communities

Similar to many rural and small communities, the Deaf community is considered a close-knit community, which increases the chance of multiple relationships between

Deaf therapists and Deaf clients. Lazarus & Zur (2005) have promoted that multiple relationships may be more prevalent and unavoidable in small communities. Every participant in this study belonged to a small and interconnected community of Deaf people. The present study suggests that Deaf therapists are engaged in numerous and complex overlapping relationships with their clients, while still trying to abide by the code of ethics. Some of the participants have stated that continuing to be part of the Deaf community is necessary in order to gain credibility in the Deaf community. Furthermore, most of the participants in this study feel that overlapping relationships are acceptable while dual relationships are considered forbidden. Many of the participants shared similar definitions of overlapping relationship as being in the same place of common interest such as attending the same church that provides ASL interpreting services, attending the open-caption movie night, or attending a large Deaf community event. Dual relationship was defined as having an additional relationship that involves some sort of power or status, which is considered unethical for many of the participants in this study. Lazarus and Zur (2005) proposed that these out-of-office encounters could be managed by discussing these possibilities with the clients at the beginning of therapy to reduce possible conflicts. Consulting with peers or colleagues is also encouraged.

While the data from this study was examined, it was noted that Deaf therapists who were raised in a predominately Deaf family were more comfortable with the concept of overlapping relationships. Two of the participants with this experience stated that their Deaf parents had professional careers and they were able to model appropriate strategies on how to deal with overlapping relationships during their upbringing. Because of this exposure, along with attending predominately Deaf school programs, they were able to

learn how to establish appropriate boundaries while still being able to have a personal life within the Deaf community. Both of them admitted that it is not simple and can sometimes cause problems and tensions. On the other hand, several other participants who learned sign language at a later age reported to struggle with trying to build credibility with the Deaf community and tend to try to interact with the Deaf community less to avoid the possibility of a dilemma. Those who admit to interacting less frequently with the Deaf community also reported that they tend to feel isolated and lonely within the Hearing world. Furthermore, some participants reported that they limit their interactions to an extremely small circle of professional deaf and hearing friends who also use sign language.

One myth about ethics is the expectation that everyone knows when they have made mistakes. The gray areas between overlapping (non-abusive) and dual relationships (potentially abusive) seem to be one of the ongoing but critical issues that need to be addressed, especially for those who work in small communities such as the Deaf community. Deaf therapists who provide services for Deaf and Hard-of-Hearing patients can expect to face perplexing dilemmas since many have different understandings and feelings about where to draw the line with clients or patients. While some behaviors are clearly unethical and unacceptable, and do not require any discussion or consideration, there will still be many other actions that lie in the gray areas where rationalization can make questionable practices seem alright if not examined closely. Deaf therapists providing professional services to the Deaf and Hard-of-Hearing population encounter many complex and gray area situations due to the fact that some Deaf Cultural values

might clash with the Code of Ethics, and this will require more deliberations to determine whether the gray area is an appropriate overlapping or potentially abusive relationship.

Identity Development

Another theme in this study addressed the variety of identity development that each participant experienced. Identity development is a multidimensional and dynamic process, which evolves over the lifetime. Identity development is influenced by the individual's social position, linguistic, cultural and social experiences. Kegan (1982) explained that as an individual goes through the process of development from one situation to another situation, the individual learns new information about the self, such as group identification, abilities, self-perception versus perceptions created by others. This entire process of information acquisition interacts with the cognitive framework of the personal self and self-perceptions.

The evolution of self and identity is considered a multidimensional, reflective process that involves psychological motivation, cultural knowledge, and the ability to perform appropriate roles (Fitzgerld, 1993). Attempting to crystallize the complexities of labels and identities can be an impossible task due to complicated and multiple identities. Dr. Irene Leigh shared her personal journey in her book, *A Lens on Deaf Identities*:

> For me, being deaf is not audiological, but rather a way of life. I sign. I speak. I comfortably navigate my environment using a hearing aid to back up my eyes. Internally, I identify myself as a person navigating the continuum between Deaf and deaf. The tension in identity commitment reveals itself when my self-perceptions collide with how others perceive me. Being labeled as Hard-of-Hearing (because I speak and use a hearing aid), "hearing," oral deaf, culturally

Deaf, academically Deaf because of my association with Gallaudet University, or whatever, poses a challenge to my internal identity. I cannot compress myself into one basic identity as I navigate my varied environments, nor can I wholly accommodate the external perceptions of me. I cannot be boxed in by the various prescriptive deaf categories reviewed in Chapter 2 (p. 43).

Dr. Leigh's personal story illustrates that identities are not limited to internal perceptions but also the influence of external perceptions, of how others (hearing and DHH individuals) perceive the DHH individual based on the limited judgment and information they may have. All these variables contribute to this multidimensional and dynamic process of identity development. Many of the participants in this research shared similar lifelong dynamic identity development similar to Dr. Leigh. Furthermore, many participants admitted that their identity would continue to transform as they are exposed to new lifestyles and life paths. While reviewing my reflection notes, I noticed that I felt connected with many of the participants during my interview with them since many of us (DHH therapists) seem to share many similar backgrounds, upbringings, obstacles and dilemmas as we try to make sense of our multiple identities based on our internal interpretations, as well as external perceptions that we don't have much control of. External interpretations consist of how the Deaf community perceives us, how our Deaf or Hearing family members perceive us, how our peers from predominately Hearing or Deaf schools perceives us, and how our Hearing or Deaf coworkers or colleagues perceives us. Many of these external perceptions depend on that particular individual's personal upbringing and their own reaction to the internal and external variables. If all these interactions and variables were placed on a grid, the number of possibilities seems

beyond measure – it would be impossible to place all these multiple interactions on a regular sheet of paper for close examination and analysis. All these multi-level and multiple interactions are responsible in shaping the individual's current identity while we consider how much that individual's identity might evolve as the person continues to encounter future life experiences, seems immeasurable and astonishing. Tatum (1997) pointed out that the entire process of identity development is dynamic and an ongoing compilation of the meanings of past experiences, present experiences, and our images of what is possible for us in the future.

While examining the data from this study, there were several similarities noted when it came to exploring the identity development process. It was noted that the two participants who were raised from a predominately Deaf family were more likely to acknowledge belonging to and identifying with the Deaf culture while growing up and that they did not have much struggle or trouble trying to describe their identities. This is based on the primordialism or essentialism perspective, which states that identity is conceived of as essential, relatively fixed, predetermined or natural, based on specific authentic characteristics that clearly define an overarching identity construct and create a related sense of belongingness shared historical truth, and stability (Croucher, 2004; Woodward, 1997, 2002; Leigh, 2009).

For most other participants, many of their identities were based on a social constructivist framework, which is also known as the non-essentialist perspective. This perspective states that identities are not inherently in the self or created by the individual's surroundings. Instead, identity is an ongoing process that constructs itself and is constructed by the social environment in the guise of political, economic, and

sociocultural forces that contribute to shared meaning systems or cultural contexts that evolve over time (Baumeister, 1997; Cushman, 1995; Lyddon, 1997, Leigh, 2009). Leigh (2009) elaborated that the interplay between one's psychological characteristics and one's family, culture, and context will ultimately define that person. In our increasingly complex and pluralistic cultural environment, individual construction of malleable and multiple identities becomes more the norm than the exception (Bronfenbrenner, 2005).

For a majority of the participants, identity development is most likely described based on the non-essentialist perspective since a culturally Deaf adult can manifest different identities surrounding that core Deaf, deaf, or Hard-of-Hearing identity, depending on environmental contexts. Leigh provided an excellent example of this non-essentialist perspective:

> For this adult, one specific Deaf cultural identity may emerge at a local Deaf festival, while a different kind of Deaf cultural identity may manifest itself in a situation involving a specific Deaf ethnic group. In another example, if a socially isolated deaf person has never been exposed to another deaf person until finally meeting a group of deaf and hard-of-hearing people in adulthood, self-perceptions of deafness in isolation can gradually metamorphose into self-perceptions of a specific kind of "deaf" or "hard-of hearing" person as exemplified by the group members. This involves internal identity changes in response to a more complex social framework incorporating deaf and hearing members, thus repudiating the notion of a fixed deaf identity. These identity changes then become pivotal for selecting behaviors, changing self-representations, and in turn influencing one's cultural world. (p.4-5)

As many authors pointed out, identity is a complex, dynamic, and multidimensional process that does not have an endpoint. Rather than pinpointing the focus on whether the individual's primary identity is Deaf, deaf, oral deaf, and/or hard-of-hearing, the focus should be expanded to incorporate a wide range of background experiences, who share and attempt to achieve common goals such as communication access and respect for individual needs. Based on this study, most of the participants reported multiple identities and believed the importance of being comfortable with various identities rather than selecting Deaf, deaf or hard-of-hearing label. Many also felt that the Deaf/deaf and hard-of-hearing should be perceived as a continuum since some of them might feel more attached to the Deaf identity on a given day and then switch over to the hard-of-hearing identity on another day. Again, many of the participants reported that exposure to various environments in their past and present life shaped them into who they are and insisted that their identities will continue to change, depending on future occurrences and encounters. After all, Deaf and Hard-of-Hearing patients or clients have the option to see a Deaf or Hard-of-Hearing therapist without communication barriers. While in session, the focus will be on the Deaf patient or client's issues, not the Deaf therapist's identities or background.

Professional and Personal Self

How Deaf therapists attempt to either interweave or separate their professional and personal self is another theme that came up in this study. This theme appears to be one of the least discussed topics in the literature and is likely one of the most important issues when addressing the multiple relationship dilemma from an ethical perspective while trying to maintain one's own cultural values. Many participants in this study

described the importance of modeling appropriate behaviors while out in the public due being in the "spotlight."

Being in the spotlight has created some tensions for many of the participants in this study. Two participants reported that they became more *paranoid* with how the Deaf community might perceive them. Furthermore, several participants reported that they tend to be more aloof and on guard while interacting or socializing in the Deaf community because in the back of some minds, they are reviewing the Code of Ethics or wondering how others perceive them. For some participants, as well as myself, how we model or present ourselves to the Deaf community is as important as maintaining credibility. This can include the clothing we choose to wear, the choice of drink (alcohol or non alcohol), whom we interact with, or how we communicate with others. In other words, it might be easier to try avoiding any overlapping or dual relationships, at any cost, even if they are not potentially harmful, to avoid any misunderstanding or negative reputation.

Similar to the participants in this study who had developed a career in the field of psychology or mental health, this researcher believes that we all have the basic right to interact and thrive with others who share common language and culture. Furthermore, this researcher considers that it will violate one of the core values as a Deaf individual if many of us were driven out from Deaf related events because the Code of Ethics are too rigid when it comes to dealing with multiple relationships. Hypothetically speaking, if the Code of Ethics made it impossible for this researcher to maintain a personal role outside of my professional role, which is the opportunity to attend Deaf related events and interact with other individuals in my native language of ASL, she would likely live an

isolated life among the Hearing world who cannot communicate effectively. This notion can be comparable to making it difficult for GLBT therapist to interact with the GLBT community, or forbidding Native American therapists to interact with the other Native Americans because of the fear of creating a potential harmful relationship with past, current, or potential clients.

Some common encounters that many Deaf therapists face can be illustrated in the following examples. A current Deaf patient, Patrick, who is a church member at the town's only church that provides interpreting services, contacted the Deaf therapist the previous night due to a crisis. After addressing the crisis with Patrick, the Deaf therapist knew that she would see Patrick the next morning at the church since they both attend the same church. The Deaf therapist struggled with the clash of personal and professional roles because the Deaf therapist felt that going to church is an important part of her values and overall spiritual identity. The Deaf therapist also felt that Patrick would benefit from gaining additional support from the church they both attend but knows that she is not able to share any information due the code of ethics (confidentiality). Attending the same church can be perceived as a multiple relationship, which could create some awkwardness. However, this is the only church in the entire town that provides interpreting services and fellowship opportunities with other Deaf church members. Will going to the same church with a current or former patient violate the Code of Ethics? Suppose the Deaf therapist was barred from attending this church, will this violate the Deaf therapist's right as a member of the Deaf community? Furthermore, the Deaf therapist, just like every member of the Deaf community, has the right to equal communication access in her native language of ASL. Will preventing the Deaf therapist

from attending a church that provides interpreting services because of overlapping or multiple relationships be considered an abridgement of her rights under ADA? How do we address another level of the dilemma, dealing with potential future patients who go to the same church? Should going to the same church be considered an overlapping relationship the way many participants in this study defined it, as "just happening to be at the same place" that provides communication access to the Deaf and Hard-of-Hearing individuals? Many participants in this study did not perceive overlapping relationships as unethical or inappropriate.

Or should this scenario be interpreted as a Dual relationship, which many participants in this study defined as being in a position of greater power that will be unfair and possibly harmful for patients such as Patrick? Suppose we decided on the latter; this might mean that the Deaf therapist cannot attend any events or services that provide interpreting services, or any Deaf related events because every Deaf and Hard-of-Hearing individual can be perceived as a potential client/patient for the Deaf therapist. This begs the question of whether the Deaf therapist has the right to have a personal role within the Deaf community. All these variables are critical for Deaf therapists to examine when navigating the strategies to merge the Code of Ethics and the Deaf culture. Deaf therapists' overall development and how to navigate between the worlds of the Deaf and the mental health field can be considered an art that requires multi-level analysis. Many of these aforementioned questions should be kept in mind while reading the next several typical encounters faced in the Deaf community.

Another familiar encounter is illustrated in this example. Donna is Deaf and was Dr. Grow's former patient for approximately two years. The therapist-patient relationship

was terminated just over two years ago. Donna just completed her graduate work and is seeking a licensed supervisor who is fluent in ASL, and is familiar with dual relationship experiences that many DHH individuals face. Dr. Grow is the only ASL fluent licensed therapist in the state. Will it be unethical for Dr. Grow to enter a supervision-supervisee relationship with a former client? Will the burden of knowing the difficult issues that Donna worked through during past sessions put Donna into an unfavorable position as a supervisee? Both of these roles, as a psychotherapist and supervisor are considered being in a position of power.

Dr. Smith is a licensed Deaf psychotherapist who has multiple roles, such as conducting research for the university as a faculty. The majority of his research focuses on the DHH population. During one of the initial screening session that was open to the DHH community, one of his patients, John, attended. Dr. Smith asked a series of standard question to every participant during this screening session. As Dr. Smith jotted down John's responses, Dr. Smith became aware that John was not truthful based on the information Dr. Smith knew as a psychotherapist. Dr. Smith will need to make a decision whether to keep this data, because John is entitled to have same privilege as every other participant regardless, or to confront John during their next session, despite the fact that these are two completely different situations.

This final example is another typical encounter that many members of the DHH community experience. Dr. Kim is a Deaf licensed psychotherapist who is also a member of a faculty at the college she teaches. Dr. Kim teaches various courses at a college where a large number of DHH students attend. Dr. Kim regularly sees many of her DHH

students in her office, as well as during events hosted by the Deaf community. Is it considered unethical for Dr. Kim to see her students in her practice?

Rather than walking on thin ice, we all need to put this complicated issue on the table. As a human being, we all have basic rights to develop as an individual within a culture in which we feel we belong. As we place these dilemmas, cultural values, and codes of ethics on the table, it will be essential for each of us to be a team player in order to think outside of the box and work through some strategies so that we can produce as many vigorous Deaf therapists who are able to provide accessible services without communication barriers for the DHH population in their native language while being comfortable in their own skin as a professional and as an individual.

Strategies

Another theme addressed strategies employed by therapists when they establish and negotiate boundaries with their deaf clients and their other various roles within the Deaf community. These strategies include outlining the expectations of therapy with their Deaf clients, role-playing and developing a script for a possible out of therapy encounters, and consulting with supervisors or colleagues. Several authors, such as Schank and Skovolt (2008), Kitchener and Harding (1990), and Lazarus and Zur (2005), offered guidelines and suggestions for therapists anticipating becoming involved in multiple relationships.

These previous ethical decision-making models have not been effective for many Deaf therapists who deals with the dilemma of nonsexual multiple relationships with individuals from the Deaf community. Below (Figure 4) is a proposed ethical decision making approach that could benefit Deaf therapists who provide services to the DHH

community. The interplay of professional and personal roles as an element of the Deaf therapist's identity development was illustrated in figure 1 and discussed in the previous chapter. This particular interplay of professional and personal role is essential for the Deaf therapist's overall identity development as a DHH individual and one of the crucial and overarching steps of gaining awareness of the self within the personal or professional role.

The first step of this proposed model, after determining whether the issue is a professional or personal one, is to identify and determine that the matter is an ethical one. Hypothetically, every encounter between the Deaf therapist and a member of the Deaf community (past, current or future client/patient) has high potential for multiple relationships. Not every encounter will bring up some ethical questions; for example, if the Deaf therapist and a deaf client show up at the same bank branch to make a deposit at the same time should not be considered unethical. However, if the Deaf therapist attended the same party as the Deaf client/patient at a local Deaf Club, then it would be helpful to explore this encounter by following this proposed decision-making strategy.

The second step is to assess the situation and determine whether the matter is potentially an overlapping or dual relationship. Based on this study, the majority of the participants defined dual relationships as having more than one role that involves being in a position of power and is potentially harmful. Potentially harmful relationships are addressed in the code of ethics. Overlapping relationships were delineated in this study as something that might be considered a gray, but not harmful, such as attending the same event or being a member of the same organization. These relationships are not addressed in the codes. In order to determine whether the situation is a dual or overlapping

relationship, the time frame needs to be examined, i.e., some relationships that may be considered dual, thus prohibited due to having two, possibly conflicting, power differentiated relationships taking place at the same time, may be considered overlapping, thus allowed, if one relationship ended before the other begins. For example, a therapist-client relationship was terminated, and this former client is seeking supervision from the same therapist since there isn't any other ASL fluent licensed therapist within several hundred-miles. The supervisor-supervisee role is considered a form of dual relationship since the supervisor will continue to be in a position of power. These two relationships could not exist at the same time, ethically speaking. The termination time frame of one year, or five years is significant. One might raise some questions if the supervisee was a former patient just a year ago rather than five years ago. Supervision or consultation for the Deaf supervisor would be crucial in this case.

The next step will be to review the current professional guidelines and standards, the state and national laws, and the rules and regulations of the institution where one works. Professional codes of ethics, such as the ones from the American Psychological Association (APA), and state laws have important influences on how we process our decisions, as well as outlining the potential consequences if not complied with. Furthermore, many individuals interpret many of these codes differently, and some individuals may challenge these codes by submitting a proposal for modifications.

While reviewing the professional guidelines and standards, it is also crucial to determine one's motives. Often our values become hidden motives that influence our decisions. Many of us have values that either directly influence our decisions or influence how we construct our decisions, and often unconsciously. It is crucial and imperative to

be aware of our values consciously in order for one to be able to reevaluate them and possibly help with the process of reframing how we structure our own decision-making strategy. This relates to personal values, cultural values, as well as the agency values.

We also need to recognize the cultural values related to the situation, and to consider possible ethical traps as well as possible consequences. Using the supervisor-supervisee example with a former client/patient, the burden of knowing past information can be considered an ethical trap with potential negative consequences. This might pose negative consequences if the supervisor unintentionally brought information that was shared during a past therapy session into the supervisor-supervisor session. However, when considering the advantages of having a shared common language, American Sign Language, one will need to determine whether it would be ethical to prevent this supervisee from benefitting from the opportunity to access direct communication and cultural knowledge, and requiring the use of an interpreter with a hearing supervisor.

Another case to illustrate a potential trap: The local community will host a biannual Deaf Awareness Week and the Deaf therapist needs to consider whether to bring her partner and children to this event or go alone. Her partner is Deaf while the children are hearing. The Deaf therapist feels that this event will be a positive experience for her children to learn more about their parent's culture. However, the Deaf therapist is consciously aware that some of her past and current patients, as well as potential patients, will be at this event. The Deaf therapist will need to decide if she would risk the chance of having her clients/patients to meet her family. If the Deaf therapist is treating a sex offender or has several patients who have personality disorders, will it be worth the risk? What is more important here, the Deaf culture exposure such as the Deaf Awareness

Week is a rare occurrence, or should protecting the identities of the family members be a priority? What will be the worst possible scenario or outcome if patients with a history of a sex offense or a personality disorder meet the therapist's family members?

Once these aforementioned topics have been outlined and analyzed, the next step is to consult with the primary licensed supervisor who is Deaf or Hard of Hearing, and a secondary local licensed supervisor. These invisible boundaries might begin to take shape when they are looked at through another person's eyes. Supervision is an essential source of objective feedback.

With consultation, the next step is to evaluate the long-term effects of how the choice will affect the client or patients. This also includes how the choice will impact the community and profession as a whole. While evaluating the issue and possible decision, one must ask the question regarding to whose needs will be met, and whose interests will be served. In addition, while considering the long-term effects, the short-term effects will also need to be considered and explored. Furthermore, examining how the decision will impact or affect future clients will need to be probed as well.

After all these steps have been processed, it will be vital to have a mutual and collaborative discussion with the client/patient regarding the choice and to process their reaction. There might be a discussion regarding to how the boundaries will be established. Having a collaborative discussion will reduce the likelihood of encountering uncomfortable moments out in the community. It will be necessary to have a conscious discussion of how such interactions out of therapy may affect the therapy relationship. Furthermore, attending certain events or belonging to some organizations, in and of itself, will result in some kind of self-disclosure of the therapist's beliefs, values, and activities.

For example, attending a church will reveal the therapist's religious beliefs. Faulkner and Faulkner (1997) have pointed out that having an open discussion of how knowing this type of information may affect a client can be a meaningful and necessary part of therapy.

Finally, documentation of these discussions and decisions is strongly encouraged to avoid a potential trap or misunderstanding. If entering into an overlapping or dual relationship that might stretch the boundaries, it is necessary to have clear documentation in the case notes of the rationale for entering into a such relationship. According to Pope (1991), the failure to document such relationship in case notes may leave therapists open to accusations of carelessness and negligence. In other words, scrupulous documentation protects therapists and provides the opportunity to reexamine complicated events and issues in therapy. Pope (1991) stated that it would be prudent to include information on relevant interactions along with how the relationship may affect the client's "clinical status, prognosis, treatment plan, or response to the treatment plan" (p.29). In other words, there is no such thing as over documenting when it comes to dealing with multiple relationships, whether it is a dual or overlapping relationship.

Overall, this proposed ethical decision-making process is explicitly influenced by the Deaf cultural identity since identifying whether a problem exists, interpreting the ethical and legal codes from a culturally-relevant perspective, consulting with a Deaf supervisor, determining the short and long term effect of the decision, and having a collaborative discussion with Deaf client/patients, are derived from the Deaf therapists' identities and his/her roles within the Deaf community.

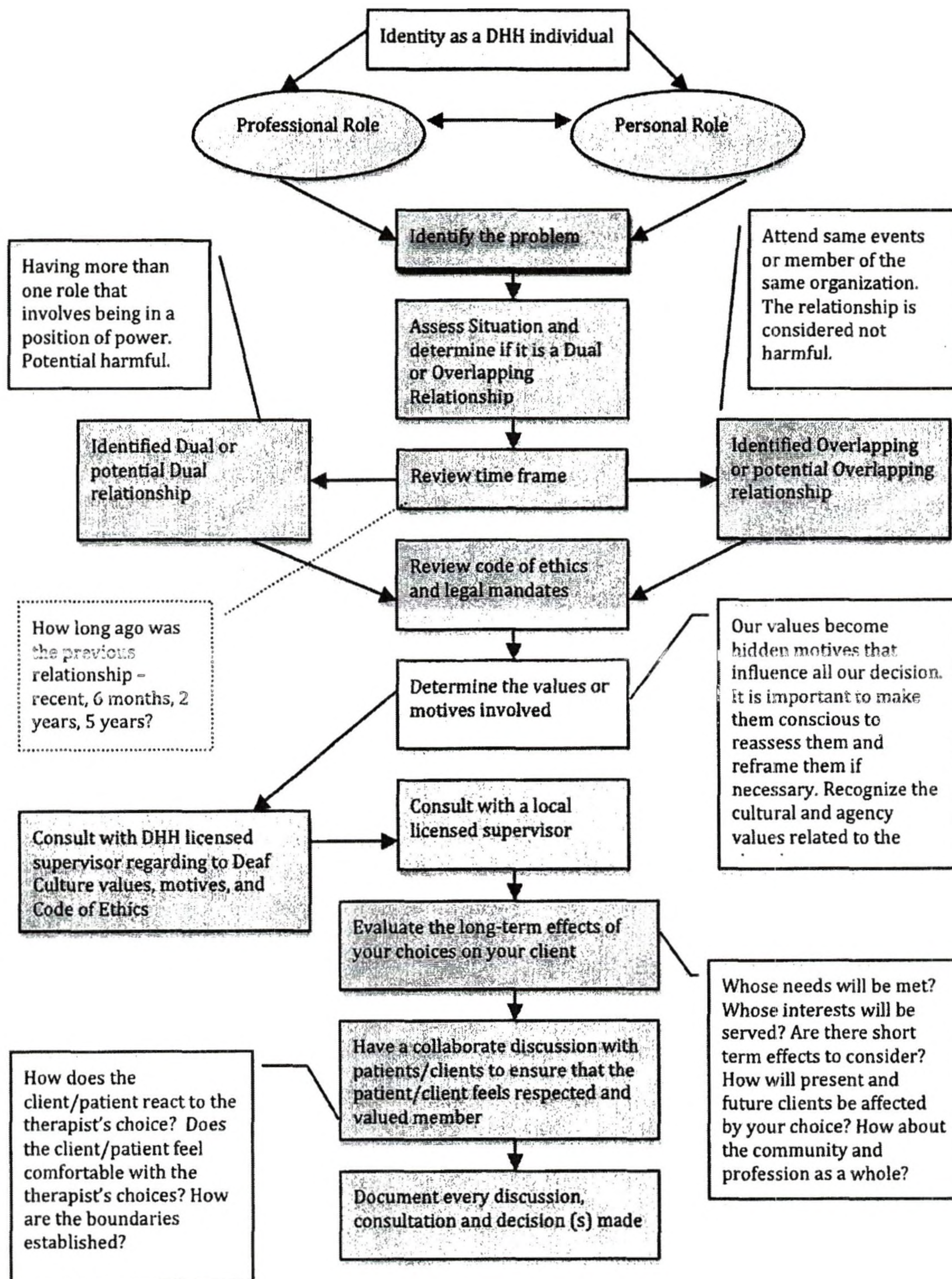

Figure 4. Proposed Decision-Making Model for Deaf Therapists who work in the DHH Community.

Limitations of the Study

This study used interviews to understand the experiences of Deaf therapists' involvement in nonsexual multiple relationships. The participants were a small sample of licensed Deaf therapists scattered around United States. The age of the participants ranged from 29 to 53 with majority of the participants within the 30's to 40's range. While only two out of ten participants came from predominately Deaf family, this ratio seems appropriate given the fact that 90 to 95 percent of the Deaf individuals come from predominately Hearing families. Furthermore, a majority of the participants reported to attend a mainstream, predominately hearing school that provided support services for Deaf and Hard-of-Hearing individuals, while some of them attended Gallaudet University or National Technology Institute for the Deaf (NTID) for their professional training. The ratio seems appropriate for this as well. Of the 10 participants, only two were male and everyone was of Caucasian ancestry. Sexual orientation was not asked during this research so this information is not available. More diversity would increase richness of data and diversity in other forms of identity such as sexual orientation and ethnicity would enhance transferability of the results. The social economic status (SES) and the amount of financial support during college were not asked nor collected during this study and this information might have provided some additional information for this study.

I was the sole instrument for data collection for this qualitative study. Efforts were made to reduce researcher bias by receiving assistance from colleagues to assist with the consistency of data interpretation and translation. Also, the transcriptions were sent to the participants for a review of accuracy. Some researchers might recommend that the translated transcriptions be sent for back-translation. I was not able to do so due to time

constraints, limited finances, and availability of the linguistics. Doing so might have increased the reliability and validity of the translation accuracy. Still, allowing the participants to have the opportunity to clarify or correct the transcription ensured the accuracy. Additionally, having an auditor who is fluent in ASL and familiar with the Deaf culture and communication norms also ensured accuracy of the interpretation of the data.

From the beginning of the pilot and current study I was aware that I was also participating in non-sexual multiple relationships with some of my participants, or potential future non-sexual multiple relationships. I formed professional and personal relationships with many of the participants from the pilot and current study. As I was analyzing the data, I attempted to set these relationships aside; however, these relationships may have directly biased the findings of the studies. In an attempt to control this, I discussed and consulted with my auditor and Deaf colleagues.

Research Implications

There is a need for more research in the area of non-sexual multiple relationships and their influence on the Deaf therapist's overall life and the impact of therapeutic relationships with Deaf clients. Learning more about these relationships and how they affect the therapeutic process may assist service providers to be more aware of how different cultural norms shape therapeutic relationships and expectations of both parties. There is little research on therapeutic relationships in the Deaf community. This study may provide useful information to Deaf therapists working with Deaf clients. This information may enhance Deaf therapists' understanding of the different needs of their own personal and professional life, as is the ethical expectation. Such study may lead to

the continuing development of an ethical decision-making model that may be appropriate for Deaf therapists working with Deaf clients.

This study is based on a small sample and generated several questions for future studies include: "How will this gathered data impact our ethical codes in the future?" "What implications do these results have for Deaf therapists and how they practice?" and, "How will these findings influence any future ethical codes for Deaf therapists?" Nevertheless, this dissertation is the first empirical study to document the dilemmas that Deaf therapists encounter while trying to blend the Code of Ethics and Deaf culture without creating a hostile environment or abusing power and status. In other words, up until now, Deaf therapists have not had much, if any, concrete and documented research to back their ongoing struggle while trying to balance their professional and personal role.

The therapists interviewed in this study all recommended the need for licensed supervisors who are fluent in ASL, preferably Deaf. Aside from acknowledging the limited resources of licensed Deaf therapists who are fluent in ASL to provide supervision to novice Deaf therapists, one of the major barriers is the difficulty of obtaining permission from the State Ethics Boards to allow cross state supervision. While the Boards probably have the good intentions of trying to ensure that novice Deaf therapists receive supervision from a local licensed therapist due to the different state and local laws, this prevents the Deaf therapist from receiving important modeling and consultation from someone who shared similar dilemmas, such as navigating and blending the culture of mental health and the Deaf culture. Due to the rapid changing in the technology world today, I would like to propose the idea of granting permission for

novice Deaf therapists to obtain supervision from a licensed Deaf therapist, even if the supervisor resides in a different state, through the video-phone. In order to honor state regulations, a second supervisor or consultant may be necessary as a supplement to the primary licensed Deaf therapist. This approach could be considered a team or triad rather than dyad – Deaf therapist in training, licensed Deaf supervisor from another state, and licensed Hearing supervisor from the Deaf therapist's current state.

The above proposal may not resolve the entire dilemma; however, based on this study, many participants reported to feel absent of adequate supervision, especially from a Deaf therapist with advanced experience and training. It will make more sense for a Deaf therapist in training to process their issues and dilemmas directly with a supervisor who shared similar issues, rather than a Hearing supervisor who cannot sign ASL and has not had any experience in dealing with the dilemmas that Deaf therapists face. Furthermore, it also makes more sense to be able to have a direct dialogue with a supervisor in ASL, just as hearing therapists have direct communication with their hearing supervisor. In order for this profession to build a solid foundation across the country, we all must be able to work together. In order for this to happen, the obstacles and barriers established by the state board of ethics will need to be more flexible. This will be the first and necessary step and this study supports this.

Clinical Implications

Acknowledging the importance of maintaining one's own cultural beliefs and values while adhering to the code of ethics is vital in clinical practice. It is imperative that trainees and professionals have the opportunity to reflect and explore these important

professional issues. Supervisors who experience similar dilemmas are scarce but imperative for the future of this profession.

Due to the limited number of Deaf licensed supervisors who are fluent in ASL around the country, advocacy is needed to allow trainees and supervisees to benefit from Deaf supervisors who are also fluent in ASL, even if the supervisor is located in another state. Currently, many state laws have made it difficult for many supervisees or trainees to obtain quality supervision from a licensed and ASL fluent Deaf therapist from another state. Technology advantages have made videophone possible and readily available, and this is something that should be encouraged to allow Deaf supervisees and trainees to get the benefit of guidance from someone from a similar cultural background and communication mode. Being able to integrate cultural values and ethics can lead to higher quality client service. A proposal to address this issue has been outlined in the previous section.

Conclusions

There have been few studies on the experiences of therapists and their participation in non-sexual multiple relationships in rural communities. There is currently very little writing on ethical practice when working with the Deaf and Hard-of-Hearing populations, and a majority, if not every one, of these publications focus on hearing professionals who are fluent in ASL working with the Deaf community rather than Deaf therapists themselves. Many of these articles are not empirical studies nor focused entirely on Deaf therapists. While many hearing therapists who are fluent in ASL experience non-sexual multiple relationships, they do not experience the struggle that many Deaf therapists face because many hearing therapists can lead a separate private

life in the hearing world. The number of Deaf professionals who serve the Deaf and Hard-of-Hearing population is growing rapidly (Hauser, et al., 2008). This study allowed me to gain an understanding of how Deaf therapists manage and negotiate their involvement in non-sexual multiple relationships. The results of this study also contribute to the limited research in this area and hopefully encourage more in-depth investigation into how culture impacts multiple relationships and how clinicians can use this information to help guide their interaction with multicultural clients.

Many participants in this study, as well as other Deaf peers with whom I have consulted report having experienced some confusion and awkwardness as we navigate through our multiple roles, especially negotiating our professional and personal lives. Figure 3 in the previous chapter illustrates the multi-level of interactions and the struggle with awkwardness, awareness and challenges as we continue to develop our multiple identities. Altogether, our primary focus should be to ensure that we have a healthy balance between our role as a professional and our desire to interact with other individuals who share similar culture and mode of communication. Limiting our opportunity for equal access to information can do more harm for many Deaf therapists. For example, many theatres at various locations host an open caption movie once or twice a month. Should Deaf therapists be barred from the opportunity to watch movies with open caption because of the high likehood that many past and current Deaf clients might attend this particular event? Deaf therapists in general should be able to enjoy an open caption movie without feeling uncomfortable. There are some strategies that the participants in this study have attempted to use that seems to be effective, however they also reported that they would like to see a standard and universal model in print.

Establishing a task force with several Deaf therapists seems to be an appropriate first step so that we all can work together to establish an universal protocol that will recognize the unique struggle that many Deaf therapists face when providing services to the Deaf community. Furthermore, many of them also would like to see the barriers to obtaining effective supervision from Deaf therapists in another state be removed.

My research journey with this study has brought up some deeper inquiry about the blending of my Deaf cultural values and the code of ethics so that I can model high profession standards while not feeling deprived of my own culture philosophy. Along with my current learning as a novice supervisor, I continue to seek further understanding of this fusion and hope to take a lead role in modifying some of the current codes of ethics so as to keep them up to date with current standards of multicultural competence and so that Deaf therapists have better guidance from our professional ethics codes.

In reference to the kaleidoscopic metaphor, the patterns and color combinations that the mirrors give off represents how the individual variables are interwoven into each other from distinctive perspectives with subjective interpretations. When a viewer looks in one end of the kaleidoscope while the light enters at the other end, reflecting off the mirrors, the viewer will see varying colors and patterns as the tube is rotated. It will be unlikely for the color bits to contact the same spot more than once. In this study, the variables as a standalone are meaningless, just as the colors in the kaleidoscope are meaningless as standalone color bits. The kaleidoscope approach allows us to interpret the data subjectively from multiple levels and interactions to generate new questions and discover new evidence. Similar to the interaction of the individual bits that is likely to be different than the last turn depending on the kaleidoscope turner, the outcome of this

research is uniquely connected to and dependent on the researcher's interpretation of the data. The researcher interwove many bits of the data into a comprehensive model that is suitable for many individuals.

APPENDICES

APPENDIX A

INFORMED CONSENT FORM

Consent to Participate

You indicated that you would be interested in being a part of a study that examines how Deaf or Hard of Hearing therapists deal with overlapping relationships. This study's purpose is to identify common experiences that Deaf or Hard of Hearing therapists face when dealing with multiple relationship or dual roles. This in turn will help Deaf or Hard of Hearing therapists understand what other therapists in similar situation faces and can help therapists to effectively resolve overlapping relationship dilemmas ethically. You are being asked to participate in a one-on-one interview based discussion about your personal experiences; this process will take approximately 90 minutes. It possible that you may feel uncomfortable or experience some discomfort as a result of your participation of this interview. If you do experience discomfort then the researcher will be able to indicate places you can access a counselor or other mental health care provider. Any information collected will remain confidential and will not be shared with your agency or the Deaf and Hard of Hearing community.

All discussion will be tape-recorded and then transcribed to more effectively organize data. Each participant will be assigned a number to foster confidentiality. Following completion of the study, videotapes will be erased in accordance with Institutional Review Board guidelines. Consent forms and data will be stored separately. Transcripts will have a number only. Transcripts of the interview will be secured in a locked cabinet within the department and will be kept for three years and then will be destroyed. The videotapes of the interview will be destroyed at the end of the research. Your participation is voluntary and in no way affects your current employment or relationship with the University of North Dakota. There is no penalty for withdrawal.

As a voluntary participant you have the right to review the results of this study when they become available. In addition, you have the right to withdraw from the study at any time; once again this in no way will affect your employment status or present or future relationship with the University of North Dakota. You may inquire about the results of this study by contacting Denise Thew in the Department of Counseling Psychology and Community Services, University of North Dakota, Box 8255, Grand Forks ND 58201, or email at denise.thew@und.edu. You can also contact. Dr. Michael Loewy, Chair, Department of Counseling, University of North Dakota, Box 8255, Grand Forks ND 58201, or email at michael.loewy@und.nodak.edu.

Thank you in advance for agreeing to participate in this study and allowing us to learn from your experiences.

I have read the above information and understand that my participation is completely voluntary. In addition, I have had all my questions answered as they relate to my participation in the above study. I agree to participate in the interview and understand that I may withdraw from the study during any time.

_______________________ _______________
Participant's Signature Date

____
Printed Name

___I request and received a copy of this consent form for my records.
___At this time I decline a copy of this consent but understand that I am free to request a copy at any time.

APPENDIX B

RECRUITMENT LETTER

Listserv Letter

My name is Denise Thew. I am a Deaf doctoral student in Counseling Psychology at the University of North Dakota in Grand Forks. I am requesting your help with my dissertation research that I hope will prove helpful for current and future Deaf and Hard of Hearing therapists who provide services primarily to the Deaf community.

For my dissertation, I would like to be able to gain a better understanding of Deaf and Hard of Hearing therapists' ethical decision making regarding nonsexual multiple relationships in the Deaf community.

This research is important for several reasons. First, there is lack of research on the struggles that many Deaf and Hard of Hearing therapists face when dealing with some of the dual or multiple relationship dilemmas while providing services to the Deaf community.

Second, by participating in this research, you will be contributing to our understanding of the different experiences that Deaf or Hard of Hearing therapists have encountered when providing service to the Deaf community.

Third, it will be beneficial to discover some of the decision-making strategies that have been either effective or ineffective when dealing with nonsexual dual relationship issues from current Deaf or Hard of Hearing therapists.

I am seeking Deaf and Hard of Hearing therapists who are currently licensed, fluent in ASL, and provide services largely to the Deaf and Hard of Hearing Community. If you are interested in participating in my research, please contact me by email: denise.thew@und.edu. Upon receiving your email, I will send you a demographics form for you to fill out and return. Once you have been selected as a participant, I will send you a consent form and then we will set up a 45-60 minute videophone interview. Every attempt will be made to maintain the confidentiality of your identity.

If you have any questions or concerns please contact me at denise.thew@und.edu or my dissertation committee chairperson, Dr. Michael Loewy, at michael.loewy@und.edu. This research has been reviewed and approved by the committee that protects participants

in research at University of North Dakota. If you have any other concerns contact Department of Research Development and Compliance at 701-777-4279 (V).

Sincerely,

Denise Thew, M.A.
University of North Dakota
Department of Counseling Psychology and Community Services
Montgomery Hall Room 326
290 Centennial Drive Stop 8255
Grand Forks, ND 58202-8255

APPENDIX C

INTERVIEW QUESTIONS

Discussion Questions

Grand Tour Question:

What is your experience of overlapping or dual relationships in the Deaf community?

1. Tell me about the development of your identity as a Deaf or Hard of Hearing person.

2. How much of your work life and personal life are in the Deaf community?

3. What is it like for you as a Deaf therapist in the Deaf community?

4. What kinds of feelings or experiences do you attribute to your role as a Deaf therapist?
   - How has being a therapist changed the way you interact with others in the Deaf community?

5. How do you negotiate multiple relationships?
   - How do you establish personal and professional boundaries?

6. What strategies do you use?

7. Anything else you would like to add that we haven't already talked about?

APPENDIX D

DEMOGRAPHICS QUESTIONNAIRE

Demographic Questions

Please do not include your name on this. When you are done, save the document with your responses, attach it to the email, then send it to me at denise.thew@und.edu.

1. Age: _________

2. Gender: _________

3. Ethnicity ___________________

4. What is your hearing loss (decibel) _________

5. Age of hearing loss____________

6. How did you lose your hearing? ___________

7. Are you a licensed therapist or psychologist? (yes/no) _____________

8. If so, in what field is your training and license? __________________________

9. How many years have you worked as a therapist? ____________

10. How much of your work is allocated to deaf or hard of hearing clients? _____%

Other (specify)__________________ _____%

11. Are you fluent in ASL? ____ yes ____no

12. Age you learned ASL _________

13. How often do you attend Deaf related events? ________

14. Is anyone in your family deaf or hard of hearing? ____ yes _____ no

15. If yes, who? ____

16. Do you have access to a videophone? _____________

17. If so, please provide the number: _____________

APPENDIX E

AUDIT TRAIL

Prior Entry into Field
(Jan-Sept 2007)

Evolution of dissertation topic initiated from personal life experiences in dealing with dual relationship dilemmas (as a supervisee and supervisor) in the Deaf community and then in combination with several discussions from other licensed Deaf therapists during various professional conferences.

January 20, 2007 to April 20, 2007: Participated in weekly meeting with Kara Wettersen, PhD, to discuss the dissertation topic and later to work on and refine the write up of my proposal.

July 13, 2007: Proposal meeting with dissertation committee. Refinement and clarification of Research Questions. Deleted instruments from the research design.

Sept 17, 2007: Human Subject Institutional Review board of University of North Dakota Approval.

Throughout these periods of time, continued reading on dual relationship issues in the Small Communities and Ethics, and Qualitative Research Method.

Entry into the Field
(September 2007)

Contacted potential participants who responded to recruitment letters/emails.

Screened several potential participants who expressed an interest to participate in the research by reviewing their answers on the questionnaire.

Continued meeting with Michael Loewy, PhD, for support.

Individual Interviews and Transcriptions
(October 2007-May 2008)

October 5, 2007: Pilot interview and transcription conducted. Modified and clarified some research questions.

Ten 40-60 minutes video phone individual interviews were conducted. I kept a self-reflective journal throughout this period, reflecting on my thoughts and feelings after each interviews. Continued reading in dual relationship and ethics related materials. Kept analytic memos at the same time.

Personally transcribed all ten videophone individual interviews. I recorded thoughts and feelings during the transcription process as well as I reread transcriptions in self-reflective journals and analytic memos.

Each of the transcription was sent to the participants for accuracy and clarification.

Data Analysis Process
(May 2008-Aug 2009)

May-July 2008: Reread individual interview transcripts to code. I also met with my auditor Dory Walker, PhD, several times to compare our coding, before I moved out of North Dakota for my pre-doctoral internship. Dory Walker has excessive experiences in Qualitative Theory methodology.

Aug 2008-Jan 2009: Writing process and I continued to analyze the data and discussed with some of my peer colleagues in dyad as part of my data analysis process.

Jan 2009-Jan 2010: Writing process and I continue to correspond with Michael Loewy to discuss further data analysis and to revise my manuscript.

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