JADARA

Volume 27 | Number 4 Article 7

October 2019

# Counseling with Deaf Clients: The need for Culturally and Linguistically Sensitive Interventions

Paul Freedman
*Counselling Services of the Canadian Hearing Society*

Follow this and additional works at: https://repository.wcsu.edu/jadara

## Recommended Citation

Freedman, P. (2019). Counseling with Deaf Clients: The need for Culturally and Linguistically Sensitive Interventions. *JADARA, 27*(4). Retrieved from https://repository.wcsu.edu/jadara/vol27/iss4/7

# COUNSELING WITH DEAF CLIENTS: THE NEED FOR CULTURALLY AND LINGUISTICALLY SENSITIVE INTERVENTIONS

**PAUL FREEDMAN**
**Counseling Services of the Canadian Hearing Society**
**Toronto, Ontario, Canada**

**Abstract**

Many counselors and therapists who work with culturally Deaf clients have had the unfortunate experience of trying to use what they consider to be an appropriate intervention, only to see it elicit a response of silence and puzzlement from the client. At other times the clinician may become creative and use an intervention that seems to propel the session forward. Why is it that certain types of interventions tend to work better with Deaf clients? Why is it that some interventions seem inappropriate? Are there certain types of interventions that are best suited for use within a visual/gestural mode of communication? The two premises being put forth in this paper are: some interventions are, in fact, better suited for work with Deaf individuals; and, the natural language of Deaf people, namely American Sign Language (ASL) as well as factors pertaining to Deaf culture, should be considered essential criteria for determining which interventions are appropriate. This paper is not meant as a "how to" document but, rather, as an invitation to counselors who work with Deaf clients to examine the extent to which their interventions complement the linguistic and cultural needs of their clients.Three examples of culturally and linguistically sensitive interventions will be examined in this paper and then applied to a case example.

**Introduction**

During the last 10 years numerous articles have been written in the area of counseling clients who are Deaf. The majority of work seems to have focused on two broad areas; one has dealt with the application of developmental psychology, counseling and psychotherapy modalities to clinical work with Deaf clients (Anderson & Watson, 1985; Farrugia, 1992; Gough, 1987; Harvey, 1989). The other area has explored issues pertaining to accessibility within a counseling environment, such as the importance of using sign language interpreters in a counseling situation (Farrugia, 1989; Glickman, 1983; Haley & Thomas, 1988; Pray, 1989; Roe & Roe, 1991). Clearly, both of these areas are of extreme importance. In addition, many mental health professionals who work with Deaf clients need specific counseling tools and interventions that are as unique as the culture itself. Simply put, we as counselors and therapists need to start *developing and documenting* interventions that seem well suited to a visual/gestural mode of communication.

The premise being put forth in this paper is that, in order to develop these types of interventions, we must first examine the language and culture of Deaf clients and use these in establishing criteria against which to assess the appropriateness of our interventions. We will now take a closer look at three interventions that seem well suited for use in a visual/ gestural mode of communication. They include the following: the



Published by WestCollections: digitalcommons@wcsu, 1994

process of "externalizing problems" as an empowering clinical tool (White & Epston, 1990); use of a "lifeline" as a visual assessment tool; and, use of "storytelling" as a counseling intervention. We will now examine these interventions and then discuss the ways in which they can be used with Deaf clients.

### Intervention I: Externalizing Problems

ASL is now recognized as a true and bonafide language in its own right. As with other languages, it has its own comprehensive linguistic properties which enable the signer to communicate concrete as well as abstract concepts. One of the most fascinating aspects of this language is the way in which spatial relationships are used to physically create and manipulate visual concepts. This raises an interesting question: Are there therapeutic interventions available to us which naturally complement this spatial aspect of ASL?

Interventions are now emerging that capitalize on this use of physical space. An example of one such intervention is the use of conversations that help to "externalize" problems. The two family therapists who have pioneered work in this area are Michael White and David Epston (1990).

#### Externalizing the Problem

The therapeutic process of externalizing a problem encourages individuals, families, and couples to separate the problem from themselves and to actually *objectify* the problem(s) they experience as oppressive. That is to say, the goal of externalizing is to place the problem outside of the client(s) which enables them to develop a relationship with the problem that is *more protest oriented*. A problem that was once considered inherent and fixed, often within the identified patient, is now seen as an outside influence that he/she can confront. Central to the concept of externalizing is the notion that neither the client, nor the relationship between members of a client system, is the problem. Rather, the problem itself as well as the person's relationship with the problem *becomes* the problem (White & Epston, 1990). The following is a summary, albeit simplified, of the steps involved in externalizing a problem. For a more detailed description of this process I refer the reader to White and Epston's book entitled *Narrative Means to Therapeutic Ends (1990)*.

#### Relative Influence Questioning

*Relative influence questioning* plays an essential part in enabling clients to experience a feeling of distance between themselves and the problem. This type of questioning involves: mapping the influence of the problem; and, mapping the influence of the person(s) in the "life of the problem".

Mapping the influence of the problem. The first step towards separating the client system from the problem is to explore the ways in which the problem is affecting the lives of the individual(s) involved. Questions can be introduced that encourage clients to explore the problem's sphere of influence in the behavioral, physical, emotional, attitudinal, and interactional domains (White & Epston, 1990). For example, in the case of "anger" as the problem to be externalized, the following questions could be introduced:

- What influence is "anger" having on your relationships with co-workers?
- When that anger starts to move closer and closer to you, you know...like it is about to get a grip on you...what does that do to your concentration in the office?
- How has anger influenced your relationship with your kids?

Mapping the influence of the person(s) in the "life of the problem." This second step involves


https://repository.wcsu.edu/jadara/vol27/iss4/7

the use of questions that bring forth information which contradicts the "problem-saturated" description of individual and/or family life. It also assists the client(s) in identifying their competence and resourcefulness in the face of adversity (White, 1989).

The following includes an example of these types of questions:

(To an individual client)

- Can you recall a time when you could have let anger really get a grip on you...you know, like you could feel it inching it's way inside, but you were able to keep it at a distance?

(To a teenager and family dealing with autonomy issues)

- Can you all think of a time when mom and dad could have let "worrying" overcome them, but they were able to fight it off and allow you to enjoy your new found independence?

This type of questioning enables individuals, couples, and families to identify "facts" or events that contradict the problem's effect in their lives and relationships. These are identified as "unique outcomes".

**Unique Outcomes and the Performance of New Meanings**

Once unique outcomes have been identified, the counselor can introduce a series of questions that encourage individuals and families to ascribe meaning to these events. The performance of new meaning invites individuals to revise their past, present, and future life stories (White & Epston, 1990).

For example, the following questions could be introduced to parents who are able to recall times in which they could have worried excessively about their teenage daughter but, instead, were able to trust her judgement:

(To the parents)

- How were you both able to do this?
- What does this say about your future wishes for your daughter?
- Does your ability to keep this excessive worrying outside of your relationship with your daughter surprise you?

(To the daughter)

- How do you think your parents were able to throw their worrying in the trash can?
- If that kind of worrying somehow finds a way of creeping out of the trash can and sneaking back into the family, who do you think would be the first person to notice it?

The types of questions used throughout the process of externalizing a problem are predominantly *reflexive questions*. These types of questions are oriented towards enabling clients and/or families to generate new cognitive and behavioral patterns on their own. The therapist adopts a facilitative posture and deliberately asks those kinds of questions that may provide opportunities for self-healing (Tomm, 1987a, 1987b, 1988). For a more detailed description of reflexive questioning I refer the reader to the work of Karl Tomm (Tomm 1987a, 1987b, 1988).

**Externalizing a Problem in American Sign Language**

An extremely important feature of American Sign Language is its use of the spatial area around the signer's body. The signer is able to make use of this three-dimensional aspect of ASL by "setting up" non-present referents such as people, places and things in specific locations around his/her body. Once these types of nouns are established in space they can be manipulated in a variety of ways depending on the intended message. Although nouns are the most common type of referents established in a signer's space, it is possible to establish abstract ideas in space such as



Published by WestCollections: digitalcommons@wcsu, 1994

Einstein's Theory of Relativity (Baker & Cokely, 1980, p. 223.). If it is possible to place the Theory of Relativity in space, what is preventing the therapist from objectifying abstract concepts such as anger, depression, anxiety, and worry by placing them in space and thereby *visually externalizing them* from the client, couple, or family? In ASL we not only have the ability to place "anger," as a separate entity, outside of the client, but we can also show him, quite clearly, how the anger is capable of moving towards or away from him.

**Relative Influence Questioning in American Sign Language**

Relative influence questioning involves an examination of the influence a given problem is having on the client and, conversely, the client's influence in the *life of the problem*. White and Epston (1990), see language as a powerful tool that can either promote or hinder the externalization of a given problem. Relative influence questions seem to be particularly well suited to use in ASL because of the counselor's ability to create *distance* between the client and the problem. To illustrate this I will provide a few examples of relative influence questions and then provide a similar ASL glossed question. ASL glossed text is, essentially, an English representation of sign concepts. Unfortunately, it can, by no means, capture the complexity, richness, or beauty of ASL in signed form.

**Mapping the Influence of the Problem**

ENGLISH

- In what way have you felt pushed into the corner by schizophrenia?

ASL GLOSS

- Up until now - schizophrenia (set up away from the signer's body on the palm) - itself (schizophrenia is moved closer to the signer's body) - bothers you..bothers you- influence (mind) - feel stuck - do..do- you - finish experience- you?- when?

ENGLISH

- When you're talking to your boss at work and you feel anger starting to take over, you know, like it is inside and taking control...what happens?

ASL GLOSS

- Curious me- your experience- look back past-work- boss comes up to you- two of you chat [gaze left] notice- " burning anger" (signed on palm away from the signer's body..then slowly moves closer)- chat - chat (anger moves closer) -bothers...bothers (two of you)- chat (escalates) - blowup- you- finish experience that - you - when?

**Mapping the Influence of the Person(s) in the Life of the Problem**

Again, we can see how this three-dimensional aspect of ASL enables the signer to place the problem at a distance from his body and then move it towards or away from himself. The counselor can ask, with curiosity, if the client has ever been able to keep the problem at a distance. One could then go on to explore what these unique outcomes say about the client's personal strengths as well as his ability and desire to not accept the oppressive influence of the problem in his life.

The following includes an example of this type of question:

ENGLISH

- Can you think of a time when you could have let negative thinking get a grip on you...but you were able to keep it at bay?

ASL GLOSS

- You think past - remember - experience - negativity (signed on palm away from the

signer's body then slowly moved closer) almost inside you - you reject it (or block it) - feel relief you - finish - experience - that - you? - when?

The use of this type of intervention via a sign language interpreter would, no doubt, require preliminary preparation to ensure that both counselor and interpreter are clear as to the intent of this type of an approach; the intent being to objectify the problem and not the client.

It should be noted that, externalizing a problem, like any intervention, may not be appropriate or helpful for all clients in all situations. It is, however, one type of empowering and depathologizing intervention that does seem well suited for use within a visual/gestural mode of communication.

### Intervention II: Lifelines

The lifeline is a clinical tool that evolved out of my own practice in working with Deaf clients. A lifeline, like a genogram, is a visual representation of a particular aspect of one's life and history. The genogram tends to focus on the larger picture of family relationships, alliances, cut-offs, and losses, while the lifeline depicts a linear representation of the client's journey from past to present, including all of the peaks and valleys. Ideally, the lifeline is created by the client during a counseling session.

The central features of a lifeline include the following:

1. A line moving from left to right depicting the movement of time from the client's birth up until the present (one could have a client create a future oriented life line as a way of imagining and *preparing for* hypothetical future events and successes).

2. The use of peaks and valleys in the line which depict positive as well as negative experiences, memories, feelings etc.

3. The use of numbers which indicate the client's chronological age at significant points along the line.

4. A brief description of those experiences, feelings, memories etc. that the client sees as being significant at different points along the line.

A lifeline provides the client with a visual and historical representation of his *emotional topography;* that is to say, the numerous high points, low points, inclines, and descents along the line. One client may be struck by the number of losses that have accompanied the low points in the line, while another client may be surprised to discover how social involvement has always accompanied upward inclines in his line. This can prove to be valuable and affirming information for clients who have difficultly appreciating the ways in which positive, as well as self-defeating, behaviors tend to be repeated over time. Examining the peaks in one's lifeline can provide *clues* as to what might be helpful in dealing with present or hypothetical future difficulties.

### The Lifeline as a Linguistically Sensitive Counseling Tool

The lifeline, as a visual assessment tool, seems to be linguistically compatible with a visual/gestural mode of communication for a number of reasons. Rather than talking [signing] about one's past experiences, the client can create and see his/her history visually unfold as the story is told. Furthermore, the horizontal peaks and valleys in the line, to some extent, mirror the directional movement of a number of signs that deal with emotion. For example, a number of signs that



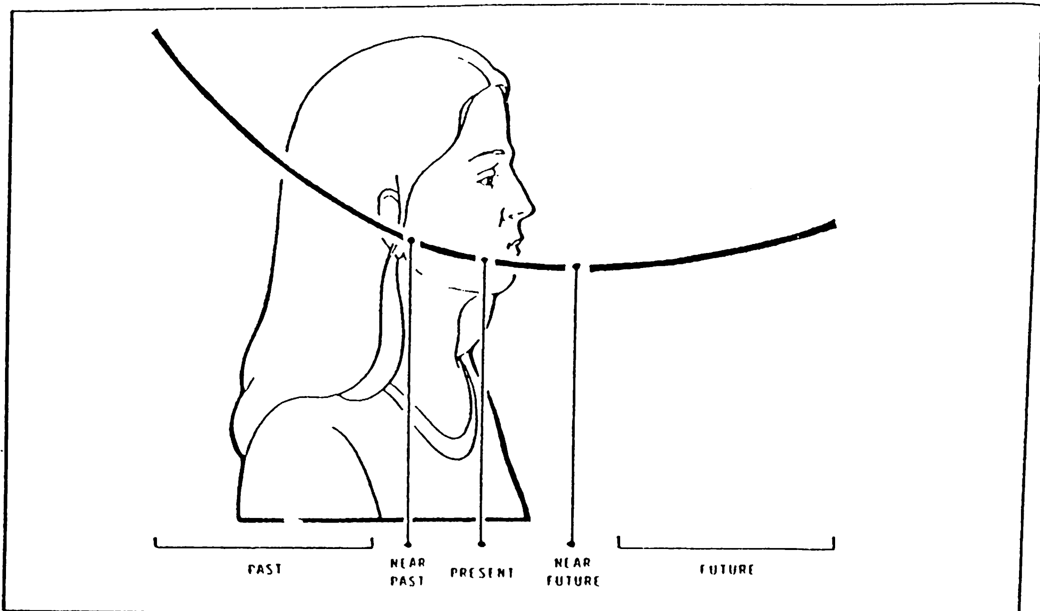
Published by WestCollections: digitalcommons@wcsu, 1994

express positive moods have an upward movement such as happy, excited, thrilled etc., while signs such as deflated, depressed, sad, etc. tend to move in a more downward direction which essentially mirror the affective movements of the lifeline. As well, the lifeline seems to be linguistically compatible with ASL because it presents the notion of *time* as a linear concept (Figure 1.) Beryl Lief Benderly (1980), discusses "time" in ASL in the book *Dancing Without Music*:

*ASL uses space the way spoken language uses sound. It is strikingly.. almost shockingly visual. ...Even time appears spatially. The signer stands at the centre of a field of time, with the past behind him and the future in the front. A line running vertically in front of his shoulders is the present and thus separates the past and future (Benderly, 1980, p.175, see pg. 13).*

Figure 1

The time line, showing points of reference for past and future
(Adapted from Frishberg and Gough 1973.)



**Intervention III:**
**The Use of Storytelling in Counseling**

A lot of what takes place in counseling involves the client telling his/her story and the counselor/therapist listening to that story. More and more, a "narrative" approach is being adopted by therapists as a way of making sense of the kinds of stories clients tell (Gilligan & Price, 1993; White & Epston, 1990). White and Epston (1990) discuss how people make sense out of their lives by "storying" their experiences and that it is the storying, itself, which determines the meaning that people ascribe to the experience. Zimmerman & Dickerson (1993) discuss the idea of storying as a way of organizing our life experiences:

> *We cannot know ourselves or describe ourselves in the totality of our experience. We can, however, describe ourselves in terms of particular events located in our experience and strung together as a "story". Usually one story becomes "dominant" and is the way we think about ourselves. Dominant stories for people in therapy are problem-saturated. The implication is that there are other possible stories available to us made up of events we have been less likely to attend to or have not noticed...using a narrative approach...a re-storying process can be facilitated by the therapist who brings forth alternative stories (descriptions) by helping people attend to other aspects of their lived experience (Zimmerman & Dickerson, 1993, p. 197).*

A number of authors have discussed the importance of storytelling as one of the central values in Deaf culture. (Lentz, Mikos, Smith, 1989; Padden, 1976). It must be remembered that the Deaf experience, traditionally, has been passed on from generation to generation in the form of signed stories. This is no surprise given the fact that it is extremely difficult, if not impossible, to capture the complexity and richness of ASL in written form. It is widely accepted in the Deaf community that storytelling is the most popular form of signed entertainment. Carol Padden, in her article, *The Culture of Deaf People* (1980), discusses the importance of "success stories" in the Deaf community:

> *Among the stories that Deaf people tell are the famous "success stories." A typical success story may go like this: A deaf person [d referring to a person who is audiologically deaf but who does not identify with the Deaf culture] grows up in an oral environment never having met or talked with a Deaf person [D referring to a person who is audiologically deaf and who identifies with Deaf culture]. Later in life the deaf person meets a Deaf person who brings him to parties, teaches him sign language, and instructs him in the way of Deaf people's lives. This person becomes more and more involved and leaves behind his past as he joins other Deaf people (Padden, p. 11).*

Padden comments:

> *In much the same way that Americans support and propagate the "American Dream," these success stories reinforce the strong belief and pride that Deaf people have in their way of life: That it is good and right to be Deaf (Padden, 1980, p. 10-11).*

**Storytelling as a Culterally Sensitive Counseling Tool**

One could argue that the use of "success stories" in the Deaf community is, in fact, therapeutic in that it reinforces and models competency themes as opposed to pathological themes regarding Deaf people's lives. A counselor or therapist can actively use storytelling in sessions as an *invitation* for clients to consider alternative stories they might wish to adopt. Time can be


Published by WestCollections: digitalcommons@wcsu, 1994

spent with clients exploring historical *evidence* of unique outcomes that contradict the client's dominant problem - saturated story. A counselor can use a sequence of short stories to illustrate a variety of problem solving behaviors or alternative ways of viewing situations, and then see which story "fits" with the client's *preferred* view of himself.

The case study that follows illustrates the use of externalizing, lifelines, and storytelling in counseling. It should be emphasized that Deaf clients, like hearing clients, vary and that these types of interventions may not be appropriate or helpful for all clients. The actual effect of any intervention with a client is always determined by the client and not by the therapist (Tomm, 1987, p. 5).

**Case Study**

Mr P. is a 29 year old Deaf man who was born and raised in North Africa. He became deaf at the age of 9 after being struck by a car. Mr. P. came to Canada alone at the age of 23. At that time he did not know any sign language. Since his arrival in Canada, Mr. P. was able to acquire proficiency in ASL as well as a variety of academic skills. At the time of referral, Mr. P. was enrolled full time in a training program.

Mr. P. wanted to see a counselor to discuss interpersonal conflicts he was experiencing at his training program. According to Mr. P., he often became angry at people for "little things" such as accidentally brushing his shoulder while passing him. On a number of occasions he lost control and physically threatened fellow students in the program. He had received two warnings from the director of the program and was clearly at risk of being expelled.

**Mr P.'s Lifeline**

Mr P. spent 2 sessions with his counselor mapping his lifeline. During these sessions he became quite animated and involved as he plotted his line. Time was spent clarifying and re-working the numerous peaks and valleys (Figure 2.)

Once the line was completed, the counselor adopted a stance of *curiosity* as he and Mr. P tried to *make sense* of the line. In working with Mr. P, he and the counselor were struck by the numerous hills he had successfully climbed and the deep "emotional drops" he had survived in his life. The lifeline was used as a starting point to explore the strengths he had made use of in the past that could again be used in the present. A number of questions were introduced that contradicted Mr. P.'s problem-saturated story:

- Did it surprise Mr. P. that he had enough strength to survive all of the emotional drops in the past?
- Were there other people in his family who possessed the same fighting spirit that he had exhibited in those situations?
- Did the fact that he had decided to come for counseling mean that he had decided to use that same kind of strength again?

**The Use of Externalizing With Mr. P.**

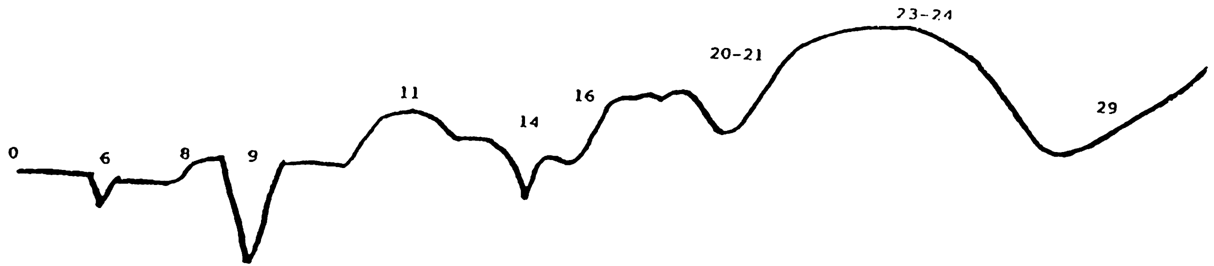
In working with Mr. P., a number of questions were introduced to help him externalize and objectify "anger." For example,

- How was anger messing up Mr. P.'s future dreams and goals in Canada?
- What did he think would happen to his life if he continued to let anger oppress him?
- Were there times at the training program when he felt that anger was going to "win" and take control but, despite this, he was able to "squash" it?
- How had he managed to do that?
- When did he first develop that skill?... at what age?
- As a child, how was he able to push anger away after the death of his sister?


https://repository.wcsu.edu/jadara/vol27/iss4/7

Figure 2

Lifeline: Mr. P.




Age and Events

6 years
- Sister dies suddenly
- Mr. P. not included in family mourning
- Mr. P. mourns loss alone

8 years
- Attends hearing school
- Fun and social life
- Feels the same as others

9 years
- Hit by car/deafened
- Hospitalized
- Lonely

11 years
- Trained as tailor
- Mixed feelings... enjoys work but feels "different"

14 years
- Political problems in country
- Mr. P. witnesses executions of men, women, and children
- Intense fear, nausea, panic

16 years
- Escapes to neighboring country
- Stays with sister
- Works as tailor, feels better

20-21 years
- Mr. P. travels to Egypt
- First Deaf club experience
- Feels connected to the people
- No anxiety, more confident

23-24
- Mr. P. comes to Canada
- Feels free
- Immersed in ASL, Deaf culture
- Starts to "question things" as he develops ASL skills
- Increase in stress and anxiety



Published by WestCollections: digitalcommons@wcsu, 1994

As counseling progressed, Mr P. was able to identify times at his training program when he felt that anger was going to "influence his mind" but he was somehow able to ignore it. Mr. P.'s use of the signed concept " influence my mind" suggested that he was feeling more alienated from the anger and better able to *take a stand against it.*

Mr. P. did need to incorporate anger into his life in a way that was empowering rather than self defeating. Deaf people often face numerous societal barriers, about which they have good reason to get angry. Although this was never pursued with Mr. P., he and his counselor might have explored ways in which he could learn to "use" anger for his own purposes in advocating for increased accessibility, interpreters, human rights etc.

**The Use of Storytelling with Mr P.**

In working with Mr. P., a number of short stories were used to illustrate the different ways people choose to deal with anger. Some aspects of the stories were intentionally created to mirror Mr. P.'s experiences. The following includes two stories, similar to those told in sessions with Mr. P. These stories were meant as invitations to Mr. P. to consider alternative behaviors. Karl Tomm refers to this type of intervention as one that creates a bifurcation (or branching) with respect to alternative meanings and behaviors. Bifurcation interventions, according to Dr. Tomm, are often stated in the form of a question which juxtaposes two contrasting options inviting the client to state his/her preference (Tomm, 1993, p. 67).

**Story A**

Counselor: Mr. P., sometimes I think it can be helpful to talk about other people's experiences in dealing with anger. I'd like to tell you 2 stories and then ask you a few questions about the stories when I am finished. Is that all right with you?

Mr. P.: You mean you want to tell me stories?

Counselor: Yes.. right.. and I'd like to see what you think of them when I am finished.

Mr. P.: Sure... we can do that.

Counselor: Okay

There was a 30 year old Deaf man named Dave who worked in a factory as an upholsterer. He was very skilled at his job and felt proud of his ability. Dave was well known and respected in the Deaf community as a skilled upholsterer. When he was at home he often felt good about himself and in control of his life. At work, however, he felt different from his co-workers who were all hearing. This made him feel bad about himself and angry at the other workers. Sometimes anger would take control of him and he would start yelling at people which was not what he really wanted to do. His co-workers started to avoid him because they felt afraid of his anger. This made Dave feel worse and even more different. He didn't want to let anger influence his mind and mess things up for him but it just kept happening. He stayed at his job for a long time but he never really felt happy about going to work.

Counselor: Now I'd like to tell you a different story.

**Story B**

There was a 33 year old Deaf man named Bob who got a new job working in a bank. He was the only Deaf person who worked there. At times he felt cut-off from his co-workers and isolated. When he started to think about it more and more, he noticed how angry feelings started to influence his thoughts. He felt like he wanted to blow-up and shout but he was able to squash the anger and not let it mess up his new job. Instead of submitting to anger he decided to deal with the isolation by finding a co-worker whom he could trust. Bob did feel different from the other hearing workers at times, but he also felt proud of what made him different. He had come to realize how Deaf culture and ASL were something to feel good about and cherish. A strange thing started to

happen: Bob began reaching out more to his co-workers which made him feel less isolated. The anger, that sometimes popped up, never had a chance to cause damage....it just stayed away.

These stories are not "used on" clients to coerce them into adopting the "right way" of behaving. They are, however, stories about *difference* and, as such, they are presented to the client as *invitations* to consider alternative behaviors, perceptions, meanings.

Once these stories have been told, the counselor can introduce a number of reflexive questions to see if the client is interested in incorporating aspects of either story into his own personal story. The following includes some of the questions that could have been introduced to Mr. P.:

- If Dave (story #1) continued to allow anger to come into his work place year after year and mess things up...what do you think might happen to him in the future?
- How do people like Dave get tricked into thinking that being different is a problem?
- What do you think would happen if Dave realized that his language and culture were special and precious in his life?
- Where, do you think, people like Bob learn to take pride in their culture and language?
- If you could be like Bob or Dave which one would you pick?
- Suppose you could invite Bob over for dinner and get some tips from him about squashing anger at the training program....what do you think he would tell you to do to improve the situation at your training program?

Again, for these questions to be considered reflexive, they must be asked with the intent of facilitating self-healing in the client. There must be an explicit *recognition of the client's autonomy in determining the outcome* (Tomm, 1987).

Clearly, there is a risk involved in focusing so much effort on using culturally and linguistically sensitive interventions with Deaf clients. The risk lies in the possibility of reinforcing the false notion that Deaf people are psychologically *different* than hearing people and that they require special "clinical treatment" because of this. This type of posture is nothing short of disabling and it is not my intent in writing this paper to perpetuate the myth of a "psychology of the Deaf". Harlan Lane, in his book, *The Mask of Benevolence: Disabling the Deaf Community* (Lane, 1992), discusses this issue:

> There is no psychology of the deaf. It is, in fact, not clear that there can be one. The term may inevitably represent the pathologizing of cultural differences, the interpretation of difference as deviance. Of course there are interesting things to be learned and reported about deaf culture, deaf language, and deaf people; the same can be said about many minorities. This knowledge may be found in the literature of that minority, or in works of anthropology, sociology, and sociolinguistics focused on that group. These descriptions are not, however, a "psychology" of the minority and are not offered as such (Lane, 1992, p. 65).

I would suspect that it is possible for counselors who work with Deaf clients to become more attuned to those interventions that are linguistically and culturally sensitive, without falling into the trap of accepting the existence of a psychology of the Deaf.

A commitment towards a counseling approach that places a priority on language and culture holds within it some interesting implications: Developing, discovering, and implementing linguistically sensitive interventions



Published by WestCollections: digitalcommons@wcsu, 1994

requires a high level of proficiency in ASL. Who, then, should be entrusted with the responsibility of delivering this type of essential service? Hearing counselors who can sign a little? Hearing counselors who can sign well? Deaf counselors only? Hearing counselors using interpreters?

Do clinicians with no knowledge of Deaf culture or ASL have the right to label a Deaf client as "unmotivated," "not appropriate for counseling," or "lacking insight" when the interventions used in the assessment have been developed for use in a spoken language? These are issues that clearly require further exploration and discussion.

### Conclusion

In this paper, I have discussed the importance of using America Sign Language and aspects of Deaf culture as sources of criteria against which to assess and critique the interventions we use in our work with Deaf clients. Three examples of linguistically and culturally compatible interventions were presented and I suspect there is a plethora of other such interventions available to us that are being used spontaneously by Deaf clinicians everywhere. It would seem essential that counselors and therapists who work with Deaf clients come together, whenever possible, to share, critique, and discover specific interventions that are well suited for use with Deaf clients. By adopting a mindful and critical approach to interventions, which includes a sensitivity to language and culture, counselors and therapists will be able to improve the quality of counseling services they provide to Deaf people.

## References

Anderson, G.B. & Watson, D. (Eds.) (1985). *Counseling deaf people: Research and practice.* University of Arkansas.

Baker, C. & Cokely, D. (1980). American sign language: A teacher's resource text on grammar and culture. Silver Springs, MD: T.J. Publishers, Inc.

Benderly, L.B. (1980). *Dancing without music: Deafness in America.* Washington DC: Gallaudet University Press.

Farrugia, D. (1989). Practical steps for access and delivery of mental health services to clients who are deaf. *Journal of Applied Rehabilitation Counseling, 20*(1), 33-35.

Farrugia, D. (1992). Borderline personality disorder and deafness. *Journal of the American Deafness and Rehabilitation Association, 25*(3), 8-15.

Frishberg, N. & Gough, B. (1973). Morphology in American sign language. In E. Klima & U. Bellugi *The Signs of Language.* Cambridge: Harvard University Press.

Gilligan, S. & Price, R. (Eds.) (1993). *Therapeutic conversations.* New York: W.W. Norton & Company.

Glickman, N. (1983). A cross-cultural view of counseling with deaf clients. *Journal of the American Deafness and Rehabilitation Association, 16*(3), 4-15.

Gough, Deborah (1989). Rational-emotive therapy: A discussion of its applicability for deaf clients. *Journal of Rational-Emotive Therapy, 5*(3),162-182.

## References

Haley, T.J. & David, T.E. (1988). Responses of deaf adolescents to differences in counselor method of communication and disability status. *Journal of Counseling and Psychotherapy*, 35(3), 258-262.

Harvey, M.A. (1989). *Psychotherapy with deaf and hard of hearing people*. New Jersey: Lawrence Erlbaum Inc.

Lane, H. (1992). *The mask of benevolence: Disabling the Deaf community*. New York: Alfred Knoff.

Lentz, E.M., Mikos, K. & Smith, C. (1992). *Vista: Signing naturally*. San Diego, CA: Dawn Sign Press.

Padden, C. (1980). The culture of Deaf people. In S. Wilcox (Ed.) *American Deaf culture: An anthology*. Maryland: Linstok Press, Inc.

Pray, J.L. (1989). *Social work with deaf persons: Special considerations*. Washington DC: Gallaudet University.

Roe, D.L. & Roe, C.E. (1991). The third party: Using interpreters for the deaf in counseling situations. *Journal of Mental Health Counseling*, 13(1), 91-105.

Tomm, K. (1987a). Interventive interviewing: Part I. Strategizing as a fourth guideline for the therapist. *Family Process* 26, 3-13.

Tomm, K. (1987b). Interventive interviewing: Part II. Reflexive questions as a means to enable self-healing. *Family Process*, 26, 167-183.

Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask linear, circular, strategic, or reflexive questions? *Family Process*, 27, 1-15.

White, M. (1989). *Selected papers*. Adelaide, Australia: Dulwich Centre Publications.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton and Company.

Zimmerman, J.L. & Dickerson, V.C. (1993). Bringing forth the restraining influence of patterns in couples therapy. In S. Gilligan & R. Price. (Eds.) *Therapeutic conversations*. New York: W.W. Norton and Company.



Published by WestCollections: digitalcommons@wcsu, 1994