A PHENOMENOLOGICAL EXAMINATION OF THE HEARING THERAPIST-DEAF PATIENT DYAD: BARRIERS, LANGUAGE, CULTURE, AND TRAINING

A Phenomenological Examination of the Hearing Therapist-Deaf Patient Dyad: Barriers, Language, Culture, and Training

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Abstract

Deaf individuals who seek mental health treatment from hearing therapists may be at risk of receiving services from professionals who are inadequately trained in the specific needs of this population. Few studies have examined the therapeutic relationship and barriers than may impair the implementation of mental health services with the Deaf population by a hearing therapist. This study sought to obtain a phenomenological understanding of the nature of the therapeutic processes that occur from the hearing therapist's perspective. Specifically, this study examined language barriers, the medical versus cultural model, and the development of the therapeutic alliance when working within this dyad. Furthermore, this study examined potential barriers to effective treatment for members of the Deaf population by examining any possible biases from the hearing therapist's perspective. Seven hearing therapists who currently or historically have treated the Deaf population were recruited via a purposive and snowball sample. Participants were asked to complete a brief demographic questionnaire followed by a semi-structured interview. These therapists stressed that it is essential to understand the cultural identity of the Deaf patient. This identity was described as a shared sense of community based on a common language. These therapists also stressed that there are basic competencies and skills that are essential in working with a Deaf patient. Several implications for clinical practice were provided. Future research needs to expand these findings to a wider range of therapists, and it needs to include Deaf patients in any assessment of what works best for them.

Introduction

Experiences of cultural and language differences between a therapist and a patient have received attention in the literature, but accounts of the experience of a hearing therapist treating Deaf individuals through American Sign Language are noticeably sparse. The purpose of this study was to focus both on the hearing therapist's perception of the impact of language within the therapeutic process and on building a culturally sensitive alliance. To achieve this goal, therapists who use American Sign Language as a second language and work with Deaf individuals were interviewed.

The Deaf population's access to mental health service is a major concern. Many Deaf individuals are confronted with barriers such as language, biases, discrimination, and a lack of trained professionals who are able to use American Sign Language, which may result in this marginalized population not receiving proper treatment. Because of the rapidly changing demographic landscape within the Deaf community, mental health professionals are under pressure to provide culturally and linguistically relevant treatments to Deaf patients [1]. Multicultural therapy has seen a deserved increase in attention in the professional literature during the past several years. This concept has been expressed as, "Each cultural group requires a different set of skills, unique areas of emphasis, and specific insights for effective counseling to occur." [2] Such clinical obstacles undoubtedly yield a unique and potentially problematic experience in therapy with Deaf patients.

Hearing loss is legally classified as a disability under the Americans with Disabilities Act [3] and is the second most common disability in the United States [4]. An estimated 35 million people in the United States are considered to be Deaf or hard of hearing [5]. Within the literature, the use of the lower case "d" (Deaf) is used to describe audiological experiences of Deafness, hearing loss and/or hearing impairment, and the capital "D" is in reference to Deafness as a cultural term for individuals who identify as a member of the Deaf community [6]. The term "d/Deaf" encompasses both phenomena [6]. For the purpose of this paper, the term Deaf represents both those associated with audiological impairment and individuals who identify as members of Deaf culture. The Deaf to whom this study refers are those who have primarily relied upon American Sign Language (ASL) for communication.

The interface between psychology and Deaf individuals as an emerging discipline in its own right has been described [7]. However, the vast majority of literature on Deafness is devoted to the medical and disability models. The scarcity of research providing insight into a hearing therapist's ability to offer therapeutic services competently and ethically to this marginalized population is the motivation for this study. Providing therapeutic services to the Deaf community may be particularly challenging for the hearing therapist. However, there are few qualified psychologists who are both knowledgeable of Deaf culture and fluent in their clients' preferred modalities of communication (ASL) [8]. The primary goal for this study was to gain a better understanding of how hearing therapists can better serve Deaf individuals through the exploration of the following topics via the perspective of hearing therapists: Deaf community, linguistic barriers, cultural competence, developing a therapeutic alliance, ethical dilemmas, and a lack of appropriate training.

One of the barriers inherent in mental health treatment with the Deaf population appears to be communication [9]. While communication is a main concern for many Deaf individuals, research also indicates that being understood by their therapists is equally important [10]. It appears that Deaf individuals want to be able to communicate in their preferred language, and also want hearing therapists to recognize and acknowledge that their Deaf patients are members of a unique culture [11]. When working in a nondominant language, a therapist can have increased feelings of insecurity, inferiority, and estrangement [12]. However, specific research that addresses how a hearing therapist can best implement culturally sensitive and linguistically competent therapy appears to be lacking.

American Sign Language (ASL) is recognized and accepted as the primary language of Deaf individuals in the United States [13]. Implementing a cultural perspective of language provides one of the basic ways in which group cohesion and identity can develop based on shared beliefs, values, and norms [14]. As such, gaining a clear understanding of the Deaf population requires therapists to engage in a multidimensional examination that encompasses culture, language, and historical influences along with the distinction between the traditional medical models versus the contemporary cultural model [13]. Both frameworks carry a myriad of assumptions that can potentially burden or liberate those to whom these assumptions are applied [15].

Deafness historically has been labeled as a disability rather than a cultural identification within a subset of the general population [6]. The majority of the existing literature conceptualizes the Deaf population from either the medical or the cultural model [14]. The medical model views Deafness as a disability, whereas the cultural model views the Deaf population as a specific culture with a distinct set of norms, values, and language [14]. A shift in recent years from the medical to the cultural model has permitted an increase in studies involving the

Deaf community from cross-cultural or multicultural perspectives [15]. These medical versus cultural frameworks for understanding Deafness appear to be poles apart. It is likely that mental health practitioners may lack training that addresses the specific cultural and language needs of the Deaf population.

It is well documented in the psychotherapy literature that the therapeutic alliance between patients and counselors is a crucial predictor for successful outcomes and is, in fact, more influential than the theoretical framework employed [16]. Specifically, therapists have a professional responsibility to be sensitive to cultural differences when working with each patient, yet many clinicians have little awareness of the cultural and linguistic dimensions of Deafness, and research on the therapeutic processes between the dyad of the hearing therapist and Deaf client is limited [17].

The literature reviewed highlights the lack of specific written information about Deaf culture and the impact of ASL in the therapeutic relationship [18]. ASL, a language primarily based on spatial movement, involves a great deal of facial expressions, body and hand movements, and close proximity to others [10]. For hearing therapists who work directly with this population, it is important to acknowledge and understand these differences from the use of spoken word with hearing patients, and to make use of increased and maintained eye contact [13]. Through the use of the Deaf patient's first or preferred language of ASL, a consideration of the linguistic nuances requires a therapist to have attained training and knowledge in this area to engage the patient in a therapeutic relationship.

Deaf individuals, just like their hearing counterparts, present with an array of mental health disorders that fluctuate in severity. It has been reported that due to the lack of available qualified therapists in a given geographic area, many clinicians may attempt to compensate or extend their scope of practice with Deaf patients to meet the mental health needs of Deaf patients [19]. The burdens on these "Deafness experts" may include working without knowledgeable supervision, leading to a predictable occupational hazard of burnout [19]. The expectations on this "expert" therapist to serve any and all Deaf persons regardless of age, severity of emotional problems, communication abilities, and cognitive resources are unfair and unrealistic [19].

The Deaf are rarely a central focus of the diversity requirement within most training programs [20]. Currently, therapists who work with Deaf individuals have no specific provisions for providing treatment. It has been proposed that, as with hearing patients, therapeutic approaches must be modified to fit the needs of the Deaf patient and not the needs of the therapists [21]. He acknowledges that this may include acquiring new language skills and adapting techniques and therapeutic approaches through specialized training [21]. Thus, it appears that advancements in graduate level training may be necessary to better address the needs of this population.

Literature defining the specific therapeutic processes and skills required for hearing therapists to effectively work with Deaf patients is currently lacking [8]. The mental health field continues to need further development and research to ensure that a consensus can be reached about whether working with the Deaf population in psychotherapy does, in fact, require any specialization. It is presumed that a basic understanding of any minority population may require some specialty training in language, culture, and implementation of services. The focus of this study was to better understand the language obstacles and cultural gaps that influence the development of a therapeutic alliance between the dyad of a hearing therapist and a Deaf patient, as well as to demonstrate the merits of further specialized training for therapists intending to work with this population.

Psychotherapy with Deaf persons may in fact not differ greatly from psychotherapy with hearing persons; however, as with any minority group, the Deaf population must contend with discrimination, marginalization, and a general lack of communication with the mainstream population [13]. Through gaining a better understanding of the Deaf community, a therapist is likely to find that there may be some preconceptions between the hearing therapist and the Deaf patient that inhibit the development of a therapeutic alliance [13]. The most important consideration initially may be to understand how the use of sign language impacts the development of a therapeutic relationship. Some Deaf individuals are discouraged from aligning themselves with the hearing world, as doing so may result in a lack of acceptance by the ethnocentric Deaf community. This tendency may result in a resistance to treatment provided by hearing mental health providers

Statement of the Problem

There has been a shift away from the medical/disability perspective on the conceptualization of psychological treatment for Deaf patients [22]. The disability perspective is being replaced by a perspective of a cultural identity embraced by Deaf patients [23]. Consequently, an important framework has been established that invites the exploration and understanding of the experiences of culturally identifying Deaf individuals who are in psychotherapy and the hearing professionals who treat them. The development of the therapeutic alliance between Deaf patients and hearing therapists may face a number of unique dilemmas. Accordingly, to engage effectively in a therapeutic relationship with a patient who is Deaf, it may be necessary to examine the therapist's views and biases related to groups that are different from his or her own

[9]. It is further advised that, when working with the Deaf population, a therapist must also understand and consider the patient's perspective on his or her cultural identity and perception of Deafness [24].

It has been proposed that an important aspect of hearing therapists treating Deaf patients is knowledge of American Sign Language [14]. In an effort to further understand this specific dyad, it is important to investigate if there are any distinctive barriers or ethical dilemmas that may arise from communicating exclusively through American Sign Language (ASL), and how the clinician's "hearingness" impacts his or her work in regard to developing a therapeutic alliance with Deaf patients. Examining these issues requires not only an assessment of hearing therapists' work with Deaf patients from a relational perspective, but also a consideration of ethical viewpoints regarding issues such as cultural competence [25].

It was the focus of this study to explore the issues that hearing therapists providing psychotherapy to the Deaf identify as important in order to understand the necessary components required for this therapeutic dyad better. This study can offer new insight and opportunity to broaden our understanding of the experiences associated when working with individuals who identify as part of the Deaf culture. The information derived from this study may assist in understanding what is necessary to develop a therapeutic alliance for hearing therapists who treat Deaf individuals, as well as provide guidance for those who will treat the Deaf in the future. It is an aim of this study to help mental health professionals become more aware of the necessary training and unique barriers that may exist within this dyad. Through this study, the idea is proposed that if mental health professionals and graduate students are more aware of the specific and specialized needs of Deaf individuals, this population would receive more culturally effective treatments, have an increase in qualified therapists, experience fewer barriers to communication, and better understand factors that could contribute to establishing a stronger therapeutic alliance.

Methods

This study utilized a qualitative method of study, interpretive phenomenological analysis (IPA) through interviewing seven participants. IPA is a subset of qualitative research similar to phenomenology. A qualitative design is appropriate for this study because it provided the most productive way to get close to the subjective world of the participant experiencing a particulate phenomenon on an insider's perceptive [26].

Participants

A combined purposeful convenience and snowball sample of seven participants was used to recruit for this study. Various mental health list servers were researched, such as Therapist.com, NetworkTherapy.com, and Psychology Today. In the searches, a need was indicated for mental health professionals who engage in American Sign Language as the first filter. Those mental health providers who identified as having a specialty in ASL as a second language were then evaluated for appropriate education level to participate in the study. Criteria for inclusion in the study stipulated that the mental health providers were currently or had previously provided treatment to Deaf individuals through ASL as a second language, and that their current or past caseloads consisted of individual therapy with Deaf adult, adolescent, or child patients. It was also indicated that the providers were working toward a license or were licensed practitioners with a masters or doctorate in social work, counseling, marriage and family, or clinical psychology. Furthermore, participants were not to identify as being Deaf or Hard of Hearing themselves. It was further stipulated that the provider engaged in direct service and did not utilize interpreters when working with Deaf patients, as the study required the dyad of a hearing therapist and a Deaf individual. The participants were expected to vary in ethnicity, gender, age, education level, religious affiliations, and socioeconomic status.

Participants for the study were recruited and approached through direct e-mail or telephone contact by the primary researcher. Participants who met the inclusion criteria and agreed to participate were provided written and verbal information regarding the study's purpose, requirements, researcher's name, school affiliation, status, and informed consent, and were asked to participate in a short demographic questionnaire and a 60-minute semi-structured interview (see Appendices A, B & C).

Procedures

Appointments were made with participants who met the aforementioned criteria. Participants were informed that the interviews were voluntary, for research purposes, and conducted either via Skype or telephone, but were only audio recorded. Participants were advised that they may withdraw from the study at any time without penalty. Each subject was sent an informed consent statement via direct email explaining the purpose and procedures of the study (see **Appendix A**). Participants returned the signed and dated informed consents via U.S. Postal Service or via email with electronic signatures. To ensure confidentiality, each participant was identified only by his or her first and last initials.

Participants were asked to complete a short demographic questionnaire containing eight questions (see **Appendix B**). The questionnaire was not intended to take more than five minutes to complete. The purpose of the questionnaire was to gain general demographic information

from each participant regarding factors such as ethnicity, age, gender, graduate training, and certification status regarding ASL. To further ensure confidentiality was maintained, the brief demographic questionnaire forms were also identified only by initials and remained in a separate lockbox away from the transcribed interviews.

Interviews were scheduled to take place via Skype or by telephone at the participant's preferred setting (office, home, neutral location) and adhered to general semi-structured protocols. The semi-structured interview format allowed for the collection of relevant information from a target audience while allowing interviewees the freedom to respond to open-ended questions, to elaborate, and to explore topics. Interviews averaged between 60 and 70 minutes. Participants were asked to not use patients' last names during the interviews, and this same protocol was followed in the study to ensure the highest level of confidentiality. Video interviews conducted via Skype allowed for the tracking of nonverbal behavior, which would guide the interview accordingly.

The full semi-structured interview protocol is provided in **Appendix C**. Interviews conducted via Skype interview were only audio recorded, not video recorded. The audio was recorded on a separate digital recording device that is the private property of and password protected by the researcher. The interviews were transcribed for content and stored within a separate lockbox accordingly. The recordings were transcribed by graduate students at Texas Women's University and the primary researcher. The primary researcher stored all data on a secure computer owned by the researcher and protected by fingerprint password technology.

Upon completion of the interview, each participant received via email a written debriefing statement with the researcher's contact information (see **Appendix D**). The debriefing statement also explained the nature of the study, how the information would be utilized, and how confidentiality would be maintained. After the participants had been debriefed, they were each mailed a Starbucks gift card for $10 as a token of appreciation for their participation, paid for by the primary researcher.

Demographic questionnaire and semi-structured interview

Demographic information provided on the questionnaire (**Appendix B**) was collected prior to the interview and is presented in Table 1. The participant group consisted of seven mental health professionals; however, there was no preferred gender or ethnicity required. Demographic information was collected in order to illustrate the training and background of each participant, and evaluated to determine the current standard of education, training, and practices of the participant group. A goal of the demographic questionnaire was to further understand what clinical training participants might have received during graduate school that related to the Deaf population and whether the participants became certified in ASL. As noted previously, a limited number of hearing therapists use ASL, thus it was another goal of this questionnaire to better understand how participants received referrals regarding Deaf individuals. Data was collected and evaluated for general information and presented in Table 1.

The review of literature on the hearing therapist-Deaf patient dyad revealed a lack of information discussing specific therapeutic processes within this type of dyad. Primary issues and concerns were noted regarding the lack of available information in regard to communication through ASL, education, training, and unique therapeutic interactions due to cultural and linguistic barriers for this demographic. Based on this review, a brief demographic questionnaire and a set of standard questions were developed for a semi-structured interview to inquire about these deficits and gather more information.

The semi-structured interview consisted of 20 questions (see **Appendix C**). Questions required a response based on the participant's unique experience of working with the Deaf population. Most questions were formulated as open-ended, which provided an opportunity for participants to elaborate on any question if desired. Questions within the semi-structured interview covered the following areas: training related to American Sign Language and certification, experience with treating members of the Deaf population, views on mental health services in general that provide therapy to the Deaf population, and any perceived differences in the therapeutic process when treating Deaf individuals. The interview was further intended to address any personal experiences, thoughts, feelings, and conflicts that may have arisen while conducting therapy with Deaf clients. Appendix C provides a complete list of questions.

Interpretive phenomenological analysis

The interviews were analyzed by interpretive phenomenological analysis. IPA was developed by Jonathan Smith, at Birkbeck University of London [26]. IPA is an experiential, qualitative approach to research in the field of psychology, similar to phenomenology, whereas it is concerned with the knowledge gained through interactions with others and the world. It aims to understand a concept through the evaluation and analysis of reports and the individual experiences of the participants [26-28]. IPA places emphasis on cognition and emotional state rather than behavior. IPA most commonly involves the systematic coding of transcripts of semi-structured interviews conducted with participants [26,27].

There are four stages of IPA, each closely followed for analysis in the present study. The first stage involves reading each transcript several times until an overall grasp of the data is obtained. Once an overall grasp of the data has been reached, notes are then made in the margin on the left-hand side of the transcripts. These notes reflect initial thoughts and observations; there are no rules or requirements for these comments [27-29].

In the second stage, the transcripts are re-read, and themes are named through the process of abstraction. These themes are noted in the margin on the right-hand side of the transcripts [27-29]. This is the most challenging stage of analysis, whereas at times themes can be easily provided names from exact text, at other times a higher level of abstraction is needed in understanding and naming the nature of the interaction or what is being discussed. In either circumstance, one is aiming to find themes that have a theoretical connection within and across cases [28,29]. This process is repeated until all possible themes are exhausted and a list of themes has been developed [27-29].

In stage three, the results of the analysis begin to be structured. The themes from stage two are extracted. They are reviewed to ensure there are no redundancies and to eliminate themes that are not strongly supported. In the present study, these initial themes are referred to as Specific Themes [27,28]. The use of a second reader, as performed in the present study, allows for the opportunity to compare findings and provides inter rater reliability to the findings. The researcher then begins looking for connections between the themes in order to cluster them together in a meaningful way. Overarching themes are then developed through the clustering of these themes [28,29]. In the present study, these overarching themes were referenced as "Higher Order Themes."

The fourth and final stage of IPA involves the production of a summary table of structured themes and quotes that illustrate the themes. Each of the overarching or superordinate themes, herein referenced as Higher Order Themes, can then be written as a narrative account with supporting quotes from the transcripts [26,28]. In the present study, this was done at two levels. First, eight of the Specific Themes were discovered to be universal across participants. As such, they were referenced as Universal Specific Themes and used to capture the universally described experiences of the participants and present a narrative of their experience as reflected by these Universal Specific Themes. Second, each of the six Higher Order Themes were reviewed in depth, providing supportive quotes from the text of the transcripts to narrate each of the Specific Themes that were clustered together to comprise each Higher Order Theme.

Results

Tables 1 & 2 present the demographic data obtained from the seven individuals who participated in this study. It can be seen that they ranged in age from 29 to 59, provided direct therapeutic services to Deaf adults and/or children, and were either certified in American Sign Language or obtained competency through external ASL classes. Interestingly, all indicated that they believed that they "understand Deaf culture." There were six female Caucasian participants and only one Hispanic male included in this study. Of the seven participants, three doctoral level therapists and four master level counselors or social workers were interviewed. It was also noted that five out of the seven stated that they receive referrals from "word of mouth." Last, as language is of key importance within this dyad, only two of the participants were ASL certified. Tables 1 & 2 also display the participants' ethnicities, referral sources, most common diagnoses treated, and whether they had any formal training in graduate school regarding Deaf culture.

Table 1: Participant demographic information.

	Participant			
	1	2	3	4
Age	29	43	59	36
Gender	Female	Female	Female	Female
Ethnicity	Caucasian	Caucasian	Caucasian	Caucasian
Education level/license	LCPC	PsyD	LP, MA	LCSW, MSW
ASL Certified	Yes	No	No	Yes
Source of ASL education		Outside certification (SCIPI-Level 3)	ASL classes/immersion	Immersion/signing since age 11
Referral sources	Schools for Deaf, Psychology Today website, Google	County social workers, School personnel, families, Word of mouth	County social workers, schools, Treatment facilities, Vocational rehab, Word of mouth	Insurance, schools, word of mouth
Most common DX	N/A	GAD, Depression, PTSD	Depression	Depression, anxiety, Adjustment disorder, ADHD

Graduate education on Deaf	Yes	No	No	Yes
Do you believe you understand "Deaf Culture?"	Yes	Yes	Yes	Yes

Table 2: Participant demographic information Continued.

	Participant		
	5	6	7
Age	34	41	34
Gender	Female	Male	Female
Ethnicity	Caucasian	Hispanic	Caucasian
Education level/license	LCSW	PhD	PhD
ASL	No	No	No
certified			
Source of ASL education	ASL classes	ASL classes/family	ASL classes
Referral sources	Schools, county social workers, word of mouth	Government Agencies – DCFS/vocational rehabilitation services	Medical insurance directors, word of mouth
Most common DX	Anxiety, adjustment disorder	No clear pattern	Depression & anxiety
Graduate education on Deaf	Yes	Yes	No
Do you believe you understand "Deaf Culture?"	Yes	Yes	Yes

Specific themes

The researcher and two other graduate students transcribed interviews. Identifying data was omitted, and the first and last initials of each participant were assigned to transcripts to ensure anonymity and confidentiality. Transcripts were reviewed using IPA to identify themes related to the possible barriers, language requirements, skills, training, and issues in building a therapeutic alliance and psychotherapy process with Deaf patients.

In accordance with IPA, as explained by Smith et al. (1999) and Smith and Osborn (2003), the first stage consisted of the researcher and a peer independently reading and rereading transcripts to independently obtain lists of possible themes. A total of 87 possible themes were identified, of which the researcher and peer reader identified 78 of the initial 87 themes independently, making a final list of 78 possible themes. Cohen's kappa coefficient of .794 was obtained.

In the next stage, the researcher and the researcher's CRP Committee Chair reviewed the list of 78 possible themes to identify similarities among the themes to develop the final list of Specific Themes. Upon consolidating repetitive themes, a final list of 44 themes was derived. These themes were given labels/names that convey the meaning of the theme and are presented in Table 3 in the order in which they emerged in the interviews, with the number of participants who expressed each theme noted in parentheses. Any Specific Themes that were expressed by every participant are labeled as Universal Specific Themes. Those are presented in Table 4.

Table 3: Specific themes found in transcripts and number of participants expressing each theme.

#	Theme	#	Theme
1	Family (2)	23	Engage in body language – facial/posture (5)
2	Formal education (2)	24	Reflect statements (5)
3	School experience/exposure (4)	25	Clarifying statements – ask/assess/feedback (5)
4	Language (7)	26	Limited referral sources/providers (7)
5	Identity (7)	27	Self-doubt of own abilities (5)
6	Not a disability (5)	28	Physically/emotionally exhaustive due to language barrier (4)
7	Lack of resources – written materials (5)	29	Use of visual aides (3)
8	Use of ASL – second language, Matching linguistics (7)	30	Competence – cultural and assessment (5)

9	Confidentiality: boundaries, family therapy, small community (7)	31	Immersion in Deaf community (6)
10	Community based on shared values, acculturation, and discrimination (7)	32	Augment learning – previous literature (4)
11	Longer treatment trajectory (7)	33	Pre-graduate formal education/training (3)
12	Teach patients social and emotional etiquette, and vocabulary (6)	34	Postgraduate formal education/training (4)
13	Assessing functional abilities – cognitive and emotion-al (4)	35	Expand diversity class section to include Deaf population (5)
14	Prove self, skills, and intent to patients (5)	36	Training on all subcultures within Deaf, Hard of Hearing, Blind population (5)
15	Preference of Deaf individuals for a hearing provider (4)	37	Include training on Deaf and comorbid impairments (cognitive/ psychological) (4)
16	Alter and tweak materials for Deaf patients (5)	38	Address double discrimination issues (3)
17	Acknowledge Deaf experiences/challenges (5)	39	Supervision & consultation (3)
18	Repeat and apologize (3)	40	Informed consent (2)
19	Cognitive behavioral therapy (3)	41	Special and unique niche – make a difference (5)
20	Dialectic behavioral therapy (3)	42	Understanding Deaf perspective is fun (3)
21	Play therapy (3)	43	Insight focused not recommended (7)
22	Direct & concrete approach (5)	44	Underserved population (6)

Table 4: Higher order themes with each component-specific theme listed.

Higher Order Theme	Specific Theme	Number of Participants
1: Deaf Culture and Identity	Language [4]	7
	Identity [5]	7
	Not a disability [6]	5
	Community based on shared values [10]	7
	Longer trajectory [11]	7
2: Building an Alliance	Use of ASL/matching linguistics [8]	7
	Prove self, skills, and intent [14]	5
	Hearing therapist preferred [15]	4
	Acknowledge understanding of Deaf experiences [17]	5
	Repeat/apologize [18]	3
	Body language/facial expressions and posturing [23]	5
	Reflect [24]	5
	Clarifying statements – ask/assess/feedback [25]	5
3: Cross-Cultural Competency	Formal education [2]	6
	Lack of resources [7]	5
	Teach social etiquette, emotional vocabulary, new signs [12]	6
	Adjust written materials [16]	5
	Cross-cultural competence [30]	5
	Immersion in Deaf community [31]	6
	Pre-graduate studies [33]	3
	Postgraduate studies [34]	4
	Address double discrimination issues [38]	3
4: Therapeutic Skills and Training	CBT [19]	3
	DBT [20]	3

	Play therapy [21]	3
	Be direct and concrete [22]	5
	Augment learning outside of formal education [32]	4
	Expand class section in graduate programs to include Deaf Culture [35]	5
	Training on all subcultures – Deaf, HOH, Blind Populations [36]	5
	Include training on Deaf and comorbid impairments (cognitive/ psychological) [37]	4
	Insight focused not recommended [43]	7
5: Ethical Issues	Confidentiality – boundaries and family therapy [9]	7
	Assessment – cognitive and pathology level [13]	4
	Limited number of providers/referral sites [26]	7
	Supervision and consultation [39]	3
	Informed consent [40]	2
6: Therapist Personal, Emotional, and Social Experience	Family member [1]	2
	Early school experiences and exposure [3]	4
	Self-doubt of own abilities [27]	5
	Exhaustive due to ASL and use of visual tools [28/29]	4/3
	Unique niche – make a difference [41]	5
	Perspective is fun [42]	3
	Underserved population [44]	6

Note: The number of each specific theme is indicated in brackets after the name of the specific theme.

High order themes

Once the final list of Specific Themes was agreed upon, the Specific Themes were independently grouped into Higher Order Themes. Where there were differences between the researcher and the CRP Committee Chair in the resultant Higher Order Themes and the Specific Themes composing those Higher Order Themes, discussion led to agreement on the final list of Higher Order Themes and the Specific Themes comprising each Higher Order Theme. Table 4 presents the final list of the six Higher Order Themes that were constructed from the clustering of the 44 Specific Themes. The six Higher Order Themes were named based on the essence of the Specific Themes included within each Higher Order Theme. The Specific Themes that compose each of the Higher Order Themes are listed under their respective Higher Order Theme in Table 4. In addition, in Table 4, the number of participants who expressed each Specific Theme is indicated as well. The Higher Order Themes differ in the number of Specific Themes that comprise each Higher Order Theme. In addition, while all participants are not represented in each Specific Theme, every participant is represented in all Higher Order Themes, thus every Higher Order Theme reflects to some degree every participant.

Universal specific themes

Specific Themes that were expressed by all seven participants were identified as Universal Specific Themes. Of the 44 Specific Themes, eight were identified as Universal Specific Themes and are presented in Table 5 along with their corresponding Higher Order Theme. The four Higher Order Themes that contained the Universal Specific Themes were: (a) Deaf Culture and Identity, (b) Building an Alliance, (c) Therapeutic Skills and Training, and (d) Ethical issues. The eight Universal Specific Themes that were expressed by all seven participants were: (a) Language, (b) Identity, (c) Community based on shared values (acculturation and discrimination), (d) ASL as a second language – use of sign, (e) Longer trajectory, (f) Insight focused modalities are not recommended, (g) Confidentiality, and (h) Limited providers/referral sites.

Table 5: Higher order themes and component universal specific themes.

Deaf Culture and Identity	Building an Alliance	Therapeutic Skills and Training	Ethical Issues
Language [4]	ASL as a second language – use of sign–matching [8]	Insight focused modalities are not recommended [43]	Confidentiality [9]
Identity [5]			Limited providers/referral sites [26]

Community based on shared values (acculturation/ discrimination) [10]			
Longer trajectory [11]			

Note: The number of the Universal Specific Themes is presented in brackets.

Universal Specific Themes provides a summary picture of the "story" that evolved from the participants. To these treating professionals, it is clear that having an understanding of Deaf Culture (Higher Order Theme 1) that includes a clear sense of identity to Deaf patients are pinnacle aspects in building a therapeutic alliance. Also, it is imperative that therapists are able to match their patients' ASL linguistic style, which leads to a longer treatment trajectory (Higher Order Theme 2), all of which requires certain therapeutic skills and training because insight focused therapy is not recommended (Higher Order Theme 4). This all occurs while confronting ethical issues created by the lack of available providers and the close-knit community, which create confidentiality issues (Higher Order Theme 5) when treating the Deaf population. Dealing with these issues successfully will allow a connection with patients that is essential to the therapeutic process and success in treatment.

Analysis of higher order themes in more depth

As seen in Table 4, a total of six Higher Order Themes were identified through the clustering of Specific Themes. In order to appropriately capture the thematic findings of this study with greater specificity than what is reflected by the Universal Specific Themes, each Higher Order Theme and corresponding cluster of Specific Themes will be described and examples from transcripts provided. The sequence of presentation of the six Higher Order Themes was guided by a perspective suggesting that the participants were expressing that working with the Deaf population first requires the therapist's awareness of the "culture" of the Deaf community (Higher Order Theme 1), which is crucial in developing a therapeutic alliance (Higher Order Theme 2). This process requires basic cross-cultural competencies (Higher Order Theme 3) that have to be addressed with specific therapeutic skills and training (Higher Order Theme 4) in working with the Deaf, and this process takes place under certain ethical strains (Higher Order Theme 5), yet therapy with the Deaf can be very rewarding and challenging to the therapist personally and emotionally (Higher Order Theme 6). Each Higher Order Theme will be described and presented in greater detail in the order the Higher Order Themes are represented in Table 4.

Table 6: Higher order theme 1: Deaf culture and identity.

Specific Themes	Sample Quotes
#4: Language	The cultural aspect is more for helping them to know who they are and the beauty of the language and the common bond everyone has. (P1)
	Just like any other ethnic group, Deaf people have their own language. Language spoke that is shared by the Deaf community. Language, I think, is a key part of Deaf culture, as well as some of their values and typical mores and things like that, that they share with each other. (P7)
#5: Identity	They have really neat narratives that they pass down, and it cannot be written. (P1)
	Cultural Deafness for me at least when I'm working with clients really comes down to their identity. (P4)
	Deaf culture is more about those people who grew up with other Deaf people probably at a school for the Deaf. When I think of Deaf culture, I think of it encapsulated at residential schools. Rather were those that kind of grew up together, you know, at the school for the Deaf. If you didn't go to the school for the Deaf, well you know the sense was you're different than me. You know you don't really understand. (P3)
#6: Not a disability	Not focused on the disability, on the loss. (P1)
	I can do everything except hear, and I am capable and willing and smart and all those good things . . . so for hearing people to come in and say 'You've got a problem, let's fix it' is actually an insult. (P2)
	Definitely with people that are in the Deaf culture I know that they don't see it as something wrong with me, I'm just part of another group of people that does life a little differently or communicates a little differently. (P3)
	At the same time, there are a lot of people who are Deaf who don't consider themselves disabled in the slightest. (P4)
	Don't see it as a disability, need to have a disability to qualify for services, but I think a lot of people who are Deaf don't see it as a disability. (P5)
	They don't see it as a disability issue. They see it as shared culture, a shared way of being. (P6)
	And they see it as empowerment. They don't see it as a disability issue. They see it as a shared culture, a shared way of being. (P7)
#10: Community based on shared values, acculturation, and discrimination	I have my own language with its own structure and its own heritage. I've got all my own cultural norms that are appropriate to me that are different from the hearing world a lot of times, and I'm very comfortable with who I am and how I live my life. (P2)

	And within context of Deaf culture, you have to know how acculturated that person is to be able to figure out where they fit, how they see themselves, and how they're going to respond to you and how you need to change yourself to make sure you're meeting their needs. (P2)
	Deaf culture as . . . identify as Deaf and really use sign language and really subscribe to Deaf culture and values and then moving out from there, they are part of a community and all the people that want to continue to support the culture and beliefs with you by learning sign language and the core coming out from there and get involved with the community. (P5)
	Deaf culture is important in terms of understanding the Deaf experience the best you can. Understanding their life experience or being willing to hear it, you know, listening to what it was like growing up being the only Deaf person in a hearing family. It's not as simple as oh you wear hearing aids and you sign, it's something much larger than that, and whether it's about sort of characteristics of Deaf culture, that's a whole other thing. (P3)
	People born Deaf and identify as Deaf, use sign language, subscribe to culture and values, part of a community, want to continue to support the culture and beliefs. (P6)
	I think there are biases toward the hearing population, but I also think there are biases toward mental health in general. . . . They are afraid that hearing people are gonna come in and try and fix it, which is what they don't want. So I feel there are a lot of Deaf people out there who aren't getting served because they are afraid of the implication of it. (P1)
	I think some hearing persons are scared of em'. Deaf people know exactly what to do, they've done this a hundred times, and they know exactly how to interact with hearing people. To the hearing person, this might be their first or second person they've ever met. (P4)
	I think there's possibly some kind of minimizing that I don't want to look crazy or I don't want to find another thing wrong with me or I'm already stigmatized. (P7)
	I think that is a big reason why there is not that many Deaf clients coming to therapy because they don't want their business shared all over. (P7)
#11: Longer trajectory	I have one hat to wear, I don't have to be an interpreter, and wearing different hats would be really challenging, and though it would make it a much longer process and longer to develop a plan. To put out terms or techniques, it takes me longer to elaborate on everything (P1).
#11: Longer trajectory (Cont.)	I find my trajectory for what I predict discharge will be much further out than it is if I come across a Deaf person who has had fantastic language skills and development and really doesn't need me to back up much. My grant allows us to do things above and beyond what the regular 50-minute therapeutic hour is, so I am expected as part of my job to attend IEP meetings, spend a lot of time with parents on the phone, Skyping, so in terms of managing my therapy with that client it involves so many pieces, so they take much more time and energy. (P2)
	Therapy moves faster with hearing people, typically language issues and savvy, lack of psychological mindedness. (P3)
	My challenge with Deaf folks are how do I make this information more accessible and move them toward behavior change without having to see them for 10 years, because I've had some clients that I have seen for that long of a period. (P3)
	No difference in session times, no difference in structure. . . . I can usually proceed faster with hearing clients than I can with Deaf clients, so their therapy takes longer. I'm talking about length of treatment. (P4)
	Depending on the language, slower because of communication. Same session time, longer trajectory. (P5)
	Truth is, I usually do a lot more time for a Deaf person, and they don't have the experience of being a client. (P6)
	No difference in session time, although it would seem like it would take longer with a Deaf-clients to get to certain points just because really Deaf seem to be extremely detailed in describing things that they want to tell you. (P7)

Note: Participants expressing the theme (in parentheses), and quotes for corresponding specific themes with the participant number listed.

Higher order theme 1: Deaf culture and identity: The first Higher Order Theme is identified as Deaf Culture and Identity. A description of this Higher Order Theme as well as a description and example quotes from transcripts for each constituent Specific Theme is provided in Table 6. This Higher Order Theme includes understanding the Deaf population and how a sense of identity (Specific Theme 5) develops through language (Universal Specific Theme 4), a community based on shared values (Universal Specific Theme 10), and acculturation and discrimination issues. This Higher Order Theme also reflects a community of Deaf individuals who do not perceive their Deafness as a disability (Specific Theme 6), and that therapists may need to expand their treatment trajectory to a longer period (Universal Specific Theme 7) due to some of the challenges of working with this population.

Those who treat this population may benefit from appreciation of the Deaf from a broader cultural perspective rather than from a medical model perspective. Through an appreciation for the cultural identity of Deaf patients, a therapist is more likely to be better prepared to work within a close-knit population that provides unique challenges. Higher Order Theme 1 contained four of the eight Universal Specific Themes, reflecting the importance that all of the participants placed on awareness of the Deaf culture and the identity of the Deaf patient with their unique language and community.

Higher order theme 2: Building an alliance: The second Higher Order Theme is identified as Building an Alliance. A description of this Higher Order Theme, for each corresponding Specific Theme, as well as a description and example quotes from transcripts, is provided in Table

7. This Higher Order Theme includes some of the challenges and adaptions that may be necessary for hearing therapists to build an alliance with this population. The first four Specific Themes that comprise this Higher Order Theme include: (a) Use of ASL as a second language in which skill, matching, and sign style are relevant (Universal Specific Theme 8); (b) The need to prove yourself, skills, and intent to patients (Specific Theme 14); (c) Preference of Deaf individuals for a hearing provider (Specific Theme 15); and (d) Acknowledging and understanding the Deaf experience and challenges (Specific Theme 17). The next four Specific Themes that comprise this Higher order included some notable suggestions on how to engage in alliance-building behaviors such as: (a) Repeat and apologize if you do not understand (Specific Theme 18), (b) Use of Body language with facial expressions and posturing (Specific Theme 23), (c) reflect statements (Specific Theme 24), and (d) engage in clarifying statements that ask, assess, and provide feedback (Specific Theme 25).

Table 7: Higher order theme 2: Building an alliance.

Specific Themes	Sample Quotes
#8: Use of second language/ matching linguistics	Mostly it is just misunderstandings, maybe the wrong sign or the wrong intention. Receptive finger styling is always my weak part. I suck at it. I practice a lot because it is something that I struggled with. (P1)
	Like I have to sign well enough, I have to understand well enough, I have to advocate well enough. Who is dysthymic, and not depressed, but the sign is the same so I came up with a criteria on a scale. (P2)
	People who get frustrated with my receptive skills; my expressive skills are pretty good. (P3)
	I adapt my signing, it's a struggle for me to remember to keep that stuff out of my language when I'm talking with a mainstream Deaf person who doesn't use a lot of those idioms or just ways we phrase things as hearing people, they don't use that. (P3)
	Making sure I'm matching linguistically what they need in terms of speed. (P4)
	If I am able to linguistically match my client, my credibility and, um, alliance with them goes up dramatically. (P4)
	I mean definitely the obvious one (barrier) that ASL isn't my first language, it's the second language. (P2)
#14: Prove self, skills, and intent to patients	I don't see that hearing people who sort of turn into the world of Deafness later can really be members of that; they can't choose to be members of the Deaf culture. I have to prove myself every time I meet a new person. My reputation is out there as a trusted person in the community. I had to tell my story; I had to explain why I'm involved in Deafness. (P4)
	I usually make it a point, I do this specifically to gain trust by telling them how many years I've worked with Deaf folks. I think I also try to immediately match their communication. (P3)
	I feel like I have to prove myself, a lot of times. I am very open and honest and say this is who I am and if you are not comfortable. Refer out if there is a problem. (P2)
	Asked if I am hard of hearing or have Deaf parents. Not going to connect with you as much unless you are fluently speaking their language. (P1)
	Wanting to see my level of signing before committing because obviously not wanting to deal with struggling to communicate while talking about such difficult things. Having to prove yourself in that way. (P7)
#15: Hearing therapist preferred	Consider myself as playing a role in the Deaf Community, as part of the Deaf Community. I don't consider myself as part of the Deaf Culture. (P5)
	Thrilled to have someone who can speak their language, see that I can be fun and laugh at hearing people. (P1)
	They actually tell me that they prefer to see me as a hearing person because I'm outside the Deaf community, the Deaf world. I think more people actually feel that way than wanting to see a Deaf person, which I find very unusual. (P3)
#15: Hearing therapist preferred (Cont.)	So I am hearing, but I am ASL fluent, and they would really look for and ask me questions sometimes before deciding that they would start with me. They didn't want me connected with certain, you know, people. People would drive farther to come and see me because I'm not in downtown, where most of them meet up groups and things like that. They kind of liked it that I was kind of out of the heart of it. (P7)
	I've had a lot of Deaf people come to me specifically because I am hearing. Because they know how rapid the grapevine is, the gossip grapevine in the Deaf community, and they like the fact that I am an outsider in that so they feel safer telling me things and knowing that I'm not gonna . . . don't socialize in the Deaf community. (P2)
#17: Acknowledge understanding of Deaf experience	Little "d" is all about the medical model, you have a problem that needs to get fixed, and your ears don't work, let's fix them, and if they're not fixed, you are disabled. I want to qualify that understanding the effect of hearing loss on development with the context of Deaf Culture is more important than anything else. (P2)
	There is a different mentality about mental health, and again that's cultural because I have some Somalian Deaf kids where you can't use the world mental health, you're either crazy or sane, there is no depressed. So you use behavioral health language with them as opposed to mental health language, but it's the same concept. (P2)
	We fix them, we medicate them. . . . We still think of it as something that's wrong. "You know," as I say to any Deaf person or hearing person, "You know from a hearing person's perspective your ears don't work. One of your senses doesn't work as well as somebody's else's." They go, "Yeah, I know, but I don't care." They're like that's fine. (P3)

	Just being a white female therapist brings with it some privilege, so in general to be sensitive to this and know that the Deaf community and our clients that we serve are a population that experiences a lot of poverty and comes from single-parent homes. (P5)
	I think one of the most important things for me is to show them that I get you and I respect you and that my therapy offers you a safe place to be. (P5)
	They still try to solve problems behaviorally instead of verbally. Deaf people are over-represented in prisons. (P6)
	Understanding how different it is to be Deaf than hearing and what that person has been through. Really similar to any kind of minority, what is different about this person and what they have been exposed to. (P7)
#18: Repeat/apologize	How I got through it was by rewording, acting it out. I have to apologize when I don't understand, have them repeat it. I admit that and say I am sorry, please say again. (P1)
	Sometimes receptively, their language is so different that when I ask them to repeat they get frustrated. (P2)
18: Repeat/Apologize (Cont.)	Struggle with understanding them and they are not finger spelling the whole word. . . . I think that might affect the therapeutic alliance because I'll be going "I'm sorry, what?" and I'll be like having to interrupt and periodically and they will look at me like "ugh," you know they'll be a bit irritated. (P3)
	One of the other hurdles has been the language barriers. Still times where I either don't understand something, I have to ask to repeat, it's still not my native language, signs look different, you know it is a dialectic. (P4)
#23: Body language, facial expression, and posturing	I think I talk less and I just use more body language. Less language and more body language and facial expression, more in tune you know attunements with your body and what not and less with your voice. (P4)
	I think it just really depends on where you're sitting you know . . . if the client is telling me something really sad and difficult . . . you might just really sit back really far and be like wow, you know that was really hard or something like that. (P4)
	I use facial movements even if the person is not looking at me, I still nod. (P1)
	I probably communicate empathy by sitting forward and hunching my shoulders and signing very empathically and using a lot of facial expression, and I use my body a lot, not just in signing, but just my body to talk to anybody, but I know I do a lot of my head going forward, leaning. (P3)
	It's a lot of head nodding. I think a lot can be conveyed through the nonverbal. (P6)
	Use facial expressions, actually part of the language. So if that's missing, you aren't actually communicating fully in the language. Actually, I use a lot of facial grammar and facial expression. Maybe sometimes my signs get bigger to show a bigger response, mostly facial but probably also some of my signs get more dramatic. (P7)
# 24: Reflect	Probably reflecting so I can be sure that I am understanding what they are saying. (P6)
	I see how they're signing and try to give them feedback, and you know you look mad, and they say they are not mad, it's just how I sign and I go I know that and understand but you need to know that in this context you've got a double duty. (P3)
	When it comes to connecting with the client, I see them connect when I'm able to reflect back to them what they said. And I mean that's true for hearing therapists with hearing clients, if I reflect that I have understood them, they'll connect with me and they'll feel safe. (P2)
#25: Clarifying statements – ask, assess, feedback	Challenge with Deaf community, help understand sequentially cause and effect. Without same structure of language and them not always using it correctly, it can be a big challenge. Being able to pick up and understanding contextually . . . clarify. (P5)
	There are times when I think I'm understanding, and then I find out that I didn't understand. My first instinct is to blame my receptive skills on that as opposed to blame the client's expressive skills. I have to personally work on pretty regularly to make sure I am being fair to myself, which means I am being fair to my client. (P2)
	I probably need to do more is continue to check with them and ask if they're getting their needs met, need more information, if there's anything I could make clearer. (P2)
	I would just ask again and say "but your face doesn't say that." (P1)
	I'm trying to clarify . . . they don't always sign at face value. I need to kind of investigate a bit more and help them get some variation or degree because sometimes it's all or nothing. (P3)
	I try to do is don't ever assume is I have any questions even if I am to bother the client to ask them, I would do a lot of clarifying. So this is what you said? You know, just to really make sure that I didn't misunderstand or miss the small phrase that would have made it a completely different meaning. (P7)

Note: Participants expressing the theme (in parentheses), and quotes for corresponding specific themes with the participant number listed. This theme is comprised of a cluster of Specific Themes that address how to build, maintain, and address the therapeutic alliance when working with the Deaf population from a hearing provider's perspective.

Several therapists in this study believed that many basic alliance-building behaviors were necessary. However, all of the participants stressed the importance of being able to match ASL signs in building the alliance. It was noted that due to the limited number of providers competent in using ASL, these therapists have had to explain some personal background to their clients to "prove" that they are qualified to

treat a Deaf individual (Specific Theme 14). According to these therapists, building the alliance requires (a) Acknowledging the Deaf patient's experiences/challenges (Specific Theme 17), (b) A direct and concrete approach (Specific Theme 22), (c) Using body language and facial expressions (Specific Theme 23), (d) Reflecting statements (Specific Theme 24), (e) Clarifying statements/asking for feedback (Specific Theme 25), and even (f) Repeating and apologizing (Specific Theme 18) for not understanding what has been communicated. Despite these alliance-building complications, these therapists indicated that their patients preferred to work with a hearing therapist (Specific Theme 15).

Higher order theme 3: Cross-Cultural competency: The third Higher Order Theme is identified as: Cross-Cultural Competency used here as a general concept distinct from specific skills. A description of this Higher Order Theme, as well as a description and example quotes from transcripts for each of the nine constituent Specific Themes, is provided in Table 8. This Higher Order Theme includes: (a) Therapists' level of comfort in their own formal education (Specific Theme 2), (b) Pre- and postgraduate studies (Specific Themes 33 and 34), (c) Cultural competence (Specific Theme 30), and (d) How gaining some insights through Immersion in the Deaf community (Specific Theme 31) has been beneficial. Several participants highlighted the adjustment they experienced in working with patients who had a limited emotional vocabulary and engaging in a more teaching role, even at times making up new signs and modeling appropriate social etiquette (Specific Theme 12).

Subsequently, these therapists stated that they often spent extra time adjusting written materials to meet the needs of Deaf patients (Specific Themes 7 and 16). Another important aspect of competency that these participants specified was the need to understand using assessments with the Deaf population. It was stated openly that unless you have both the competency in providing cross-cultural assessments and a clear understanding of the Deaf culture, as one participant said, "just don't do it."

Higher order theme 4: Therapeutic skills and training: The fourth Higher Order Theme is identified as: Therapeutic Skills and Training. A description of this Higher Order Theme, as well as a description and example quotes from transcripts for each of the nine corresponding Specific Theme, is provided in Table 9. This Higher Order Theme includes therapeutic techniques and practices that were described as either helpful or unhelpful by participants providing treatment for Deaf individuals. Findings indicated that several participants felt that they had to augment much of their learning outside of their formal education (Specific Theme 32). Furthermore, many participants expressed that it was important for training programs to include Deaf Culture (Specific Theme 35) and the subculture (Specific Theme 36) to better treat those with Dual Diagnosis and other impairments (Specific Theme 37). These therapists unanimously stated that insight-focused therapy is not recommended (Universal Specific Theme 43). It appears that using more tool-based approaches such as Cognitive Behavioral Therapy (Specific Theme 19) and Dialectical Behavioral Therapy (Specific Theme 20) modalities has shown a sense of success for these therapists. The therapists also recommended using more visual and spatial tasks such as those involved with Play Therapy (Specific Theme 21). Subsequently, the therapists interviewed reported that a more direct and concrete approach (Specific Theme 22) with Deaf patients is helpful, as many of the social and language idiosyncrasies are often not learned within this population.

Higher order theme 5: Ethical issues: The fifth Higher Order Theme is identified as: Ethical Issues. A description of this Higher Order Theme, as well as a description and example quotes from transcripts for each corresponding Specific Theme, is provided in Table 10. This Higher Order Theme includes participants' thoughts and feelings regarding their challenges in regard to ethical dilemmas that may be present when working with the Deaf population.

All of the participants felt as though there are a limited number of providers and/or referral sites (Universal Specific Theme 26), which compounded the ethical issue of when to refer out due to scope of practice limitations. The lack of resources includes limited availability of supervision and consultation. In addition, this problem is further compounded when family or group therapy may be indicated, as it is not typical practice for one to provide both the individual and family therapy, yet this is often the case for these providers. During the interview, therapists often discussed the issue of confidentiality within a small community (Specific Theme 9), but more importantly as to how this can push their own personal, professional, and social boundaries (Specific Theme 40). Informed consent was a specific ethical issue that was mentioned (Specific Theme 40). Immersion into the Deaf community was noted to be a great learning tool, but once being recognized in a community as a patron, it is often difficult for therapists to separate professionally without appearing rejecting. Therapists also mentioned that providing psychometric assessments on Deaf individuals requires a special knowledge and that ethically one should not engage in such assessments unless trained appropriately (Specific Theme 13).

Higher order theme 6: Therapists' personal, emotional, and social experience: The sixth and final Higher Order Theme is identified as: Therapists' Personal, Emotional, and Social Experiences. A description of this Higher Order Theme as well as a description and example quotes from transcripts for each of the eight constituent Specific Themes is provided in Table 11. This Higher Order Theme includes reasons therapists initially were interested in this population and some of the personal rewards and challenges that affected their motivation to work with the Deaf population. These therapists indicated that it was highly common for hearing therapists to gain an interest in this population

from a very young age (Specific Theme 3) that begins with exposure to either a Deaf individual or a family member (Specific Theme 1). Some participants reported that having ASL as a second language often led to self-doubt in their abilities (Specific Theme 27). Findings indicated that using ASL can be exhausting due to the nature of the language and converting to more visual and spatial language and tools (Specific Theme 29). It was also highly common for therapists to report that they found working with such a unique population allowed them to feel like they were making a difference (Specific Theme 41) and contributing to an overall marginalized population (Specific Theme 44). Last, it was stated that working across cultures often leads to learning a new perspective of how the Deaf view the world, especially the hearing world, and allows the therapist to have some fun in learning the differences (Specific Theme 42).

Table 8: Higher order theme 3: Cross-cultural competency.

Specific Themes	Sample Quotes
# 7: Lack of resources	I'm not familiar in or skilled at and yet there wasn't anybody else out there that way either. I'm like I don't know what to do with it . . . if I could work collaboratively with that person (another therapist) that is my best bet. (P2)
	We don't have that many Deaf-friendly resources unless I create them. (P3)
	There are so many Deaf clients around the country and so few therapists. (P1)
	I think part of the challenge is in the inner city area we don't have a huge number of signing therapists . . . if we want to refer someone . . . a lot of times there are resources out there, but often there are not enough. If I could refer more, more professionals who specialize . . . more able to provide group therapy, yeah that would take a load off. (P5)
	Barriers out there . . . lack of resources. There just aren't enough resources and as much as I want to respond to every referral that I get. . . . (P6)
	I would refer, and I do have two or three in all of the . . . county. (P7)
#12: Teach patients social and emotional vocabulary	I have to explain more things to Deaf people just because they miss out on all the incidental learning and whatnot over the years, so I am explaining more things to them through the course of therapy in terms of social etiquette, idioms, social interactions with other people, things like that which is a lot of my work. (P4)
	I think it's a bit more interesting with Deaf folks. They need help understanding some kind of simple social thing that they didn't get, that would never happen with a hearing person, but this person needed help knowing is this okay to do and this . . . they have more limited exposure to social norms and so on. It's sometimes life skills training that I kind of have to do more with my Deaf clients, and I'm talking Deaf "D" clients. (P3)
	I would say that the Deaf clients that I work with do come in with a much more restricted-feeling vocabulary, and sometimes it's really challenging for them to name their feelings and for them to process the therapy. (P5)
	If they said depressed, they don't know the difference between sad and depressed, so I have to teach that. They sometimes overstate their emotions, and they don't have the words to talk about it; they don't have the signs to talk about it. (P3)
	It's very sad. They are not picking up on affect vocabulary because happy is the only sign they have for expressed emotion. (P6)
#12: Teach patients social and emotional vocabulary (Cont.)	Yeah, I definitely think that emotions, emotional expressions, identifying the emotions, I would say, it's so hard because a lot of my clients really struggle with that, but yes I would probably would be able to say that I see that pretty consistently with Deaf clients. (P7)
	Deaf clients whose language exposure was different when they were growing up or whose ability to express themselves is different, or they just don't have the vocabulary to even start with the deeper insightful therapy, that I actually have to back up and start at a much different level than I would have if they had been hearing and had pretty good language exposure. (P2)
#16: Adjust written materials for Deaf patients	I find that I have to modify things that are developed for a hearing population so that they work better for the Deaf and hard of hearing people. That takes extra time and energy. (P3)
	I guess I do a lot of adjusting. I do get bogged down because we don't have that many real Deaf-friendly resources unless I create them, and there was a period of time where I was trying to create more of that stuff. (P3)
	I change everything. Anything that's written or that's expected to be, you know, logged or anything like that I change or I modify or I do, you know, depending on their linguistic abilities. I've got all varieties of resources to pull from and then I just tweak stuff as needed so yeah I mean I do change things as necessary. (P4)
	The tools I pick are very different; I find that I have to modify things that are developed for a hearing population so that they work better for Deaf that takes extra time and energy. (P2)
#30: Cross-cultural and assessment competence	Therapists that understand the language and culture are rare. It's not enough to work with a Deaf person. You have the training and you know ASL and that's all you need to know, I'd be wrong. There are so many nuances . . . so many cultural pieces, and there are all the Deaf plus aspects. Deaf plus I mean other aspects that add on to the Deafness and the disability culture, ages of hearing loss onset. (P6)
	You have to know how acculturated that person is to be able to figure out where they fit, how they see themselves, and how they're going to respond to you, and how you need to change yourself to make sure you are meeting their needs. (P2)
	I think a therapist needs to have the insight to know that being a person with a hearing loss is so all-encompassing in terms of how you experience the world. That's what I tell hearing people is that you can't expect a Deaf person to hear better. You have to accommodate their hearing needs and their communication needs. (P4)

	And assessment, just don't do it. Don't do it with Deaf people, that's all there is to it. You've got to be able to incorporate the information of Deaf Culture and Deaf development into your assessment to make sure you're not misdiagnosing or making recommendations that don't make any sense. You need to have an understanding of all the biases that could happen within testing. (P2)
#30: Cross-cultural and assessment competence (Cont.)	One of the most difficult things to assess in another language. I wasn't solid enough that it was actually different personalities, and I really struggled to actually know . . . with a hearing person it's never been a problem for me to directly identify if they have a dissociative identity disorder and I admittedly so, even at the end of therapy with that client I was not actually sure. (P7)
	I think it would be a little unethical to be working with a Deaf client and you don't have the background, the history of Deaf culture. (P7)
# 31: Immersion in Deaf community	Taught at a high school for the Deaf and fell in love, and that was honestly and truly the best advice I'd ever gotten in my life because I got the language. I got the culture; there was no question about it. (P2)
	I was in the community . . . just socializing with Deaf adults and children and everything like that and functioning in part of the community . . . all contributed to being ready to work in the community and being better accepted. (P4)
	I really enjoyed working with the community, learning the language, and had a lot of really interesting volunteer opportunities . . . so that is how I continued to get immersed in the culture and loved it. (P5)
	I would truly immerse myself in the Deaf, when there were events I would try to go. (P6)
	It is important that I would say they do need to have more exposure and competencies in the culture and be immersed even if just for a little while. (P7)
#33: Pregraduate formal education/training	I decided to go to school for Deaf studies and counseling at the University of Pittsburg . . . so I transferred to Western Maryland College with a major in art and a minor in education for Deaf studies. (P1)
	My background was as a speech therapist. (P3)
	I started college at Jacksonville Illinois in a community college in education for the Deaf. (P4)
	It (training in Deaf culture) was pregraduate. That was before going to graduate school. (P7)
#34: Postgraduate formal education/training	Postgraduate work at Gallaudet. (P1)
	I have my master's degree in Deaf education, so that gave me access and knowledge and information about working with Deaf kids, how they learn, and their cognitive development pretty much. My graduate program, I am an Argosy grad also, so it was nothing related to Deaf and hard of hearing related. (P2)
	I went to get the mental health part, and I then applied it to my knowledge of Deaf people . . . how they thought about things I could take that new clinical information and plug it in to what I knew and then work with it and to be honest I think that's how most of us are currently doing the work you know, many of us I should say kind of learn, we kind of learned on the fly. I didn't get that specific training with Deaf; I got it related to hearing people, so I applied it. (P3)
	Graduate work at Gallaudet. (P4)
	I have a masters, and I am a licensed social worker, so I have a masters in social work and a masters in rehabilitation counseling. So for me, my training in Deaf therapies came with rehab counseling. (P5)
	Masters focused on your efficacy with Deaf people, but I wouldn't say they did such a good job of highlighting this is what you need for working with a Deaf person. (P6)

Note: Participants expressing the theme (in parentheses), and quotes for corresponding specific themes with the participant number listed. This theme is comprised of a cluster of Specific Themes that address therapist cross-cultural competencies regarding education and specific needs for this population.

Discussion

General discussion

This study was designed to investigate the unique factors that occur when a hearing therapist conducts psychotherapy with Deaf individuals from the perspective of the therapist. Specifically, in the case of this dyad, the particular phenomena that emerged were that these dyads have linguistic, therapeutic, ethical, and personal challenges, but therapist-Deaf patient dyads were also found to be very intrinsically rewarding to the hearing provider. The current study explicated these experiences using the qualitative methodology of IPA, which enabled a rich account of the experiences of the seven participating clinicians to be presented. As a result, the current study has found empirical support for much of the previous literature on the proposed necessary skills and knowledge needed to work within this dyad from a cross-cultural perspective.

The method of analysis used for this qualitative study was IPA [27,28]. This methodology provided openness to learning from experienced professionals as to what factors contribute to understanding Deaf culture and linguistics as well as factors involved in building a therapeutic alliance with Deaf individuals. This methodology also enabled the discovery of these participants' experiences working with Deaf patients that emphasized ethical issues and their suggestions as to what competencies and/or skills may be most useful when working with this population. Forty-four Specific Themes were identified. The Specific Themes were then clustered and organized into six Higher Order Themes. Some aspect

of each of the six Higher Order themes was expressed by all seven participants, thus each Higher Order Theme appears in some form in 100% of the interviews of the therapists who participated in this study.

Of the 44 Specific Themes, eight were expressed by every single participant (Universal Specific Themes). Thus, there was complete uniformity and agreement among these therapists regarding certain issues in working with Deaf patients. These Universal Specific Themes reflected the strong emphasis that the participating therapists uniformly asserted are essential in working with Deaf patients. Specifically, they stressed that therapists must understand that their Deaf patients do not self-identify as having a disability, but rather that they have an identification based on a common language (use of sign) and a community based on shared values. These therapists also stressed that specific issues in working with the Deaf are created by the limited resources and providers available, which creates ethical conflicts for the therapist, including issues of confidentiality. The participants also all agreed that insight-focused treatment is not recommended and that therapists need to be prepared for the trajectory of therapy being longer than with other patients with similar issues.

The research showed that many Specific and Universal Themes are interwoven among each other and across multiple Higher Order Themes. In the following sections, an effort is made to integrate these individual themes so as to illuminate the complicated and varied factors that these clinicians indicated are so important for hearing therapists working with Deaf patients.

Deaf culture, identity, and community

The participants in this study emphasized that in working with the Deaf, therapists must understand the combined factors of language, identity, and community in the lives of their Deaf patients. Linguistic and cultural groups have their own way of seeing and expressing how they see and interpret the world, and how they interact in it [17]. This concept was reflected in the present study by the therapists unanimously emphasizing the fundamental importance of American Sign Language (ASL) in understanding the world of their Deaf patients and in communicating with them in therapy (Universal Specific Theme 4: Language). The fundamental importance of language and culture as interrelated concepts was expressed clearly by Participant 1, who said, "The cultural aspect is more effective for helping them to know who they are and the beauty of the language and the common bond that everyone has." Padden [30] proposed the following:

Culture consists of language, values, traditions, norms and identity. Deaf culture meets all five sociological criteria for defining a culture. Language refers to the native visual cultural language of Deaf people, with its own syntax (grammar or form), semantics (vocabulary or content), and pragmatics (social rules of use). It is highly valued by the Deaf community because it's visually accessible. Values in the Deaf community include the importance of clear communication for all both in terms of expression and comprehension.

Thus, the current study's results are supportive of Padden's [30] statement that Language is a key factor defining this culture. The relevance of this Universal Specific Theme also integrates across other Higher Orders such as Building an Alliance and Skills because language issues are fundamental as a skill needed in order to build a good working alliance. The participants stressed the cultural importance, implementation, and significance of relating to their patients' culture in the patients' primary language.

Once the cultural relevance of language has been acknowledged by a hearing therapist, another important aspect to providing services with the Deaf community that may be a challenge is the necessity to understand the role that Deafness plays in a patient's identity (Universal Specific Theme 5). Perhaps the most important premise of the concept of the Deaf culture may be identification with Deaf people through shared experiences and active participation in group activities [31]. It was noted that the label a person gives himself or herself is an important indicator to Deaf people of their identification with their own culture [31]. Across the entire sample of participants within the current study, they universally were able to illustrate that identifying with the Deaf culture provided a sense of identity for their patients. This impression is specifically evidenced by Participant 4, who stated, "Cultural Deafness for me, at least when I am working with clients, really comes down to their identity."

The results of the current study demonstrated that an overall relationship among language, cultural identification, and identity are significant factors when a hearing therapist engages with a Deaf patient. These findings are consistent with previous literature. For example, Thomas, Cromwell, and Miller (2006) stated, "Language provides one of the basic ways in which group cohesion and identity can develop based on shared beliefs, values, and norms." [13] Similarly, Roots stated:

Identity is one of the key components of the whole person. Accepting that one is Deaf and is proud of his/her culture and heritage and a contributing member of that society is key to being a member of the cultural group [32].

An example of how relevant this perspective is viewed by these therapists appears in a statement by Participant 5, who said, "If you are working with someone who identifies with culturally Deaf, it is probably one of the most important things for me to get their understanding of Deafness and Deaf culture."

The findings of the current study conform with the literature regarding the importance to the Deaf of their identity, their language, and their Deaf culture. These ideas were further reflected in the Universal Specific Theme of Community Based on Shared Values (Universal Specific Theme 10), which was expressed repeatedly within the interviews. These themes of shared identity, values, and community also included the Deaf community's experiences with discrimination and acculturation that relate to the issue of the medical model versus the cultural model [19]. The current participants universally recognized their patients as part of a cultural minority group and treated them accordingly. As such, it was also important for these therapists to highlight that their patients did not base their identities on being disabled (Specific Theme 6, which was expressed by five of the seven participants). This shared belief within the Deaf community is likely based on a history of marginalization and discrimination through the medical-pathological model, rather than the cultural model to which these therapists adhere.

Glickman argued that a hearing bias against Deaf people begins with this medical-pathological assumption that Deafness is a tragic disability [19]. The disability model appears to still operate within medical settings [20]. This is best illustrated by Participant 3, who stated,

I work in a hospital, so we look at everything pathologically. I come from that's just sort of the way of problems, we fix them, we medicate them.... Even in our DSM-IV, it still says hearing-impaired or Deaf-mute or stuff like that, it makes me insane. So, we still think of it as something that's wrong.... They go "Yeah, but I don't care." They are like that's fine.

The findings of the current study are consistent with proposal that therapists and other professionals serving the Deaf population need to revise their conceptualization of Deafness as a disability [20].

Participants in the current research stated that most of the patients they treat do not initiate therapy because they are Deaf per se. In fact, what these therapists stressed was the cultural identify that their Deaf patients share. This was best illustrated by Participant 6's and 7's comments (See Table 5). Participant 6 stated, "They don't see it as a disability issue. They see it as a shared culture, a shared way of being," and Participant 7 stated, "They see it as empowerment. They don't see it as a disability issue. It is apparent from the results of this study that these participants clearly understand that their patients do not view Deafness as a deficit, but rather their language contributes to an identity with a sense of shared beliefs, hence a cultural perspective rather than the medical-disability model.

This study also found that many of the participants remarked that the "choice" to identify as Deaf often gives meaning and purpose to the shared cultural aspects of Deafness. This was specifically indicated by Participant 4, who stated:

I look at it as a choice, more so than for example race or something like that. There's a lot of people that [are] a certain race, you're often considered in that culture automatically, but Deafness is, I think, very different from that.

Padden and Humphries pointed out that in hearing culture, it tends to be desirable to distinguish between degrees of hearing loss (i.e., hard of hearing, hearing impaired, Deaf, etc.) [33]. In the Deaf culture, these distinctions are not considered to be important in terms of the group functioning [33]. The label "Deaf" is not so much a label of Deafness, as it is a label of identity with other Deaf persons. This concept of identification is best illustrated by the fact that the sign for Deaf may be used in an ASL sentence to mean "my friends," which in turn conveys in a single sign the cultural meaning of Deaf [33].

Treatment length, competence, specific skills, and the therapeutic alliance

Therapists also universally reported that one of the consequences of the issues of language and their patients' identification with the Deaf culture is that when therapists are providing treatment to the Deaf population, the treatment trajectory was found to be longer as compared to hearing patients (Universal Specific Theme 11). This concept is best illustrated by Participant 1, who stated, "To put out terms or techniques, it takes me longer to elaborate on everything." The participants reported that the Use of ASL as a second language (Universal Specific Theme 8) can slow down the speed of therapy and prolong the trajectory (path and length) of therapy. It was clear that having the ability to communicate effectively through the use of a second language (ASL) is an imperative aspect that must also be utilized in order to build a strong therapeutic alliance, which can take time. It is well accepted that an alliance is known to be a key indicator for a favorable therapeutic outcome [34]. Therefore, factors that impinge on hearing therapists' ability to form good working alliances with their Deaf patients must be recognized and addressed.

Other Specific Themes suggest that the need to assess the patient's functional abilities both cognitively and emotionally (Specific Theme 13) and teach patients social and emotional vocabulary (Specific Theme 12) also can lengthen the treatment trajectory. This concept was illustrated by Participant 3, who stated, "Therapy moves faster with hearing people—typically, [slower due to] language issues and savvy, and lack of psychological mindedness." Other Specific Themes also provide an explanation for a longer trajectory, including: Proving their self, skills, and intent to patients (Specific Theme 14), the need to Alter and tweak material for Deaf patients (Theme 16), increasing the use of Visual aids (Specific Theme 29) as a means to augment the Lack of written materials (Specific Theme 7). The difficulties and issues that were

identified above in working with Deaf patients also require therapists to consistently engage in Clarifying statements (Specific Theme 25) to ensure that communication ruptures do not inhibit the therapy process.

The participants were clear in stressing how the issues of language, identity, and shared culture not only affected the course and length of treatment, but they also called for special competence and skills in order to build the therapeutic alliance. The Higher Order Theme of Building an Alliance reflects a number of specific factors that these therapists also believe are important in facilitating the therapeutic alliance with Deaf patients.

The current study revealed that when building an alliance with Deaf patients, it is extremely important to match the signing style of the patient (Universal Specific Theme 8). This Universal Specific Theme relates to a skill of language efficacy. It had been stated in the literature that counselors who could not expertly match the communication skills of their patients and stay empathically attuned to them increased the likelihood of a rupture in the therapeutic alliance [35]. Participants of the current study agreed that matching the patient's signs and being able to use facial and body language (Specific Theme 23) as a means to communicate empathy are important factors in building a therapeutic alliance (see Table 10).

Table 10: Higher order theme 5: Ethical issues.

Specific Themes	Sample Quotes
#9: Confidentiality, boundaries, family therapy	One of the biggest difficulties to overcome is you do have a fairly small community. Because once you're in the community long enough you know everybody and everybody knows you, so then it gets harder to treat people without knowing six degrees of separation that come along with it. (P4)
	I don't go to Deaf events intentionally because of my role in the community and I will bump into everybody I know there. It's uncomfortable for them and for me because the world is so small. (P4)
	Ethics is the biggest problem in working with Deaf people. End up providing the family therapy and the individual therapy, boundary issues, confidentiality, do more than the general therapists in a small community where it is difficult boundaries and protecting information in a small community. I mean it's a complicated mess and you have to deal with it and the bigger the community gets the bigger your team gets the more complicated that can be because the more people you're treating in that community. (P5)
	With confidentiality and the limits of that, but for a Deaf person I have to be very specific, so I am going to bump into so-and-so in the community and I'm not going to tell them I see you. I have found that boundaries within the Deaf culture are different, and understood differently than boundaries in the hearing culture. (P2)
	We've had the problem where we're seeing multiple family members because there just aren't enough providers to spread it out. (P2)
	I'm always aware that what I do with one particular Deaf person will get around the Deaf community, you know so it's sort of damage control is much more an issue in the Deaf community than with my hearing people. The other biggest challenge is so many of my clients know one another so I have to be careful how I schedule people. So having to try and keep that confidentiality and really really so they have no earthly idea, that's a challenge. (P3)
	Yes, I think definitely there is a confidentiality issue in a small community. Having multiple clients who know each other. [Clients] may have to wait quite a while to get you in with a family therapist and yet if I do it, I don't want to compromise my individual rapport, so obviously that becomes an ethical issue that we explore together. (P5)
	Because it is small community a lot of clients that I have know each other so yes, keeping things confidential is an ethical issue. Also, getting invited to things that may be not appropriate, taking that kind of line to not have a dual relationship. I didn't feel it was appropriate for me the therapist to the people who were at a social event together. So that was an ethical decision I had to make. (P7)
#13: Assessing functional abilities – cognitive and emotional	Assess early on in a therapeutic relationship where the person's psychological and therapeutic savvy is, and certainly their language level. (P3)
	Yeah, I mean I do a lot of assessment and so I, there are some assessments I won't do because I don't trust my ASL skills, my ASL receptive skills enough to do them. Like the Rorschach for example, I wouldn't do that. (P2)
	You've got to be able to incorporate the information of Deaf culture and Deaf development into your assessment to make sure that you are not misdiagnosing or making recommendations that don't make any sense. (P2)
	The majority of the people I work with aren't astute high functioning Deaf adults. It doesn't matter if they're Deaf or hearing, it's just the more depressed they are, the more disordered they are, the more difficult they are to deal with in terms of their mental health conditions, is where my exhaustion comes from. (P4)
	I really try to look at the individual and assess it kind of more from personality and resiliency and ability at coping and decide kind of more from that. (P7)
#26: Limited number of providers/referral sites	Common barriers . . . ignorant hearing people who just don't get it, barriers not allowing us access to students in schools, to their families or the parents . . . that's just frustrating. Not only can they not provide linguistically matched services, they can't provide culturally matches services. (P4)

	Don't have a huge number of signing therapists. Not enough resources to refer to group or family. Forces us signing therapists to become generalists. If I could refer more, If I could do the individual and someone else do the family. More professionals to refer to, who specialize and provide group therapy. There are not enough therapists to serve this community. (P5)
	I think it's a lack of resources, as much as I want to respond to every referral that I get, the best thing I can do is point in the right direction. Not start what I can't follow through on. Sometimes collaboration is hard to get a psychiatrist to prescribe appropriately if they don't have the background that they need to understand and communicate effectively with the Deaf patient. (P6)
	With Deaf people there is such a small network of individuals, so what's unique I think probably we evaluate, like you refer to yourself. That's just not ethical. (P2)
	Only three of us in this area and two of the others are Deaf themselves. There are so many Deaf clients around the country and so few therapists. (P1)
	When you are a hearing person working in the Deaf world as a therapist, you have to be a generalist, expert in everything and master of none . . . and I would never take on a hearing person with those problems. When they come to me, I almost feel like well I need to at least give them my best shot. (P3)
#26: Limited number of providers/referral sites (Cont.)	I was making an exception if they were Deaf and needed ASL I would see people under the age of 18 and really that is not my area and that's not even that comfortable for me, but I just didn't want anybody to not be able to get services. I have been pushed to work probably I was open to at least working outside my main areas just to be able to give them a therapist who knew their language. (P7)
#39: Supervision and consultation	I can consult with other people or bring in some new information. But what's frustrating I think is that my skills are challenged more with Deaf people in a sense because I don't always feel like I know how to help them, but I know I have the communication to do so. (P3)
	I realize how heavily I rely on my clinical supervision, and we really need to check in when I feel a little bit out of my comfort zone, and I double-check with you. I have also got some outside supervision. To really be able to say can I consult with you and then I can make a referral to someone who maybe has a specialization. Really making sure consultation is there. I do is try to do my best to make sure that I am not working outside my competency area and making sure that I am getting supervision and additional training. (P5)
	So I do think it's important that you collaborate with the schools and that you collaborate with the family and other providers, and as part of an agency that is easier for me to do. But if I were in private practice, that would be a lot harder to do. Like a lot harder to do. (P2)
#40: Informed consent	I'm one of those people who if it comes into my mind it comes out my mouth or my hands, so I very much am open and honest and say this is who I am, and you know if you're not comfortable working with me I am okay with that, I will try to find you another therapist, but how can we get through this? (P2)
	I would be very upfront about your experiences and knowledge of working with this population and seek resources and support as much as possible. (P2)

Note: Participants expressing the theme (in parentheses), and quotes for corresponding specific themes with the participant number listed. This theme is comprised of a cluster of Specific Themes that address participants' thoughts and feelings regarding ethical issues that may occur when working with this population.

This concept was highlighted by Participant 4, who stated, "If I am able to linguistically match my client, my credibility and alliance with them goes up dramatically. Making sure I'm matching linguistically what they need in terms of speed" (see Table 6). An example of how empathy can be projected physically through sign language was provided by Participant 3 (see Table 6), who said, "I probably communicate empathy by sitting forward and hunching my shoulders and signing very empathically, and using a lot of facial expression, and I use my body a lot, not just in signing."

The participants emphasized that linguistically matching a patient demonstrates empathy, which in turn strengthens the therapeutic alliance. Likewise, it is also equally important that therapists recognize that facial and body language are primary aspects of ASL. This was stated by Participant 7, who said:

I would think that if I didn't have the facial part that would be a major part [of building a therapeutic alliance] for a Deaf client, making it kind of flat, I think it would be a major problem because it's actually part of the language. So, if that's missing, you aren't actually communicating fully in the language [ASL].

The ability to demonstrate empathy through the use of ASL to the Deaf patient appears to be another key factor when building the alliance.

Another aspect of using ASL as a second Language (Universal Specific Theme 8) that challenged the participants was the need to continually translate to themselves while engaging the patient, and without causing a therapeutic rupture. Participant 2 reflected, "I put so much energy into making sure I am understanding and reflecting back. . . whereas in my own language, my first language, it is not hard to do." This differs than with hearing patients, as exemplified by Participant 2, who also stated:

I have become a visual person, I view things visually, it looks like this, but feels like this, and you can't say that to a hearing person. In some areas it's more exhausting because I work so much harder to make sure that I understand, so I am drained more at the end of a slot with Deaf people.

It appears from the results of the current study that working in a second language challenges the therapist emotionally, physically, and therapeutically. This further demonstrated how related the challenges of this dyad can be, as interacting in sign language is often physically and emotionally exhausting due to both ASL (Specific Theme 28) and having to use visual tools (Specific Theme 29).

Consequently, the difficulties that arise from using ASL as a second language often require therapists to prove themselves to their patients. An important aspect of building the alliance is the need for clinicians to prove themselves, their skills, and intent to the patient (Specific Theme 14). Participants noted that one way they were able to prove themselves to their Deaf patients was to consistently monitor their own ASL skills. The ability to demonstrate to the patient that they were capable of communicating cross-linguistically in an effective manner ensured a better therapeutic alliance. This finding is interesting, as it demonstrated that working in a second Language is often a challenge within this dyad. However, the therapists who participated in this study reported that Deaf patients prefer a hearing therapist (Specific Theme 15) over a Deaf provider.

Although the Deaf patients may seek a hearing provider, it is only once the hearing provider has proven himself or herself that the therapeutic alliance can build and the therapy can occur. The results of the current study are in agreement with the proposals of [15,36], which stated that patients pose tests of trust for their therapists, and therapists must successfully pass these tests in order for therapy to be successful. In the case of Deaf patients, certain tests have been suggested as a standard part of relationship development [15]. This concept of "passing a test" was found within the results of the current study as illustrated by Participant 7, who stated, "So I am hearing, but I am ASL fluent, and they would really look for and ask questions sometimes before deciding that they would start with me. They didn't want me connected with certain people." Another example of a "test" was shared by Participant 1, who said,

Most Deaf patients are thrilled to have someone who can speak their language. . . so they can use their first language and not use an interpreter. I do silly things to relate, like say, "A hearing person would say," in a humorous way, and if they see that I can be fun and laugh at hearing people, [they will stay on as patients]. A lot [of Deaf patients] ask me if I am hard of hearing or if I have Deaf parents, so I guess I learned fluently [sign skills].

It appears that therapists who "passed" their patients' tests, based on comfort level of signing and ability to understand that hearing people are not always trusted easily within the Deaf community, are better able to build an alliance.

Results of the present study also provide some information as to correlations among the preference for a hearing provider (Specific Theme 15), confidentiality (Universal Specific Theme 9), and the small interwoven Deaf community (Universal Specific Theme10). Four of the participants acknowledged that the preference for a hearing therapist is a direct result of the close-knit community, and the patients' distress that confidentiality may be broken. This perspective can be seen in the statement by participants quoted in Table 7. For example, Participant 3 said, "They actually tell me that they prefer to see me as a hearing person because I am outside the Deaf community, the Deaf world," and Participant 2 stated:

I've had a lot of Deaf people come to me specifically because I am hearing. Because they know how rapid the gossip grapevine in the Deaf community [is], and they like the fact that I am an outsider, so they feel safer telling me things . . . knowing [I] . . . don't socialize in the Deaf community.

These types of responses occurred throughout most of the interviews. These results indicate that once the patient is able to establish that the hearing therapist will and can maintain confidentiality and is able to communicate effectively through ASL, then and only then will the patient engage in a therapeutic alliance.

The previous section emphasized the importance of the therapist understanding the Deaf patient's identification with the Deaf culture and not with having a disability, and that Deaf patients have suffered discrimination due to the disability perspective. The therapist also needs to understand how the Deaf patient's identity and discrimination experiences affect building the therapeutic alliance. Thus, another factor in building a therapeutic alliance is when hearing clinicians are able to validate to the patient that they understand that many of the experiences of the Deaf may have included discrimination and biases toward them by the hearing society (Specific Theme 17). Admitting this openly as part of the therapy discourse may provide the patient with more trust that their hearing provider understands their experiences [24]. It had been proposed that an important aspect of understanding Deaf individuals from the hearing perspective is to be cognizant that these individuals have the ability to give meaning to their experiences and view the world via their interpretation of their cultural experiences [38].

In the current study, participants were able to provide concrete examples as to the importance of this notion of the value of the therapist's awareness of discriminatory experiences suffered by Deaf patients. Relevant comments were provided by Participant 5's remarks (Table 6): "I think the most important things for me is to show them that I get you, and I respect you, and that my therapy offers you a safe place to be," and Participant 7, who stated, "Understanding how different it is to be Deaf than hearing, and what the person has been through, really similar to any kind of minority, what is different about this person and what they have been exposed to." These are just two examples of how approaching a Deaf patient requires a therapist to look beyond simple therapy tools and ASL skills and consider the cultural prejudices patients may have experienced. The ability to acknowledge a clear understanding of the Deaf experience provides therapists the chance to openly discuss with their patients any experiences with discrimination, marginalization, and belonging to an underserved population with regard to mental health services. Participant 2 expressed her opinion on how Deaf patients may perceive the hearing provider and vice versa:

Little "d" is all about the medical model. You have a problem that needs to get fixed, your ears don't work, let's fix them. If they're not fixed, you're disabled. Whereas the Deaf model is: I can do everything except hear, and I am capable and willing and smart and all those good things. I have my own language with its own structure and its own heritage. I've got all my own cultural norms that are appropriate to me, that are different than the hearing world a lot of times, and I'm very comfortable with who I am, and how I live my life. So for hearing people to come in and say "You've got a problem. Let's fix it" is actually an insult.

As with all minority patients, therapists are advised to evaluate their own biases and countertransference within the therapeutic context to ensure cultural competence (Peters, 2007). Glickman (2009) indicated that providing culturally affirmative psychotherapy with Deaf people requires that therapists must first become culturally and personally self-aware, so they are not defensively working from unexamined prejudices. This concept appeared in the present study as five of the six participants expressed the importance of cross-cultural competence as it applied to working with the Deaf patient (Specific Theme 30).

This concept of cultural competence on the part of the hearing therapist is best thought of as a basic kind of competence that is essential in working with Deaf patients. Fusick had asserted that therapists who lack self-awareness may engage in potential biases toward Deaf patients due to limited experience and lack of knowledge [20]. Participant 5 was able to explain the importance of acknowledging biases in working with Deaf patients. She said, "Biases go both directions absolutely ... but the interesting part is that you're not breaking down any biases other than toward yourself." This example was expressed earlier by Briffa, who also highlighted the need for clinicians to be sensitive to cultural differences [17]. In addition to the importance of clinicians being sensitive to the culture of Deaf patients, it is also relevant for clinicians to be aware of their own biases as they relate to the Deaf population and address them appropriately within their own professional development. For example, Participant 2 stated, "I have biases for sure, and I'm a person who believes you do the best you can with what you've got ... so I definitely have biases, and I'm learning more and more every day." In every therapist-patient dyad, there are presumed biases that exist and possible experiences with discrimination that may need to be addressed. In the hearing provider-Deaf patient dyad, it is imperative that both therapist and patient acknowledge that these biases do exist in order to move forward in establishing a therapeutic alliance.

In addition to issues of general or basic competence associated with understanding the issues of the Deaf culture, identification with a common community bound by a common language and comfort with acknowledging and discussing issues of disability and discrimination, therapists in this study stated that it is important to use an array of specific skills to ensure that the Deaf patient is being understood. These skills are listed in Table 6 and include the following: Ask and asses through clarifying Statements (Specific Theme 25), Reflecting patient statements (Specific Theme 24), and Repeat and apologize (Specific Theme 18).

Participants indicated that they were able to build better therapeutic relationships with their Deaf patients by periodically assessing whether the patient understood them (Specific Theme 25) and also checking in with the patient to ensure that all cultural and linguistic needs were being met. A prime example of this concept was illustrated by Participant 6, who stated,

I feel it is part of [the] work with a Deaf client . . . you really have to work creatively to make sure the message gets across. Sometimes you have to really work hard to . . . make sure that they are doing their part too and that progress is being made. It's easier to listen to [a] hearing person talk, and you see that they are doing what they're supposed to be doing.... With a Deaf person, you really have to work harder and do periodic assessments along the way.

Participant 5 mentioned, "[The] challenge with Deaf community, helping [patients] understand ... without [the] same structure of language ... and them not always using it correctly, it can be a big challenge ... [need to] clarify!" The need to engage in clarifying and reflective statements (Specific Theme 24) is not an uncommon therapeutic technique and is used with most patients, hearing or Deaf. However, it appears that this need is amplified due to the cross-cultural relationship within the hearing therapist-Deaf patient dyad. This epitomizes Peters' statement that

therapists need to consider the linguistic nuances of ASL to engage a patient in a therapeutic relationship. An example of this was highlighted by Participant 3, who stated [13],

Well, I think it's to be able to kind of assess early on in a therapeutic relationship . . . where their language level is. One of the barriers I think for me personally is bearing that in mind at all time[s] and then needing to kind of readjust my communication ... being able to read literally their signs, but also just read their understanding, so I know if I lose them.

The need to engage in these types of techniques brings to the forefront the idea that during therapy sessions with Deaf patients there is constant evaluation required to maintain the therapeutic relationship.

These clinicians were able to provide concrete examples of how having to repeat and apologize to the patient could interfere with building a therapeutic alliance and some of the challenges it entails for both parties (Specific Theme 18). An illustration of this perspective is seen by Participant 1 (Table 6), who stated, "I have to apologize when I don't understand, have them repeat it. I admit that and say 'I am sorry, please say again.'" Participant 3 stated:

[I] Struggle with understanding ... I think that might affect the therapeutic alliance because I'll be going, 'I'm sorry, what?' and I'll be having to interrupt and periodically and they will look at me like 'ugh.' You know they'll be a bit irritated.

The therapists interviewed stated that implementation of services may in fact look differently than working with a hearing client. The current study is consistent with the proposal that "the nature and principles of counseling with Deaf people are no different than those that characterize counseling with other people; rather it is their implementation that differs." [37] Higher Order Theme 4 includes suggestions on specific skills, tools, and modalities that were indicated as critical in working with Deaf patients by the clinicians interviewed in the current study.

Skills with specific kinds of therapy were another concept that emerged in this study. Glickman argued that traditional insight-oriented psychotherapy tends to be ineffective with Deaf patients, but that a modified form of cognitive behavioral therapy, which he describes, can work quite successfully [19]. Every therapist in this study endorsed the concept that insight-focused therapy is not recommended for psychotherapy with Deaf patients (Universal Specific Theme 43). The participants strongly encouraged more direct and concrete approaches (Specific Theme 22). This makes sense, because it is considered culturally appropriate for Deaf people to be very forthright in their conversation. Descriptions of events, people, and places become vibrant in the hands of a Deaf signer. It is common for descriptions to be both concrete and candid. The Deaf attitude is not one of insensitivity, but it is one of frankness. The perceptions of Deaf people tend to be emphatically visually based, and their world views tend to be likewise.

Skills of being concrete and direct are typically associated with the techniques commonly practiced within Cognitive Behavioral Therapy (CBT, Specific Theme 19), Dialectical Behavioral Therapy (DBT, Specific Theme 20), and/or Play Therapy (Specific Theme 21) as preferred modalities that are better suited for Deaf patients. This perspective was expressed by Participant 4, who remarked, "I don't think psychodynamic work suits Deaf people terribly well. I feel like the more directive kind of approaches are better," and Participant 3 who reflected, "Real insight-oriented therapy I think is a little troublesome. They don't make a lot of those connections as easily."

The current study's finding is consistent with the literature provided by Duffy, who stated, "Traditionally underserved Deaf patients appear to be poor candidates for psychodynamic therapy due to lack of insight." He further indicated that working with two languages and with persons who were not skilled in any language increased the chances that there would be empathic failures on the part of the therapist [35]. As suggested by the participants in this study, the treatment models such as CBT, DBT, and Play Therapy may be more appropriate for the Deaf population due to the concrete nature of the skills taught.

O'Rourke and Beail has also endorsed the use of cognitive behavioral approaches in therapy with Deaf persons [38]. These authors argued for a "Deaf-centered approach" to treatment that goes beyond adapting existing models, asserting that an approach can be Deaf-centered if: (a) it recognizes that the presentation of a disorder may be different in a Deaf person and (b) specific tools may need to be modified. With regard to the latter, O'Rourke and Beail advocates for less reliance upon written tools and more use of videotape and visual aids [38]. They further argued that DBT approaches that target skill deficits are made to order for Deaf people who have developmentally based deficits in the acquisition of psychosocial skills.

Therapists who are aware of the special cross-cultural needs of the Deaf population also will find the need to engage in teaching emotional vocabulary and social etiquette as a necessary skill (Specific Theme 12). For example, this need is emphasized by Participant 4, who said:

I have to explain more things to Deaf people just because they miss out on all the incidental learning and whatnot over the years, so I am explaining more things to them through the course of therapy in terms of social etiquette, idioms, social interactions with other people, things like that which take a lot of my work.

Participant 6 reacted to the same issue by stating, "It's very sad, they are not picking up on affect vocabulary because happy is the only sign they have for expressed emotion."

Therapists in the current study stated that they are often asked questions by their Deaf patients regarding social norms and etiquette that may occur in the larger social context of the hearing world. An example of this perspective was shared by Participant 3:

I think it's a bit more interesting with Deaf folks. They need help understanding some kind of simple social thing that they didn't get, that would never happen with a hearing person, but this person needed help knowing is this okay to do and this . . . they have limited exposure to social norms and so on. It's sometimes life skills training that I have to do with my Deaf clients. (Table 7)

A focus on appropriate life and social skills appears to help the therapy process, making it concrete, understandable, and useful for the Deaf patient. Therapists who recognize that the Deaf population often requires support of these specific needs demonstrate competency in cross-cultural counseling in their use of such skills.

Ethical Issues

The participants stressed that therapists and other service providers face ethical dilemmas on a daily basis that involve confidentiality, dual relationships within the Deaf community, boundary issues, and questions related to self-disclosure (Higher Order Theme 5). Thus far, the focus in this section has been on theory and practice of working within the hearing provider-Deaf patient dyad, which requires understanding of cultural, linguistic, and therapeutic abilities as they apply specifically to Deaf patients. Two ethical concerns were unanimously expressed by these participants. These were problems related to complications with confidentiality (Universal Specific Theme 9) and limited numbers of qualified providers and referral sources (Universal Specific Theme 26). Specifically, these therapists indicated that confidentiality issues arose primarily due to the small close-knit community of the Deaf, and the need to often engage in dual relationships.

These findings are consistent with the proposals Herlihy and Corey (1992), who addressed the issue of dual relationship problems that occur when working with Deaf patients [39]. According to the APA Ethics Code [40], Multiple Relationships are defined as:

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 [40].

Herlihy and Corey proposed: The issue of dual (multiple) relationships is especially complicated when a Deaf or hearing person who is actively involved in the Deaf community is working in the profession. Many issues surface on a daily basis for people working in this profession and living in a community where they socialize with the same Deaf people who are their clients [39].

Participant 5 expressed this concern by stating, Ethics is the biggest problem in working with Deaf people. [I] end up providing the family therapy and the individual therapy, boundary issues, confidentiality, and do more than the general therapists in a small community where it is difficult with boundaries and protecting information. I mean it's a complicated mess, and you have to deal with it. Her statement is just one of many examples that appeared in every transcript.

With a limited database of providers to refer patients to, these clinicians often must push their ethical limits and risk breaking confidentiality by treating family members while continuing to treat the individual primary patient. Furthermore, it was reported by the participants in this study that there is often a break in confidentiality, and personal and professional boundaries are often pushed due to the nature of the community. It appears that these issues begin with the differences between the hearing and Deaf culture, as stated by Participant 2: "With confidentiality and the limits ... I have found that boundaries within the Deaf culture are different and understood differently than boundaries in the hearing culture." Participant 3 also elaborated on this concept:

I'm always aware that what I do with one particular Deaf person will get around the Deaf community, you know, so it's sort of damage control ... [this] is much more an issue in the Deaf community than with my hearing people. The other biggest challenge is so many of my clients know one another so I have to be careful how I schedule people. So, having to try and keep that confidentiality... that's a challenge.

These quotes exemplify how this small community of patients can test the limits of a therapist's ethical duty to maintain confidentiality and professional boundaries (See Table 9 for further examples).

Table 9: Higher order theme 4: Therapeutic skills and training.

Specific Themes	Sample Quotes
#19: Cognitive behavioral therapy	CBT tools, I can deliver those to a Deaf client, it's kind of an oral assessment. (P1)
	I tend to gravitate a lot towards CBT model. (P5)
#20: Dialectal behavioral therapy	DBT is my comfort zone. (P4)
	DBT . . . any of those behavioral things I think are real helpful because they are tangible, they're not metaphorical. (P3)
#21: Play therapy	We could use some of these play-based interventions to bridge and none of them were language issues. And I think that really helped with rapport building and takes pressure off the language. (P5)
	I would say play therapy is another of my models . . . my biggest comfort zone outside of that kind of more like CBT kind of model is where I suit best. (P4)
	I try to encourage play therapy. Sometimes they need something different, something they can see better, so role playing using some of the techniques and pictures, its more dynamic, you can show a person what you are talking about, and let them show you that they understand it. (P6)
#22: Be direct and concrete	Just have to be very direct with them, where empathy is not a good thing. (P2)
	I usually have to be more direct. (P3)
	A lot of the clients that I work with in the Deaf communities that are very concrete in their thinking that skills are therapeutic. So I think very skilled base, cognitive behaviorally model works well. (P5)
	With adults, there is one thing that I didn't say that is a general rules for me sort of try to be more concrete in general. (P6)
# 32: Augment learning outside of formal education	Immersion helped with the culture. (P1)
	I did quite a bit of reading of articles that other Deaf people were writing back in the day . . . about the Deaf experience and so on and I went to some of their classes just to kind of augment my learning on the fly or through the Deaf community themselves to help kind of plug in some of that clinical piece and help me get my mind working in those directions, but I know I could of used more. (P3)
	Spend as much time as they possibly can with Deaf people, the most respected hearing clinicians in our field are people who are eminently comfortable with Deaf people. (P3)
	I was in the community and functioning there you know amongst all of these Deaf adults and children and everything like that and functioning in part of the community . . . all of that contributed to being ready to work in the community and being better accepted because you know I'll be honest with you, my signing style is more natural and more casual. (P4)
# 32: Augment learning outside of formal education (Cont.)	You can take all the classes you want to take and you still won't be good at it until you actually do it in the community . . . this is something you're never going to be good at by studying it. You have to go do it. (P4)
	[Graduate school] did not do a really good job of pointing out the unique aspects of working with Deaf clients. Once I started learning on my own, I would go to workshops, I would listen closely. I would read articles written by people I looked up to. (P6)
	Other than just normal, you know, research reading that kind of stuff to make sure that I am competent. You know I took Deaf culture classes, reading books, reading about it, and then also, which I think is more than anything is just putting yourself out in the Deaf culture. Becoming friends and getting involved in the community and those kinds of things, I think are pretty educational. (P7)
# 35: Expand class sections in graduate programs to include Deaf Culture	So in mainstream college you get a diversity class, and it teaches you about ethnicities, and it doesn't really speak to the Deaf population as a culture or a minority or a marginalized population. There would have to be several classes. Then you have the Deaf and then perhaps black or lesbian or gay. There is a subculture in the culture. Capital "D" and lowercase "d" and then Deaf with other disabilities/disorders are important to know. (P1)
	I think there should be a course in sensory impairments or especially issues with Deaf individuals and hard of hearing individuals, the differences of those two populations just so that they can have that on their radar. Have somebody come in during your diversity class or during your other complicating conditions whereas somebody, an expert can explain you maybe a two or three week series on that, to whet their appetites if nothing else. (P3)
	I think changing that model to include Deafness not only as a physical disability but also as a cultural minority would be good so that people acknowledge the fact that there's this whole culture out there that is different and that it's not just a hearing loss. I think that exposure at the graduate level, undergraduate level, exposure at any level! (P4)

	I would say you need to have more exposure and competencies in the culture and be immersed even if just for a little while. Who needs even more is clinicians that don't know ASL. I can't even imagine going to a therapist and bringing an interpreter with me and not being private. I don't even know how someone would get to that point, where they are in a psychology program and they happen to know ASL but they don't have any of the other aspects. I agree that as far as psychology with Deaf clients is not quite as much out there as with normal training. (P7)
	All kinds of studies that show Deaf people have an increased need for mental health services as compared to hearing people. But for some reason there isn't a strong enough lobby, we need to do something about this. (P6)
# 36: Training on all sub-cultures – including Hard Of Hearing H and blind populations	Deafness combined with immigrant families or Deafness combined with cognitive disabilities, Deafness and autism, and really focusing on how Deafness interacts with some of these other medical and disabilities. (P5)
	I am seeing more and more families with three languages spoken. These cultures have different understandings of Deafness and different understandings of mental health issues, so kind of being able to bridge and pull together all those different understandings. It's scary sometimes working with some of these families when the there is no communication. (P5)
	So if they are bicultural or if they're marginally cultural or whatever it is, that's going to play a big role in your therapy and how you conceptualize the case, what tools you use, and how long the therapy goes on. (P2)
	I agree that culture is more important than knowing ASL, if you understand their culture, experience, background, and then you have a competent mental health trained therapist. (P6)
	It is unethical if you do not have any knowledge of the culture. Differences between hard of hearing and who really wanted to be identified with either hard of hearing . . . and not being lumped together with Deaf. (P7)
	Also looking at Deaf and blindness, you know. Um, is also a whole other category and that's a culture all of its own.. (P4)
# 37: Include Training on Deaf and comorbid impairments (cognitive/ psychological)	People who have additional disabilities, Deaf and cognitive functioning, or schizophrenia, etc. It's extremely difficult to work with somebody like that and know if you're making progress. (P6)
	Deafness combined with cognitive disabilities, and autism, and really focusing on how Deafness interacts with some of these other medical disabilities. (P5)
#43: Insight-focused treatment not recommended	Real insight-oriented therapy I think is a little troublesome; they don't make a lot of those connections as easily. (P2)
	All that theoretical stuff, ehh, but if they just give me the nuts and bolts of the practical stuff they can put into action. (P3)
	I don't think psychodynamic work suits Deaf people terribly well. I feel like the more directive kind of approaches are better. (P4)
	I do think that those insight therapies could work very well just because, but for most of who I work with I would say no. (P5)
	Get away from the insight-focused and abstract phenomena and I think that would be a general rule, although I wouldn't say that is a requirement. (P6)

Note: Participants expressing the theme (in parentheses), and quotes for corresponding specific themes with the participant number listed. This theme is comprised of a cluster of Specific Themes that address therapeutic skills, techniques, training, and practices that were described as either helpful or unhelpful by participants providing treatment for Deaf individuals.

It is evident that the limited number of providers and referral sources compounds the issue of confidentiality with Deaf patients. This finding was consistent with the literature that has pointed out the scarcity of mental health professionals who sign competently and specialize in working with Deaf people [41]. Results of the current study also found that the limited amount of providers can make referring Deaf patients to other providers quite problematic ethically. A specific example of this issue is provided by Participant 2, who stated, "With Deaf people, there is such a small network of individuals [providers], so what's unique, I think probably we evaluate, [and] like you refer to yourself. That's just not ethical." This participant happens to be the only provider in a large geographic area, which required her to complete the intake, perform assessments, and provide individual and family therapy to her patients.

However, being the only provider in a specific area appears to be a common problem. This was documented by Participant 7, who stated:

I was making an exception if they were Deaf and needed ASL, I would see people under the age of 18, and that is not my area, and that's not even that comfortable for me, but I just didn't want anybody to not be able to get services.

Many of the participants also shared how the need for working with such an array of patients has forced them to be more generalized in their practices, as specialization in a particular area would limit the resources available to the Deaf population.

As most therapeutic relationships begin, an informed consent that includes a discussion of confidentiality is provided to the patient [40]. In regard to informed consent with Deaf patients, Brusky proposed the following:

Patients who are not proficient in English, including Deaf or hearing-impaired patients are at higher risk of ineffective communication which can compromise patient safety. If a patient does not understand the implications of his or her diagnosis or treatment plans, a problematic event may occur. Likewise, healthcare practitioner's lack of understanding of the patient or the cultural context within which the patient receives critical information may have serious implications for the outcomes of the treatment, healthcare or patient's safety [42].

The participants in this study reported that they attempt to be as honest and upfront with their patients regarding their specialty and competencies. However, even when provided with an appropriate informed consent, they are often pressed to engage in skills that may require special training, such as when conducting assessments (Specific Theme 13).

Conducting assessments was another specific ethical issue mentioned by these participants (Specific Theme 13). Performing assessments with Deaf patients without some specialized knowledge regarding language and culture could be considered an ethical violation. Denmark's primary concerns regarding assessment with Deaf patients were that clinicians be properly trained to understand the problems and abilities of Deaf people and then makes appropriate assessments [43]. The current study supports Denmark's [43] concerns, as some of the participants commented that they had to augment their learning (Specific Theme 32), or simply would not attempt to perform psychological measurements (Specific Theme13) with Deaf individuals without some specialized training. These participants affirmed that, working cross-culturally and cross-linguistically (Specific Theme 30) can challenge even the most-secure therapist when performing assessments and should probably not be attempted until properly trained with this population. A prime example of this was illustrated by Participant 2, who stated in some detail:

And assessment, just don't do it. Don't do it with Deaf people. That's all there is to it. Not just the cognitive development, but social and emotional and personality, all those things. But you need to have an understanding of all the biases that can happen within testing. You've got to be able to incorporate the information of Deaf culture and Deaf development into your assessment to make sure you're not misdiagnosing or making recommendations that don't make sense.

In another example of how assessment and language skills specifically are relevant when working with Deaf individuals, Participant 2 (Table 9) stated:

Yeah, I do a lot of assessments and so I, there are some assessments I won't do because I don't trust my ASL skills . . . enough to do them. Like the Rorschach for example, I wouldn't do that.

These perspectives are further supported by Participant 6, who indicated:

I don't think there is one thing that I would say . . . this never works with Deaf people. But I think we should always be mindful of the language issues, for example, but assessment is one area where you can really mess up.

The results of the current study are consistent with earlier literature regarding assessment with the Deaf that proposed that performing English-based written assessments with Deaf patients is difficult and can lead to communication and diagnostic errors [44,45].

The ethical issues discussed here imply an increased importance for the need for supervision and consultation to supplement areas where a provider does not have competency (Specific Theme 39). The limited resources for working with Deaf patients also resulted in problems when there is the need of and for Supervision/Consultation (Specific Theme 39). An important element of ethics is to differentiate which services and treatments should be provided by other professionals and knowing who can provide those services. Each professional cannot provide every service needed by every patient. Knowing one's limitations and when it is appropriate to make referrals to other agencies for services one cannot, or chooses not to, offer is a basic ethical obligation, as well as to obtain supervision and/or consultation when appropriate. Based on the results of the current study, the temptation these therapists reported is to want to handle everything alone because there is simply not anyone else who can provide the service, nor is supervision nor consultation reasonably available.

For example, Participant 5 stated:

I realize how heavily I rely on my clinical supervision, and we really need to check in when I feel a little bit out of my comfort zone.... I do try my best to make sure that I am not working outside my competency area and making sure that I am getting supervision and additional training.

The lack of adequate referral sites and resources was a major frustration and ethical dilemma noted by the participants in this study.

These participants also shared many personal, emotional, and social experiences (Higher Order 6, Table 11) when working with Deaf patients. It was reported that being exposed to and understanding a different perspective is fun and allows for therapy to stay fresh and exciting (Specific Theme 42). As one therapist stated, she is often shocked by the direct nature of her patients but can also appreciate their honesty.

Table 11: Higher order theme 6: Therapists' personal, emotional, social experiences.

Specific Themes	Sample Quotes
#1: Family members	My influence mostly came from my own brother . . . I watched him struggle with three years of language loss. (P2)
	I have some Deaf family members, in my nuclear family. (P6)
#3: School experience	When I was a teenager . . . I walked up to her and said "Hi" . . . she pointed to her ear and she said she was Deaf. So I started to finger spell . . . and her whole face lit up . . . and I thought "This is so cool." (P1)
	I did some of my student training with Deaf kids, and I was just interested. (P2)
	When I was young, in the fifth grade. We were in a public school, and there was Deaf kids being streamed into my classes. Became friends with them, learned sign language that way, and initially decided I would be an interpreter. (P4)
	When I was in elementary school, we had a program at my school for the Deaf, and every year we do a program in sign language, and so I found that I always had this interest in sign language. (P5)
	Having American Sign Language as a second language all the way from Junior High and High School all the way through the program in college. (P7)
#27: Self-doubt about own abilities	I get really comfortable in one language, and then switching back and forth sometimes can take a bit more time. There is a lack of confidence in me or that extra practice time that is needed to feel really confident. (P5)
	In some ways I am operating a little outside my comfort zone. That's my two biggest insecurities, my language and am I doing the best service, even though I know I'm trying hard and I'm adapting things and trying to meet their needs, but this isn't my first language. (P5)
	I thought I understood, but I didn't and it was a rupture in the rapport that I had to repair that now . . . I wish I had more confidence in that ability. (P2)
	I just want to know that people are improving and that I'm not making them worse. Maybe the confidence and knowing that I know what I am doing, I'm providing good effective treatment to people. (P4)
#28/#29: Exhaustive due to ASL and use of visual tools	A lot more paper and pencil, a lot more drawing, Deaf people can't do abstract thinking. (P1)
	More laborious, it takes two to three times longer; I give to them in piecemeal. (P3)
	I have become a visual person, I view things visually, it looks like this, but feels like this, and you can't say that to a hearing person. In some areas it's more exhausting because I work so much harder to make sure that I understand, so I am drained more at the end of a slot with Deaf people. I put so much energy into making sure I am understandings and reflecting back . . . whereas in my own language, my first language, it is not hard to do. (P2)
	One of the things I have found with Deaf folks is if it feels too much like school they won't do it. It's like "Oh please, don't make me write. I hate it. I hated it." (P3)
	I have my handy toolkit that I carry around, and I have a lot of feeling posters in it, and so a lot of times I will pull those out with people, and we will look at those and say, you know, match the facial expression to the feeling. (P5)
	I have had back to back clients that are ASL users. I am a little bit more fatigues, and there is definitely high fatigued. Sometimes I find that I am more physically and emotionally exhausted. (P5)
	I think I put more into it cognitively when I work with a Deaf person. With a Deaf person, you really have to work harder to do periodic assessments along the way. Hearing person, we don't have to work to make sure we are being understood. (P6)
	Because it is such a physical language, I would probably feel more drained or tired. I tend to be more drained physically, probably because of the concentration of my eyes. (P7)
#41/#44: Unique niche – make a difference with underserved population	There is a challenge to seeing the world as being Deaf because people don't always get it and may see them as being rude. (P1)
	Intrinsically, working with a population that is completely underserved, and that it's a unique niche, it's a unique skill that I have that I can help improve the life of somebody who may not have been served if I weren't here. (P2)
	Deaf people deserve the right to be able to pick and choose their therapist. (P2)
	Because I felt that there just aren't that many options for them, I feel this not burden but responsibility to do the best I can because I don't want them to get stuck with "I've got to go to her because she signs." I want it to be able to be good for them, so that puts the pressure on me to do well. (P3)
	Yes, at the hospital that I work with I am the only person who works with Deaf people. (P3)
#41/#44: Unique niche – make a difference with underserved population (Cont.)	I was guided toward doing this work. It's a skill that I have in being fluent in ASL, and I feel like I should employ it somehow. I feel like not using that skill is more of a waste, I guess the thing that I like best about it is the fact that I can do it and I choose to do it. (P4)

	I think it's very rewarding, make a difference, as an individual and clinician the fact that there are not a lot of people in the field helps me be a bigger fish in the field, and in some ways that's good for me and my career. Field is so small has helped me network with leaders and build relationships and advance my career. I feel a lot of satisfaction; I can make somebody's life better. I was not sure that I am ready to start testing Deaf people, so I took additional courses so that I could build my competency. (P6)
# 42: Deaf perspective is fun	The cultural difference and how they don't expect people to understand their needs, especially if they weren't born Deaf. They see it differently. Their perspective about things, it's vastly different than a hearing perspective most of the time. (P1)
	The very favorite thing I think is the rawness of it. Some of the stuff that comes out their hands I kind of want to go "Did you just say that?" No one Deaf person is like another. Can't put in a box of "those Deaf folk." They're all so special and unique and they all teach me, they teach me. (P3)
	By being a hearing person spending time in the Deaf community, I don't think you're changing the Deaf community's impression of hearing people, you know I think you're changing the Deaf community's impression of you. (P4)

Note: Participants expressing the theme (in parentheses), and quotes for corresponding specific themes with the participant number listed. This theme is comprised of a cluster of Specific Themes that address reasons therapist have personal, emotional, and social benefits and consequences while working with the Deaf population.

In addition, these seven therapists categorically stated that the work they are completing is rewarding on personal and professional levels as well. Whether they came into the field through a family member (Specific Theme 1), early school experience (Specific Theme 3), or just the love of the language, all of the participants at some point stated that being within a unique niche of psychology (Specific Theme 41) and making a difference with an underserved population (Specific Theme 44) were the main reasons they continued to do the work.

It was also apparent from the results of the current study that working with this population may often challenge therapists to doubt their own abilities (Specific Theme 27). It was evident that many of the clinicians interviewed felt that they must not only prove their intent, skills, and abilities (Specific Theme 14), but also prove their ability to keep confidentiality (Specific Theme 9). The participants reported challenges to be creative by providing information visually (Specific theme 29) or teaching new words/signs (Specific Theme 12). These factors appear to contribute to therapists reporting feeling physically and emotionally exhausted after sessions due to ASL and the use of visual tools (Specific Theme 28), although this was also very rewarding.

Thus, the findings significantly illustrate that these professionals, regardless of their personal and educational background, are often challenged by unique aspects of providing psychotherapy to the Deaf. This was demonstrated by five of the participants who expressed feelings of Self-doubt about own abilities (Specific Theme 27) and concerns about assessing functional abilities (Cognitive and Emotional) of Deaf patients (Specific Theme 13). A particular remark made by Participant 5 highlighted these issues:

In some ways I am operating a little outside my comfort zone. That's my two biggest insecurities, my language, and am I doing the best service even though I know I'm trying hard, and I'm adapting things and trying to meet their needs, but this isn't my first language.

This quote expresses the concerns and motivations expressed also by the other participants who are motivated to provide their best expertise to their patient but are often challenged by the language barrier.

Therapists of the current study appeared to find the directness of Deaf patients a characteristic that was part of the charm in working with this population (Specific Theme 42). For example, Participant 3 stated:

The very favorite thing I think is the rawness of it. Some of the stuff that comes out their hands, I kind of want to go 'Did you just say that?' No Deaf person is like another.... They're all so special and unique, and they teach me, they teach me.

It was noted that this participant was often shocked by the directness of her patients yet found it helpful in moving the therapy forward. In terms of counseling, this characteristic of Deaf people can be very beneficial. It is common for Deaf patients to get to the heart of the issue immediately and attend to the peripheral details later. This does not imply that resolution of issues occurs any quicker for a Deaf patient.

The results of the current study indicate that Pre- and Postgraduate formal education do not necessarily prepare a therapist to work with the Deaf population (Specific Themes 33 and 34). These findings are consistent with Fusick's proposals that the Deaf are rarely a central focus of the diversity requirement within most training programs. In particular, Participant 3 stated [20],

I went to get the mental health part, and I then applied it to my knowledge of Deaf people.... I could take that new clinical information and plug it in to what I knew and then work with it ... to be honest I think that's how most of us are currently doing the work ... many of us, we kind of learn on the fly. I didn't get that specific training with the Deaf; I got it related to hearing people, so I applied it.

Sadly, this statement demonstrated that although many therapists are trained appropriately in providing clinical services to a range of patients, they have not had the training required to work with the Deaf culture.

Another opportunity participant reported that facilitated a gain in cultural and linguistic competence for them was the concept of immersion in the Deaf culture (Specific Theme 31). This immersion allowed many of the participants to experience a number of the nuances in working with the Deaf that are often found outside of formal education. It was through immersion that many of the participants gained knowledge that might not be formally taught. For example, they shared that many Deaf individuals have a limited emotional vocabulary and have different socially accepted norms. This can pose some challenges within the therapeutic dyad but are better understood once a provider has had the experience first-hand through immersion.

Boyarin, Burke, Evans, and Lee found that comfort with Deaf patients may come before language fluency, and they further suggested visiting a place where Deaf people are interacting as a way to determine one's own interest and comfort in working with Deaf people [46]. The present study's participants described the impact of their early experiences with family members (Specific Theme 1) and early childhood school experiences and exposure (Specific Theme 3). Those personal reflections support the proposals of [46]. Boyarin et al. proposed that a primary path to being comfortable with this population can be achieved through exposure and immersion. [46] This is reflected by Participant 6, who reported, "I have some Deaf family members in my nuclear family," and Participant 4, who stated, "When I was young, in the fifth grade, in public school, and there were Deaf kids being streamed into my classes, [I] became friends with them, learned sign language that way, and initially decided I would be an interpreter." It is evident through these examples that early exposure had a great impression on these clinicians and allowed them to gain both language and cultural knowledge of the Deaf. It is likely that this may have contributed to their competency level with their Deaf patients.

A drawback to becoming familiar with and immersed within the Deaf community is that there will be a high likelihood that therapists would see their patients at events and gatherings and be invited to personal events (Specific Theme 9). This was reported to possibly cause some uncomfortable interactions between both the clinician and the patient and could lead to a break in confidentiality. Participant 6 specifically stated:

When I was younger, before I really got into the mental health field, I would truly immerse myself in the Deaf [culture].... Now I know lots of Deaf people in the community, and they still know who I am. I have just withdrawn from social events. I think it's best for professionalism.

Nevertheless, the participants did give emphasis that they initially gained an interest, language skills, and cultural knowledge by immersion. Three participants reported that they initially learned sign language through immersion rather than formal education or certified American Sign Language courses. Participant 4 mentioned:

I was just working in the community, in addition to when I was in High School and socializing with Deaf friends ... all contributed to being ready to work in the community and being better accepted in the community ... my signing style is more natural, more casual.

It appeared that this participant was more aware of the nuances and slang of Deaf language, rather than the mechanical nature of just knowing how to communicate through ASL, due to her exposure in the Deaf community. Therefore, it is implied from the results of the current study that being exposed to the Deaf community at a younger age leads to immersion and contributes to better fluency with language and understanding of cultural norms prior to working in the field.

The findings of the current study support literature found in other areas of cross-cultural and cross-linguistic research. For example, the current study presented that there may be unique challenges in the hearing therapist-Deaf patient dyad. Tang, Lanza, Rodriguez, and Chang stated that language differences between patient and clinicians often jeopardize communication, leading to compromised care, dissatisfaction with care, and inefficiency in the health care system [47]. It was also proposed by the participants in the current study that having a linguistic match can provide a stronger therapeutic alliance. Tang et al. stated that patient-clinician language concordance can enhance health care and equity, patient safety and satisfaction, and resource stewardship [47].

Another concept found within the current study that is supported across other multi-cultural research relates to cultural identity and therapeutic alliance. Mezzich pointed out that the patient's cultural identity is an important factor in assessment, and that cultural elements associated with interpersonal relations influence the manner in which the patient interacts with the clinician [48]. This proposal was supported by the current study's findings that a therapeutic alliance is more likely to develop when therapists have a clear understanding of a patient's cultural identity and relation to their community.

Also, within the cross-cultural literature, the issue of training and competency is often addressed as a critical element in development of cross-cultural treatment. This concept was affirmed within the current study. It is often a prominently stated aim of training programs for mental health practitioners for the need to include training to ensure cultural competency [49]. Unfortunately, often this recognized need is insufficiently met because (a) training programs lack a definitive structure and specific goals to achieve cultural competency in therapists, and

(b) there is scant empirical data to support one training model over another [50]. The current study provided evidence that there is a need for further training in regard to the Deaf culture within graduate programs in order to increase the cultural competency of clinicians. The need for further training and culturally competent therapists appears to span across other ethnicities and minority populations that may also need specific therapeutic skills and modalities which are best suited for their population [51].

Cross-cultural and cross-linguistic literature provides some evidence that patients' perceptions of the therapist's cultural competence can improve the working alliance [51,52]. It is certainly not enough to just educate oneself about cultural differences between therapist and patient [53]. Rather, therapists need to have a keen awareness of their own cultural and racial identities and develop an understanding for how this may impact their relationship with patients [54]. Flaskerud proposed that culture and ethnicity also influence diagnosis [55]. Misdiagnosis can occur for a variety of reasons when therapist and patient do not share cultural meanings. Perception of the problem by the patient and how it's communicated and elicited, how symptoms are identified by the therapist, how stereotyping is addressed by the therapist, and language differences between patient and therapist are just some of the reasons that misdiagnosis may occur [55]. The participants in this study emphatically embraced the notion that misdiagnosis of the Deaf is problematic for all of those reasons. Thus, the findings in the current study support the cross-cultural literature that cultural competency and an awareness of the patient's identity are necessary to ensure appropriate diagnosis and build a therapeutic alliance.

Clinical Implications

One of the major clinical implications of the findings was that clinicians who want to work with the Deaf population would be well served to gain access to the Deaf culture by immersing in the Deaf community. Such immersion facilitates being able to appreciate the uniqueness of the Deaf patient as well as how the Deaf are similar to other patients. It appears that exposure is a key to gaining competency and understanding the culture and identification of the Deaf population.

The findings indicate that clinicians will benefit from training programs that focus on not only the loss of hearing, but also the unique positive qualities of this population that have resulted in the close-knit community of the Deaf. Groups are generally defined by the dominant society that surrounds them. Sue and Sue stated that there is much to be acquired regarding common the life experiences, strengths, and problems of Deaf people [11]. Changes in cultural views can dramatically change the perceptions of marginalized groups. If mental health professionals gain more awareness of the Deaf culture and identity, as well as the critical importance of (sign) language, then culturally effective treatments would be more easily developed for this population.

It was further suggested by Thomas et al. that additional education regarding the Deaf culture, specifically American Sign Language (ASL), can provide therapists the opportunity to engage in consultative roles that will empower therapists and agencies to provide additional services to Deaf patients [14]. This will not only better serve this traditionally underserved population, but also inform clinical practice and enable ethical standards, training, and intervention. Also, engaging and including all areas of the Deaf community in this discourse will ensure the development of culturally sensitive psychological services and better trained providers.

Schlesinger and Meadows's Sound and Sign research asserted:

Staff . . . in . . . (Deafness mental health) programs need special training . . . to understand the language and special needs of the Deaf . . . the manual sign language of the Deaf, with the cultural factors, the conflicts, and the developmental stresses to which Deaf individuals are subjected. (p. 230) [56].

The findings of the current study are consistent with Schlesinger and Meadows's [56] assertions as evidenced by Participant 6:

I think that's [Deaf culture] more important than knowing ASL. If you understand their culture, experience, the background, you have a competent mental health trained therapist. [If] you understand the patient's background, their culture, you are probably going to be on very good footing as a hearing therapist.

The concepts found in the literature regarding competency consistently entwine language, culture, and a clear understanding of the experiences of the Deaf and are echoed throughout the current study's findings. It is clear that these are not singular requirements for the hearing provider, but more of a set of competencies.

Being able to treat the Deaf population adequately and ethically may require therapists to have specific knowledge, skills, abilities, and experiences such as those described in this study. An efficient way to gain the recommended skills is by immersing oneself into the Deaf culture, obtaining formal education on a pre- or postgraduate level, augmenting learning through continuing education and relevant literature, or through personal experiences. The suggestions of the participants (see Table 9) include ways to provide future clinicians with training that will

increase knowledge regarding culture, language, comorbid impairments, and subcultures within the Deaf community. Thus, the current study indicates that there is a need to reformulate the training curriculum in formal education systems to better serve this marginalized population.

The participants also specifically recommended that the Diversity requirement within graduate programs could benefit if more class time was dedicated to discussing the specific needs of the Deaf, hard of hearing, and even blind individuals. Therapists are trained to accommodate for possible gender or ethnic issues. Deaf individuals are likely to present with an array of mental and emotional difficulties in therapy. A specific suggestion of some of the participants was having guest speakers come into the class and give presentations that address dual-diagnosis and issues of being a double-minority.

These ideas were stated repeatedly within Table 9, which provided an array of scenarios of varying Deaf patients, including a Deaf patient with Autism, or with lower cognitive functioning, or with schizophrenia, or Hard of Hearing. These therapists stressed that the ideal qualifications for a therapist to possess would be fluency in ASL and comfort with Deaf culture. Many of the participants highlighted their need to immerse within the Deaf culture to truly understand it and feel comfortable, which further required them to augment their learning to gain competency. However, Halgin and McEntee pointed out, most psychotherapists are unlikely to undertake the rigorous training and time required to reach this level of competency [57]. Prior research suggests that the majority of those working with Deaf patients (85%) did not have a focus on Deafness in their formal training [58,59].

Several ethical issues with clinical implications also emerged from the current study. One major concern suggested that working with Deaf patients challenges a therapist's competence level due to the lack of available resources and materials. With a limited number of providers to whom to refer, therapists must often provide services that threaten confidentiality, such as family and individual therapy. Therapists are therefore required to acknowledge their own professional boundaries, strengths, and limitations regarding assessment and scope of practice. Consequently, it appears that through supervision and consultation that a therapist would be better able to maintain higher ethical standards. Unfortunately, supervision and consultation are not readily available to those currently working with Deaf patients.

Limitations of the Study

There were several limitations to this study. First, attempts to recruit participants from a general geographic area were unsuccessful. During the recruitment process, it became evident that obtaining a local sample was implausible due to the lack of qualified therapists in the area; therefore, participants from various geographic locations were recruited, thus it is unclear as to what localities the findings may be restricted. This geographic distribution required the use of other means of communication such as Skype and telephone for interviews, which may have lacked the personal attention needed to form a positive working alliance.

This study did not control for gender, age, and professional degree, all of which may contribute to being confounding variables. Another limitation was the sample size. The small convenience sample of hearing therapists working with Deaf patients limits the generalizability of the study's results to the general population of hearing therapists who treat the Deaf. Although this study garnered useful information, future research should include a larger sample size in order to substantiate the current findings. A larger sample size would also allow for a wider range of diversity among the participants, including ethnicity, age, and education level. The use of a control group of Deaf providers would permit a comparison and assessment of the difference a hearing provider versus a Deaf provider makes, if any at all.

Another drawback to this study was a lack of a formal assessment of the participant's experiences; simply their self-reported responses were used. There was also no formal assessment of their patients' progress in treatment. No formal assessment was made as to the satisfaction these therapists felt in working with the Deaf, and no information was obtained from Deaf patients to independently affirm the therapists' perceptions of their Deaf patients. Thus, it is unknown whether the responses are affected by self-report bias.

Another limitation to the present study was the semi structured interview that was utilized. The interview questions were created by the researcher based on the research reviewed, which may have restricted the selected questions. Also, the inability during the interviews to clarify two-part questions often resulted in incomplete information.

Recommendations for Future Research

Because the validity of the interview used here is unknown, future research should utilize a measure with better reliability and validity. The measure should be reviewed by Deaf individuals as well as hearing clinicians who are fluent in ASL and have knowledge of the Deaf culture in order to ensure the clarity and appropriateness of the measure. The measure should be translated into ASL and placed on a DVD for individuals to view. Should measures need to be in written format, a certified interpreter should be present to assist Deaf providers and Deaf patients.

Further research would benefit from focusing on the differences between those individuals who do and do not identify as "culturally Deaf" or Big "D." This may provide greater insight into the similarities and differences of experiences of these individuals. Within these subcultures,

larger sample sizes that include a much wider group of clinicians is also necessary if a more complete and thorough understanding of the experiences of this particular dyad is to be obtained.

Future research that focuses on therapists who treat a particular diagnosis, ethnic group, or gender may also prove to be beneficial. For future considerations, mental health professionals who work in other settings and have varying degree statuses may perceive the therapeutic processes differently. Other relevant factors to investigate are settings, spectrum of disorders treated, and modalities of services provided.

It also appears that continued research on how mental health issues and stigma affect this population is necessary in order to provide this population with appropriate services. Future research should examine therapists who specialize in the treatment of Deaf individuals and survey them regarding their commonly used treatment modalities and what has been found to be effective with Deaf patients. Future research may implement more standardized treatment modalities in training treatments (i.e., CBT or DBT) that have been demonstrated to benefit therapy with Deaf individuals. Therefore, future research might examine how graduate programs and continuing education programs are providing exposure for future therapists on how to engage in this dyad.

Conclusions

The therapists who participated in this study viewed their Deaf patients as identifying with a Deaf culture, a culture that reveals a powerful legacy of group solidarity through shared language (specifically ASL), set of values, traditions, and rules of behavior. It is the responsibility of the psychologist to fully understand the framework of the Deaf culture and the identity within which the mental health of the Deaf population is expressed and experienced by a Deaf patient. It is only with this understanding and awareness that clinicians will be able to fully provide appropriate psychological services to this population.

It is clear that in many therapy situations, the hearing mental health clinician takes on a role and importance beyond what it is traditionally expected. The findings provide insight into a phenomenon that has all too often been previously misunderstood and misrepresented by the medical-model, as Deaf psychotherapy patients do not experience themselves as having a disability. As such, psychotherapy with the Deaf presents a whole set of new challenges for these few providers who are able to provide linguistically and culturally appropriate services, and likewise presents a whole set of unique rewards. Therapists working with Deaf patients need to understand and appreciate that their patients' identities are based on a common language and a shared sense of community.

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Conflict of Interest

None of the authors have a conflict of interest.

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