Cultural Competence in Mental Health: A Theoretically Grounded Training for Working with the d/Deaf Community

Brittney Keith

Clinical Research Project

September 28, 2019

Cultural Competence in Mental Health: A Theoretically Grounded Training for Working
with the d/Deaf Community

This Clinical Research Project by Brittney Keith, directed and approved by the candidate's Clinical Research Project Committee, was approved by the faculty of the Hawai‘i School of Professional Psychology at Chaminade University, Honolulu in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

Sean Scanlan, Ph.D., Program Dean
College of Clinical Psychology

Clinical Research Project Committee

Lianne T. S. Philhower, Psy.D., MPH
Chair

Michael M. Omizo

Michael Omizo, Ph.D.
Committee Member

10.10.19

Date

Acknowledgements

I would like to express immense gratitude to my family and friends for providing endless support throughout this process. I dedicate this project to my sister Nikki for inspiring me and showing me that disability status is a source of strength, one to be proud of. I would like to thank the members of the Deaf community who have graciously welcomed me and supported my pursuit in understanding Deaf culture. Finally, I would like to thank my Clinical Research Project advisors Lianne Philhower, Psy.D., and Michael Omizo, Ph.D. for creating a space of pu’uhonua for me during recent times.

Table of Contents

Chapter I: Introduction

People in the deaf/Deaf community make up a unique population comprised of individuals with a myriad of personal and cultural identities that may or may not incorporate their deafness. In recent years mental health resources have increased in terms of the number of programs that involve some type of diversity training for providers. However, diversity training programs do not focus on the unique mental health needs of people who are d/Deaf. Although general diversity training themes apply to working with clients who are d/Deaf, working with the d/Deaf community brings up other issues that are not addressed in existing diversity training programs.

I will begin by providing a brief overview of the current literature on relevant issues of providing mental health services to people in the d/Deaf community. Notably, there is not a large quantity of research on the d/Deaf community or working with the d/Deaf community. For this reason, I incorporate literature on people with disabilities. Although people in the d/Deaf community may or may not consider their deafness to be a disability, society at large consider deafness to be a type of disability. For this reason, disability literature addresses many of the issues that make up how society currently conceptualizations treating d/Deaf clients. It is valuable to know both how society views deafness and how d/Deaf clients conceptualize themselves in order to formulate a treatment model to address the differences between them.

Following a brief overview of literature, I will explain the rationale and purpose of this study as well as the research questions for this study. Chapter II will give a thorough review of the literature including the current approach to treatment, models on identity and cultural development, an overview on the importance of American Sign Language (ASL), stigma and discrimination, relevant provider characteristics, the current approach to provider diversity training, and proposed intervention techniques for working with the d/Deaf community. In Chapter III and IV I will discuss the development of a theoretically grounded workshop to ensure cultural competence for mental health providers who work with people in the d/Deaf community.

This program will help providers become more aware of issues concerning this population, build skills to address these issues, thereby increasing their ability to provide culturally appropriate care. As a result, increasing the number of providers who are culturally knowledgeable will increase the number of resources for people in the d/Deaf community to access to alleviate mental health issues, thereby fostering inclusivity and positive outcomes for providers and clients.

Brief Overview of the Literature

Literature on providing mental health services with d/Deaf clients is limited but is growing. Much of the current literature considers deafness to be a type of disability, which is why much of the information on working with d/Deaf clients is included as part of disability literature.

The amount of "people who are 'functionally deaf' make up about 0.3% of the population in the United States, and people who use a signed language as a primary means of communication make up less than half of that group" (Ulloa, 2014, p. 7). The small population of people who are d/Deaf in the United States has both contributed to and maintained the lack of awareness on cultural issues concerning mental health treatment with his population. Although the ethics code of mental health professionals including psychologists and social workers requires providers to be culturally competent when working with any client, that is not the case when it comes to d/Deaf clients. The lack of accessibility of d/Deaf clients to mental health resources as well as lack of availability of information to help providers become culturally competent with this population leads to less effective treatment.

Based on psychosocial theory including Social Identity Theory, stigmatized minority groups may assimilate by incorporating the majority culture's values, thereby separating themselves from the disability population, or they may embrace their disability status and incorporate the disability population's values and norms. Adopting and embracing a disability identity may serve as a protective factor against psychological distress.

Another important factor to consider when working with the d/Deaf community is cultural affiliation. Acculturation theory explains how people incorporate or reconcile various cultural identities. The d/Deaf community is unique because of the language used to identify members or non-members. People who are members of the Deaf community refer to themselves as capital "D" Deaf. This indicates that the person chooses to identify as being Deaf primarly by using sign language as their primary mode of communication, subscribes to Deaf values, and spend time with other members of the Deaf community.

Gaining accurate prevalence rates of psychological distress within the d/Deaf community is difficult for many reasons. The complex nature of incorporating deafness into personal and cultural identity makes it difficult to categorize data. People's identity and cultural affiliation may change over time. They also may identify with both deaf and Deaf culture. Nevertheless, data show d/Deaf individuals exhibit increased rates of trauma symptoms and substance abuse symptoms compared with the general population. This shows that d/Deaf individuals are currently experiencing increased psychological distress and more attention needs to be given to serving this population.

Potential interventions for providers to become familiar with in order to increase cultural competence when working with this population includes awareness about identity and cultural issues for the d/Deaf community. Providers should become aware of how having an interpreter present during session can alter the dynamic (Ulloa, 2014, p. 3) and how using motivational interviewing and positive psychology can empower clients and combat historical stigma.

Rationale for the Study

Although mental health providers seek to provide culturally appropriate care to any client that walks in for treatment, the current standard for training on cultural competence when working with the d/Deaf community is lacking. Mental health providers generally are not educated and made aware of common issues that d/Deaf clients go through such as identity formation, cultural alliance, language barriers, and how all of these factors contribute to psychological distress. Without awareness on these issues, mental health providers are at risk for making incorrect assumptions on how their client conceptualizes their identity, their place in the world, and what positive outcomes for treatment look like.

Typically, people understand deafness to be a disability. The term "disability" has historically been attached to a myriad of negative connotations as people who are "less able" to function and/or contribute to society (Nichols, 2016). The Deaf community is most unique in their conceptualization of d/Deafness as not a disability, but a difference. Deaf culture has emerged as a standalone culture with American Sign Language (ASL) providing the foundation for distinct cultural norms. However, people who identify as deaf may not even consider themselves members of Deaf culture and may prefer communicating using other methods rather than ASL. This example shows how even within the d/Deaf community there can be a wide variation in identity and cultural conceptualizations. However, mental health providers typically are not aware that these distinctions exist. These distinctions can have a large impact on what clients feel is important to them and what they want to get out of treatment.

Developing a more culturally appropriate training program for mental health providers would help increase the amount of resources available for d/Deaf clients to access, increase the quality and effectiveness of treatment, and further encourage collaboration and mutual respect between larger society and the d/Deaf community.

Purpose of the Study

The purpose of this study is to propose a potential intervention in the form of training for mental health providers to provide culturally competent services to working with people in the d/Deaf community. Although there is not a large quantity of current literature on this topic, existing research explains how people in the d/Deaf community do not have an adequate amount of mental health resources in general, especially culturally appropriate services. As more research is done, other types of interventions may become more appropriate, but the program discussed in this project represents a response to the current need for culturally competent mental health treatment for this population.

I chose to undertake this project as a close family member of someone with a disability. I have experienced the difficulty in locating resources for people with disabilities and how biases and societal stigma persist in today's society, thereby leading to low self-esteem, depression, anxiety, and isolation. Although people in the d/Deaf community may not align themselves with the disability community, my passion to work towards the celebration and inclusion of all people into society drives this project.

I became familiar with the d/Deaf community through working at an office providing services to students with disabilities at a four-year university. While working there I was able to interact with people in the d/Deaf community who educated me on issues they continue to face despite improved legal representation and steps toward inclusivity. I learned about the immense variations to how people who are d/Deaf understand deafness in terms of identity and culture. More recently, I began providing mental health services to a Deaf patient in individual therapy. This continues to give me first-hand experience in the unique considerations that come with working with a Deaf person. However, service providers generally are not aware of how rich and diverse the d/Deaf community is and how these variations can affect treatment of mental health symptoms.

Mental health providers in general have a passion for helping others and alleviating their clients' distress. Providers also have a duty, however, to provide the most appropriate care for their clients. In order to do this, providers must have insight into their clients' world: how they understand themselves and their place in the world. It still occurs too often that providers oversimplify deafness as a type of disability, but in reality, this strips the client of the rich meaning that deafness can give to their lives.

Society continues to view disability as a negative concept and something to be ignored or minimized. Even though use of some derogatory labels such as “deaf and dumb” has decreased, hearing society continues to oppress Deaf individuals through constructing their identity for them rather than empowering actual members of the community. It is time for providers to become more aware of the deep diversity among the d/Deaf community and help their clients feel heard and understood in ways people with deafness have not had access to before.

Research Questions

This study seeks to answer the following research questions:

1) What are the unique mental health issues that people in the d/Deaf community experience?

2) What types of programs currently exist that address working with people in the d/Deaf community?

3) What types of interventions would best address mental health concerns of people in the d/Deaf community?

4) What type of training would benefit providers in order to increase cultural competence when working with this population?

5) What would an effective training look like for mental health providers working with this population?

Significance of the Study

Improved care would empower people in the d/Deaf community as well as provide another setting for patients to improve relationships with family members, caregivers, friends, and navigate societal issues. Participating in therapy would help d/Deaf patients gain practical skills to help them overcome psychological barriers such as elevating mood and reducing anxiety. Therapy would provide a safe space for the patient to express themselves without judgment. As a result, it can help d/Deaf individuals feel more comfortable interacting in society and expressing themselves in general. For example, they could be empowered to seek out job opportunities and build new relationships with others. Improving care could help d/Deaf patients improve self-efficacy and give them the confidence to achieve their goals.

Increasing education and awareness of the process of identity formation, cultural identification, discrimination, and language barriers can empower providers to feel more competent when working with the d/Deaf population as well as empower clients to feel more included and understood in therapy. This change in provider and community awareness could also lead to increased well-being and decreased psychological distress for people in the d/Deaf community.

Chapter II: Review of Literature

The current literature on experiences of the d/Deaf community is limited but growing. In the past decade the amount of research is increasing as people in the d/Deaf community have begun doing research on their own community. However, due to this lack on specific literature on the d/Deaf community, most literature conceptualize deafness as a disability. As a result, much of the literature in this paper refers to the experience of people with disabilities and/or working with people with disabilities. For some people in the d/Deaf community, they may align themselves with the disability community. However, people who identify with the Deaf community may not. It is important to address this limitation at the start of this literature review. Nevertheless, disability research provides the closest field of comparison since general society historically and currently understand deafness to be a disability.

There is much more available about the experiences of having a disability compared to people who work with those with disabilities. Historically, abled individuals may have a perception of people with disabilities as incompetent, strange, foreign, and sometimes less of a person. Much of these derogatory and incorrect perceptions stem from growing up in a culture that fosters those ideas. One article explains that the disability experience may require a significant alteration of values and an affirmative relinquishing of the dominant cultural standards (Robey, Minihan, Long-Bellil, Earl Hahn, Reiss, & Eddey, 2013). The authors explain how individuals with a disability have a starkly different view on disability, and the everyday experiences of living with a disability, compared to able-bodied individuals. This difference in view involves varying priorities and worldview. The literature highlights how people without disabilities fail to understand the disability experience.

Definitions

To provide an adequate foundation to this project, it is necessary to provide definitions to terms that are typically found in literature on people with disabilities. Currently, deafness is considered a disability. The term *disability* has many definitions, but one that is most typically used is a major life impairment that prevents someone from participating easily in major activities such as walking, seeing, hearing, and/or thinking (Brown, 2002). This paper will seek to highlight hearing disability. The lack of specific literature on the experience of people with deafness highlights the importance of this project for increasing awareness to issues relevant to working with this population. The range and presentations of disabilities is almost endless. Disability is best conceptualized as a spectrum in terms of functional ability and presentation. This heterogeneity is applicable for people in the d/Deaf community.

Deafness comes in many forms. One important distinction is congenital deafness or acquired deafness. Congenital deafness is considered deafness from birth (Spencer, Tomblin & Gantz, 2012) whereas acquired deafness occurs when people become deaf after birth. This distinction has important implications to how a person may view their own deafness in terms of how and if they incorporate deafness into their personal and cultural identity.

Currently, deafness is legally considered to be a disability and the rights of people who have deafness falls under the Americans with Disabilities Act (ADA) as well as the UN Convention on the Rights of Persons with Disabilities, a piece of legislation signed in 2006 and adopted by most of the countries in the UN. These legal documents demonstrate a cross-cultural acknowledgement in recent decades that people with disabilities need to be treated equally and included in society.

One unique consideration when discussing people in the deaf community compared to the wider disability community is the existence of Deaf culture. People experiencing deafness consider the Deaf community as a tight-knit, self-identified cultural and linguistic minority rather than viewing deafness as an impairment that should be fixed (Nichols, 2016). Deaf culture is built upon the foundation of American Sign Language (ASL) as well as distinct cultural norms. A more thorough discussion of Deaf culture will occur later on in this paper.

Among literature on the d/Deaf community, there is an increasing use of the term "d/Deafness" as a way to include all people that experience deafness. Traditionally, little-d deaf is the term referring to individuals who are functionally unable to hear, but do not consider themselves members of Deaf culture. People who identify themselves as deaf may use ASL and/or speech to communicate. However, capital D Deaf is the reference term used to identify someone who is a member of the Deaf community. Similar to the trend in literature to use inclusive terms as to not exclude any individuals, this paper will use the term "d/Deaf."

Models of Identity Development

A person's identity can include input from a variety of sources and experiences with disability are often multifaceted and complex. It is difficult to discern how disability status is likely to contribute to someone's identity, if at all, and how that disability status may or may not affect the person psychologically. For people in the d/Deaf community, considering whether they view their deafness as a disability at all is one of the foundational issues that makes d/Deaf identity so complex.

Due to the lack of information provided to mental health providers on d/Deaf individuals, it is crucial to use identity development theories as a framework for understanding this unique population. A section on various theories will be included in the training manual as means of helping providers conceptualize where a d/Deaf patient is in the identity formation process. It can also help providers understand the difficulty d/Deaf patients experience when trying to make sense of their deafness intra-personally, inter-personally, and societally.

Psychosocial Model of Identity Formation

Understanding identity formation from a psychosocial perspective involves exploring group dynamics such as how stigma, prejudice, discrimination, and language affect identification with a group. American Sign Language (ASL) is the language that some people who are d/Deaf choose to communicate with. ASL is a fully formed language with its own syntax and linguistic norms It is not merely a translation of spoken English. Just as ASL includes its own rules, ASL also functions as a foundational element for preserving Deaf history and customs as well as facilitate identification with other Deaf individuals as a group. This paper will discuss stigma and discrimination in more detail later in this literature review, but the presence of these concepts in d/Deaf discourse illustrates how potent in-group and out-group boundaries can be. Notably, historical perception by hearing society to not accept d/Deaf individuals and rather view them as an outsider illustrates how prejudice can actually make membership in Deaf culture more desirable. Deaf people have used the stigma and prejudice they've experienced as a source of strength to unite.

Understanding that some people with deafness, particularly people who identify with Deaf culture attribute negative connotations to people who do NOT subscribe to Deaf culture shows as stigma and discrimination fueled the creation of Deaf culture, Deaf people may also apply stigma in the same way to other groups in society. It is clear that psychosocial concepts can interact in a variety of ways that can result in many ways for people to construct their identities.

Social Identity Theory

Social Identity Theory asserts that minorities cope with a stigmatized identity in one of two ways. They may assimilate by incorporating the majority culture's values, thereby separating themselves from the disability population, or they may embrace their disability status and incorporate the disability population's values and norms. Adopting and embracing a disability identity may serve as a psychological support system by instilling a sense of pride and self-acceptance (Bogart, 2015).

In a quantitative study on the protective effects of disability identity in people with multiple sclerosis, researchers found that when participants had a stronger disability identity, they also had lower levels of depression and anxiety (Bogart, 2015). This study suggests that people who incorporate their disability into their identity experience less psychological distress. Other benefits of adopting a disability identity could include a more defined perspective on the self, access to a wider range of social support, increased pride, and empowerment through advocacy.

Researchers also found in that study that younger participants had higher levels of depression and anxiety. This may have been because having a disability is less common in younger people so they may have more difficulty accepting a disability identity. Also, up until the late 20s, people are still exploring and constructing their identities including ethnic background, economic background, and more. Reconciling disability status along with these other factors could cause increased distress for younger people.

In another study, researchers studied a sample of 18 participants ages 5-65. Some participants had disabilities that were present from birth, which was considered as a disability that was identified by the age of 5, and some had acquired disabilities, diagnosed from the 5th birthday or later. This study looked at qualities of cultural identity related to participants' disabilities as well as whether participants' age, type of disability, and onset of their disability led to differences in disability identity. The participants were interviewed using a semi-structured clinical interview lasting between one to two hours. They were first asked open-ended questions and then asked structured questions if necessary. The interview transcripts were then analyzed in order to identify themes. Five themes emerged from the interviews including "fitting in," "disability wisdom," "it's just what you do," "I can do it despite what you say," and "disability talk as shared interest versus talk as boring" (Gilson & Depoy, 2015). The findings provide insight into the disability experience as well as implications for practice. It appears there are a variety of ways that an individual can make meaning for themselves regarding their experiences of living with a disability. This highlights the importance for providers to spend time discussing how a patient's disability plays a role in their lives and conceptualization of self.

As discussed earlier regarding disability culture, there is still debate about whether a disability culture would help or hurt the disability community. Among the d/Deaf community in particular, culture is an even more complex issue. The Bogart (2015) looking at disability identity as a protective factor among participants with multiple sclerosis corroborates the results found in a study by Spencer, Tomblin and Gantz (2012) that looked at cultural identification among people with cochlear implants. In the latter study, people who used cochlear implants had a higher likelihood of identifying with hearing society compared to people who did not use cochlear implants. However, for both people who use cochlear implants and those who did not, they most often reported a bicultural identity comprised of Deaf and hearing. This indicates that for some people with disabilities and particularly within the Deaf community, people find acceptance and understanding within two cultures, thus bolstering their support system and helping them feel confident in an identity within two communities.

The Spencer, Tomblin and Gantz (2012) study in particular included a pediatric population. These participants had cochlear implants and this study followed them in order to discern how they identified themselves and constructed their cultural identity later in life. The researchers assessed educational, vocational, and family status, overall quality of life, and identity patterns. Results found that fourteen out of the 85 participants had discontinued using their cochlear implants. They had a final participant response group of 61. The researchers explained that the majority of participants identified with both a hearing and Deaf identity. Therefore, it is possible for individuals to feel comfortable moving within and between both hearing and Deaf communities. This corroborates the general literature and contradicts earlier concerns that those who had cochlear implants would grow up with no culture. Instead, results indicate people feel identification and connection with multiple identities. It is notable that this study was done with a population such as the d/Deaf community where they have the most defined and structured cultural affiliation compared to other types of disabilities. In this sense, results are more impactful.

The studies mentioned in this section demonstrate that for treatment, mental health professionals need to note that multiple identities are possible and can be a protective factor from distress such as depression and anxiety. It is important to investigate these identity issues with the client and look into how the various facets of the person with disability's identity affects their overall social support network as well.

Reconciling and Incorporating Multiple Layers of Identity

One of the most foundational aspects of the disability experience that people must realize is that disability presents and is experienced in a variety of ways. The way that people with a disability perceives and interprets the behaviors of others could be very different based not only on the type and severity of disability that they have, but the interaction of all the other aspects of their background. This could include ethnicity, identity, community connectedness, life satisfaction, psychological well-being, and experiences within society up until that point. The dynamic and complex nature of this topic indicates the necessity for more understanding by people who have disabilities, people around someone with a disability, as well as the mental health professionals who are attempting to help everyone involved.

In contrast, people who are secure in identifying with their disability may experience the opposite struggle. For people with disabilities that are not visible, meaning excluding a disability requiring use of a wheelchair or other identifiable aids can lead to the individual facing stigma when trying to access to facilities such as accessible bathrooms or parking in handicapped parking stalls (Reeve, 2006). Although the person with the disability are secure in knowing they have a right to use these types of facilities, they are faced with outside judgment by others that they in fact do not deserve access. They may avoid using the facilities, causing increased psychological distress, or choose to begin using something that outwardly identifies their disability, just to be able to use disability facilities without judgment and discrimination (Reeve, 2006). However, choosing to visibly identify as disabled would result in an emotional toll. They may feel angry at society that they need to alter their life to fit into the “mold” of what society says disability looks like.

For people with d/Deafness, choosing to make their d/Deafness visible to others may occur in the form of wearing hearing aids in public or using American Sign Language (ASL) to communicate rather than using verbal expression. People who are not comfortable making their d/Deafness visible to others may choose to use lip reading and speech while in public in order to avoid bringing attention to themselves.

Cultural Development in the d/Deaf Community

Acculturation theory describes the process of cultural change that occurs when people experience multiple cultures interacting. Acculturation can be distressing to people when the various cultures interacting clash with each other in terms of language, customs, social perception, and more.

Social inclusion is a concept involved in the acculturation process. Although there is currently no unified definition of social inclusion, many researchers define social inclusion by whether people are considered socially excluded. This contradictory idea often confuses policymakers as well as providers, making creating meaningful applications difficult. This provides a direct link to the experience of people with disabilities who may feel that they themselves are confused about where they fit into society.

Cobigo, Ouellette-Kuntz, Lysaght, and Martin (2012) explain that social inclusion is typically associated with acceptance of the dominant culture’s values. This could be complicated for people with disabilities because gaining social inclusion to mainstream society in this context could mean disavowing their personal values and identity within the disability community. This highlights the internal psychological struggle that people with disabilities go through to construct their place in society as well as the source of potential psychological distress. This study asserts one’s role can be thought of as a mix between an individual’s expectations of themselves and expectations placed on them by the dominant cultural group (Cobigo et al., 2012). Other factors include an individual’s own decisions and needs. In other words, inclusion would be based on a mutual exchange for the greater good of the community instead of individuals seeking to attain the established norms defined by the group.

This understanding of social inclusion would be beneficial because people with disability including d/Deafness are often excluded because they may lack the physical capabilities that society considers necessary for inclusion. However, if social inclusion is considered a mutual exchange then people’s disabilities would be irrelevant to the community because they would instead contribute in a different way. They would instead be included based on what they are able to do instead of excluded based on what they are not able to do.

The Debate on Disability Culture

As human beings we identify ourselves in many ways. There are many “cultures” that we consider ourselves to be a part of and among the disability community there is a growing discussion about whether a “disability culture” exists and what that would look like. Our cultural identity can be a large contributor to how we orient ourselves in the world on an interpersonal level and on a societal level.

The concept of a disability culture is debated among the disability literature because in American society, this group is typically referred to as *impaired* or *crippled*. It would be difficult to infer strength and positivity from these terms (Brown, 2002). When the larger society perceives disability in such negative terms and also excludes people with disabilities physically and in other ways, it is difficult for people with disabilities to want to identify themselves as “disabled” and identify themselves with other disabled people. They instead want to minimize or hide their differences, thereby distancing themselves from other people with disabilities. This isolation can lead to feelings of shame, embarrassment, anxiety, sadness, and less social support.

A complicating factor that a disability culture would elicit is the immense diversity among the disability community. Compared to other “cultural” groups, people with disabilities are arguably the most diverse group. How do these diverse experiences connect to form one disability culture? One author explains an important factor is whether differences in experiences of different types of disabilities are looked at as a way to separate people. For example, do people with physical disabilities such as vision loss feel that their experience is far different from people who have developmental disabilities. In a society where disabled people are often looked down upon, do people with disabilities seek to differentiate themselves as “less disabled” than others? This formation of a hierarchy of disability experience may seek to alleviate individual anxiety and lead some people to think that they better than others.

Another important consideration is how association with disability culture is not assumed at birth or the moment the individual acquires their disability. For example, people are often born with assumed membership into ethnic cultures. However, disabilities may not be acquired until later on in life. People may acquire their disabilities suddenly or over time. Acquiring a disability during adulthood presents an individual with the task of incorporating their disability status into their pre-existing understanding of identity (Robey et el., 2013). This consideration makes disability culture unique compared to other types of cultural membership, and that quality could also lead to psychological distress about whether the individual feels they “should” incorporate disability culture into their lives or not.

d/Deaf Culture

As the larger disability community discusses the feasibility of an overall disability culture including what the implications would mean, the d/Deaf community has already taken these ideals and leapt forward with them, including nation-wide adoption of a signed language and unique cultural norms and customs. American Sign Language (ASL) is a rich language that although was formed to accommodate a disability, has flourished and is now a foundational element of an entirely unique culture. Notably, people who are hard of hearing or are d/Deaf are not necessarily part of D/Deaf culture. Rather, identifying as a member of the Deaf community is a conscious choice. A person makes this decision as evidenced by using ASL as their primary means of communication, adopting Deaf values including viewing deafness as a difference not a disability, and spending time with other Deaf individuals including Deaf community events. An appropriate analogy for people who do not identify as Deaf may be the example of someone who has the racial background of one ethnic group but is not familiar or chooses not to practice any of that culture's customs. People in Deaf culture have immense pride and love for the people in that community and all that their culture entails.

The Deaf community seeks to distinguish and separate itself from a larger disability culture. Deaf people do not consider themselves disabled and do not want society to see them as disabled. Notably, scholars in the Deaf community have created an environment where people in the community may stigmatize people with other disabilities in an effort to dispel prejudice towards Deaf people. This infers the idea that people in the Deaf community see themselves as a higher status than those with other types of disabilities. Deaf culture provides an overall sense of belonging and identity, sometimes leading to a sense of superiority. Feeling superior to people with other disabilities may serve to alleviate anxiety that Deaf people feel on an everyday basis interacting in the world. The structure of society today involves oppression and marginalization in many domains and holding an idea of superiority to another group may give people in the Deaf community comfort. This could be perceived as a way of coping by finding solace in an overall Deaf culture and community.

Deaf people seek to change the way society views their community from that of a disability community to that of a minority culture. For Deaf community members the issue is not disability status, rather, it is about values. This is an important distinction to understand the way that people in Deaf culture view the world and themselves. Further, Deaf individuals feel a deep sense of pride regarding their cultural identity and sometimes feel that associating with disability takes away from Deaf culture. This idea of association with disability as contamination of Deaf cultural identity may not necessarily relate to a feeling of superiority but may be related to how much work and time this community has put in to shift society's perception on Deaf people. They may not overtly seek to degrade and oppress people with disabilities, but that may be an unfortunate byproduct.

Despite this drive to distinguish themselves as a linguistic minority culture, Deaf culture exists within the larger hearing society and must function within those societal government systems. This means that if Deaf culture is considered a linguistic minority group, Deaf individuals would no longer be entitled to protection under the Americans with Disabilities Act and other legislation referring to rights of people with disabilities. This realization could lead to psychological consequences such as anxiety, sadness and frustration. This realization could lead to psychological consequences such as anxiety, sadness and frustration. An alliance and conversation between Deaf culture and disability culture would serve to provide a larger support network both interpersonally and politically. Their resources would grow and their voice in the larger society would become louder that having a disability can be a source of strength rather than weakness. These shifts in disability culture and community can play a large role in how people with disabilities perceive themselves. Trends such as how these cultural groups formulate their group identity and ways of relating to others can inform the way that the individual members form their ways of interacting.

This separation of Deaf culture from the overall disability community creates a disconnect for those without disabilities because in seeking to understand people with disabilities they do not understand that the Deaf community exists as a separate entity. This contributes to the confusion and distress that people without disabilities feel because the social “rules” and “customs” when interacting with someone in the Deaf culture is different than interacting with someone in disability culture. Deaf culture individuals seek others to treat them as if they are members of another culture such as when interacting with someone from a different country. People without disabilities, through indoctrination from society such as the media and dominant discourses, sometimes feel that people who have disabilities are a lower status than them. For those in Deaf culture, however, they want others to see them as equals, but belonging to a separate culture with their own language and customs.

As a therapist, when interacting with someone who is hard of hearing or d/Deaf it is important to note that they may not be a member of Deaf culture. It is necessary to be mindful that Deaf culture is a solidified and growing presence in society and whether someone identifies as a member of this community could affect them in many ways. Someone who is not a member of Deaf culture may feel their deafness is a disability that they seek to correct or fix. However, a Deaf individual would instead be more likely to be satisfied living with deafness or exhibit pride that they are Deaf. Therapists should seek to understand how their client locates themselves within or outside of this community and how that conceptualization may affect their psychological resources and how they perceive the rest of the world.

The Deaf culture movement is one of the central aspects of the deaf experience whether patients identify with or outside of Deaf culture. Therefore, a section explaining the dynamics within and around Deaf culture will be included in the training manual.

Stigma and Discrimination

Stigma is a powerful force that can affect how people view themselves and how society views certain groups. Stigma refers to marginalization of groups of people based on that group's characteristics or beliefs because they are different from the majority group's beliefs (Ali, Hassiotis, Strydom, & King, 2012). Self-stigma involves internalizing these societal views. Effects of self-stigma on psychological well-being include lowering self-esteem, thereby exacerbating psychiatric symptoms.

Stigma alone can expand to the concept of stigma extension. Munyi (2012) explains, however, how the concept of stigma extension can develop and influence how people view not only disability but devalue the person as a whole. Stigma extension refers to seeing a person with a disability as disabled, not only as a result of a specific disability, but including other characteristics, such as personality and adjustment (Munyi, 2012). This can largely occur unconsciously much like how discrimination can occur unconsciously. It is important for people without disabilities, particularly those who make up the person with the disability's support system, to be aware of these ingrained biases.

Stigma from society is referred to as structural discrimination. This occurs when society defines perception on disability and leads people in the general population to adopt that perspective. This imposition is evident by society failing to meet people's needs through creating barriers (Ali et al., 2012). These societal barriers prevent people with disabilities from fully engaging and integrating in their communities (Ali et al., 2015). Stigma imposed by society as well as internalized stigma occur concurrently, thereby amplifying psychological distress.

Psychological distress typically includes symptoms of depression and anxiety (Ali, King, Strydom, & Hassiotis, 2015). There is a strong association between self-reported stigma and psychological distress (Ali et al., 2015). This finding supports that stigma could put people at higher risk for developing mental health problems. Data also suggest psychiatric symptoms are a crucial factor for long-term disability (O'Donnell et al., 2013), indicating that these variables can also influence each other conversely.

Provider Characteristics: Effects on Care

It is noteworthy that the researchers gathered data both from beneficiaries of the services, people with intellectual disabilities, as well as providers. It is also notable that researchers felt it important to investigate personal qualities of staff members as important for working with this population. This is another example of how working with this population can call for unique character traits within staff.

Researchers conducted focus groups including a mix of service users and staff. They also conducted individual interviews with only staff members for a sample of 16 service users and 38 staff. Participants felt that important personal qualities when working with people with intellectual disabilities include clinical experience, certain interpersonal styles, skills, and sincere interest (Kroese et al., 2013). Areas of expertise include working with people with intellectual disabilities as well as mental health issues. This emphasizes the complex nature of working with this population and how certain personal qualities influence a staff member's ability to meet the needs of both clinical areas. Results also suggested that sufficient and ongoing training is crucial to ensure providers are prepared to provide services to this population. Participants report it is important for providers to complete regular training as well as reviews to ensure providers are behaving appropriately and implementing what they learn (Kroese et al., 2013). Therefore, it appears most beneficial to provide ongoing training to equip staff appropriately.

Overall, this study concluded that, even though the quantity of mental health services have improved when it comes to serving people with intellectual disabilities, the quality of that care and ability of patients to access appropriate care, remains inadequate (Kroese et al., 2013). Researchers recognized that multidisciplinary and preventative approaches have improved services, but there still needs to be improvement. One of the most valuable aspects of this study is including input both from staff and service users. By including people with intellectual disabilities as participants can validate their opinions, improve their self-esteem, and also get information straight from the participants about what they feel would improve the services they are receiving as well as their relationships with staff members.

Similar to the study by Kroese et al. (2013), other studies have investigated how employees that work with people with disabilities possessing certain characteristics can improve patient care. A qualitative study by Lovell, Bailey, Kingdon, and Gentile (2014) investigated what nurses who work with patients with learning disabilities perceive as important for working with that population. Researchers conducted focus groups and semi-structured interviews with nurses who work with people with learning disabilities and who also have a legal history. The nurses were from various settings including community, low, medium, and high. The nurses identified four competencies central to their work. These competencies include “knowledge assimilation and application, team working, communication skills, and decision making” (Lovell et al., 2014, p. 2041). Knowledge assimilation and application refers to having basic knowledge about learning disabilities as well as being able to incorporate that knowledge with the individual patient's needs and apply the knowledge in the way the nurse interacts with the patients. Team working and communication skills refer to the employee's ability to communicate openly and clearly with other employees in order to provide a team approach to care. Decision making refers to using clinical judgment gained through experience as well as formal education to provide the best care (Lovell et al., 2014).

The nurses in the study noted that staff members who possessed these competencies were more likely to provide beneficial care. They did not specify how they operationalize appropriate or beneficial care. Regardless, this study is valuable in that data was gathered from various settings. This suggests these are able to be applied to many varying disciplines. This study suggests providing competent care requires a variety of knowledge and skills. For working with d/Deaf patients, it is necessary to gain more knowledge as well as practice skills. For this reason, the designed training will include both didactic information as well as activities to practice skills.

This study is useful to provide insight into the experiences of employees who work with people with learning disabilities and who also have a legal background, however the methodology the researchers chose may have negatively affected the data they received. They chose to gather data through focus groups as well as semi-structure interviews. The negative aspect of using focus groups is that participants may be influenced by other participants. They may be hesitant to share their own experiences depending on the cultural protocols within the setting. This should be considered when thinking about the study's findings.

Provider Bias

The previous studies have looked at staff characteristics and traits and how that influences the quality of their work. Another aspect worthy of investigation, however, is potential staff biases and perceptions and how that may affect the care they provide. A Dutch quantitative study investigated the relationship between staff attributions, emotions, and interpersonal styles when working with the clients with disabilities. Ninety-nine staff members were randomly paired with clients with intellectual disabilities ranging in severity. The staff members worked with their client for at least one month and the staff members then completed questionnaires in regard to their clients. They completed the same questionnaires two weeks apart.

Results of this study suggested that there was a meaningful relationship between the constructs measured. One particular finding was that ‘stability’ significantly predicted a style of support-seeking (Zijlmans, Embregts, Bosman, & Willems, 2012). This suggested to the researchers that when staff members perceived challenging behavior as something they could not change, they were more likely to respond to the client with a supportive style. By randomly pairing staff members with participants and having them complete measures multiple times allowed for various analyses to be run. Results suggest that staff members’ perceptions and biases could influence the way they interacted with clients both positively and negatively.

Based on results of the previous study by Zijlmans, Embregts, Bosman, and Willems (2012), it is prudent to investigate whether there might be literature investigating cultural differences in staff attitudes and how those attitudes may or may not affect treatment of clients with disabilities. One study done in Pakistan looked at attitudes of staff members towards their clients with intellectual disabilities. As a notable caveat on Pakistani cultural perceptions on disability, it appeared that parents participating in the study had different perceptions towards different types of disabilities. Parents were more accepting of their child’s disability when the child had a physical disability, were d/Deaf, or blind, compared to if their child had an intellectual disability (Patka, Keys, Henry, & McDonald, 2013). The researchers attributed this difference to the lack of education on the nature of intellectual disability relative to other disabilities. Culturally, Pakistani parents believed intellectual disability was caused by God or due to possession by an evil entity. As a result, parents feel ashamed of their children. This study demonstrated how it was important in the community studied to keep in mind the society's perceptions of disability when evaluating research.

In this study, 452 Pakistani community members including 190 staff members who work with people with intellectual disabilities completed questionnaires that were translated into Pakistan's national language of Urdu. Different researchers then back translated the data back into English. Results suggested that "specific demographic characteristics and experiences, including participant role, relationships with people with intellectual disability, gender, age, level of education" impacted staff members' attitudes toward their clients (Patka, Keys, Henry, & McDonald, 2013, p. 39). This study corroborated the other studies included in this review, showing that results were consistent across the cultures studied.

Patka et al. (2013) also found evidence after working with people with a disability, staff members' attitudes may have become less positive. They based this on their findings that certain demographics and experiences by staff members affected their attitudes. Researchers asserted that when people had more positive contact with people with intellectual disabilities they might be more likely to engage in social contact in the future such as wanting to work with the population. They further asserted that people who had more positive beliefs or attitudes about disability status also might be more likely to accept jobs in that field.

The above research suggest how provider bias can play a large role in the care provided to the patient. Therefore, an activity will be included in the training manual that requires mental health providers to examine their own biases around deafness. Providers must be able to monitor their own assumptions in order to recognize when biases are influencing treatment. At that point providers can address them and ensure the patient is receiving the most appropriate care.

Provider Burnout

Another related area of research is the experience of burnout among people who work with those with disabilities. Burnout is a concept widely researched among various fields of work and all jobs typically involve some level of stress. Burnout is defined in this study as, "a prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by the three dimensions of exhaustion, cynicism, and inefficacy" (Kozak, Kersten, Schillmoller, & Nienhaus, 2013, p. 102). Since people with intellectual disabilities can present with irritability, researchers wanted to investigate what factors contribute to burnout among employees who work with this population.

In their quantitative study looking at burnout among staff who work with people with intellectual disabilities, Kozak et al. (2013) wanted to look wanted to look at variables that could predict staff burnout for a population of staff members working with individuals with intellectual disabilities. Burnout itself can stem from decreased well-being both mentally and physically as well as strained workplace social relations. All of these factors are crucial for staff members to provide quality care. The researchers conducted a paper and pencil survey from January to March 2011 among staff from various backgrounds who work with adults who have intellectual disabilities. Researchers had participants will out the Copenhagen Psychosocial Questionnaire. They had an n-size of 409, with a 45% response rate and they found that protective factors for staff include receiving appropriate information, gaining feedback on their work, being acknowledged and praised for their work (Kozak et al., 2013). This corroborates the studies by

Lovell et al. (2014) and Kroese et al. (2013) that communication, feedback, teamwork, and valuing staff effort were especially valuable when working with people with disabilities.

Current Approach to Cultural Training for Providers

Although mental health providers go through years of training to work with clients from diverse backgrounds, working with people with disabilities and namely people with d/Deafness, is not yet addressed in traditional training programs.

One study investigating the experiences of college students with disabilities seeking accommodations from faculty members in a university setting found that multiple participants cited experiences with professors where students did not receive their accommodations despite presenting documentation for their disability. The students also reported their professors were uninformed, did not communicate effectively with them, and had negative interactions with them (Stein, 2014). The literature review from the Stein (2014) study explains that a large factor contributing to stigma around disabilities is due to a lack of appropriate training for professors. It appears higher education training programs lack a focus on training to work closely with people with disabilities.

One of the factors that contribute to the lack of awareness of mental health professionals on working with the d/Deaf community is the small numbers of people who are d/Deaf in America in general. Since the population is so small to begin with, providers may have the opportunity to interact regularly with d/Deaf individuals. Without interaction with d/Deaf individuals, providers may be unable to have experiences that could help shift incorrect beliefs about deafness to be more realistic and appropriate. Providers may also be uneducated on unique issues for the d/Deaf population including basic concepts on American Deaf culture or familiarity with American Sign Language (ASL). Notably, there is a significant lack of provider training material on characteristics of the Deaf community (Ulloa, 2014, p. 3). Current research shows how current diversity programs emphasize the need for cultural competence and duty of providers to educate themselves on the cultural identifications of their clients. However, due to the lack of resources available on the d/Deaf community, providers who seek information have difficulty finding appropriate materials (Ulloa, 2014).

Intervention Techniques

Although much remains unexplored in the literature regarding evidence-based treatment for working with people in the d/Deaf community, theoretical models provide a strong foundation to build interventions that will ideally be culturally appropriate for this population. Referring back to acculturation theory, there is pressure of managing assimilation to the dominant culture as well as retain aspects of your own identity (Goldston et al., 2009). Retaining some aspects of one's original culture may be a protective factor against poor outcomes such as suicide risk. Findings from this study corroborate findings from the study by Bogart (2015) that showed higher disability identity correlated with lower levels of depression and anxiety for participants with multiple sclerosis. This strong evidence in the literature illustrates the efficacy and need for community-based and culturally sensitive services.

An example of provider cultural sensitivity in terms of assessing acculturation would be to ask the client how they view their personal identity and cultural identity. This would give the provider an understanding of how much the client incorporates or distances themselves from their disability status as well as the cultural values most important to them.

Humanistic Approach

In order for a mental health provider to apply the above cultural considerations, providers must feel culturally competent. The lack of cultural training to ensure competence in treating people with disabilities exists not only in the field of mental health, but also in other helping professions including nursing. Robey et al. (2013) explain how more cultural competence training has improved students' knowledge, leading to improved satisfaction by patients. This illustrates the positive impact that increased awareness can have on the quality of care for the client as well as the confidence and psychological comfort of the provider.

The psychological pre-conceptions and biases of the provider are important for the provider to be aware of and acknowledge when treating someone with a disability. Robey et al. (2013) address this concept when they explain hospital staff perceptions about an individual's quality of life after an injury were significantly more negative compared to the person's view on their own quality of life. This disconnect between the provider's perception and the client's perception can be damaging to rapport as well as overall treatment. For mental health providers in particular, if the provider's own biases blind them from understanding how the client views themselves and their goals then there is no way the provider can construct appropriate interventions.

Positive Psychotherapy

Interventions involving people with disabilities typically include social skills or other skills training groups that are psychoeducational in nature, but have limited therapeutic usefulness (Tomasulo, 2014). Potential successful interventions include strength-based positive psychotherapy administered both in individual formats as well as through an interactive behavioral therapy (IBT) model (Tomasulo, 2014). One consideration, however, is that typical interventions require literacy. In order to account for potential literacy limitations, providers can employ strategies for more visual learners. For example, providers can ask clients to draw pictures or do role-plays. Culturally relevant adaptations might include an exploration of Deaf identity issues that could be implemented by socializing with and seeking support from other Deaf people. In this way, clients may also become involved in the process of Deaf peer recovery (Anderson et al., 2016).

One aspect of positive psychology would include empowering d/Deaf clients. This is particularly important for d/Deaf clients due to deafness historically being treated as an impairment, exclusion, and being perceived as inferior. Research suggests motivational interviewing can be beneficial for d/Deaf clients to become more confident in terms of gaining and implementing new skills in order to create positive change in their own lives (Anderson et al., 2016).

A Biopsychosocial Approach

One of the themes that stood out from this literature is a focus on how service providers can use a biopsychosocial approach to help their clients with disabilities. This is valuable for my study to know how professionals are typically taught to work with people with disabilities. A study that investigated applying a biopsychosocial approach to case formulation on training workshops for employees reported that a “framework for understanding difficulties in intellectual disability has been one of challenging behaviour rather than mental health” (Ingham, Clarke, & James, 2008, p. 41). While it is acknowledged that there is an interaction between mental health and challenging behavior, the nature of the relationship has not been identified yet. Therefore, understanding working with intellectual disabilities cannot be adequately explained by only looking at challenging behavior.

Ingham et al. (2008) note that “there is a suggestion that incorrect attributions in relation to the challenges [people with disabilities] are presented with can lead to unhelpful staff responses” (p. 42). It appears that even among staff whose jobs it is to help people with disabilities, personal biases and societal stereotypes and perceptions can nevertheless influence workers' behavior. The researchers felt that a way to remedy this phenomenon would be to better inform the staff on how to formulate treatment for their clients through a biopsychosocial approach that includes multi-disciplinary collaboration (Ingham et al., 2008).

A biopsychosocial treatment model can be implemented by various members of the treatment team (Ingham et al., 2008). Researchers conducted a pilot study where a workshop on biopsychosocial skills and case formulation were taught. The employee participants reported increased understanding of treatment conceptualization and skills to create an effective biopsychosocial treatment (Ingham et al., 2008). This illustrates that for people who work with people with disabilities, their formulation of their patients is not as integrative or individualized as it could be. Although this was a pilot study, results show promise that with more training, a biopsychosocial formulation could increase staff helping behavior (Ingham et al., 2008). For a population so diverse as people with disabilities, this study points to the need for more flexible and diverse ways to formulate treatment as well.

A study by Kroese, Rose, Heer, and O'Brien, (2013) corroborate Ingham et al.'s (2008) finding, but take it a step further by explaining that the structure of current training for staff members is inadequate, which can lead to these variations in responses to clients. Researchers took a qualitative look into the experiences of staff members who work with people with intellectual disabilities. The aims of the study were to identify helpful personal characteristics for staff working with people with intellectual disabilities, gather information on provider experiences with this population, assess positive and negative aspects of current care provided, and garner suggestions to improve quality of care. The researchers wanted to get an overview of what types of people are better suited for work with people with disabilities, evaluate the current services, and gather information to make improvements.

General Considerations for Mental Health Providers

One example of how a client who has a disability can have goals that differ from an able-bodied provider's goals is discussed in Robey et al. (2013). The researchers explain that when comparing a sample of men who had spinal cord injuries to a sample of men who did not have a disability on rating life priorities there were significant differences. The participants with disabilities put higher value on priorities that remained attainable after their disability. However, this study did not measure disability identity and how participants incorporate or reject their disability as part of who they are. Their level of acceptance of their disability may have influenced the way they value various priorities. Regardless, this study indicates that individuals without disabilities have inherent biases and preconceptions that whether consciously or unconsciously could affect the way they conceptualize a client with a disability.

Another example of how beliefs about health and well-being can vary from able-bodied perception is explained in Robey et al. (2013) when the authors note that when people with disabilities exert their own autonomy, provider assumptions of disability as an "impairment" are challenged. Providers need to be culturally sensitive to how disability does not mean that they are passive receptors to care but are still able to be collaborative and expressive in developing their treatment.

Aside from the biases and inherent perceptions that providers have when they treat a client, appropriate communication with clients is also crucial for quality of care. Communication can be difficult when treating clients with disabilities because they may have difficulty understanding language, expressing language, or both. For people in the d/Deaf community, they may prefer to use ASL or not. As mental health providers, the Code of Ethics demands that we do everything possible to provide the most appropriate care to the client. Being knowledgeable about accommodations for clients with disabilities is a simple way to minimize or ideally eliminate language or communication barriers, thereby building trust and rapport for the provider and client.

Pre-Treatment

When working with d/Deaf clients, providers must remember how this population experiences lack of resources in society. This could include inaccessible services because appropriate communication modality is not provided (auditory only) or inaccessibility because providers do not provide ASL interpreters (Anderson et al., 2016). This lack of access can prevent clients from gaining knowledge about how mental health treatment could help them. The d/Deaf population is very heterogeneous in terms of literacy, familiarity with language in general or familiarity with a signing language, and exposure to formal education. Factors that can affect an individual's improvement in these areas could include having family members who are d/Deaf, and exposure to language from a young age. As a result, d/Deaf clients may then not understand treatment concepts. They could feel anxious or hesitant about the treatment process if they are unable to understand what is being conveyed to them.

To help d/Deaf clients orient themselves to the treatment process, mental health providers should actively seek out psychoeducation and use motivational interventions to help patients be more willing and able to engage and benefit from treatment. Psychoeducation could include discussing coping skills, perceptions on mental illness, and the nature of various psychological conditions such as trauma or addiction. Motivational concepts can include working with patients to identify goals and evaluate how their behavior connect to their goals. This pre-work can help providers and clients communicate clearly throughout the therapy process.

When Clients Use Interpreters

There is currently a lack of health care providers fluent in ASL in general, and an even smaller number of mental health providers knowledgeable in ASL (Ulloa, 2014). This means that if d/Deaf clients present for mental health treatment, they typically are working with a hearing provider. In order to facilitate communication, they may choose to use an interpreter. Having an interpreter in session can change the therapy dynamics especially given the emotionally sensitive conversation that can take place in mental health treatment. Providers who develop relationships of trust with interpreters may be able to improve communication with Deaf clients (Ulloa, 2014). The interpreter is crucial to the treatment process because they are the instrument in which both the client and the provider’s words and meaning will be transmitted. Research on interactions between mental health providers and interpreters explain mental health providers and interpreters prefer to work with the same provider in order to maintain consistency in language and terminology used. This facilitates ease in translation as well as increased comfort and familiarity during the therapy process for everyone in the room.

Providers should also communicate with the interpreter on therapy concepts to ensure that meaning is being conveyed to the client appropriately. Regardless, having the interpreter present has a clear impact on the treatment process whether it be emotional, cultural, or linguistic (Ulloa, 2014). Mental health providers would benefit from treating interpreters as equals in terms of professionalism and recognition of the complex nature of interpreting. This perspective by mental health providers would help foster trust and commitment between the mental health providers and the interpreter.

Chapter III: Training on Working with D/Deaf Clients

People in the d/Deaf community are a unique population who experience increased rates of psychological distress due to a myriad of factors. However, there is a current lack of training on cultural competence to address this need. There is also a lack of providers who feel competent enough to accept d/Deaf patients as a result.

Existing research explains how people in the d/Deaf community do not have an adequate amount of mental health resources in general, especially culturally appropriate services. As more research is done, other types of interventions may become more appropriate, but the program discussed in this project represents a response to the current need for culturally competent mental health treatment for this population. This training provides a broad foundational look at the most important considerations providers are likely to encounter when working with this population.

Theoretical Foundations

Theoretical Underpinnings

This project utilizes a variety of theories that provide a foundational understanding for this training. These theories provide a framework for understanding the importance of establishing a training for working with the d/Deaf population as means of addressing the lack of mental health providers willing to provide services to d/Deaf patients.

The psychosocial model examines in-group and out-group dynamics with regards to stigma, prejudice, discrimination, and language. It is important to also look at how these factors influence patients’ identification with or without various cultural groups such as Deaf culture. Considering the historical exclusion individuals with deafness have experienced, it is crucial to address perpetuated societal stigma as well as individuals’ own stigma.

Social Identity Theory refers to how minorities who experience a stigmatized identity cope with that. One way involves assimilating through adopting the majority culture's values. Another option is that individuals identify with their minority status and rather adopt the minority culture's values and norms. For the d/Deaf population, in a general sense this can be explained as identifying with deafness or with Deaf culture. However, identity is not typically that clear.

An important factor when considering identity formation is that deafness can be experienced in a variety of ways. When constructing their identity, individuals must also reconcile deafness in relation to other aspects of themselves such as race and ethnicity. One way d/Deaf people must decide to identify themselves is whether to show they experience deafness. This could include choosing to use American Sign Language (ASL) when in public or using hearing aids.

Overall, though, these are decisions that must be made repeatedly whenever an individual enters a new situation and circumstance. All of the above theories show that identity cannot be understood in one view alone. It is important to take all the theoretical approaches into consideration due to the complexity of meaning-making that occurs during the identity formation process.

Assumptions of the Program

This program assumes people in the d/Deaf population experience increased rates of psychological distress, emphasizing the need for mental health providers to work with people in the d/Deaf community. However, this program also assumes there is a lack of information available in order to accurately prepare mental health providers to work with the d/Deaf population in terms of cultural competence. This training assumes through participant education both on their own implicit biases as well as general education, applying skills, and having access to further learning, mental health providers will be more likely to be willing to see more d/Deaf patients in the future.

Conceptualization of the Process of Change

This workshop's perspective on the process of change includes change in the level of cultural competence within mental health providers with regards to working with the d/Deaf population. Change will occur through acquiring knowledge and skills to combat incorrect stereotypes that have been perpetuated through media and academics. Incorrect information about d/Deafness itself as well as characteristics of people who experience d/Deafness continue to contribute to stigma. This training assumes that providers assessing their own implicit biases regarding deafness and learning new information and skills to provide a more accurate perspective on deafness, change can be facilitated. This training also assumes practice through case examples is necessary for participants to apply new knowledge in potential clinical situations. Through this variety of learning and applying information, participants will increase their knowledge base and shift their perspective on deafness in general as well as d/Deaf individuals as patients in a mental health setting.

Rationale for Program

The rationale for this program is based upon the lack of current literature on cultural competence for working with d/Deaf patients. This lack of research is partly due to the small number of people considered d/Deaf or hard-of-hearing in the United States. The small population makes it challenging to access these participants in the research. The lack of current research leads to a lack of available information to train mental health providers on cultural competence issues for the d/Deaf population. This lack of culturally competent mental health providers creates a situation where providers, seeking to comply with APA Ethics to work within their areas of competence, may not be willing to see d/Deaf patients. Likewise, due to historical stigma of d/Deaf individuals by hearing society, d/Deaf individuals many times resist sharing openly with hearing health care providers. These two dynamics lead to an environment where providers both avoid d/Deaf patients and d/Deaf patients resist seeking mental health treatment. This training serves as a first step towards bridging this gap and helping providers feel more knowledgeable on issues affecting d/Deaf patients, provide guidance on how to effectively work with these patients, and as a result empower mental health providers to become more open to seeing d/Deaf patients.

Program Fundamentals

Structure of the Program

This program is structured as a one-day training to provide an introduction on relevant topics and areas of focus when working with the d/Deaf patient population. The presentation style of this program includes a variety of formats including didactic information, worksheets for participants to complete, and case examples for discussion. This variety of presentation style is meant to both keep participants engaged as well as address the variability in participant learning styles. This structure is also grounded in the learning approach of taking in new information and consolidating that information through practicing skills.

Participants will complete a knowledge assessment in the beginning of the training in order to assess baseline knowledge. Participants will also complete a program evaluation at the end of the training to assess effectiveness of the training in terms of content, training design, and facilitator skills.

Content Covered

The training will begin with the introduction of the facilitator, their clinical experience of working with the d/Deaf population, and their knowledge base on the d/Deaf population. This is included in order to orient the participants and establish the facilitator as an authority on the training topics. Next, participants will introduce themselves including their clinical background, any experience they have had interacting and working with d/Deaf patients, the setting they practice in, and what they hope to gain from this training. This information is important so the facilitator can identify what information will be most relevant for each participant.

The next activity in the training will include participants completing the knowledge check, included in appendix 1. The purpose of the knowledge check is to orient participants to common misconceptions about d/Deaf individuals. All of the answers on the knowledge check are false. However, the messages conveyed by hearing society create an incorrect view on d/Deaf persons' abilities. When the facilitator goes over the answers to the knowledge check, this conveys to participants that their own implicit biases about deafness and d/Deaf individuals may be inaccurate. Including this activity at the beginning of the training is meant to help participants be more open to learning more accurate information.

Participants will then complete the assessing biases form. This form includes four questions designed to get participants to reflect on their own biases in a more explicit way. It is important for participants to reflect on their own perspective in order to understand how these biases could influence their work with d/Deaf patients. The first two questions refer to the messages they received from society about deafness, while the latter two questions are meant for participants to understand what life would be like living with deafness. This activity serves as another way to encourage an open and curious attitude about the d/Deaf population.

d/Deaf Population Basics. The first didactic topic of this training covers basic information about the d/Deaf population such as politically correct terminology, rates of deafness in the United States, various types of hearing loss, and characteristics of the d/Deaf population. This section is included because understanding of these concepts provides a foundation for understanding more complex and unique issues related to deafness that will be discussed later in the training.

Deaf History. The next topic covered is significant events in deaf history in the United States. Including notable historical events is crucial to understanding the framework of how d/Deaf patients may construct their ideas of themselves and the Deaf community at large. This section also includes relevant laws that have affected d/Deaf individuals' rights and experiences interacting within a hearing society.

Theories of Identity Development. Next, theories of identity development will be highlighted for the purpose of providing a theoretical grounding for the training. The psychosocial model of identity formation as well as social identity theory is introduced in the context of explaining how d/Deaf individuals can come to understand their d/Deaf identity as well as their place relative to the Deaf community. The topic of incorporating multiple layers of identity will also be discussed in this section. This is particularly relevant in areas of practice where people are from a variety of racial and ethnic backgrounds as well as belonging to other cultural affiliations. It is important for participants to consider how deafness fits in with the patient's other identities.

American Sign Language (ASL) Basics. The next topic covered is American Sign Language (ASL) background and basic information. This section is a central consideration when working with d/Deaf patients as ASL is the primary (or only) communication method for those who identify as Deaf. ASL is also a central characteristic of Deaf culture. This section provides background on the structure of ASL and features of ASL, which is helpful for providers to know. This will help providers understand why reading and understanding spoken English can be challenging for d/Deaf patients.

ASL Basics: Alphabet. The next section includes a graphic of the ASL alphabet. In this section the facilitator will go through the alphabet and have participants practice fingerspelling. The facilitator will also teach participants basic phrases such as “nice to meet you,” “thank you,” and “my name is (fingerspell name).” Practicing ASL in the training is a valuable experience for participants in order to understand more about what it feels like to communicate through sign and not through spoken word. Participants having knowledge of basic phrases can also increase providers’ confidence in interacting with a d/Deaf patient. Likewise, the d/Deaf patient is more likely to respond positively when they see a provider using phrases in their own language (ASL). This activity gives participants a way to bridge the gap between hearing individuals and d/Deaf individuals and begin to form a connection between provider and patient.

Deaf Culture. The next section includes information on Deaf culture. This section explains the difference between a deaf person and a Deaf person as well as central characteristics of Deaf culture. This section is important to include because Deaf culture can be the patient’s primary identity and also the primary way in which they conceptualize their position in society.

d/Deaf Etiquette. The next section is on etiquette when interacting with a d/Deaf person. This section is important because interacting with a d/Deaf person can be confusing and intimidating for a hearing person. This is because social cues hearing people are accustomed to are often verbal. When interacting with a d/Deaf person though, these cues could be absent, leaving the hearing person unsure how to interact appropriately. The tips discussed in this section are important so that the hearing provider can ensure they do not accidentally offend their d/Deaf patient and also make a positive impression by showing their d/Deaf patient they respect their Deaf culture background (if they identify as members of the Deaf community).

Complying with the Americans with Disabilities Act (ADA). The next section provides guidelines for complying with the Americans with Disabilities Act (ADA). The ADA is commonly referred to as the premier civil rights legislation for ensuring people with disabilities have equal opportunities. This section is important to include so that providers are aware how to comply with the law and not leave themselves vulnerable to legal action by their patients for not providing appropriate accommodations. As this training focuses on deafness, the section in this training refers only to complying with ADA in terms of d/Deaf or hard-of-hearing individuals. This section is particularly relevant to providers working in private practice and may not have the same guidance and oversight by an organization to ensure they are in compliance.

Office Arrangement with a d/Deaf Patient. The next section includes information on appropriate furniture arrangement when working with a d/Deaf patient. This section includes a graphic example of appropriate furniture setup. Since d/Deaf patients are likely to use ASL to communicate, the visual arrangement of the space is important to increase ease of communication. This section addresses these considerations.

Working with Interpreters. The next section addresses tips for working appropriately with ASL interpreters. Use of an interpreter is one of the most unique aspects of working with a d/Deaf patient. This is one of the most important sections in the training due to the wide variety of ways that having an interpreter in session can influence and effect treatment.

Cochlear Implants. The next topic is on cochlear implants. It was important to have a separate section on cochlear implants due to necessity to explain what cochlear implants are functionally in order to dispel misconceptions that these devices can “cure” deafness. This section also discusses the debate among the Deaf community about whether cochlear implants belong in the Deaf community and how having a cochlear implant can affect a d/Deaf patient’s experience of the world.

Current Technology for Communication: Assistive Technology. The next topic is on current assistive technology available for d/Deaf individuals. This section is useful for providers in order to be more aware of the options that currently exist. This section addresses the various types of assistive technology and can also give providers useful information they can recommend to patients who may or may not be aware of the most up to date technology. The use of technology is important to assist the d/Deaf individual in navigating through a hearing society in terms of attaining and maintaining employment, excelling in an academic setting, and also being able to thrive in everyday life.

Current Technology for Communication: Phone Apps. The next topic is an overview of current phone applications available. This section includes phone applications for d/Deaf patient use as well as applications to assist providers become more familiar and comfortable with ASL themselves. This section was important to include in order to address the current trend towards incorporating technology into clinical work with patients.

Prevalent Mental Health Concerns for the d/Deaf Community. This section addresses typical mental health concerns within the d/Deaf community. Although this is not an exhaustive list, it can provide a starting point for providers when doing an intake with a d/Deaf patient. Providers should be sure to assess for these symptoms in every intake as research indicates people in the d/Deaf population experience these concerns at increased rates compared to the general population.

Culturally Appropriate Therapeutic Intervention Tips. The next topic in this training includes tips for providing effective therapy services with d/Deaf patients. This section is crucial for providers to have a better idea on how to structure a culturally appropriate treatment plan as well as how to adjust typical therapeutic interventions to ensure d/Deaf patients benefit appropriately. This section also includes brief background on considerations for administrating and scoring brief assessment measures. The facilitator would explain that the information in the section referring to assessment measures is not a complete guide on doing assessments with this population. This training is limited to cultural competence in an individual psychotherapy modality only.

Case Examples. The next section of the training includes three case studies. For this portion of the training the facilitator would break up the participants into three groups and each group would work together to respond to one of the case examples. After time for discussion and answering the questions written under each case study example, the participants would present their case to the larger group. The facilitator would then encourage discussion among the other participants including getting feedback from other participants. The facilitator would offer comments and suggestions on each case example to encourage participants to incorporate what they have learned in the training and apply it to a clinical example.

Resources. The final topic in the training includes a list of resources. A list of resources is included because as stated earlier, this training alone is not sufficient to cover all topics both in breadth and depth required for sustaining cultural competence with the d/Deaf population. In order to account for this, a list of resources included for providers to seek further education. The resources listed include various categories both for providers to gain further education as well as resources for d/Deaf patients. The resource list focuses on Hawai'i resources as Hawai'i is the location where this training is created. However, some national resources are included as well.

The topics covered in this training were chosen in order to cover the most common areas of concern for providers working with d/Deaf patients. These topics were included because they address the issues providers are most likely to encounter when working with this population.

Appropriate Membership of Program

This workshop is best suited for any type of mental health provider who has had experience working with patients in an individual psychotherapy format. A mental health provider is defined as someone with an advanced degree (master's degree or higher) in a mental health field. Degrees may include psychology, social work, marriage and family therapy, mental health counselor, and licensed professional counselor. This training is suited to participants who already have experience working with patients in an individual psychotherapy setting. This training does not cover basic clinical skills, so participants are expected to already have experience in clinical work. Providers who will gain the most from this training are those who are curious about learning about the d/Deaf population, are currently seeing d/Deaf clients, or are open to seeing d/Deaf clients in the future. Providers who seek information on working with d/Deaf patients in the setting of group therapy or assessments may find the general background information on deafness relevant, but this training does not include specialized information for those settings.

The screening process of this training involves participants reporting their certifications and degrees earned. Participants will also report amount of time worked with patients in an individual psychotherapy setting. These screening criteria is important because without foundational knowledge about clinical skills and experience, the information presented in this training could be misunderstood or misconstrued.

Role of Therapist/Facilitator

The role of the facilitator of this training is to provide knowledge and skills to participants in order to improve their level of cultural competence with regards to the d/Deaf population. The facilitator is responsible for creating an environment that encourages participants' self-reflection on their own assumptions and biases of people in the d/Deaf community. As explained earlier, people in the d/Deaf community continue to perceive stigma by hearing society and it is important for mental health providers to be aware of their own beliefs and views as members of the hearing community. Facilitators also need to be able to create a supportive learning environment because many of the biases that hearing people hold are inaccurate. It is important for participants to feel comfortable acknowledging these views as well as be able to process the new information presented.

Therapist Training

The therapist or facilitator required training would include having worked with a d/Deaf patient in the past or currently. Typically, therapist training for a workshop on unique populations would require a certain amount of experience both in number of patients from that population as well as amount of time spent working with patients from that population. However, due to the scarcity of d/Deaf patients accessing mental health services currently, it would be challenging to find many therapists who fulfill a guideline referring to number of patients seen.

Another important requirement for a facilitator of this training would be familiarity with topics relevant to deafness. Many of these topics have been included in the participant manual such as important statistics, appropriate terms, etiquette, and technology for hearing impaired people. For example, it is important for the facilitator to know basic phrases in ASL and are able to teach participants basic phrases in the training. The facilitator would be required to have a breadth and depth of knowledge greater than that covered in the manual so as to answer any questions participants may have. This would include being familiar with the research literature concerning mental health and Deaf patients.

The facilitator would also be expected to stay updated with news important to the Deaf community. This includes staying up to date with trends in the community such as popular culture, and the most up to date technology to assist d/Deaf people in interacting in hearing society. It would also be crucial for the facilitator to be familiar with the characteristics of the Deaf community in their area of practice. This is important because Deaf individuals' views can vary based on the d/Deaf community views in their areas. Much of d/Deaf community culture can depend on the number of d/Deaf individuals in the area and views by hearing society in that area in terms of level of inclusivity in public places and societal acceptance. It is also important for the facilitator to be familiar with the d/Deaf resources in their own area of practice such as d/Deaf events and social gatherings. The facilitator needs this knowledge in order to provide insight and relative examples of how d/Deaf community members interact with each other.

The small number of d/Deaf people in the United States, and even smaller number of d/Deaf individuals willing and able to access mental health services highlights the limits of facilitator access to experience working with d/Deaf patients. However, by becoming familiar with relevant literature as well as keeping up to date with technology, events, and new developments for the d/Deaf community can provide the foundational knowledge and skills to participants of this training.

Ethical Issues

An important ethical consideration for this training includes recognizing that this training alone is not sufficient to attain the depth and breadth of cultural competence for working with d/Deaf patients. Rather, this training serves as an introduction to the d/Deaf population in general as well as an introduction to the clinical considerations for mental health providers. Further training and education on these topics are necessary in order to maintain a sufficient level of cultural competence that is appropriate for working with a unique population. In order to address this ethical consideration, resources will be included within the training manual for participants to access. These resources address a variety of topics including resources for d/Deaf patients as well as resources for providers to gain more knowledge.

Program Evaluation Protocol and Form

The program evaluation form, found in Appendix C, serves as a means to assess the workshop's effectiveness in achieving its objectives and improves the cultural competence of participating mental health providers with regards to d/Deaf patients. There are four sections in the evaluation form. The first three sections use a Likert scale format and assess workshop content, workshop design, and the facilitator respectively. The last section includes an open-ended free response format.

Using a Likert scale for responses was chosen because Likert scales are the most commonly used method to attain psychometric measures on people's opinions. Since Likert scales are widely used, it is easy for participants to understand. A five choice Likert scale was chosen to provide respondents more options and consequently make it easier for participants to respond. The five choices include: strongly disagree, disagree, neutral, agree, and strongly agree.

Including a “neutral” response option also accounts for participants who do not have strong feelings on an item.

The first section on the program evaluation form addresses the workshop content. Items ask respondents if they learned new information and met workshop objectives. Items also address whether the case examples portion of the workshop was helpful as well as if the workshop in general met their expectations. These five items were chosen because they gather general information on how effective the content is.

The second section on the program evaluation form assesses workshop design. Including a section on workshop design is important because information must be conveyed in an effective and appropriate way. If information is not presented in an effective way, participants may not learn or understand the content well. Items in this section of the program evaluation form ask about whether the objectives were clear, the amount of content covered, the variety of instructional methods used, the organization of the information, and whether the case examples stimulate learning.

This next section on the program evaluation form assesses the facilitator. It is important to assess the facilitator separate from the workshop content itself to assure if the facilitator is communicating content appropriately. This section of the evaluation is a way to check if guidelines for selection of the facilitator is sufficient for participants to learn objectives in this workshop.

The last section of the program evaluation form uses a free response format. Including a free response section was important in order to allow participants to share opinions they are not able to include with a closed-ended format. Questions in the last section were written with an open-ended style to encourage participants to elaborate in their responses. These items were included in order to capture participants' comments on areas that are not addressed earlier in the form. This program evaluation form will be used to assess the effectiveness of this workshop in attaining its objectives and improving participants' level of cultural competence when working with d/Deaf patients.

Summary

This project attempts to highlight the current gap in attention given to both d/Deaf patients experiencing mental health concerns as well as a lack of appropriate training for mental health providers on working with the d/Deaf population. Schild and Dalenberg (2012) summarize the problems succinctly in that there is an extreme heterogeneity of deaf individuals, a virtual absence of valid and reliable measures, a general lack of research with Deaf individuals, and a shortage of qualified, cultural and linguistically competent mental health professionals to provide the needed services. This project addresses the latter by providing a foundational knowledge base to help mental health providers learn more about the needs of this population as well as teach them skills to address these needs with d/Deaf patients in session.

Chapter IV: Discussion

This project sought to address a broad topic of cultural competence for a population not well understood by hearing society. The lack of information on this population both in general and in terms of mental health contribute to erroneous stereotypes and beliefs. By creating a training to address these issues, this hopefully facilitates an acknowledgment of d/Deaf community's existence as well as a developing conversation to address their needs.

Research Questions

The first research question for this project was: What are the unique mental health issues that people in the d/Deaf community experience? Although research is limited in this area, preliminary data show d/Deaf individuals experience higher rates of trauma both in the form of PTSD as well as interpersonal trauma. They also have higher rates of substance use disorders relative to the general population as well as psychological distress including depression and anxiety. Although d/Deaf individuals experience higher rates of these mental health concerns, they are rarely receiving treatment to address these issues. This training serves as a response to fill this need.

The second research question for this project was: What types of programs currently exist that address working with people in the d/Deaf community? There is a current lack of literature in existence on disability, and even fewer available literature on deafness and the experience of d/Deaf individuals in a mental health setting. There is a lack of any formal program addressing cultural competence for mental health providers working with this population. This emphasizes how crucial this project is to contribute to the literature and bridge the gap between needs of the d/Deaf community and lack of competence among mental health providers to work with that population.

The third research question for this project was: What types of interventions would best address mental health concerns of people in the d/Deaf community? There are not currently specific interventions designed for working with the d/Deaf population. Rather, there are certain ways providers can present information in order to make the information easier to convey to a d/Deaf patient. These include focusing on incorporating visual interventions because in Deaf culture, information is primarily presented and understood visually. Providers also need to take into account the educational background of the d/Deaf patient including early exposure to language including ASL, spoken language, or home signs. Providers need to individualize interventions based on their patient's level of understanding. This may include allowing ample time to explain and practice an intervention so that patients are able to ask questions and providers can review instructions to ensure clarity. Also as explained earlier, historical stigma from hearing society against d/Deaf individuals can lead to a guarded attitude by the d/Deaf patient, and more time building rapport could be necessary in order to gain patient buy-in for interventions.

The fourth research question for this project was: What type of training would benefit providers in order to increase cultural competence when working with this population? Research on this population includes data highlighting stigma by hearing society against d/Deaf individuals leading to mistrust of hearing health care providers. Research also highlights the importance of Deaf culture in d/Deaf individuals' identities. A type of training that recognizes these characteristics within the d/Deaf population would inform providers on how to guide their conceptualizations of patients as well as treatment with this population.

The fifth research question for this project was: What would an effective training look like for mental health providers working with this population? An effective training on increasing cultural competence for mental health providers working with d/Deaf patients would include information on deafness in general as well as how deafness can play a role in d/Deaf patients' identities in a psychotherapy setting. Information included in this training must include basic background on the deafness as well as Deaf culture. An effective training would include a variety of topics addressing common aspects of deafness that providers are likely to encounter as well as techniques on how to address those in psychotherapy. An effective training would include a variety of teaching methodologies including didactic information, and assessment of providers' own biases, learning new skills, and an opportunity to practice those skills in the training with feedback by facilitators. By incorporating these elements, the training would be able to demystify the d/Deaf population in general, demonstrate the significant barriers d/Deaf individuals have encountered to access mental health treatment, and encourage providers to become more open to working with the d/Deaf population.

Overall, although this project is not sufficient alone for mental health providers to attain and maintain cultural competence to work with the d/Deaf community, it does demonstrate the discrepancy between hearing providers' lack of knowledge and abilities to appropriately interact with d/Deaf patients. This project then provides new information, skills, and opportunities for discussion and application of those skills. As a result, participants will complete this training feeling more open, comfortable, and willing to accept d/Deaf individuals as patients, thereby accessing a population that continues to remain underserved by mental health providers.

Limitations

This project seeks to address the gap in literature on how mental health providers can work appropriately with Deaf patients. A strength of the project is consolidating what little information does exist in the literature on the various issues and complexities for this population.

This project clearly explains how the Deaf community relates to the disability community, and more importantly, how Deaf individuals distinctly separate themselves from the disability community. This project provides a good breadth of information for providers, so providers feel more comfortable and open to seeing these patients.

Another strength of this study is that unique mental health issues for the Deaf community are highlighted. With such a lack of information on this population, providers may not be aware of specific symptoms Deaf patients should be screened for. Covering typical symptoms patients could present with give providers guidance on what to ask about during an intake session. This can make a difference for providers who may feel anxiety about working with a patient who communicates with a different language (ASL) and has a unique culture (Deaf culture).

This project does a good job of providing guidance on successful interventions for this population. Providers may hesitate to accept Deaf patients because they are unsure what interventions they could use in session. This project provides tips on how to adjust traditional therapy interventions, so they translate well when working with d/Deaf patients.

Although this project exhibits many strengths, limitations must also be addressed. One limitation of this project is the inability to explore depth of knowledge on various topics within Deaf culture or characteristics of the population. Due to the large amount of information to achieve breadth and depth on this population, it was not possible to include both in this project. The choice to cover a breadth of topics was made because breadth provides a wide foundation of knowledge. It was important to increase awareness on the existence of various topics so that providers can then seek out further information on their own. Resources are also provided to assist providers in gaining depth of knowledge.

Another limitation of this project is the inability to provide as much information on different subgroups within the wider d/Deaf community. It was also not possible to address the intersection of d/Deaf identity in relation to other identities such as racial or ethnic identity. The d/Deaf population is extremely heterogeneous so even when taking all of the recommendations into account, it may not fit every patient that comes in. For example, the wide variety of education levels within the d/Deaf community would affect the patient's ability to understand concepts and terms. This scope of this project was not wide enough to cover examples of applicable interventions across other factors such as education level or communication styles.

Overall this project does a good job of providing a foundational breadth of knowledge so providers feel less wary and more comfortable to take on these patients in therapy. However, limitations including an inability to address how different characteristics of the population may interact and impact provider approaches, conceptualizations, and treatment.

Clinical Implications

If the information in this project were provided to all mental health providers, clinical implications would be far-reaching. Firstly, more providers will be aware of the unique considerations for this population based on the increased access to information this training would provide. The information included in this training could not only serve as new information to mental health providers who lack general knowledge about the d/Deaf community. It could also function as corrective information to providers who may have inaccurate beliefs about this population due to stigma and stereotypes attached to d/Deaf individuals throughout history. Providing new and accurate information to mental health providers would open the door for clinicians to begin acknowledging not only the existence of d/Deaf individuals in general, but d/Deaf individuals as members of a population with increased need for mental health services.

With increased awareness and increased literature to reference, it is likely that more providers will be open to accepting d/Deaf patients. Providers would feel more culturally competent from this training and also feel more supported knowing the available resources. Likewise, if there are more providers educated on d/Deaf issues, d/Deaf patients would feel more comfortable accessing mental health services. Although stigma of hearing health care providers still persists in society, this could be a crucial step in helping mental health providers appear more approachable and trustworthy to d/Deaf patients. Therefore, the implications of this project would increase the number of d/Deaf patients accessing care as well as the numbers of mental health providers giving care to this population.

Finally, increased awareness of the unique issues of this population also demonstrates the need for more consistent and thorough diversity training within mental health graduate programs. This project highlights how treatment would look different when working with a d/Deaf patient, and consequently, the necessity of diversity training. It would be much easier to incorporate this training as part of graduate programs so that when mental health providers begin practicing, they are already trained. Incorporating training on diverse populations in general would help mental health providers be more reflective and reflexive when working with a patient from any minority background. This would contribute to more well-rounded and skilled clinicians who are able to recognize when more research and more training is needed to serve patients from any minority group.

Overall, clinical implications of this project include improving cultural competency at the individual level for providers and d/Deaf patients as well as on a macro scale of breaking down the barrier of access between d/Deaf patients and hearing mental health providers. This project also demonstrates a need to incorporate cultural competency and diversity training as a standard requirement for graduate mental health care programs.

Recommendations for Future Research

Much more research needs to be done on the d/Deaf population in general. The lack of research is evident in the review of literature as it was challenging to find many studies on d/Deaf individuals. Due to the unique characteristics of the d/Deaf community, it is challenging to make conclusions about the population without research specifically on d/Deaf individuals.

More research also needs to be done on the d/Deaf population with regards to mental health specifically. This would provide more information on symptoms d/Deaf patients are more likely to exhibit as well as building an evidence base for various interventions with this population. This research would also help providing a literature base for psychological assessments with the d/Deaf population. There would be more evidence for norming measures on a d/Deaf population as well as translating measures for assessment in American Sign Language. This would lead to more accurate test scores and consequently more accurate views of the individual's functioning.

Finally, research needs to be done on mental health providers who work with d/Deaf patients. It may be difficult to gather that data currently, though, as most mental health providers are not seeing d/Deaf patients. Ideally as more providers become comfortable seeing d/Deaf patients, this data will become available. This information will help shed light on what further training is needed to maintain cultural competence, encourage more providers to be open to seeing d/Deaf patients, and likewise more d/Deaf patients being willing to access mental health services.

Conclusion

This project focuses on increasing cultural competence in mental health through providing a theoretically grounded training for mental health providers. The need for this training is due to the unique considerations to provide appropriate mental health care to the d/Deaf population. People in the d/Deaf community are heterogeneous in their personal and cultural identities, making it difficult for providers to discern how to approach treatment in a culturally sensitive way. The training program outlined in this project serves as a response to fill the need of culturally competent mental health providers and culturally competent mental health interventions for this population.

The research questions for this project include: investigating what the unique mental health issues that people in the d/Deaf community experience, what type of programs currently exist that address working with this population, what interventions would best address d/Deaf patients' concerns, what type of training would benefit providers in order to increase cultural competence with d/Deaf patients, and what would an effective training look like for mental health providers working with this population?

Although including diversity training for mental health providers is becoming more typical, they do not include information on the d/Deaf population. The literature of this project reviews the significant gap in research on the d/Deaf community. This could be because of the difficulty accessing this population or researchers' lack of awareness on how d/Deaf patients are unique. The review of the literature highlights how people in the d/Deaf population do not have an adequate amount of resources in general, as well as mental health resources. Chapter II discusses the development of Deaf culture as a protective factor as well as various models of identity development underpinning how this training was created. Stigma and discrimination are explored and how these factors can influence treatment, particularly when the patient is d/Deaf, and the mental health provider is hearing. Current approaches to diversity and cultural competence training for providers is explored, which demonstrates the lack of diversity training focused on the d/Deaf population. Finally, the literature review identifies what potential intervention techniques could be appropriate.

Chapter III explains the theoretical models that provide a foundational understanding for the training. These theories include the psychosocial model, and Social Identity Theory. The rationale for the program addresses the barriers to care including historical stigma of d/Deaf individuals leading to d/Deaf patients being unwilling to trust hearing providers as well as a lack of appropriate training for providers.

This training covers a breadth of topics important to providing culturally competent care for the d/Deaf population. Topics include appropriate terminology, a brief history, theories of identity formation, basics of American Sign Language (ASL), information on Deaf culture, appropriate etiquette when interacting with a d/Deaf person, complying with the Americans with Disabilities Act (ADA), logistical concerns such as arranging an office and working with interpreters, current technology available to facilitate communication, prevalent mental health issues for this population, tips for interventions, and resources to get further information. The focus on breadth rather than depth for this training was made due to the lack of awareness on the various issues. Resources are provided so trainees can seek further information to increase depth of knowledge.

The results of this project include identifying higher rates of trauma, substance use disorders, and psychological distress for people in the d/Deaf community. Regarding the second research question, no formal diversity training program was found in the literature to address cultural competence for mental health providers working with d/Deaf patients. The third research question focused on what types of interventions would best address mental health concerns for the d/Deaf population. Results show there are no psychological interventions specifically designed for d/Deaf patients. Rather, there are ways mental health providers can adjust traditional interventions to facilitate d/Deaf patients' understanding. These adjustments include presenting information in a visual format including pictures or experiential formats. Also, taking into account the patient's language abilities whether English or ASL. This can help providers understand how best to convey concepts. An investigation into what type of training would benefit providers in working with this population, a training that includes information on stigma, Deaf culture, and provides accurate information about d/Deaf people's abilities would inform providers on accurate conceptualization and treatment plans. Finally, characteristics of an effective training on this topic would include didactic information, anticipate potential barriers for patients to access care as well as barriers providers might experience in being willing to see d/Deaf patients, an assessment of providers' biases, learning new skills, and having providers practice those skills. This training seeks to bridge the gap and build more connections between d/Deaf patients and mental health providers.

This training provides an introduction to d/Deaf mental health needs as well as an introduction to accurate information on the d/Deaf population in general. Strengths of the training include covering a wide breadth of topics, bringing awareness to the variety and heterogeneous nature of the d/Deaf community. Some limitations of this training include the inability to cover depth within the various topics, inability to cover the various subgroups within the d/Deaf community, and lack of information on how deafness can relate to a d/Deaf patient's other identities. As a result, this training alone is not sufficient to give mental health providers all of the knowledge they need to work with this population. However, more resources for further information are included and future research would benefit from additional training models and additional research focusing just on the d/Deaf population in order to bolster the program created here. Nevertheless, clinical implications of this project include more providers willing to serve this population, as well as improved quality of care for d/Deaf patients due to more educated providers.

I believe this project accomplishes its goals of increasing awareness of this population in general as for so long d/Deaf people have been ignored in society. This project serves to help show how valuable these people are and how unique their experience of the world is. Although there is much more work to be done to normalize access to care and improve the quality of that care, this project achieves an important milestone of being the first formal cultural competence training for this population. I am optimistic that the barriers between d/Deaf individuals and mental health providers can continue to dissipate, bringing the two together and facilitating healing.

References

Ali, A., Hassiotis, A., Strydom, A., & King, M. (2012). Self stigma in people with intellectual disabilities and courtesy stigma in family carers: A systematic review. *Research in Developmental Disabilities, 33,* 2122-2140.

Ali, A., King, M., Strydom, A., & Hassiotis, A. (2015). Self-reported stigma and symptoms of anxiety and depression in people with intellectual disabilities: Findings from a cross sectional study in England. *Journal of Affective Disorders, 187,* 224-231.

American sign language. Retrieved from: https://www.medicinenet.com/sign_language/article.htm

Americans with disabilities act of 1990, as amended. (2009). Retrieved from: https://www.ada.gov/pubs/adastatute08.htm#top

Anderson, M.L., Glickman, N.S., Mistler, L.A., & Gonzalez, M. (2016). Working therapeutically with deaf people recovering from trauma and addiction. *Journal of Psychiatric Rehabilitation, 39*(1), 27-32. doi: 10.1037/prj0000146

Brown, S. E. (2002). What is disability culture? *Disability Studies Quarterly, 22*(2). Retrieved from www.dsq-sds.org

Cobigo, V., Ouellette-Kuntz, H., Lysaght, R. & Martin, L. (2012). Shifting our conceptualization of social inclusion. *Stigma Research and Action, 2*(2). 75-84. doi: 10.5463/SRA.v1i1.10

Deaf websites. (2013). Retrieved from www.deafwebsites.com

Doe, T. (2014). The difficulty with Deafness discourse and disability culture. *Review of Disability Studies: An International Journal.* Retrieved from http://www.rds.hawaii.edu/ojs/index.php/journal/article/view/

Gilson, S.F., & Depoy, E. (2015). Disability, identity, and cultural diversity. *Review of Disability Studies: An International Journal, 1*(1). Retrieved from http://www.rds.hawaii.edu/ojs/index.php/journal/article/view/435

Glickman, N.S. (2013). *Deaf mental health care.* New York, NY: Routledge.

Goldston, D.B., Molock, S.D., Whitbeck, L.B., Murakami, J.L., Zayas, L.H., & Nagayama Hall, C. (2009). Cultural considerations in adolescent suicide prevention and psychosocial treatment. *Am Psychol, 63*(1). 14-31. doi:10.1037/0003-066X.63.1.14.

Hearing Loss Association of America. (n.d.) Types, Causes and Treatment. Retrieved from: www.hearingloss.org/hearing-help/hearing-loss-basics/types-causes-and-treatment/

Heller, T., Fisher, D., Marks, B., & Hseih, K. (2014). Interventions to promote health: Crossing networks of intellectual and developmental disabilities and aging. *Disability and Health Journal, 7,* S24-S32. 1-10.

Illinois Service Resource Center. (2011). Guidelines for psychological testing of deaf and hard of hearing students. Retrieved from: www.isrc.us/sites/default/files/pdf/psychguidelines2011.pdf

Ingham, B., Clarke, L., & James, I. A. (2008). Biopsychosocial case formulation for people with intellectual disabilities and mental health problems: A pilot study of a training workshop for direct care staff. *The British Journal of Developmental Disabilities, 54,* 41-54.

Kafle, N. P. (2011). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal, 11*(1). 181-200.

Kozak, A., Kersten, M., Schillmoller, Z., & Nienhaus, A. (2013). Psychosocial work-related predictors and consequences of personal burnout among staff working with people with intellectual disabilities. *Research in Developmental Disabilities, 34,* 102-115.

Kroese, B. S., Rose, J., Heer, K., & O'Brien, A. (2013). Mental health services for adults with intellectual disabilities – What do service users and staff think of them? *Journal of Applied Research in Intellectual Disabilities, 26,* 3-13.

Law, M., Hanna, S., Anaby, D., Kertoy, M., King, G., & Xu, L. (2014). Health-related quality of life of children with physical disabilities: A longitudinal study. *BMC Pediatrics, 14*(26),

Lovell, A., Bailey, J., Kingdon, A., & Gentile, D. (2014). Working with people with learning disabilities in varying degrees of security: Nurses' perceptions of competencies. *Journal of Advanced Nursing, 70,* 2041-2050.

Medicinenet. Retrieved from: https://www.medicinenet.com/sign_language/article.htm#what_is_american_sign_language

Munyi, C.W. (2012). Past and present perceptions towards disability: A historical perspective. *Disability Studies Quarterly, 32*(2). Retrieved from: http://dsq-sds.org/article/view/3197/3068

Name signs: naming custom in Deaf culture. (2019). Retrieved from: https://www.handspeak.com/culture/index.php?id=79

National Institute on Deafness and Other Communication Disorders. (2016). Quick statistics about hearing. Retrieved from: www.nidcd.nih.gov/health/statistics/quick-statistics-hearing

Nickels, L. C. (2016). The issue of "impairment": An analysis of diverging discourses used to represent the d/D/Deaf population in America. *Studies in the Linguistic Sciences: Illinois Working Papers* 1-19.

Nussbaum, D.B., & Clerc, L. (2003). American deaf culture. Retrieved from: https://www3.gallaudet.edu/clerc-center/info-to-go/deaf-culture/american-deaf-culture.html

Nussbaum, D.B., & Clerc, L. (2003). Cochlear implants: Navigating a forest of information. Retrieved from: www3.gallaudet.edu/clerc-center/info-to-go/cochlear-implants.html

O'Donnell, M. L., Varker, T., Holmes, A. C., Ellen, S., Wade, D., Creamer, M., Silove, D., McFarlane, A., Bryant, R. A., & Forbes, D. (2013). Disability after injury: The cumulative burden of physical and mental health. *Journal of Clinical Psychiatry, 74*(2). 137-143. *doi:10.4088/JCP.12m08011.*

Padden, C., & Humphries, T. (2005). *Inside deaf culture.* USA: Harvard University Press.

Patka, M., Keys, C. B., Henry, D. B., & McDonald, K. E. (2013). Attitudes of Pakistani community members and staff toward people with intellectual disability. *American Journal on Intellectual and Developmental Disabilities, 118,* 32-43.

The President and Fellows of Harvard College (2019). Deaf history timeline. Retrieved from: https://projects.iq.harvard.edu/asl/deaf-history-timeline

Reeve, D. (2006) 'Towards a psychology of disability: The emotional effects of living in a disabling society', in D. Goodley and R. Lawthom (eds) *Disability and Psychology: Critical Introductions and Reflections*, London: Palgrave, pp. 94-107.

Rights of deaf and hard of hearing people to accessible communication. (n.d.) Retrieved from: https://www.chicagohearingsociety.org/interpreter-services/information-for-deaf-customers/your-rights

Robey, K.L., Minihan, P.M., Long-Bellil, L.M., Earl Hahn, J., Reiss, J.G., & Eddey, G.E. (2013). Teaching health care students about disability within a cultural competency context. *Disability and Health Journal, 6.* 271-279.

Schild, S., Dalenberg, C.J. (2012). Trauma exposure and traumatic symptoms in deaf adults. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(1). 117-127. doi:10.1037/a0021578

Spencer, L.J., Tomblin, J.B., & Gantz, B.J. (2012). Growing up with a cochlear implant: Education, vocation, and affiliation. *Journal of Deaf Studies and Deaf Education, 17*(4). 483-498. doi:10.1093/d/Deafed/ens024

Stein, K. (2014). Experiences of college students with psychological disabilities: The impact of perceptions of faculty characteristics on academic achievement. *International Journal of Teaching and Learning in Higher Education, 26*(1). 55-65. Retrieved from: http://www.isetl.org/ijtlhe/

Tomasulo, D.J. (2014). Positive group psychotherapy modified for adults with intellectual disabilities. *Journal of Intellectual Disabilities,* 1-14. DOI: 10.1177/1744629514552153

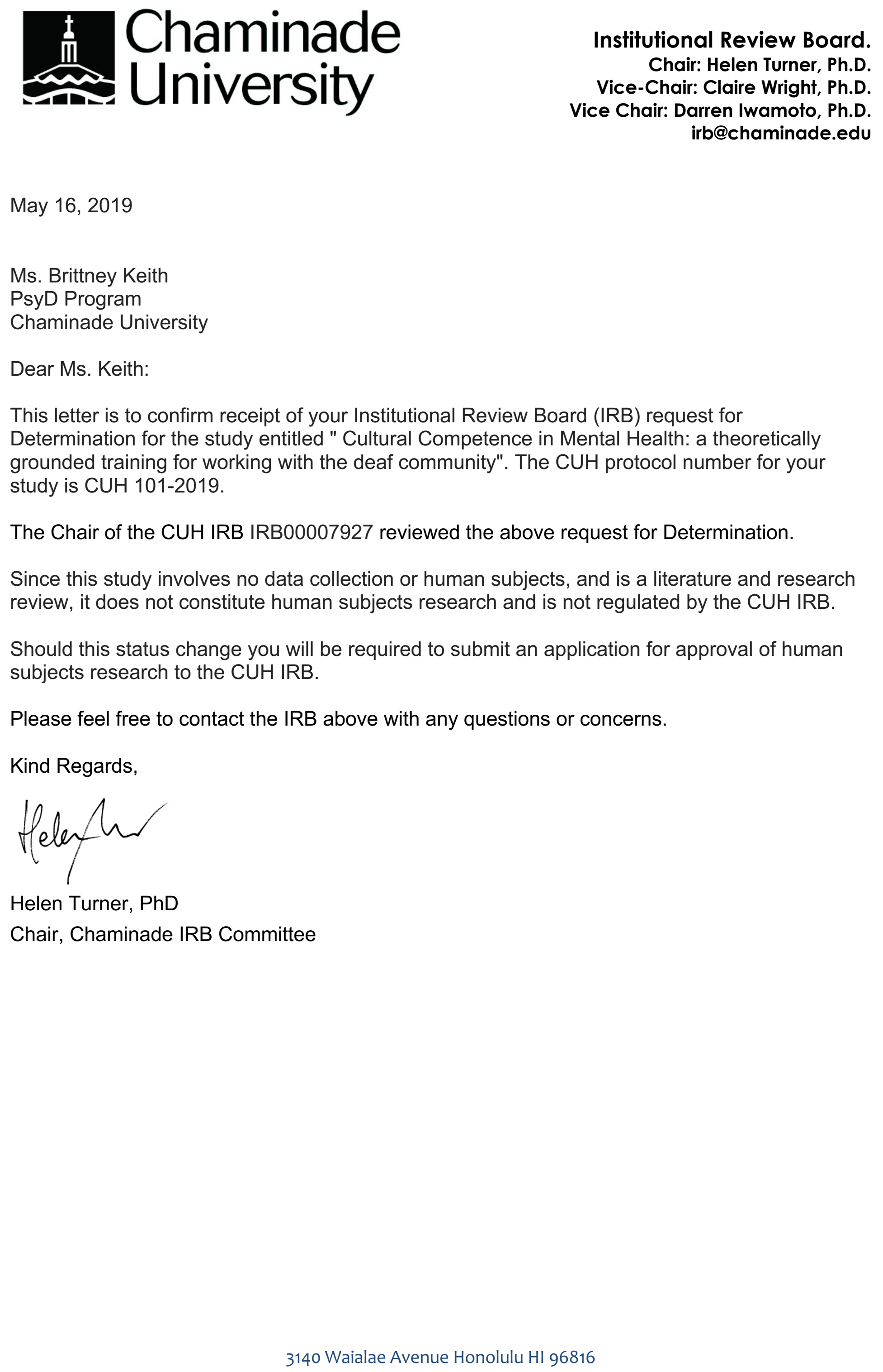
Ulloa, A. W. (2014). Social workers' cultural competency with deaf clients: A continuing education module. *Master's Theses.*

U.S. Department of Justice. (2009). A guide to disability rights laws. Retrieved from: https://www.ada.gov/cguide.htm

Zijlmans, L. J. M., Embregts, P. J. C. M., Bosman, A. M. T., & Willems, A. P. A. M. (2012). The relationship among attributions, emotions, and interpersonal styles of staff working with clients with intellectual disabilities and challenging behavior. *Research in Developmental Disabilities, 33,* 1484-1494.

APPENDICES

Appendix A:



Chaminade University

Institutional Review Board.
Chair: Helen Turner, Ph.D.
Vice-Chair: Claire Wright, Ph.D.
Vice Chair: Darren Iwamoto, Ph.D.
irb@chaminade.edu

May 16, 2019

Ms. Brittney Keith
PsyD Program
Chaminade University

Dear Ms. Keith:

This letter is to confirm receipt of your Institutional Review Board (IRB) request for Determination for the study entitled " Cultural Competence in Mental Health: a theoretically grounded training for working with the deaf community". The CUH protocol number for your study is CUH 101-2019.

The Chair of the CUH IRB IRB00007927 reviewed the above request for Determination.

Since this study involves no data collection or human subjects, and is a literature and research review, it does not constitute human subjects research and is not regulated by the CUH IRB.

Should this status change you will be required to submit an application for approval of human subjects research to the CUH IRB.

Please feel free to contact the IRB above with any questions or concerns.

Kind Regards,

Helen Turner, PhD
Chair, Chaminade IRB Committee

3140 Waialae Avenue Honolulu HI 96816

Appendix B:

Cultural Competence for Working with the d/Deaf Community

Participant Manual

By Brittney Keith, M.A.

User Guide

This document contains participant materials. The modules in this manual are not meant to be used individually. As cultural competance relies on both a breadth and depth of knowledge, the objectives of this workshop could not be attained without using the manual in its entirety.

Should you have any questions, please contact the author of this workshop, Brittney Keith, M.A..

Table of Contents

Workshop Objectives

- Increase self-reflexivity by evaluating your own biases about the d/Deaf community
- Become familiar with d/Deaf population basics including terminology, American Sign Language (ASL), Deaf culture, and cochlear implants
- Learn about relevant events in American Deaf history
- Become familiar with theories of identity development related to the d/Deaf population
- Learn about appropriate etiquette when interacting with a d/Deaf patient
- Learn how to maintain compliance with the Americans with Disabilities Act (ADA) when working with d/Deaf patients
- Increase awareness on considerations when using an ASL interpreter with a d/Deaf patient
- Learn about prevalent mental health concerns and useful interventions for the d/Deaf population
- Practice skills using case examples
- Become aware of current technology for d/Deaf patients and attain resources for further learning

Knowledge Check

1. Hearing aids restore hearing loss. **TRUE or FALSE**
2. Deaf people tend to be less intelligent than the general population. **TRUE or FALSE**
3. Deaf people can‘t listen to music. **TRUE or FALSE**
4. Deaf people don‘t talk. **TRUE or FALSE**
5. Reading lips is a preferred communication method for Deaf people. **TRUE or FALSE**
6. All hearing loss is the same. **TRUE or FALSE**
7. It is unsafe for Deaf people to drive. **TRUE or FALSE**
8. All Deaf people sign. **TRUE or FALSE**
9. All Deaf people use interpreters. **TRUE or FALSE**
10. All Deaf people lipread. **TRUE or FALSE**
11. Cochlear implants restore hearing. **TRUE or FALSE**
12. You must use simple English when talking to a Deaf person **TRUE or FALSE**
13. Most Deaf people have Deaf parents. **TRUE or FALSE**
14. All Deaf people can communicate with each other. **TRUE or FALSE**
15. Deaf people bring their own interpreters with them. **TRUE or FALSE**
16. Deafness is genetic. **TRUE or FALSE**
17. Sign language is universal. **TRUE or FALSE**
18. All Deaf people wish they were hearing. **TRUE or FALSE**
19. People with hearing loss can understand you better when you shout. **TRUE or FALSE**
20. All Deaf and hard of hearing people benefit from hearing devices. **TRUE or FALSE**

Assessing Biases

When growing up, what were you taught about Deafness?

What experiences did you have with people who have hearing loss?

How do you feel your life would be different if you could not hear?

How would your life be the same if you could not hear?

d/Deaf Population Basics

Appropriate Terminology

deaf: A person who is “lowercase d deaf” refers to a person who is audiologically deaf. They have hearing loss, but do not identify as part of Deaf culture. Deaf culture will be described in more depth later on in this manual. These people do not use a signed language as their primary method of communicating.

Deaf: A person who is “capital D Deaf” refers to a person who identifies with Deaf culture in terms of using signing as their preferred method of communication, adopting Deaf values such as viewing Deaf individuals as a cultural minority, and viewing deafness not as a disability.

Hard of hearing: Hearing loss in the mild to moderate range.
Congenital deafness: Hearing loss or deafness since birth.
Acquired deafness: Hearing loss or deafness occurs after birth.

Child of a Deaf adult (CODA): A hearing child born and raised by one or more d/Deaf parents or caregivers. CODAs typically serve as liaison between the Deaf world and the hearing world possibly as interpreters.

Deaf and dumb, deaf-mute, and hearing-impaired: These terms are typically considered offensive by those in the Deaf community. The connotations of these terms are that Deaf people are unintelligent, and experience deafness as a negative aspect of their lives. It is best to avoid using these terms even if your patient does not identify as a member of the Deaf culture community.

Rates of Deafness in the United States

- Approximately 0.3% of children in the United States are born with hearing loss in one or both ears at a detectable level.
- Over 90% of children with deafness are born to parents who are hearing.
- About 15% of adults in America aged 18 and over report some difficulty hearing.

The number of people who use a signed language including American Sign Language (ASL) as their primary way of communicating are less than half of the 0.3% of functionally deaf people in America.

Aspects of Hearing Loss to Assess

Not all Deafness is the same. Various causes of hearing loss can manifest differently. Classification of degrees of hearing loss typically include mild, moderate, severe, and profound.

Types of hearing loss:

The first type of hearing loss is conductive. Conductive hearing loss is caused by problems within the inner portions of the ear. These problems could include a malformation within these structures, fluid buildup in the middle ear, an ear infection, allergies, a perforated eardrum, benign tumors, impacted earwax, foreign objects in the ear, and otosclerosis. Permanent hearing loss may not always occur as a result of some of these problems. However, for problems such as malformations or tumors, surgery is typically required. For others, use of a hearing aid may be necessary.

The second type of hearing loss is sensorineural. Sensorineural hearing loss (SNHL) is caused by problems in the inner ear. This type of hearing loss may be caused by disease, injuries, or exposure to noise. Treatment for SNHL varies based on the cause of the hearing loss. Treatment can include medication to alleviate inflammation, use of hearing aids, or surgical procedures including installing cochlear implants.

Mixed hearing loss can also occur. This refers to a combination of damage to multiple parts of the ear or auditory nerve. Treatment of mixed hearing loss includes focusing on the conductive damage first.

Heterogeneity of the d/Deaf population

There is extensive heterogeneity among the d/Deaf population. Given that most d/Deaf individuals are born to hearing parents, they are also likely to have hearing members of their families. They may or may not have other d/Deaf family members. In many cases, d/Deaf children are raised with limited abilities to communicate such as when parents do not choose to learn American Sign Language (ASL). Parents may also not expose their d/Deaf children to learning ASL or be around other d/Deaf individuals. Notably, the number of families who are capable of communicating with a d/Deaf family member through sign language is fewer than 10%. This may seem surprising, but it is more common for families with hearing parents and a d/Deaf child to develop *home signs*. Home signs refer to unique signs developed between the family and the child to facilitate their communication. Therefore, each household has their own home signs. When families use home signs to communicate, families may only develop signs to facilitate necessary communication. This could include signs for necessities including food, water, and grooming and hygiene. Families may not, though, make the effort to communicate with their d/Deaf child in terms of socializing and fostering their character development.

Deaf History

This list is not an exhaustive account of Deaf historical events, but rather highlights of important events in history for Deafness in the United States.

1760: Charles Michel de L'Eppe, a French priest, created the first public school for the deaf. The school employed a system using signs.

1817: First school for the deaf in America was founded in Hartford, Connecticut by Thomas Gallaudet and Laurent Clerc. This fostered the development of American Sign Language (ASL).

1864: Gallaudet University was founded. This university remains the only university created and designed to serve students who are d/Deaf and/or hard-of-hearing.

1872: Alexander Graham Bell founded his own school for the deaf based on his strong belief in oralism. Oralism is the belief that deaf people need to learn speech in order to integrate into society.

1880: Deaf educators gathered at an international congress meeting. Congress members endorsed oralism and passed a law, which banned sign language in schools.

1890: The National Association of the Deaf was founded. This organization promotes civil rights for deaf people in the United States.

1973: Rehabilitation Act was passed into federal law. This act outlaws discrimination of people based on disability status including Federally funded agencies and programs.

1975: Law PL 94-142 was passed into law. This law enabled children with disabilities, including deaf children to attend public schools.

1990: The Americans with Disabilities Act was passed into federal law. This law remains the standard ensuring people with disabilities do not face discrimination in America.

Theories of Identity Development

Theories of identity development provide a framework to understand how d/Deaf patients come to conceptualize their deafness as well as how their deafness may or may not be a part of their identity.

Psychosocial Model of Identity Formation

Understanding identity formation from a psychosocial perspective involves exploring group dynamics such as how stigma, prejudice, discrimination, and language affect identification with a group. d/Deaf discourse includes concepts of stigma, language, and prejudice. Examples include identification as deaf compared to Deaf. Those who identify with Deaf culture can attribute negative connotations to people who do NOT subscribe to Deaf culture. Use of American Sign Language (ASL) for communication among those who identify as Deaf can be a method of exerting in-group and out-group dynamics. Notably, historical perception by hearing society to not accept d/Deaf individuals and rather view them as an outsider illustrates how prejudice can actually make membership in Deaf culture more desirable. Deaf people have used the stigma and prejudice they've experienced as a source of strength to unite. These psychosocial concepts can interact in a variety of ways to construct a person's identity.

Social Identity Theory

Social Identity Theory asserts that minorities cope with a stigmatized identity in one of two ways. They may assimilate by incorporating the majority culture's values, thereby separating themselves from the disability population, or they may embrace their disability status and incorporate the disability population's values and norms. Adopting and embracing a disability identity may serve as a psychological support system by instilling a sense of pride and self-acceptance (Bogart, 2015). Mental health professionals need to note that multiple identities are possible and can be a protective factor from distress such as depression and anxiety. It is important to investigate these identity issues with the client and look into how the various facets of the person with disability's identity affects their overall social support network as well.

Reconciling and Incorporating Multiple Layers of Identity

The way that people with a disability perceives and interprets the behaviors of others could be very different based not only on the type and severity of disability that they have, but the interaction of all the other aspects of their background. This could include ethnicity, identity, community connectedness, life satisfaction, psychological well-being, and experiences within society up until that point. The dynamic and complex nature of this topic indicates the necessity for more understanding by people who have disabilities, people around someone with a disability, as well as the mental health professionals who are attempting to help everyone involved.

For people with d/Deafness, choosing to make their d/Deafness visible to others may occur in the form of wearing hearing aids in public or using American Sign Language (ASL) to communicate rather than using verbal expression. People who are not comfortable making their d/Deafness visible to others may choose to use lip reading and speech while in public in order to avoid bringing attention to themselves. Due to the multitude of layers involved in a person's identity, mental health providers should be mindful of asking about all the various factors in order to understand the patient better.

American Sign Language (ASL) Basics

American Sign Language (ASL) is a complex language that uses signs made with a person's hands as well as body posture and facial expressions. ASL has a distinct grammatical structure from the English language.

ASL is one of various communication options that d/Deaf people use. Some individuals and families choose to use ASL exclusively, some use a mix of ASL and English spoken word, and some use English spoken word only. Due to this variability in communication styles used by d/Deaf people, not all d/Deaf people are able to communicate with each other. In clinical practice, it is important to ask about the communication style your patient uses as well as the communication style those around them use.

ASL is not a universal language for d/Deaf people worldwide. Rather, different countries have their own sign language such as Japanese Sign Language (JSL) or British Sign Language (BSL). It is believed that French Sign Language (FSL) influenced the development of ASL when Laurent Clerc, a teacher from France, founded the first school for deaf students.

ASL language acquisition can vary greatly among d/Deaf people. Since most d/Deaf children are born to hearing parents, their parents may not know or use ASL. If hearing parents do choose to learn ASL they tend to learn the language at the same time their children do. Exposing d/Deaf children holds just as much importance as exposing any child to language as early developmentally as possible. If they are not exposed to communication during critical periods of development, it can make acquiring language and becoming proficient in a language more challenging.

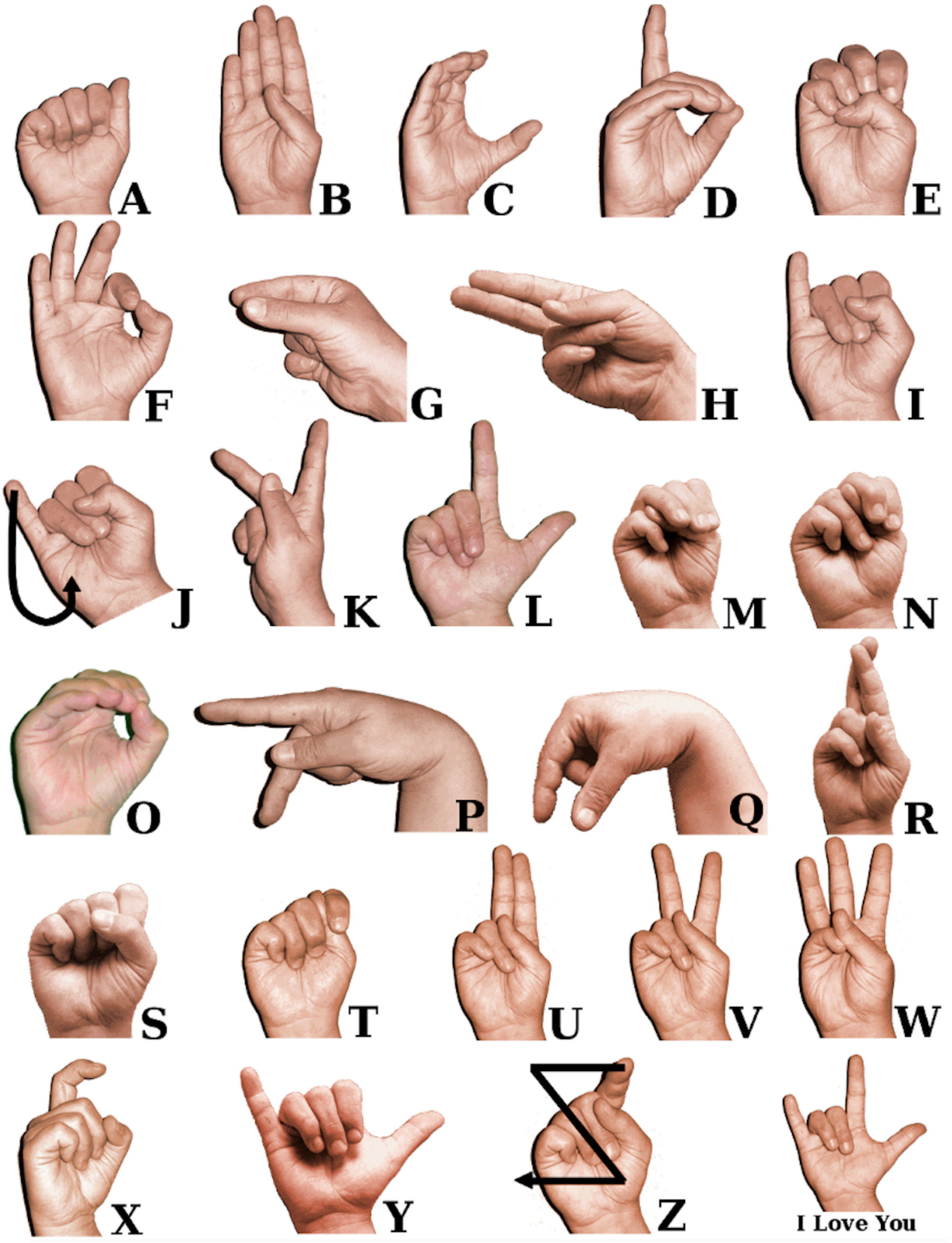
In the past there have been misconceptions that people who do not use a spoken language are less intelligent. In recent years that myth has become less pervasive. Rather, studies have shown that people who use ASL are capable of processing visual information faster than English speaking individuals. This may be because they rely on processing visual information more consistently and have a higher need to process such information accurately.

Name signs are a unique concept found in ASL. They are distinct from a person's written name. A name sign is one sign representative of a person's name rather than using fingerspelling. Attaining a name sign involves a member of the Deaf community giving a name sign to a non-native Deaf person. When a member of the Deaf community gives someone a name sign, it is considered a gift. A name sign is reminiscent of the Native American tradition of giving names to honored outsiders. Since receiving a name sign is an honor, it is inappropriate for non-native signers to create their own name sign. Rather, it is appropriate to fingerspell your name.

Name signs may be changed once in a person's life, but many times once it is given it is used throughout that person's life. There are guidelines to creating a name sign, which is another reason why a non-native signer creating their own can be problematic. There are two types of name signs. Initialized name signs use the hand shape for the first letter of a person's name as part of the name sign. Descriptive name signs, however, incorporate a unique characteristic of the person. Characteristics could include aspects of physical appearance, related to their employment, habits of body movement, personal habits or quirks, a similar sound or meaning of a person's name, or any other distinct characteristic. In some cases, signers prefer not to use a name sign, usually when their names are short. The signer would instead fingerspell their name.

On the next page is a picture of the ASL fingerspelling alphabet. Familiarity with signing the ASL alphabet can help you understand what it can feel like to use your hands for communication. An important consideration though is that it is not tactful to try and fingerspell sentences. It would be as if someone tried to introduce themselves to you by saying "M-Y N-A-M-E I-S." Although the good intention to communicate in the patient's preferred mode of communication is there, in practice it is awkward and uncomfortable for both you and the patient. Instead searching online and using phone apps listed at the end of this manual can assist you in learning basic greetings to use with your patients rather than relying solely on fingerspelling.

ASL Basics: Alphabet



Deaf Culture

Deaf culture has developed as a unique community with American Sign Language (ASL) serving as the foundational element. Notably, people who are hard of hearing or are d/Deaf are not necessarily part of D/Deaf culture. Rather, identifying as a member of the Deaf community is a conscious choice. A person makes this decision as evidenced by using ASL as their primary means of communication, adopting Deaf values including viewing deafness as a difference not a disability, and spending time with other Deaf individuals including Deaf community events. An appropriate analogy for people who do not identify as Deaf may be the example of someone who has the racial background of one ethnic group but is not familiar or chooses not to practice any of that culture's customs. People in Deaf culture have immense pride and love for the people in that community and all that their culture entails.

The most important aspect of Deaf culture is that **Deaf people do not consider themselves disabled and do not want society to see them as disabled.** Deaf culture provides an overall sense of belonging and identity. Deaf people seek to **change the way society views their community from that of a disability community to that of a minority culture**. They feel that the issue is not disability, but instead about values. This is an important distinction to understand the way that people in Deaf culture view the world and themselves. Deaf individuals feel a deep sense of pride regarding their cultural identity and sometimes feel that associating with disability takes away from Deaf culture. In this way Deaf people seek to distance themselves from people with other conditions considered to be disabilities.

However, the challenge the Deaf community faces, is that if they are considered a minority group instead of a type of disability, Deaf individuals would no longer be entitled to protection under the Americans with Disabilities Act and other legislation referring to rights of people with disabilities. This realization could lead to psychological consequences such as anxiety, sadness and frustration, thereby fueling a dilemma and conflict within Deaf people. Do they assert their identity as the minority culture they identify as and as a result forego the services that they also believe they have a right to? This conflict can further contribute to anxiety and depression symptoms for Deaf patients.

Important facets of Deaf culture include:

- Promoting a society where vision is the predominant sense used in order to communicate in a variety of settings. This is important because vision is the sense that provides Deaf people access and independence in society.
- Fostering the growth and development of deaf children as the future of Deaf culture.
- Perpetuating and promoting use of ASL as well as other communication methods.
- Advocating for bilingual education of children with deafness so they are competent in ASL and English.
- Adherence to social norms of communication specifically for Deaf conversations. These include visual attending to the speaker through maintaining eye contact (not looking away). Also important is that the person signing has the metaphorical “right of way” to speak until they exhibit a visual cue that they are done.
- Preserving and maintaining Deaf culture through various cultural traditions. These include movies, writings, sports, events, performance, and community gatherings.
- Using appropriate cues for garnering someone’s attention. Appropriate behavior is tapping the person on the shoulder if they are not within sight range, waving if the

person is in sight range, or in the case of large groups of people turning a light switch on and off.

d/Deaf Etiquette

It can be confusing and intimidating interacting with someone from a different culture for the first time. It can be even more confusing when their communication method is not a spoken language, as most providers are used to. These are some helpful tips for how to appropriately interact with someone who is d/Deaf and use American Sign Language (ASL) to communicate.

1. Treat the d/Deaf individual with respect.

   This may seem obvious, but due to long-term historical stigma originating from the *deaf and dumb* label, you may find yourself assuming that a d/Deaf individual does not engage in the same activities as you do. That they may not be capable of living as full a life as a hearing person. Rather, when you begin communicating you likely will realize you both have a lot in common.

2. Many d/Deaf individuals prefer no extra accommodations than an interpreter.

   There is no need to go out of your way in public to make the d/Deaf person feel comfortable. Rather, that can cause them to feel uncomfortable. Speaking to a d/Deaf person as you would any other person is most appropriate.

3. Garner their attention in an appropriate way.

   Giving a shorthand wave in their range of vision or a tap on the shoulder is sufficient when trying to get a d/Deaf person's attention. It is not necessary to make exaggerated movements. d/Deaf people understand that others need to get their attention visually before starting a conversation.

4. When the d/Deaf person you're interacting with is using lip-reading, enunciate clearly and at a normal pace.

   Although not all d/Deaf people rely on lip-reading for communication, some do. When speaking to someone who is doing lip-reading, speak clearly. It is also important to speak at a normal pace. Sometimes hearing people have an unconscious tendency to speak slower when communicating with a d/Deaf person. This could be coming from an intention to make communication easier, however, speaking at a slower rate can distort your mouth and make it more difficult for the d/Deaf person to understand you. Ensure there are no obstructions between your mouth at the person you are talking to. Make sure the d/Deaf person has a clear view of you when you speak, and don't wear anything that covers your mouth such as a mask. Even when taking these steps to communicate clearly, less than half of words are able to be understood through lipreading without amplification. Follow the d/Deaf person's lead on what they need to help communicate clearly.

5. Speak at a normal volume.

   This may also seem intuitive. However, when interacting with a d/Deaf or hard-of-hearing person, it can be tempting whether consciously or unconsciously to begin speaking at a higher volume. You may even find yourself yelling. As much as we would like to think this is helpful, speaking loudly can distort our mouths. This can make lip-reading difficult. Also, when an interpreter is present, it can make interpreting challenging because the interpreter is trying to focus on interpreting. Too much auditory stimulation can make interpreting significantly more difficult. Also, if the d/Deaf person you are speaking to is using a hearing aid, do not assume speaking at a higher volume is more helpful. The purpose of a hearing aid is to increase volume of sound, but they may not assist with clarity. Speak at a normal volume unless the d/Deaf person asks you to speak louder.

Complying with the Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) is civil rights legislation passed in 1990. ADA focuses on ensuring people with disabilities have equal opportunities in all aspects of life. The law covers employment, purchasing goods and services, and participating in government programs.

The ADA defines a disability as an impairment, whether physical or mental, that a physical or mental impairment that substantially restricts at least one life activity, is known to have a history of impairment, or is perceived to have a limitation of that nature. Although members of the Deaf community do not perceive their deafness as a disability, they must still legally qualify their deafness in that context in order to receive accommodations.

Title III of the ADA refers to equal access to public places. For d/Deaf and hard-of-hearing people, this means businesses must remove communication barriers. This includes willingness to provide appropriate aids and services when necessary. These aids include quality interpreters, notetakers, computer transcription services, written materials, assistive listening devices, telephones compatible with hearing aids, closed caption decoders, captioning, a TTY machine, and a method of translating auditory information available to d/Deaf or hard-of-hearing people. Qualified interpreters are defined as someone capable of interpreting effectively, with appropriate accuracy, and impartiality.

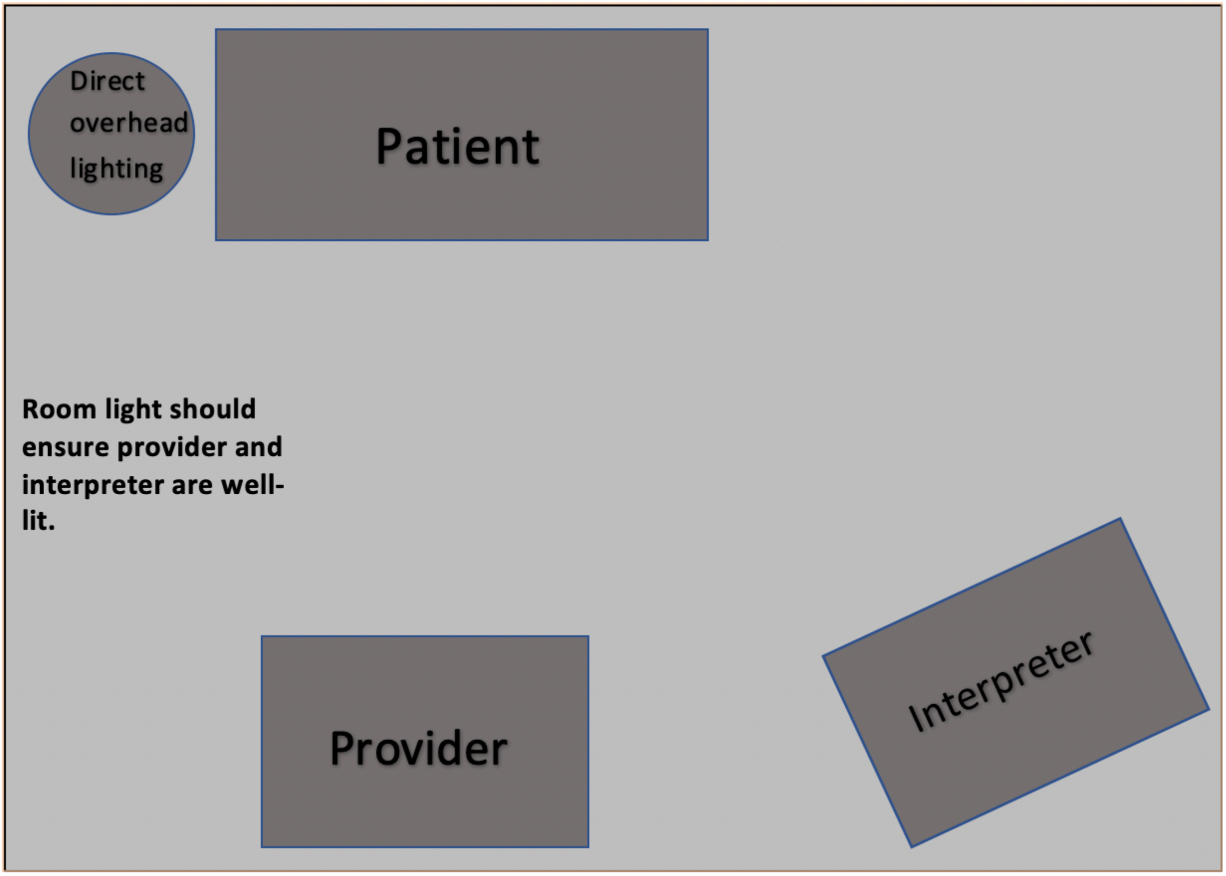
In order to discern what accommodations and aids your Deaf patient may require, consult with them on intake. Consider that in order to achieve effective communication, it may be important to rearrange furniture or lighting to facilitate easy view of the interpreter for the d/Deaf patient. Also ensure there is minimal noise so that the interpreter is able to clearly hear you as the provider. If your d/Deaf patient requires use of a TTY machine, not only ensure that a machine is available, but train any employees how to use it. Also address any policies that may not fulfill requirements of effective communication.

In some cases, a business may deny providing an auxiliary aid unless they can provide evidence that the aid would change the essence of the service provided or cause to fundamentally change the nature of the service, or would constitute an excessive burden. When this occurs, though, the business must also be able to provide an alternate aid. Excessive burden refers to the financial burden only. This means you may still be required to provide aids to your d/Deaf patient even if your income from that patient is less than that of another patient, provided that aid did not cause undue burden on the business as a whole.

Regarding who pays for accommodations under the ADA, the d/Deaf person is NOT responsible for paying for their aids and accommodations. Title III states, providers are not able to force patients who have a disability to pay for the cost of communication aids. Businesses that pay for the costs of interpreters and other aids are entitled to an income tax credit in addition to typical business-related deductions on expenses. The IRS has various specifications regarding limits on tax credits. The IRS can be reached directly at 800-829-1040 (voice) and 800-829-4059 (TTY) for further inquiry on tax credit limits.

It can be initially intimidating when working with a d/Deaf patient and trying to ensure compliance with the ADA. However, it is typical that your patient has had experience working with other providers to ensure they receive appropriate accommodations. They will likely know exactly what equipment they will require for communication. Do not feel concerned about asking clarifying questions regarding the aids they are requesting. Often taking the time to invest in your patient's comfort and access to your business can speak volumes for building rapport and getting therapy started on the right foot.

Office Arrangement with a d/Deaf Patient



Above is a suggested office furniture arrangement when working with a d/Deaf patient. The two most important aspects to consider is seat placing and lighting. Place the furniture such that the interpreter and patient are in comfortable view of each other. Having the patient and interpreter seated next to each other would be very uncomfortable as they both would need to turn their bodies sideways to sign. Lighting should properly illuminate the room through direct overhead lighting. This arrangement is the most appropriate so that the d/Deaf patient and interpreter do not strain their eyes when signing. The placement of the door does not have to be taken into consideration when working with a d/Deaf patient.

Working with Interpreters

Working with an ASL interpreter is a likely occurrence when working with the d/Deaf population. Included here are some important considerations when providing mental health services to a d/Deaf patient while using an ASL interpreter.

1. Not all interpreters are trained to the same extent.

   Registry of Interpreters for the Deaf (RID) currently provide the standards as well as certification system for ASL interpreters. Interpreters certified through RID learn about ethics and professionalism as well as standard interpreting of language. However, not all interpreters are certified. Particularly when working in rural areas, ASL interpreters may be limited. Therefore, you may be forced to use an un-certified interpreter. Regardless of interpreter certification, providers should ask the interpreter if they have been trained or have experience interpreting in a mental health setting. Due to the specialized terminology used in the mental health field, encourage your interpreter to ask you for clarification on terminology rather than interpreting based on their assumption of the terms used.

2. Limits of Confidentiality

   Although certified interpreters are educated on confidentiality, as mentioned before, not all interpreters are certified. Also, even if your ASL interpreter is certified, it is important to review confidentiality with both the patient and interpreter to ensure that everyone is in understanding. This can also provide the patient more peace-of-mind that both the interpreter and their mental health provider take their right to privacy seriously. This is particularly important given the close-knit nature of the d/Deaf community. It could be highly likely that the interpreter present also does work interpreting for the patient's family and friends. Also considering the personal nature of topics being discussed in a mental health session, it is crucial to highlight limits of confidentiality with both patient and interpreter.

3. d/Deaf individuals may have interpreters they do and do not want to work with

   The Deaf community, and particularly the ASL interpreters who work in an area, can be small. As a result, it is typical for interpreters to work with d/Deaf individuals repeatedly over the years. It is common for d/Deaf individuals to be familiar with the interpreter that gets assigned to your session together. d/Deaf individuals often times have a preference of interpreters they enjoy and prefer working with, and other interpreters who they dislike working with for various reasons. It is important to clarify at the intake session if the interpreter provided is someone they feel comfortable working with. If not, ask the patient if they have another interpreter they know of that they would prefer. At future sessions when requesting interpreting services, request the specific interpreter to ensure continuity. If possible, it is most beneficial to use the same interpreter at all sessions to limit the number of people the patient must discuss symptoms in front of. This can contribute to a more comfortable atmosphere for the patient, so they feel able to share openly.

4. Speak facing the d/Deaf individual, not the interpreter

   Since the d/Deaf person is the one you are communicating with, it is rude to instead look and speak to the interpreter. This can cause the d/Deaf person to feel dismissed and disrespected. For a hearing person, this would be as if you were talking to someone while turned away from them.

5. Interpreters can also be d/Deaf or hard of hearing

Many people who choose to become ASL interpreters do so because they have a connection to the Deaf community. As discussed in the technology section of this manual, current technology allows some people born d/Deaf or hard of hearing to hear depending on type and severity of hearing loss. Therefore, it is possible for an interpreter to also be d/Deaf or hard of hearing. Interpreters who are d/Deaf or hard of hearing may take a few extra seconds to interpret. This can be because the interpreter may need to look directly at the provider in order to properly hear the information. They then will turn to the patient and sign. If you observe the interpreter taking the time to visually attend to you before signing to the patient, ensure you speak at a normal volume and enunciate. Also remember to pause after speaking a few sentences so that the interpreter is able to convey your message in entirety. If you do not take appropriate breaks it can be difficult for the interpreter to recall all pieces of what you say. This can be particularly important if the interpreter is less familiar with mental health terms and concepts. It can be helpful to ask the interpreter, regardless if they are hearing or not, if they have any preferences that would assist them in interpreting most effectively.

6. Interpreting Style

Each interpreter has their own interpreting style. Some interpreters interpret in a more formal style. This can include using formal terminology. ASL, like any language, also includes colloquial terms, slang terms, and informal signs. Some interpreters use more colloquial signing techniques in order to save time to convey concepts. In Hawai’i, interpreters may or may not feel competent in interpreting pidgin terms. It can take a few sessions for both you and the patient to become familiar with the interpreter's style. That is another advantage to retaining the same interpreter, as when a new interpreter is used it can be challenging to adapt quickly to a new style. It is appropriate whenever necessary to ask the interpreter if you are unsure that they understand certain concepts or terms. You can also let the patient know that you intend to check in with the interpreter to ensure proper communication. This way, you are still including the patient in the discussion, and also conveying to the patient that you have their best interest in mind by ensuring clear communication.

7. Speech and Turn-taking

   Based on the communication style of both the d/Deaf patient and interpreter, the pace of speech and turn-taking can vary. If your patient communicates with both ASL and speech, they may prefer to express themselves in spoken word. Also, the interpreter may have learned ASL as their first language. Their spoken translation of what the patient is saying may have a mix of ASL and English grammar. Due to the various possibilities in communication methods, it may take a few sessions to become comfortable with the flow of conversation.

8. Scheduling an ASL interpreter

   Based on the insurance that your patient has, you may need to work with their insurance company to coordinate scheduling for the ASL interpreter. Each insurance company has varying policies on how the logistics of scheduling take place. Your clinic or site may also have their own policies and paperwork for scheduling. Or your patient may prefer to schedule their own interpreter. Interpreters are typically paid for their travel to and from an appointment in addition to the time spent in the appointment. If you work in a rural area, which requires significant travel arrangements, you may need to put in a travel request. Do research to discern how long these arrangements take to submit, and plan accordingly. Also, the interpreter may bring to session with them paperwork for you to sign, confirming they were present. At the intake session, be sure to reserve time to clarify with the patient and interpreter together how scheduling and logistics will be handled.

Cochlear Implants

A cochlear implant is an implanted device designed to enable d/Deaf individuals to hear. Cochlear implants are made up of a portion that is surgically implanted as well as a portion that is worn externally. There are currently four commonly used manufacturers in the United States.

The way a cochlear implant works includes first the microphone identifies the sound. The sound goes to the speech processor, one of the external components of the cochlear implant. The speech processor turns the sound into an electrical format. The electrical signal then goes to the transmitting coil. The signal moves across the skin from the transmitting coil to the receiver, an internal component, through a radio signal. The receiver transports the electrical signal to electrodes within the implant. Finally, the electrodes use the auditory nerve to carry the signal to the brain.

Data from December 2012 show around 324,000 implants have been used worldwide. In the United States, however, approximately 58,000 devices are used by adults and 38,000 for children.

For those who receive cochlear implants as children, most are between 2-6 years of age. Getting a cochlear implant includes a rigorous process. Criteria includes the type of hearing loss and level of hearing the child has, although cochlear implants are typically done on individuals with sensorineural hearing loss. Assessing candidacy typically includes an interdisciplinary team, which includes the family and professionals involved in the child's life. The family should taper their expectations, though, because even though a cochlear implant is installed does not mean the recipient will be able to benefit from it.

Current requirements for candidacy include:

- **Age:** The recommended age is currently 12 months; however, this is not a requirement. Hospitals sometimes do the procedure on children younger than 12 months, hoping for better outcomes by implanting the device earlier. Notably, insurance companies will typically pay based on FDA recommendations so if families choose to do the procedure prior to 12 months it could be challenging to receive insurance coverage. Children who have not had success with developing spoken language through use of hearing aids can also be good candidates for a cochlear implant.
- **Hearing Aid History:** Implant centers can have different requirements for using hearing aids. For example, some clinics require evidence that a child has tried using a hearing aid and will have better success with a cochlear implant.
- **Family involvement:** Whether or not the family is able and willing to follow up with appointments after implantation including appointments to test and adjust the device can be a factor in candidacy.
- **Medical comorbidities:** The child should not have any medical contraindications.
- **Home environment:** The environment at home should be one that supports maintaining the cochlear implant including use of spoken language.

- **Biological:** Children who do not have an auditory nerve in their brain would not be candidates because then there is no biological way for sound to get from the cochlea to the other parts of the brain for processing.
- **Type of hearing loss:** Children who have unilateral hearing loss or conductive hearing loss would not be candidates because the device would not be able to correct that type of hearing loss.
- **Access to hearing aid technology:** Children who are able to hear sound through technologically advanced hearing aids may not be a candidate because these hearing aids can provide just as effective outcomes without surgery.
- **Child characteristics:** Some clinics will withhold implanting a device when the child exhibits behavioral, emotional, or cognitive delays. This is due to the possibility that the child would not be able to use the device effectively.
- **Consistent hearing aid use:** In the case of older children and teens who have congenital hearing loss, but have not consistently used hearing aids, they may not be candidates. This is because using hearing aids consistently stimulates the auditory pathways in the brain. Without consistent use the brain can reorganize and if a cochlear implant occurs the brain may no longer be able to understand the incoming signals.

Performance Outcomes:

When a cochlear implant is done, that does not mean that the moment when the device is turned on the child or individual can suddenly hear a full range of sound and be able to interact with the hearing world. Rather, there can be large variations in terms of what type of sounds a person can hear with the device and whether the person can comprehend those sounds. The person must then learn and practice skills in order to make sense of the sounds as well as learn to communicate through sound. Each person is different in terms of their ability to learn these skills. Some are able to learn more quickly and are able to achieve higher levels of skills, while others may learn some skills and not progress further.

The best outcomes tend to be related to younger age of implantation. This is because language acquisition occurs at a young age. Individuals tend to have a more successful transition to spoken language if they had early exposure to language including ASL because their brain is already accustomed to language acquisition. If the individual had already acquired language prior to hearing loss and/or have had success with a hearing aid prior to implantation, they are more likely to achieve positive outcomes from a cochlear implant.

The skill development process people must go through when they receive a cochlear implant and are working towards comprehending and expressing themselves through spoken language.

Receptive listening begins with being able to detect sound in general. Next, the person learns to discern differences in sounds, then comprehend sounds in the environment. The person then works on understanding one word at a time or phrases, using lipreading to assist in comprehending the sounds. Next, the person works on understanding words and phrases without lipreading. The next step is understanding sentences, and then finally understanding conversations.

Expressive language starts with using voice to communicate, first by generating appropriate patterns of speech. Next the person imitates syllables, words, short phrases, and then speaking sentences with details. Finally, the person learns to speak in conversations.

As noted earlier, not everyone who receives a cochlear implant progresses through all the steps of receptive and expressive language development. Each individual has individualized outcomes.

Cost of a Cochlear Implant:

The cost can range from $50,000 to $100,000. The amount covered by insurance varies based on insurance company. If your patient is considering getting a cochlear implant for themselves or a child, advise them to contact their insurance company and find out exactly what procedures will be covered prior to beginning the cochlear implant process.

The Debate:

It may seem like all Deaf people would yearn to get a cochlear implant for them and their family members to be able to use spoken language. However, within the Deaf culture community, a debate rages about cochlear implants. People who identify with Deaf culture, as stated in the earlier section on Deaf culture, do not view deafness as something to be fixed. Deaf people can sometimes view getting a cochlear implant as departing from Deaf culture values. They can feel that giving a child a cochlear implant is a loss for the Deaf community and that it forces Deaf people yet again to take extra steps to fit in to hearing society. This is because typically children who receive cochlear implants do not learn ASL, thereby further separating them from Deaf culture. When these children grow up, though, they may not have had a choice or understood the implications of having an implant. Parents of Deaf children, though, sometimes view that not getting their child a cochlear implant is child neglect.

Although the official stance of the National Association of the Deaf is inclusion for all Deaf people regardless of whether they have a cochlear implant or not, the experiences of Deaf people may vary in terms of the discrimination they may experience from members of the Deaf community. Having a discussion about the topic can be insightful in terms of understanding your patient's conceptualization of their place within the Deaf community and how their personal views may align or be separate from the Deaf community's opinions.

Summary of considerations about the cochlear implantation process:

- **Outcomes are individualized.** Advise your patients to do research and have realistic expectations.
- **Cost can vary** and can sometimes be high depending on how much insurance coverage is allowed. For patients who come from a low-income background, this can be a large factor in deciding whether or not to go through cochlear implantation.
- **Travel expense.** Implantations are only done at certain hospitals. For patients living in rural areas travel can be a barrier considering that the patients must attend numerous appointments after the device is implanted.
- **Time expense.** Likewise, taking time off from work to attend appointments can be a barrier. This can also contribute to financial burden as time off from work can result in less income.

- **Deaf culture identity.** It is likely that your Deaf patient has strong opinions about cochlear implants. As this can be a divisive topic among Deaf family members and friends, it is valuable to ask your patient their perspective on it. Asking whether they received an implant can also give you information on their language acquisition and development during childhood.

Current Technology for Communication: Assistive Technology

There are a variety of assistive technologies available to assist people with d/Deafness and who are hard of hearing to communicate with others. These types of technologies are commonly referred to as Hearing Assistive Technologies (HATS). Some devices work by translating information to a visual form, and others augment auditory information. These devices can be used by people of all ages and in numerous settings such as at home, work, school, at recreational events, in medical settings, at court, and more.

According to law, all telephone companies must have a relay service for phone communication. Toll-free numbers connect callers to a confidential operator. This can be particularly helpful for providers and d/Deaf patients who do not share communication styles. With video phone calling, a provider can call a d/Deaf patient, and they are automatically connected to a certified ASL interpreter. The ASL interpreter is at the same time connected to the d/Deaf patient's video phone. The provider then speaks into the phone as usual, the interpreter conveys the information to the patient, and vice versa. If the patient does not answer the phone, the provider can also leave a voicemail through the interpreter. The other assistive technologies listed below can further facilitate communication between d/Deaf individuals and others.

Technology for Visual Communication

1. **Alerting devices.** These devices produce a visual or vibrating notification to people instead of a typically auditory alert. Commonly used alerting devices include specially created alarm clocks, doorbells, baby monitors, timers, and smoke detectors. Some of these devices work independently from other devices, while some work by connecting to

other devices. These devices can be used by d/Deaf or hard of hearing people in their homes for safety and can be purchased online for a variety of settings.

2. **Captioning.** Captioning refers to a written transcription of auditory information. Captioning is most typically discussed in relation to media. All television sets are equipped with a closed captioning setting for programs that include captioning. Other media devices include closed captioning, labeling programs with "cc" to symbolize closed captioning is available. Notably, some movie theaters offer captioning for specific movie dates and times.
3. **Real-time Transcription.** Software such as Communication Access Real-time Translation (CART), C-Print, and Typewell, convert auditory information to text in real time. The former program, CART, translates information word for word. The latter two programs, however, convert the core concepts of the topic into text. The individual then is able to read the text on their individual screen or a larger screen.
4. **Telecommunication.** Telecommunication through a text telephone (TTY) machine is rarely used today due to the development of advanced technologies. However, TTY machines used to be commonly used among d/Deaf, hard of hearing, or speech impaired individuals. A TTY machine is a typewriting device that is used for communication through landline phones. The machine includes a typewriting keyboard as well as acoustic cups. TTY translates incoming auditory signals to text by placing the handset of the phone tonto the cups. The user then types their response onto the keyboard and the text is converted into sound through the phone handset.

Current Technology for Communication: Phone Apps

Communication Apps

1. Live Caption

   This app costs $2.99 and provides real time transcribing. To use, have the person you want to communicate with speak into the microphone and the phone will translate the audio into text. It is also compatible with most Bluetooth devices.

2. ntouch

   This app is a mobile version of Sorenson Communication's video relay service.

Learning ASL

1. The ASL app

   This free app designed by Deaf people helps users learn conversational ASL through more than 1,000 videos.

2. ASL Fingerspelling

   This app, costing $3.99, helps users improve their skills of reading fingerspelling. There are options for slowing down speed on the videos as well.

3. Sign School

   This free app is designed to help users learn ASL through browsing the dictionary, signs on various categories and topics, and providing a sign of the day.

Prevalent Mental Health Concerns for the d/Deaf Community

Within psychological literature, data attempt to look at trends and characteristics of different population groups in order to discern unique mental health needs by group. Among the d/Deaf community, individuals experience increased trauma and substance abuse symptoms relative to the larger population.

Trauma:

Just as trauma symptoms can be prevalent in a large number of unique populations. It is not surprising to find that the d/Deaf population also experiences significant incidences of trauma. d/Deaf individuals are exposed to trauma at a significantly higher rate than people who are hearing. Trauma also occurs in a variety of settings including a long history of sexual abuse in d/Deaf schools.

One aspect of trauma that could play a central role in exacerbating symptoms in d/Deaf individuals is known as Information Deprivation Trauma (IDT). IDT is a newer term in literature referring to how people can be more likely to experience events as traumatic when information about the event is inadequate or unavailable. This may be because they are unable to hear natural disaster warning signals such as sirens and be unable to hear potential warning signs that would prompt them to remove themselves from the traumatic situation. IDT trauma, therefore, is less predictable, less avoidable, and less controllable. d/Deaf individuals may not be aware of a traumatic event until years later, such as a death of a loved one. This contributes to an increased emotional response and psychological distress later on.

Sexual trauma in particular, has been reported in up to 50% of children who are deaf whereas for hearing children rates are 10-25%. This corroborates historical accounts from the original schools for deaf children explaining students were frequently physically and sexually abused by both staff and other classmates. Sexual trauma may occur because deaf individuals can be perceived as weak or less intelligent by hearing individuals. Although these perceptions are not accurate, it can leave d/Deaf individuals at higher risk for encountering dangerous situations. For providers, it is important to provide education to d/Deaf patients on prevalence of trauma and review plans for patients to be aware of their surroundings so they can protect themselves.

Depression and Anxiety:

Psychological distress typically includes symptoms of depression and anxiety. Research suggests stigma is significantly related to psychological distress. d/Deaf individuals are at a higher risk for experiencing depressive symptoms as well as anxiety symptoms due to the stigma they face daily when interacting in a hearing world. d/Deaf individuals may feel isolated from others including people in their own home. This isolation can exacerbate depressive symptoms and lower self-worth.

Substance Use:

Research shows d/Deaf individuals experience higher rates of substance use disorders relative to the general population. This may be due to the isolation d/Deaf individuals frequently experience as a marginalized group in the majority hearing society. Limited data exists on the types of substances d/Deaf individuals typically use, but it is clear that d/Deaf individuals can frequently turn to substance use to cope with difficulties such as trauma, depression, and anxiety. Providers should ensure they assess for substance use with their d/Deaf patient upon intake.

Culturally Appropriate Therapeutic Intervention Tips

When working with any patient from a different cultural background than our own, it can be difficult to discern what approach to take. When working with a d/Deaf patient, it is important to assess any potential intervention for logistical fit in terms of explanation and application both in session and in the patient's daily life.

1. Visual interventions

   Using interventions that are primarily visual can garner the most success with a d/Deaf patient. For people with hearing loss, they are accustomed to learning information primarily through sight. The way they understand the world is also organized primairly through sight. Therefore, describing concepts in picture form as well as having visual examples can be of greatest use in therapy.

2. Linguistic challenges

   Due to the wide variation in educational background for d/Deaf and hard-of-hearing patients, as well as the linguistic differences between ASL and English, your patient may not be familiar with language used on therapy tools. Do not assume that your d/Deaf patient will understand all of the language written on the page although they may try to answer your questions the best they can. They may just not want to seem "dumb" by asking what certain words are. Due to the persisting *deaf and dumb* stigma, many d/Deaf people still will refrain from asking clarifying questions for fear of confirming that stigma for their hearing providers. The way you can overcome this challenge is to ask the patient if they have any questions and normalize that mental health language is specialized and it is typical to not understand words. Also, after going through the explanation of the activity or worksheet, ask the patient to repeat back what they heard from the explanation.

3. Give yourself extended time to complete an intervention.

   Given that your d/Deaf patient communicates in a different language, and the interpreter needs time to accurately translate to both parties, allow extra time to complete interventions. An intervention that typically takes around 15 minutes could take up to 30 minutes. This can include explaining terminology and giving numerous examples to ensure appropriate understanding on the patient's part.

4. Considerations for administering and scoring measures.

   The first step in assessing someone who is Deaf includes considering the language used in the measures. Language used in items can include idioms and words with double meanings. It can be difficult for Deaf patients to understand the meanings of these items since their exposure to spoken English can be limited. Items may also require knowledge that Deaf people may not be exposed to such as questions about sounds or music. Although Deaf people enjoy music by feeling the vibrations, there are aspects of music that they are not able to experience. Finally, time limits on testing measures are created based on a spoken response. A signed response may take longer to convey, which could affect a Deaf individual's score. Based on these considerations, providers can alter administration instructions, they may accept responses such as pointing, or adding additional examples. These changes to standardized administration could lessen the validity of results, the provider should also discuss what changes they made when they write up results of testing. Another consideration is that using test results for diagnosis can be inaccurate as few measures have been normed for Deaf individuals. Providers should take this into consideration when analyzing results. Finally, providers should consider the way instructions are given during testing. The way instructions are given can significantly impact how the individual responds. Some tips that can assist in test administration include breaking complex sentences into more simple sentences. Ensure the essence of the sentence is maintained, but you may use simpler wording to assist in translation. It can be helpful to use synonyms to assist the test-taker in understanding. Finally, consider that in changing the instructions, the alterations do not provide too much information to the test-taker. If there is a chance that the results of subtests would be comprised by modifying the instructions, consider interpreting results with caution or invalidating the subtest/test.

Case Example #1

David is a 31-year-old individual referred to treatment by his PCP for depression symptoms. He arrives with an ASL interpreter. He appears nervous as he enters the room and tells you he has never been to a mental health appointment before.

1. How do you orient David to therapy with you?

2. What information would you like to get from David that will be useful in conceptualizing his case?

Case Example #2

Sarah is a twelve-year old d/Deaf girl referred to therapy by her hearing parents for symptoms of anxiety. Her parents typically use American Sign Language (ASL) to communicate with her and serve as interpreters in the session. They feel that getting a cochlear implant will be helpful for her and are beginning the process to get her one.

1. How do you proceed in treating Sarah?

2. What information do you need to conceptualize her case?

3. What information do you discuss with her parents?

Case Example #3

Ryan is a 35-year old man self-referred for relationship distress with his wife. His wife is Deaf and they communicate primarily with ASL. They have been married for five years and have two children. He reports they have always had frequent arguments and he is unsure if he wants to stay in the relationship.

1. What information do you need to assess Ryan and his wife's relationship dynamics?

2. What concerns, if any, do you have about this case?

3. What referrals and/or consents to speak to other providers would help you in treating Ryan?

Resources

d/Deaf Person Education and Employment

1. Hawaiʻi School for the Deaf and Blind (HSDB)
   An ASL immersion school on Oʻahu including grades K-12 within the Department of Education system in Hawaiʻi . All faculty teach using American Sign Language (ASL) and are certified teachers for d/Deaf students. Students have the opportunity to participate in sports that are not provided at HSDB at Kalani High. HSDB provides transition services to students for moving on to post-secondary education as well as employment. HSDB has a dormitory program to accommodate students who are from neighbor islands. The school also pays for the dorming students to fly home every weekend in order to maintain family ties. HSDB also offers ASL classes to parents as well as in rural communities on Oʻahu.
   3440 Leahi Ave.
   Honolulu, HI 96815
   Phone: (808) 733-4999
   Website: www.hsdb.k12.hi.us

2. Kapiʻolani Deaf Center at Kapiʻolani Community College
   Programs and services for d/Deaf students on campus. Program focuses include services for d/Deaf children and their families, faculty, and the wider Deaf community.
   Website: www.kdc.kapiolani.hawaii.edu

3. Vocational Rehabilitation
   The Division of Vocational Rehabilitiation (DVR) is a program for people in the state of Hawaiʻi who have a physical or cognitive disability and have barriers to attaining employment. This program was created under the Rehabilitation Act of 1973.
   1010 Richards Ste. #217
   Honolulu, HI 96813
   Oʻahu General Contact: (808) 586-9745
   Oʻahu Voice Phone: (808) 586-4824 in Honolulu, (808) 692-8604 in Kapolei
   Oʻahu Video Phone: (808) 447-1454
   Hawaiʻi Island: (808) 974-6444 in Hilo, (808) 323-0025 in Kona
   Kauaʻi: (808) 274-3333
   Maui County: (808) 984-8350
   Website: http://humanservices.hawaii.gov/vocationalrehab/

Technology and Communication

1. Relay Hawaiʻi
   Free service providing telephone accessibility for people who use a variety of communication formats. People who are d/Deaf, Deaf-blind, hard-of-hearing, or have a speech impairment can benefit from these services. Communication forms include using text telephones (TTYs), captioned telephones (CapTel), or personal computers through

the internet. Operators are able to voice conversations to voice using recipients or type conversations to text users. To connect to Relay Operator, call 711 any time of day.
Website: www.relayhawaii.com

4. Island Skills Gathering
   Provides assistive listening and alerting devices for d/Deaf, hard-of-hearing people, as well as people with speech disabilities, low vision and blindness, physical impairments, and learning disabilities. This organization also provides solutions for public access at public venues.
   472 Kanaina Ave.
   Honolulu, HI 96815
   Phone: (808) 732-4622
   Fax: (808) 739-5464
   Website: www.isghawaii.com

Miscellaneous Community Resources for d/Deaf persons

1. Aloha State Association of the Deaf (ASAD)
   Nonprofit organization working to provide resources for the d/Deaf and hard of hearing people in Hawai'i. This organization sponsors social events for the Deaf community as well as providing a bi-monthly newsletter.
   Website: www.facebook.com/ASAD.Hawaii

2. Signs of Self
   Nonprofit organization providing independent living services for people who are d/Deaf, hard of hearing, or Deaf-blind. Their website includes a community calendar which lists Deaf community events.
   1481 S. King St. #541
   Honolulu, HI 96814
   Voice/Text Phone: (808) 382-3881
   Video Phone: (808) 442-6434
   Fax: (808) 951-0848
   Website: www.signsofself.org

3. Disability and Communications Access Board (DCAB)
   Community resource for people with disabilities through disseminating information on legislation, policies, and procedures regarding people with disabilities. There is also information on civil rights and service needs for people with disabilities.
   Phone: (808) 586-8121
   Email: dcab@doh.hawaii.gov
   Website: www.health.hawaii.gov/dcab

Interpreters

1. Hawai’i Interpreting Services
   Communication access between providers and d/Deaf, hard of hearing, and Deaf-blind patients by providing sign language interpreters and captioners.
   P.O. Box 734
   Kaneohe, HI 96744
   Website: www.hawaiiinterpreters.com
   Voice Phone: (808) 394-7706
   Video Phone: (808) 692-0595
   Email: info@interpretinghawaii.com

2. Hawai‘i Registry of Interpreters for the Deaf (HRID)
   Non-profit organization providing the national testing system for interpreter certification. The registry also includes a list of local interpreters.
   P.O. Box 12200
   Honolulu, HI 96828
   Website: www.hawaiirid.wildapricot.org

3. Isle Interpret
   Facilitating communication with and between d/Deaf and hard of hearing people in Hawai‘i through affordable and convenient ASL interpreting. Interpreters are available both on-site and remotely through video. Real-time captioning as well as computer assisted note taking (CAN) services are also available.
   Voice/Text Phone: (808) 445-9125
   Video Phone: (808) 791-0505
   Fax: (855) 475-0236
   Website: www.isleinterpret.com

Provider ASL Education

1. American Sign Language Interpreter Education Program
   American Sign Language classes for the general public. In-service training to organizations serving people who are Deaf and hard of hearing.
   Website: www.kcc.hawaii.edu

National Resources

1. Gallaudet University
   First and only higher education liberal arts institution in the world providing all programs and services in ASL and written English (for instruction). Programs include both undergraduate and graduate education. Gallaudet also provides online ASL courses as well as Deaf Studies online courses.
   800 Florida Ave., NE

Washington, DC 20002
Voice Phone: (202)-651-5000
Website: https://www.gallaudet.edu

2. National Association of the Deaf (NAD)
Non-profit civil rights organization created by and for d/Deaf and hard of hearing people. Areas of advocacy include the right for d/Deaf individuals to use sign language, to discuss important issues, and represent Deaf issues at a national level. NAD also represents the USA on an international level at World Federation of the Deaf (WFD).
8630 Fenton St. Ste 820
Silver Spring, MD 20910
Videophone: (301) 587-1788
Fax: (301) 587-1791
Website: www.nad.org

3. Hands and Voices
Non-profit organization focused on supporting children who are d/Deaf or hard of hearing, their families, and professionals caring for them.
P.O. Box 3093
Boulder, CO 80307
Phone: (303) 492-6283
Email: parentadvocate@handsandvoices.org
Website: www.handsandvoices.org

Appendix A:

Appendix C:

Evaluation Form: Cultural Competence in Mental Health: A Theoretically Grounded Training for Working with the d/Deaf Community

Please mark in the columns the degree to which you disagree or agree with the following statements on the content of this workshop.

Workshop Content	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I am more aware about topics important to the d/Deaf community.					
I learned information I did not know before.					
The objectives of this workshop were met.					
The case examples were helpful to me.					
This workshop met my expectations.					

Please mark in the columns the degree to which you disagree or agree with the following statements on the design of this workshop.

Workshop Design	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The objectives of this workshop were clear.					
The amount of content in this workshop was appropriate.					
The variety of instructional methods used were sufficient.					
The information in this workshop was organized well.					
The case examples stimulated my learning.					

Please mark in the columns the degree to which you disagree or agree with the following statements on the facilitator.

Facilitator	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The facilitator was knowledgeable on the workshop topics.					
The facilitator was well-prepared.					
The facilitator was willing to respond to questions.					
The facilitator provided sufficient responses to questions.					

What was the most valuable part of this workshop?

What was the least valuable part of this workshop?

What would have made this workshop more helpful?

Any other suggestions for improvement?

Thank you for attending this workshop! Please return this form to the facilitator after completing.