PERSPECTIVES OF COUNSELING AMONG A SAMPLE OF DEAF ADULTS

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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ABSTRACT

Though members of counseling professions are responsible for maintaining multicultural competency, there is a dearth of research literature to inform culturally-relevant counseling strategies for Deaf adults. This study uses naturalistic inquiry to better understand Deaf perspectives regarding counseling to provide a foundation for multicultural research and practices aimed at serving the Deaf community. Five participants contributed data in interviews which were transcribed, coded, and subjected to constant comparative analysis. As a result, the following five themes emerged from the data: *Struggles and Trauma, Importance of Counseling, Barriers to Counseling, Emotional Support Role of the Counselor,* and *Desirable Counselor Characteristics.* Implications for counselors, researchers, and educators are discussed.

DEDICATION

This work is dedicated to my children, Warren and Maria, who daily inspire me to persist in the face of hardship and temper my passion for social justice and equity with gentleness and empathy. Make good choices, my loves. Be good examples, good leaders, and good friends. In all that you do, show kindness, wisdom, and love, and always remember that the world is a better place because of you.

ACKNOWLEDGEMENTS

My efforts alone could never have accomplished this work. Although I am unable to express thanks to each supporter individually here, please know that I am forever grateful for your tireless guidance and encouragement. What I cannot repay, I intend to pay forward, if God chooses to continue blessing me as He has throughout my educational journey.

To my incredible committee, I offer my heartfelt appreciation. Dr. Hollenbaugh has not only served as the long-suffering chair to this years-long endeavor, but she has also been a source of inspiration throughout my doctoral education. I will never forget how she once told me she admired my tenacity. That memory has roused me to action each and every time I felt like giving up. Likewise, Dr. Oliver has offered support and guidance since the beginning of my program. I have maintained that I chose her as my methodologist because of her high standards of excellence, and while that is certainly true, it is only half the story. Dr. Oliver has shed light on my darkest moments and helped me find my footing in troubled waters. Dr. Leeth stepped up to assist me when I needed him most, and Dr. Byus challenged me to think about concepts in new and innovative ways. To say I am grateful for their support is an understatement. It is my greatest hope to be for others the source of encouragement, guidance, and unwavering strength they have been for me.

Additionally, I have been blessed with friends and colleagues who have offered practical advice and kept my motivation high whenever it faltered. My work supervisors and co-workers have offered flexibility and coverage to allow me to finish my research. I would especially like to thank Linda Lugo from Deaf Studies for providing interpretation of my recruitment materials and feedback regarding my research questions and progress. Deaf Interpreter Services was also very helpful and instrumental in providing interpretive services for the interviews, and the Deaf

and Hard of Hearing Center of Corpus Christi provided not only a recruitment site but feedback and advice regarding several aspects of the project and Deaf culture.

My greatest and most enduring source of support has been my family. My mother, Amber Walker, was my first model of advocacy as she fought to secure my rights as a functionally deaf student. My siblings have always challenged me in their teasing ways; yet I know without a doubt they have my back at all times. More recently, my husband, Brian, has joined my band of sponsors. He has provided material, emotional, and even academic support as I have labored over this work, and I could not have completed it without his patient love and assistance.

Finally, I would like to thank the Deaf communities with whom I have associated throughout this project and before. Their heart-rending stories have inspired me, and I have learned so much about both Deafness and myself. For my motivators, my participants, and every other Deaf person seeking access and acceptance, I will continue this work. Thank you all.

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CHAPTER I

INTRODUCTION

Over 350 million people worldwide are reported to have some level of hearing impairment (World Health Organization, WHO, 2013). Of these individuals, approximately 22 to 37 million live in the United States (Kochin, 2005; Lin, Niparko, & Ferrucci, 2011; Wright & Reese, 2015). There is a glaring need for appropriate and effective counseling services within the deaf population. Research suggests people who are deaf are more likely to be victims of violent crimes and psychological abuse than members of the general population (Anderson & Leigh, 2011; McQuiller Williams & Porter, 2014; Pollard, Sutter, & Cerulli, 2014; Porter & McQuiller Williams, 2011; Smith & Pick, 2015). Furthermore, deaf adults may be at greater risk for depression and anxiety, and rates of emotional, behavioral, and psychosocial problems among deaf children are two to four times as high as their hearing peers (Critchfield, 2002; Fellinger, Holzinger, & Pollard, 2012). Despite the apparent need, counseling services for the deaf remain largely inaccessible and underutilized (Critchfield, 2002; Feldman & Gum, 2007; Fellinger, Holzinger, & Pollard, 2012; Vernon & Leigh, 2007).

The crossroads of deafness and mental disorders has not been well-researched. In fact, Vernon and Leigh (2007) have called this group the "most neglected segment of the mentally ill population in the United States" (pg 374). There are many ways in which mental health professionals are failing to reach people who are both deaf and diagnosed with a clinical disorder. This population has limited access to media and mental health education (Anderson & Leigh, 2011; Smith & Pick, 2015; Wright & Reese, 2015), and those who might seek help have little awareness of local mental health services (Feldman & Gum, 2007; Wright & Reese, 2015). Studies suggest there may not be enough mental health services for deaf adults (Feldman &

Gum, 2007; Vernon & Leigh, 2007). Few interventions have been designed specifically for deaf clients (Porter & McQuiller, 2011), and when they do exist, clients may have difficulty accessing them, especially since specialized treatments can be expensive (Fellinger, Holzinger, & Pollard, 2012; Vernon & Leigh, 2007).

A shortage of training opportunities has led to a deficit of counselors who are academically and experientially prepared to provide services for deaf clients (Critchfield, 2002; Vernon & Leigh, 2007; Wright & Reese, 2015). Even licensed and seasoned counselors may have limited experience providing services for this population (Critchfield, 2002; Vernon & Leigh, 2007; Wright & Reese, 2015). Misdiagnosis and errors treating deaf clients are commonplace and have led to mistrust of mental health providers among members of the Deaf community (Vernon & Leigh, 2007; Wright & Reese, 2015).

One of the greatest barriers mentioned in literature is communication (Critchfield, 2002; Feldman & Gum, 2007; Vernon & Leigh, 2007; Wright & Reese, 2015). Although some clients, particularly younger ones, are open to the use of an interpreter during sessions, people who are deaf show an overwhelming preference for counselors who can effectively communicate using sign language (Feldman & Gum, 2007; Wright & Reese, 2015). Few counselors understand the subtleties of signed communication well enough to offer services in sign language (Critchfield, 2002; Vernon & Leigh 2007; Wright & Reese, 2015). When interpreters are used, it is difficult to find one who is skilled at interpreting emotional and other mental health concepts; in fact, most fall below minimum coherence standards (Vernon & Leigh, 2007). Interpreting services can also be quite expensive, and more research is needed to determine how the presence of an interpreter affects the dynamic between the counselor and the client (Wright & Reese, 2015). Although ideal, offering a referral to a counselor who is well-versed in Deaf culture, sufficiently fluent in

sign language to offer effective services, and competently able to diagnose and treat people who are deaf and mentally ill is not always possible (Wright & Reese, 2015). It is no wonder, then, that many people in the Deaf community choose to rely on friends and family for help with mental health needs rather than seek out a professional (Feldman & Gum, 2007; Wright & Reese, 2015).

A counselor's responsibility to understand the perspectives of deaf clients is both legal and ethical in nature. The Americans with Disabilities Act (ADA) of 1990 affirmed the rights of deaf clients to equal access to mental health services (ADA, 1990; Vernon & Leigh, 2007). Title II refers to the responsibilities of counselors and others who provide services for state or local government programs to ensure that people who are deaf have equal access to those services, and Title III applies to accommodations in public and commercial facilities that improve accessibility for those who are deaf (ADA, 1990). This includes, at a minimum, the right to effective communication between the counselor and the client (Wright & Reese, 2015). This could be accomplished by a counselor who is fluent in the client's preferred language (typically sign language) or hiring a skillful interpreter. In addition to adhering to these laws, counselors are encouraged to advocate for consistent enforcement of these laws (Vernon & Leigh, 2007), which could prove a fruitless endeavor if the counselor does not understand the client's perspective.

Laws serve as the foundation and not the endpoint of a counselor's ethical responsibilities. The American Counseling Association (ACA) holds its members to the higher standards described in the Code of Ethics. Besides meeting the communication needs of the client by hiring an interpreter or providing other accommodations, counselors are required to communicate with clients in culturally appropriate ways and to consider their work from a multicultural standpoint (ACA, 2014). It is important to note that Deafness or Deafhood (observe

the capital D) is differentiated from deafness (lowercase d) in that the former is an established and recognized culture and the latter is a physical condition (Wright & Reese, 2015). Culturally Deaf people are united by a common language (typically American Sign Language, ASL, in the United States), history, and perspective as well as shared norms and traditions (Wright & Reese, 2015). When referring to both physically deaf and culturally Deaf individuals simultaneously, I will use the term "d/Deaf." Counseling professionals are mandated to offer services that honor diversity and to develop multicultural competence (ACA, 2014).

Deaf clients can be found in every region of the country and in every counseling setting, from schools to clinics to prisons. Although the ACA (2014) requires counselors to practice with cultural competence, there are few clear guidelines and standards for treating d/Deaf clients (Porter & McQuiller, 2011). Much of the available research is written from the clinical model, which emphasizes deafness as a physical condition, a problem that needs to be solved, without respecting the cultural aspects of Deafness (Wright & Reese, 2015). Very few research studies incorporate input from d/Deaf participants. To practice effectively, professionals need to understand the Deaf perspective of counseling. A naturalistic inquiry approach will provide a foundation on which to build a counseling framework based on the viewpoint of Deaf clients.

Statement of the Problem

It is the legal and the ethical responsibility of counseling professionals to provide accommodations for d/Deaf clients and to use culturally appropriate interventions (ACA, 2014; ADA, 1990). To this end, it would be reasonable for counselors to consult research literature for guidelines and effective interventions. However, few treatments have been empirically validated as efficacious for the d/Deaf population (Porter & McQuiller, 2011). The existing research is often based on the clinical model, which frames deafness as a problem that needs to be overcome

rather than focusing on Deafness as a rich culture whose members have unique strengths and resources (Wright & Reese, 2015). This may be due in part to a dearth of research studies that solicit the perspectives of d/Deaf participants. Counseling professionals have no theory or model of counseling based on the experiences, preferences, and perceptions of Deaf clients. This study aimed to address the deficit of qualitative input from members of the Deaf community by using naturalistic inquiry to uncover themes that can be used to shape counseling practices for that group.

Theoretical Framework: Naturalistic Inquiry

Naturalistic inquiry involves exploring a concept by relying on the participants to provide both the questions and the answers (Lincoln & Guba, 1985). Although it may be necessary to form at least one research question, this framework flexibly allows participants to inform the investigator as to what topics they should be investigating relevant to a predetermined concept. It employs grounded theory methods to collect and analyze data and negotiates the final outcomes of the research with the participants themselves through member checking (Lincoln & Guba, 1985). Its overarching purpose is to construct meaning of an enigmatic situation to improve understanding and generate directions for practice and future research (Erlandson et al., 1993).

To fit this paradigm, research must begin from the perspective that a multitude of complex social realities exist and interact internally and interpersonally in the lives of both the sample participants and the investigator (Lincoln & Guba, 1985). Arguably, this is the assumption for any research that solicits the unique perspectives of minority groups, as the agents of the study strive to recognize and honor the diverse social interpretations of their participants. This inquiry aims to examine the constructed realities of Deaf adults as related to counseling.

Researchers who identify with the participants in significant ways or hold a position that may conflict with or influence their responses should maintain an awareness of the complex dynamics inherent in a naturalistic inquiry study (Lincoln & Guba, 1985). My relationship to the Deaf community is tangential in the sense that I have some residual hearing, I was raised in a hearing family, and I did not adopt sign language or Deaf culture until adulthood. Furthermore, as a doctoral candidate in a Counselor Education program, it is likely assumed, and rightly so, that I have an optimistic view of counseling services. My midline Deaf heritage and my position within my program may influence, positively or negatively, the participants' reception of my involvement in Deaf-centered research and the transparency with which they respond to my questions.

Like some other qualitative paradigms, naturalistic inquiry uses emergent (or grounded) theory methods to collect and analyze data and acknowledges that any findings must be considered context dependent (Lincoln & Guba, 1985). The inextricable relationship between various factors such as the intentions of the participants, their interactions with the investigator, and even the time period in which the research took place render concepts such as generalization and causal assumptions moot (Lincoln & Guba, 1985). In this study, context included a recent pandemic, use of video technology, and the assistance of interpreters, to name a few. The resulting narratives and informative responses are, therefore, impossible to replicate.

Purpose of the Study

Lincoln & Guba (1985) describe the purpose of naturalistic inquiry as a means of collecting information from members of a population for the purposes of promoting understanding and producing an emergent theory of a social reality. The purpose of this qualitative research study was to explore how members of the Deaf community interpret the

meaning of counseling and to give voice to a marginalized minority. Data was collected and analyzed using established grounded theory methods, beginning with unstructured interviews aided by a certified ASL interpreter and expanding data collection dictated by the emerging findings. Results provided insight into the culturally Deaf perspective of counseling and contribute to a growing body of literature aimed at developing a cohesive theory of Deaf counseling and mental health. This study was conducted by a doctoral candidate in a Counselor Education program at a four-year university in the Coastal Bend region of Texas with recruitment from the local Deaf community center and social media.

Research Questions

1. How do Deaf adults interpret the meaning of counseling?
2. How do Deaf adults perceive counseling services?
3. How do Deaf adults perceive counselors?

Methods

Grounded theory was developed by Barney G. Glaser and Anselm L. Strauss in 1967 as a reaction to positivist research methods (Dey, 2004; Suddaby, 2006). This approach avoids some of the pitfalls of true experimental research, such as exampling, or finding examples to fit a theory; instead, the researchers shape a theory that fits the available data (Glaser & Strauss, 1967). Although the strategies have been revised and expanded over the years, the grounded research methods still emphasize the interpretation of the meaning of some event or phenomenon by the actors who are directly involved (Suddaby, 2006).

Grounded theory assumes that the researcher will approach the data empirically, with curiosity and without preconceptions (Dey, 2004; Glaser & Strauss, 1967). Unlike positivist methods, which often require large samples of participants, the sample size need be only as large

as required to reach data saturation; this may require many participants or only a few, depending on the emergent data (Dey, 2004; Glaser & Strauss, 1967). The researcher also retains the option to explore the same sample more deeply or in different ways (Glaser & Strauss, 1967). The methods of data collection evolve with the developing themes (Dey, 2004; Suddaby, 2006). Each study begins with broad information gathering (semi-structured interviews, in this case) and narrows to more structured forms, as directed by the initial findings (Dey, 2004). The collected data is then coded into categories, analyzed, compared, and refined until it can be meaningfully interpreted (Dey, 2004; Glaser & Strauss, 1967).

Rather than occurring sequentially, data collection and analysis in grounded theory research operate simultaneously (Dey, 2004; Glaser & Strauss, 1967; Suddaby, 2006), like a conversation in which collection informs analysis which in turn generates questions requiring further data collection. Collection and analysis continue until data saturation, a point when no more meaningful concepts or themes emerge (Dey, 2004; Glaser & Strauss, 1967). Because premature discontinuation of data collection or shallow analysis may result in trite observations and overly simplistic results, it is imperative for the researcher to follow the pattern of collection and analysis until the concepts discovered are both complete and cohesive (Suddaby, 2006).

The Current Study

As this study focuses on the perceptions of Deaf adults, recruitment efforts carefully targeted this population in search of sample participants. Initially, I intended the boundaries of the study to be limited to a specific geographical area, a city in the Coastal Bend region of south Texas. However, the onset of the coronavirus pandemic limited options for in-person interaction. Therefore, the interviews took place virtually, allowing a greater geographical scope and the parameters of the study shifted to Deaf adults living in the United States. Expansions of initial

boundaries and assumptions are common and even encouraged in the context of naturalistic inquiry (Lincoln & Guba, 1985).

I created flyers to advertise the study at the local Deaf community center and posted ads in written English and with a signed video on social media. I notified contacts at the community center and requested their assistance in generating a participant pool. I also planned to make an appearance at a local Deaf Chat event and request participation with the assistance of a certified ASL interpreter; however, the circumstances surrounding the coronavirus pandemic prevented me from doing so. Given the collectivist nature of Deaf culture (Wright & Reese, 2015), other interested participants emerged through secondhand contact with those recruited. Potential participants were asked to contact me via e-mail to protect their privacy throughout the study. To be eligible to participate in this research study, the potential participant had to be at least 18 years of age, be their own guardian, and self-identify as culturally Deaf.

In keeping with established naturalistic inquiry principles and grounded theory methods, data collection and analysis occurred simultaneously (Dey, 2004; Glaser & Strauss, 1967; Suddaby, 2006). The first stage of data collection consisted of virtual interviews facilitated by an interpreter (if the participant indicated ASL as their preferred method of communication). The presence of the interpreter provided the participants the opportunity to contribute data in their chosen language and allowed me to comply with the ADA as well as the ethical codes set forth by the ACA (ACA 2014; ADA, 1990). These semi-structured interviews were video recorded with the audio portions transcribed. All videos and transcripts were stored in a passwordprotected file on a locked external hard drive in my possession. This was to ensure the privacy and confidentiality of all participants in accordance with ethical guidelines (ACA, 2014). During the data collection stage, I used comparative analysis techniques to conceptualize themes

within the data and shape future data collection (Dey, 2004; Glaser & Strauss, 1967; Suddaby, 2006). I also kept a reflective journal throughout the study to record my own reactions, biases, and experiences relative to the study. When no new themes emerged from the data, I invited participants back for follow-up interviews to clarify, explore, and augment the data (Dey, 2004; Glaser & Strauss, 1967; Suddaby, 2006). Two participants accepted the invitation. The procedures were similar to the first interviews; however, this round included a discussion of the emerging themes as part of the member checking process as well as questions relevant to those topics.

Trustworthiness

Lincoln and Guba (1985) describe in detail the criteria for trustworthiness in naturalistic inquiries. The concepts of credibility, transferability, dependability, and confirmability replace traditional conventionalist elements such as reliability and validity. Each standard for trustworthiness has been met in this study.

Credibility

One of the benchmarks for credibility is that of prolonged engagement (Lincoln & Guba, 1985). This allows the researcher not only to learn about the culture of the target population but also to develop rapport with its members. I have been immersing myself in Deaf culture for my own benefit for about ten years. I have taken signing classes and regularly attend Deaf events in my area. My engagement with the subject of my research, therefore, existed prior to the conception of this study.

Lincoln & Guba (1985) also recommend persistent observation. This involves observing the data during its emergence and revisiting it after the emergence of new data. This criterion is innately fulfilled in the method of constant comparative analysis. Rather than existing as separate

process, data collection and analysis occur simultaneously. As new data emerges, it is compared with existing data, and the tentative themes that form are constantly re-evaluated and adjusted.

Central to the concept of credibility is the criterion of triangulation. Triangulation can be achieved in any one of several ways or through multiple methods. Lincoln & Guba's (1985) description of triangulation of sources allows for gathering data at multiple time periods. In this study, a single form of data collection, semi-structured interviews, was applied to the five participants. The contributions of each interviewee were compared to the raw data and emergent themes from previous participants. These participants were then invited to return for a second interview to follow up on the emerging findings.

Another benchmark of high credibility involves negative case analysis. In those situations in which outliers were identified, I sought to explain the singularities that existed within the boundaries of the purpose of this study. Further research was recommended to explore avenues beyond those limitations.

The final criterion submitted in consideration of the credibility of this study is member checking, which Lincoln & Guba (1985) describe as essential to naturalistic inquiry. This was achieved in two ways. First, participants were sent transcripts of their interviews to check for accuracy. This step was especially vital to this study. English is not a direct translation of sign language; therefore, the transcripts allowed participants to confirm the fidelity of the interpretations. As themes emerged, I solicited feedback from participants during follow-up interviews.

Transferability

Generalizability, a staple of positivist research, is irrelevant to the purpose of qualitative frameworks; instead, the concept of transferability has far more utility and meaning (Lincoln &

Guba, 1985). This can be achieved through the provision of thick descriptions, or detailed depictions of the context, setting, and processes that emerged during data collection and analysis (Lincoln & Guba, 1985). In keeping with the purpose of naturalistic inquiry, the setting should be as natural as possible in the sense that it should take place in the locations most relevant to the sample (Lincoln & Guba, 1985). Data collection took place after the peak of the coronavirus pandemic. Therefore, the safest context and most relevant setting was a virtual interview participants could attend from the comfort of their homes. Processes, including technical considerations, sign language interpretation, and rapport-building, are described in detail in later chapters.

Dependability and Confirmability

Lincoln & Guba (1985) argue that both criteria can be satisfied with a single audit. They recommend retaining artifacts from six distinct categories throughout the course of research. The audit trail generated in this study included documents and notes in each of the recommended categories (see Table 1).

Table 1

Audit Trail Documentation

Categories	Documentation	Location
Raw Data	Initial questionnaires	Qualtrics server
	Interview recordings and transcripts	Encrypted file on passwordprotected laptop in a locked bag
Data reduction and analysis products	Copies of the transcripts with line-by-line analysis	Encrypted file on passwordprotected laptop in a locked bag
Data reconstruction and synthesis products	Theme and subtheme tables and slides (used for constant comparative analysis)	Encrypted file on password-protected laptop in a locked bag

Process notes	Notes about methodology, interview schedules, and similar information	Handwritten in a spiral notebook kept in the laptop bag described above
	Reflective journal	Encrypted file on password-protected laptop in a locked bag
Materials related to intentions and dispositions	Proposal Personal notes and predictions	Encrypted file on password-protected laptop in a locked bag
Instrument development information	Initial questionnaires development history	Qualtrics server
	Interview questions	Spiral notebook described above

Note. This table details audit trail documentation including the audit category, the names of the documents themselves, and the locations where each of the documents were stored.

Significance of the Study

Previous research has failed to deliver a cohesive interpretation of the meaning of counseling from the perspective of those who are culturally Deaf. Without this essential information, previous attempts to provide culturally relevant and effective treatments for the Deaf community have fallen short of their goals time and time again (Anderson & Leigh, 2011; Critchfield, 2002; Feldman & Gum, 2007; Fellinger, Holzinger, & Pollard, 2012; Porter & McQuiller, 2011; Smith & Pick, 2015; Vernon & Leigh, 2007; Wright & Reese, 2015). By focusing on the perceptions of individuals who are Deaf, this study sought to uncover key information vital in developing effective treatments, ethical research procedures, and successful professional counseling relationships within the Deaf community.

This study contributes to the research literature related to the needs, strengths, and unique characteristics of Deaf individuals for the formation of ethical and culturally appropriate interventions. The current body of research does little to guide counselors in their treatment of people who are Deaf (Vernon & Leigh, 2007). Understanding the values and perceptions of a

cultural group can and should guide counseling practice. Additionally, supervisors and educators of counseling professionals require this information to enhance training practices and increase multicultural competency among their students. With greater training opportunities and more appropriate counseling interventions, many of the problems with service accessibility within the Deaf community would decrease (Critchfield, 2002; Fellinger, Holzinger, & Pollard, 2012; Porter & McQuiller, 2011; Vernon & Leigh, 2007; Wright & Reese, 2015).

Ultimately, this study aimed to provide a foundation for the development of Deaf counseling theories upon which to build culturally relevant interventions that are both practical and effective for hearing counselors to implement. The qualities of naturalistic observation and, by extension, grounded theory promote empowerment within a marginalized population by soliciting their participation in building the theories that will eventually influence the treatment strategies used within the population. In time, this should lead to greater accessibility to appropriate counseling services for Deaf clients. Therefore, as much as these findings could impact the training and development of practitioners and educators, the greatest benefit was intended for the Deaf community.

Limitations

Every research design is limited to some degree by the assumptions of the theoretical approach, the practical aspects of the methodology, and the characteristics of the participants, the investigator, and others who may be involved. When comparing naturalistic inquiry methods with other research frameworks, several limitations are apparent. As previously mentioned, findings that emerged from the data cannot be generalized (Dey, 2004). The study's theoretical foundation also limited the types of results in that, although the final report is meant to influence

the development and testing of future interventions, the present study will provide no direct measurement of the effectiveness of any given counseling technique.

Within the sample, the recruitment criteria did not differentiate between types of deafness (conduction or sensorineural) or timing of the onset of deafness. It is possible that the diversity within the initial sample affected findings. Other samples are sometimes recruited for comparison or contrast as dictated by the emergent data (Dey, 2004; Glaser & Strauss, 1967; Suddaby, 2006); however, no benefit was expected for this study. In any case, the entire Deaf population cannot be accessed for this project; therefore, the results may be subject to sampling error (Krumpal, 2013).

This study began with semi-structured interviews which were aided by a certified ASL interpreter when indicated as a participant preference. There is a possibility that interpreting errors affected the research process or findings. This was minimized by checking in with participants and soliciting their feedback when the transcripts were complete and by clarification of the emerging data in the follow-up interviews. This does not eliminate all potential for communication errors. Because ASL is the primary and native language for many Deaf individuals, reviewing a transcript in English may have been challenging. Furthermore, the participants were asked about their perceptions of counseling by an investigator known to be counseling field. This introduced the potential for social desirability bias, a phenomenon in which participants adjust their answers based on their assumptions about the investigator's preferences or expectations (Krumpal, 2013).

Neither was the investigator completely without bias. In the interest of full disclosure, I have a mixed hearing impairment (conduction and sensorineural). Although my experiences differ significantly from someone who is hearing, I do not identify as culturally Deaf, though I

am active in the Deaf community. I rely on hearing aids, I am not fluent in sign language, and I may not share other unifying experiences prevalent within Deaf culture. My personal experiences and characteristics, both from my field of study and hearing status, may have affected my subjective interpretation of the data. Additionally, Glaser and Strauss (1967) discourage investigators from conducting a lengthy literature review before embarking on a research project to reduce the potential for previous findings to influence the process and results of the current study. However, my familiarity with the literature relevant to Deaf mental health has prompted this study and may have shaped my expectations and decisions during data collection and analysis. Therefore, I kept a reflective journal to record my thoughts, reactions, and experiences throughout the study. In addition to the reflective journal, I used member checking to ensure my biases were not unduly affecting my interpretation of the results.

Summary

Counselors are charged with the responsibility of providing access to mental health services that fit the needs of their clients (ACA, 2014; ADA, 1990). In spite of evidence indicating a need for culturally-relevant and efficacious mental health services for members of the Deaf community, the majority of research supports the notion that Deaf clients have insufficient access to treatment and when services are available, they may be inadequate or inappropriate to address the unique needs of the Deaf community (Anderson & Leigh, 2011; Critchfield, 2002; Feldman & Gum, 2007; Fellinger, Holzinger, & Pollard, 2012; Porter & McQuiller, 2011; Smith & Pick, 2015; Vernon & Leigh, 2007; Wright & Reese, 2015). To fulfill our legal and ethical responsibilities as counseling practitioners and counselor educators, more research is required to determine the best approach to counseling Deaf individuals.

Ideally, counseling strategies, assessments, and interventions for Deaf clients will be built upon a foundation of theory constructed from counseling principles and the perspective of the individuals served. Because such research is scarce, this naturalistic inquiry study utilized grounded theory methods to generate themes relevant to the Deaf community's counseling perspectives. This was accomplished by recruiting a sample from members of the local Deaf community for unstructured interviews, collecting and analyzing data simultaneously, and letting emergent data dictate the directions in which the study progressed. Additionally, I used memberchecking to verify the transcripts and a reflective journal to maintain awareness of my subjective influences.

The sample was recruited from flyers and social media ads and may have cultural characteristics that are markedly different from other Deaf communities. The goal of naturalistic inquiry is not generalizability, but the concept of transferability, the ways in which some facets of the study may easily transfer to other settings or populations, may be affected (Glasser & Strauss, 1967; Lincoln & Guba, 1985). Furthermore, I required the services of a certified interpreter, which may have influenced results. Naturalistic inquiry acknowledges the subjective nature of the researcher and the participants as a fundamental influence on findings (Glasser & Strauss, 1967; Lincoln & Guba, 1985). The addition of an interpreter means that my views, as communicated to the participants, and their views, as communicated to me, were filtered through yet another subjective lens. More research is needed to determine the extent of the ASL interpreter's influence on findings in a qualitative study. Nevertheless, the themes generated by this research could offer benefits for both the counseling profession and the Deaf community, and the potential to better serve our Deaf clientele more than merited the study, despite its limitations.

Terminology

American Sign Language, or ASL: the common language of culturally Deaf Americans with several regional variations (Gournaris, 2022; Horejes, 2013; Knapp & Corina, 2008; Ladd, 2003; Leigh, 2008; Padden & Humphries, 2006; Pickens, 2021; Scherer, 2013)

Audism: a form of prejudice that values hearing individuals or the ability to hear over those who are d/Deaf or hard-of-hearing or over deafness/ Deafhood itself (Brueggemann, 2008; Humphries, 2008; Ladd, 2003)

Clinical model: a research and treatment model that conceptualizes deafness as a medical problem in need of a solution rather than acknowledging Deaf individuals as a cultural group; also known as the medical model or deficit model (Brueggemann, 2008; Harmon, 2008; Horejes, 2013; Ladd, 2003; O'Brien & Placier, 2015; Padden & Humphries, 2006; Wright & Reese, 2015)

Cochlear implant (CI): a surgically-implanted medical device that stimulates the auditory nerve, providing the opportunity for individuals with severe to profound sensorineural deafness to transduce sound waves and perceive sound (Blankmeyer Burke, 2008; Horejes, 2013; Ladd, 2003; Leigh, 2008; Padden & Humphries, 2006)

Cultural model: a research and treatment model that conceptualizes Deafhood as a distinct culture with its own shared languages, history, perspectives, and traditions rather than focusing on deafness as a medical problem in need of a solution (Brueggemann, 2008; Harmon, 2008; Horejes, 2013; Ladd, 2003; O'Brien & Placier, 2015; Padden & Humphries, 2006; Wright & Reese, 2015)

Deafhood vs deafness: A capital D is used to indicate cultural Deafhood or individuals who are culturally Deaf. They typically communicate using sign language and share similar perspectives and experiences with others who are Deaf. The lowercase d is used to refer to

deafness in a medical sense. Individuals may be deaf (physically unable to hear) without identifying as culturally Deaf (Brueggemann, 2008; Ladd, 2003; Padden & Humphries, 2006; Wright & Reese, 2015)

Lipreading: a method of communication in which the receiver attends to the movement of the speakers lips and other nonverbal cues to understand a spoken message (Ladd, 2003)

Oralism: the perspective that orally-based forms of communication, such as lipreading, speaking, and hearing, are superior to other forms of communication (Ladd, 2003; Padden & Humphries, 2006)

CHAPTER II

LITERATURE REVIEW

Prior to the study and throughout its duration, I kept abreast of historical and current research and scholarly observations relevant to counseling d/Deaf and hard-of=hearing individuals. I limited the literature review to peer-reviewed material and used the search term "deaf" combined with "mental health" and "counseling." Guided by research findings, I also searched "deaf" with both "anxiety" and "depression" to learn more about those specific findings. Many of the results had to be discarded due to irrelevance; for example, genetic counseling techniques to predict deafness in the embryonic stage are fascinating but not of much use to school, vocational, family, and mental health counselors. The remaining results were quite limited; however, I believe this is due to the overall dearth of literature available and not a consequence of overzealous eliminations.

This chapter begins with a review of our obligations to our Deaf clients and research participants from both practical and sociocultural perspectives. To emphasize the culture nature of this population, an overview of Deaf culture and historical accounts will follow. The rich international history of the global Deaf community lays the foundation for modern Deaf practices and social nuances. It also helps to explain the needs for and barriers to culturally appropriate mental health services for Deaf clients. Some researchers have sought to remedy this deficit; a summary of their research findings will follow. Finally, this chapter seeks to illuminate gaps in the literature that still exist.

Ethical and Legal Obligations of Counselors with Deaf Clients

As this study aims to explore the perspectives of Deaf adults regarding counseling, it is essential to understand the sociocultural context of the question. Counselors have both legal and ethical mandates to provide quality services to people from every walk of life (American

Counseling Association, 2014; Americans with Disabilities Act of 1990, 1991; Lomas & Johnson, 2012). The Americans with Disabilities Act of 1990, or the ADA, requires that those providing public services make reasonable accommodations to ensure that those with disabilities have equal access to those services. In the context of providing counseling services, this could include providing a certified sign language interpreter or using written instead of oral communication for scheduling. The American Counseling Association (ACA) echoes this requirement by stating that counselors may not discriminate against any person based on disability status or culture, among other specific characteristics (ACA, 2014).

However, simply providing communication assistance is not the extent of the duties of an ethical counselor. The ACA Code of Ethics also requires cultural sensitivity in assessment, diagnosis, and treatment of mental disorders (ACA, 2014). This involves maintaining a sense of multicultural awareness of client rights (B.1.a) and careful interpretation of assessments that were not normed for Deaf populations (E.7.a., E.8). Those counselors with websites must make sure they are accessible for Deaf individuals (H.5.d.); for example, any videos on the website should have accurate and appropriate captions. Counselor training programs are charged with infusing the curricula with a multicultural approach through direct instruction, workshops, and other andragogical methods (F.7.c., F.11.c.). Furthermore, as all counselors are expected to develop and maintain diverse multicultural knowledge, they may not claim that understanding Deaf culture is beyond their boundaries of competence (C.2.a.).

Thus, there is a foundation of legal and ethical responsibility on the part of counselors to provide effective and relevant services for clients that address both their culture and their practical needs. However, researchers have found that there is often a discrepancy between policy and practice when counselors and other professionals are faced with providing services to Deaf clients (Darroch, 2018; Vernon & Leigh, 2007; Wright & Reese, 2015). In 2008, it was

estimated that there was one qualified therapist for every 8,300 deaf individuals in Great Britain (Oldale, 2008). There is a clear emphasis on multicultural diversity within the counseling professions, but there is a distinct lack of research on counseling within the context of Deaf culture (Wright & Reese, 2015). This leaves practitioners without a basis for providing culturally relevant and appropriate services for Deaf clients, which results in inappropriate assessment and misdiagnosis (Feist, Saladin, & Hansmann, 2013; Gala, 2017; Vernon & Leigh, 2007; Wright & Reese 2015).

Deaf Culture

As many as 10% of adults will lose their hearing at some point in their lives; however, being deafened is not the same as being culturally Deaf (Ladd, 2003). In contrast to both the medical definitions of deafness and the geographic conceptualization of culture, a Deaf person might have more experiences, values, and traditions in common with another Deaf person from across the globe than with a hearing neighbor in the adjacent apartment (Scherer, 2013). Ladd (2003) describes Deaf culture as a hidden room in a museum. The public walks through the main area with displays promoting advances in technology that eliminate deafness and honor charitable hearing benefactors. Meanwhile, the art, history, relics, and achievements of Deaf people are rumored to exist somewhere behind a wall, accessible only through an external door rather than an internal door mediated by the preconceptions of hearing narratives. In defiance of a perspective that frames a deaf individual as an "unfinished hearing person" (Padden & Humphries, 2006, pg 161), most members of the Deaf community are proud to be Deaf and view it as a positive attribute, a cultural and linguistic heritage rather than a disability (Horejes, 2013; Ladd, 2003; Padden & Humphries, 2006; Wright & Reese, 2015).

The concept of culture extends beyond geographical barriers and generally encompasses observable phenomena, language, folklore, a sense of identity, shared history, and internalized

values and attitudes, and the concept of Deaf culture is exemplified by these standards (Fellinger, Holzinger, & Pollard, 2012; Ladd, 2003; Wright & Reese, 2015). There is a dearth of research literature regarding Deaf culture, especially as it continues to evolve (Ladd, 2003; Vernon & Leigh, 2007). Attempts to explore this elusive concept have resulted in framing Deaf culture in terms of language or communication preferences, shared perspectives, hearing abilities, and social environments of Deaf people (Leigh, 2008).

However, it is becoming abundantly clear that Deaf culture is not a fixed or universal construct, and theorists in every discipline from audiology to anthropology seem to struggle in defining its boundaries and social constructs (Blankmeyer Burke, 2008; Horejes, 2013; Ladd, 2003; Leigh, 2008; Padden & Humphries, 2006). Often, as in this study, the lowercase d in "deaf" refers to the physical condition of deafness as measured by an audiogram (a graph indicating one's hearing range) while an uppercase D is reserved for references to Deaf cultural experiences (Padden & Humphries, 2006; Wright & Reese, 2015); however, there has been little consensus about the proper usage of these terms, who qualifies as d/Deaf, and whether or not there is any utility in making such a distinction (Brueggemann, 2008; Harmon, 2008; Ladd, 2003; Young, Napier, & Oram, 2016). A great many frameworks have been suggested for classifying degrees of d/Deafness- a simple dichotomy of d/Deaf and hearing, a spectrum with hearing on one side and Deaf of Deaf (the Deaf child of Deaf parents) on the other, and even a sociocultural linguistic model emphasizing the richness of signed languages and Deaf experiences (Brueggemann, 2008; Emery, Middleton, & Turner, 2010; Harmon, 2008; Ladd, 2003; O'Brien & Placier, 2015; Padden & Humphries, 2006; Wright & Reese, 2015; Young, Napier, & Oram, 2016). Although Deafhood qualifies as a culture in its own right, to exclude any mention of the physical condition of deafness as a part of that description would be incomplete and disingenuous, as acknowledgement of one's inability to hear is, with the possible

rare exception, required in order to access the cultural aspects of the Deaf experience (Brueggeman, 2008; Ladd, 2003; Padden & Humphries, 2006; Wright & Reese, 2015; Young, Napier, & Oram, 2016). For that reason, some researchers prefer an intersectional approach, exploring the physical and cultural aspects of d/Deafness as entwined concepts that shape Deaf identity (Young, Napier, & Oram, 2016).

Ladd (2003) suggests that there exist three routes to membership. First, one may be born deaf into a Deaf family. A second route, which is more typical for deaf children born to hearing parents, is to attend and graduate from a Deaf school. When Deaf people meet one another, a standard introduction includes a lot of information about oneself, and which school one attended is considered an essential revelation (Harmon, 2008; Padden & Humphries, 2006). These extended introductions, which also include deaf family members or other contacts, communication preferences, and self-identification as Deaf, hearing, or hard-of-hearing, also establish the newcomer as a full-fledged member of the Deaf community, a fringe participant, or an outsider (Harmon, 2008). The final possibility for accessing membership into the world of the Deaf is to get involved in the Deaf community as an adult. However, because the community lacks consensus on its boundaries and membership, the ease with which this can be accomplished varies (Ladd, 2003). It is safe to assume that a deaf person born into a hearing family and placed into a mainstream educational program has had less exposure to Deaf culture and American Sign Language (ASL) than those who entered the community through the former methods. Because standards for acceptance are not homogenous, that person may or may not face resistance from existing members of the community.

A Brief History of Deaf Culture

The most prominent historical viewpoint of deafness, the medical model, also permeates contemporary literature. This perspective, sometimes referred to as the deficit model, approaches

the experience of deafness as a physical disability in need of treatment and ignores, downplays, or completely denies any cultural constructs associated with being Deaf. However, most Deaf people do not consider their deafness a disability but a sociolinguistic identity complete with a community who shares their language, history, values, and experiences (Horejes, 2013; Ladd, 2003; O'Brien & Placier, 2015; Padden & Humphries, 2006; Scherer, 2013; Wright & Reese, 2015). Horejes (2013) explains that the medical model is a reaction to perceived abnormality in a society dependent on audible cues and communication rather than an inherent biological deficit, as deafness alone does not impair functioning. In the Deaf community, a society where sound is irrelevant and communication is visual, a person who cannot hear suffers no disability at all, and in fact, hearing people who cannot sign struggle with the same challenges faced by Deaf individuals in the hearing world. Furthermore, in some parts of the world, deafness is not considered a disability at all (Horejes, 2013).

Nevertheless, as the primary discourse in the dominant hearing society, the medical model has influenced the way d/Deaf people are perceived (Horejes, 2013; O'Brien & Placier, 2015; Padden & Humphries, 2006; Wright & Reese, 2015). Many parents of Deaf children and hearing teachers of Deaf students still subscribe to oralism, an audio-centric educational system that removes Deaf culture and sign languages from the lives of Deaf children in an effort to promote speechreading and hearing technology over Deaf cultural values and practices (Ladd, 2003; Padden & Humphries, 2006). Terms such as "hearing-impaired" are commonplace, despite being regarded as offensive and inaccurate by the Deaf as it implies that something is broken and needs to be repaired (Scherer, 2013). Far from accepting the notion that they are disabled, culturally Deaf individuals recognize that the structure of society benefits the hearing majority and often resent the systems that require their accommodations be provided by hearing benefactors (Ladd, 2003). The tendency of some hearing people to treat the provision of services

in one's preferred language as benevolence instead of a basic right is discriminatory and denies full citizenship to Deaf people (Ladd, 2003).

The 19th Century: Deaf Schools and Oralism

Throughout history, hearing perspectives of Deaf people have influenced Deaf identities through the narratives and differing approaches to the treatment of the hard-of-hearing, signing Deaf, oral/aural d/Deaf, indigent d/Deaf, wealthy d/Deaf, white d/Deaf, Black d/Deaf, and others within or at the fringes of the Deaf world (Blankmeyer Burke, 2008; Padden & Humphries, 2006). Modern Deaf culture has been wrought by the residual effects of many collections of d/Deaf histories (Harmon, 2008; Padden & Humphries, 2006). Such accounts are tempered with conflicting and even contradictory perspectives at times; for example, many Deaf adults recall with pride and joy their childhood and adolescent days at Deaf schools, even as they acknowledge a persisting record of abusive treatments at such schools (Harmon, 2008; Padden & Humphries, 2006).

The first Deaf school in the United States opened in 1817 at the insistence of an influential hearing philanthropist whose daughter, deafened by a case of scarlet fever, had struggled under the mentorship of private tutors (Padden & Humphries, 2006). A committee sent Thomas Hopkins Gallaudet to Europe to study pedagogical methods in schools for deaf children, and he returned with Laurent Clerc, a Deaf teacher from France (Padden & Humphries, 2006). Their work helped to establish what is now known as ASL, the accepted language of Deaf Americans, and others were quick to model new schools for deaf children after their prototype (Padden & Humphries, 2006).

According to Padden & Humphries (2006), these early schools adopted a proprietary view of their charges, requiring the parents of deaf children to surrender their parental rights to the school in exchange for education, room and board, and any other necessities their child might

require as a resident of the school. Within very little time, shocking claims of physical and sexual abuse came to light, resulting in the dismissal of a principal accused of inappropriately touching and kissing a 14-year-old girl and her friend. Unfortunately, the details of the case may be lost due to the inability of the hearing committee to understand any of her signed testimony; it had to be interpreted by an employee of the principal, and the accuracy of the employee's version has always been a matter of debate. Other cases of maltreatment and irrational punishment have been more clearly documented. One contributor to the book, *Inside Deaf Culture* (Padden & Humphries, 2006) recalled his teachers locking deaf students in dark closets as a form of punitive sensory deprivation, and as recently as 2001, deaf schools have been charged with accounts of physical and sexual abuse of their students. Still, others remember their deaf schools with fondness and appreciation as a place of respite from the hearing world, a chance to engage with other Deaf individuals who understood their language and experiences, and an opportunity for education at a time when schools were not required to accommodate the needs of deaf and other students.

The National Deaf-Mutes College, later renamed Gallaudet University, was founded in 1864 and remains the world's only Deaf university, though other Deaf colleges with connections to mainstream hearing universities have since formed (Ladd, 2003). Although Gallaudet is internationally recognized as an advocate for Deaf culture (Emery, Middleton, & Turner, 2010), at the time of its founding, oralism was taking root in deaf education. In 1867, just three years after the opening of what would be Gallaudet, the Clarke School was founded as a fully oralist deaf school where sign language was strictly prohibited (Padden & Humphries, 2006). The oralist movement continued to gain traction in the 1870s and 1880s championed by none other than Alexander Graham Bell, inventor of the telephone (Padden & Humphries, 2006). Bell, whose mother and wife were both deaf, adamantly opposed sign language, calling it "primitive"

and “backward,” and while he stopped short of promoting the eugenics measures such as forced sterilization that were being proposed at the time, he passionately argued for the diffusion of deaf populations through dissolution of deaf schools and communities and by encouraging marriages between hearing and deaf people in order to reduce the propagation of Deaf culture, to which he referred as a “calamity to the world” (Padden & Humphries, 2006, pg 174). Bell was later invited to join the American Breeders Association whose mission was, among other things, to eradicate d/Deafness by enacting mating laws to limit the reproductive rights of Deaf people. In 1880, another victory for advocates of Deaf culture, the establishment of the National Association of the Deaf (NAD) in the United States, was once again overshadowed by oppression as the Congress of Milan abolished deaf education across Europe in favor of oralism (Ladd, 2003).

The Eugenics Movement Gains Momentum

Over the next five decades, as institutionalism took hold and the Great Depression devastated financial resources, d/Deaf people were often sent to asylums where the eugenicist dreams of the previous century were realized through disruption of Deaf communities and mandatory sterilization of inmates (Brueggemann, 2008). History darkened further with the T-4 program of the early 1940s. Prior to their Final Solution massacres of Jewish Europeans, Nazis euthanized thousands of people in gas chambers, through drug overdoses, and by starvation; victims were selected based on any of eight criteria, one of which was partial or total deafness (Blankmeyer Burke, 2008; Brueggemann, 2008).

Post-War Conditions for Deaf Communities

Fortunately, the tragedies of World War II were not suffered without some victories. As the “able-bodied” soldiers left for war, those Deaf individuals who stayed behind faced greater opportunities for employment, and though they often lost their positions as soldiers returned, the Deaf middle class was firmly established during this time, and conditions began to improve for

the culturally Deaf community (Humphries, 2008). However, their troubles were far from over, and as deafness continued to be over-pathologized in medicine and mental health, misdiagnosis was (and continues to be) a common occurrence (Blankmeyer Burke, 2008; Vernon & Leigh, 2007; Wright & Reese, 2015). Prior to the deinstitutionalizing movement of the 1960s, many d/Deaf people were housed in asylums and subjected to abuse and neglect (Vernon & Leigh, 2007; Wright & Reese, 2015). According to Teresa Blankmeyer Burke (2008), philosopher and bioethicist at Gallaudet University, two deaf children were mistakenly diagnosed with intellectual disability and sent to the Willowbrook State School in Staten Island, New York. At the time, researchers were conducting a deeply controversial experiment in which they infected children living at the school with hepatitis, sometimes by mixing the stool of the infected into their food, in order to track the untreated progression of the virus and evaluate the effectiveness of experimental vaccines (Blankmeyer Burke, 2008). This study lasted 14 years before public outcry shut it down (Blankmeyer Burke, 2008). Importantly, these and other abuses led to widespread distrust of mental health professionals among members of the Deaf community (Wright & Reese, 2015).

The Deaf Resurgence and its Opposition

By the mid-1960s, Deaf culture was experiencing a strong resurgence as ASL became recognized as a valid language (Humphries, 2008). It was not immediately accepted as such, even among those who considered themselves culturally Deaf, and was at first viewed as a grassroots movement, one that was reserved for less educated Deaf individuals and rejected by educated professionals in the Deaf community who had been trained under the oralist schools of thought (Padden & Humphries, 2006). However, many hearing individuals remain fascinated by the beauty and expressiveness of manual communication (Harmon, 2008; Horejes, 2013). This did not go unnoticed by the National Theatre of the Deaf, founded in 1967, or by Deaf poets,

both of whom propelled the use of sign language to new heights in the public view with their performances (Padden & Humphries, 2006). In the years that followed, employment demand for those fluent in ASL skyrocketed (Padden & Humphries, 2006).

One of the most impactful outcomes of the public enthrallment with ASL was a shift from medical ways of thinking of deafness (the deficit model) to a cultural understanding of what it means to be Deaf (Brueggemann, 2008; Horejes, 2013; Ladd, 2003; Padden & Humphries, 2006). The distinction between the lowercase *deaf* to indicate a physical condition and uppercase *Deaf* to discuss social, linguistic, and cultural experiences came about in the early to mid-1970s (Brueggemann, 2008; Ladd, 2003). As the Deaf community was acknowledged, so too were its detractors and those who assumed a more ethnocentric stance. The term "audism" was coined in 1975 to describe the attitude that awards a higher status to those who can hear and a lower one to those who are d/Deaf as well as the prejudices and discriminatory acts that often result from that manner of thinking (Humphries, 2008).

In the late 1970s, Reuben Conrad of Oxford conducted a longitudinal study to examine the effectiveness of the oralist approach (Ladd, 2003). Although the programs billed themselves as superior to signing programs and claimed their students would better integrate in a hearing world, the deaf children who had received an oralist education could barely read at second grade level, could only be understood verbally by their teachers and parents, and could read speech only as well as hearing peers who had no experience or training (Ladd, 2003). Clearly, the oralist system had failed. As researchers and the Deaf community alike compared it to the Holocaust (as one Deaf individual stated, "One destroyed the body, and the other destroyed the mind"), the repression of sign languages in the United States slowed and even halted in some places (Ladd, 2003, pg 28). However, oralist methods, including sign language suppression, are still used by many educators even to this day (Emery, Middleton, & Turner, 2010; Harmon, 2008; Ladd,

2003; Padden & Humphries, 2006).

The questions surrounding this newly recognized culture were numerous, complicated, and often emotional (O'Brien & Placier, 2015). To help answer them, some researchers in the 1980s began partnering with Deaf people and conducting a range of studies *with* them rather than *on* them (Horejes, 2013). Still others continued their pursuit of eradicating deafness and, with it, Deaf culture. They began promoting the cochlear implant (CI) as a miracle cure for certain forms of deafness (Blankmeyer Burke, 2008; Horejes, 2013; Ladd, 2003; Leigh, 2008; Padden & Humphries, 2006). Although implantation of CIs has become routine (Padden & Humphries, 2006), they were initially endorsed by many proponents of the medical model and eugenics movement without any evidence of their effectiveness or any mention of the risks, such as loss of all residual hearing (Ladd, 2003; Padden & Humphries, 2006). Additionally, implant clinics were given quotas to fill and had to compete with one another for potential patients (Ladd, 2003). This resulted in subjecting parents to emotional blackmail and pressure regarding their so-called social responsibility (Ladd, 2003). Thus, their use, especially in experimental scenarios, has been hotly debated by bioethicists (Blankmeyer Burke, 2008).

Caught between social insistence and lack of information and faced with the daunting alternative of learning a new language and culture, many hearing parents of deaf children opted for the cochlear implant without consulting with anyone from the Deaf community, and many doctors have been reported as playing on the parents' fears of abnormality and disability (Horejes, 2013; Ladd, 2003; Leigh, 2008). Many of the Deaf community's objections to promotion of CIs without evidence or disclosure of risks and alternatives have been met with harsh reprove. Ladd (2003) noted cases in which Deaf protests were met with accusations that anyone opting out of a CI were denying their children a miracle or that they must enjoy seeing their child suffer if they find their Deafness acceptable. As those with CIs grow and enter

programs for deaf children, their parents often request that they remain segregated from culturally Deaf children, some from fear that their child might not succeed in the hearing world unless immersed in oralist education, and some from a sense that their child's membership in the Deaf community might threaten the integrity of their family structure, because the parents and siblings will likely remain on the fringes of Deaf society (Ladd, 2003).

1990s to Today

As the Deaf community persisted in their struggle to be seen as a cultural entity, a new term, Deafhood, was coined in 1990 by Paddy Ladd to describe the existential experience of being culturally Deaf (Ladd, 2003). The modern Deafhood experience shares many similarities with our Deaf ancestors, and yet, much has changed. Possibly due to the reports of abuse and neglect, which have unfortunately followed us into the modern age, enrollment at deaf schools has dropped from around 85% of deaf children in 1950 to around 27% in 2002 (Padden & Humphries, 2006). The eugenics movement still exists in full strength but uses different methods than those of the past (Blankemeyer Burke, 2008; Brueggemann, 2008; Emery, Middleton, & Turner, 2010; Ladd, 2003; Padden & Humphries, 2006). In the UK, a law has been passed that requires parents using in-vitro fertilization (IVF) to dispose of any embryos found to carry genes for deafness if there are any other embryos available (Blankmeyer Burke, 2008; Brueggemann, 2008; Emery, Middleton, & Turner, 2010; Padden & Humphries, 2006). The underlying message of these mandates is clear: the government has deemed the lives of deaf children not worth living (Brueggemann, 2008; Emery, Middleton, & Turner, 2010).

In 2020, the COVID-19 pandemic swept across the globe, reducing an already limited number of services available to Deaf communities (Perkins Nerlich et al, 2021). In the ensuing chaos and confusion, it seemed everyone was having difficulty finding accurate information, and for Deaf citizens, low-quality captions, a lack of interpreters, and masks covering the faces of the

speakers (and thus preventing lipreading) rendered communication even more frustrating than before (Perkins Nerlich, et al., 2021). It is unclear what challenges lie ahead for the Deaf community, but a comprehensive awareness of the historical context of this proud and diverse group will lend greater insight to the current cultural traditions, perceptions, and values.

Deaf Culture and Practices Today

Collectivism in the Context of Deaf Culture

About 70% of people around the world are part of collectivist cultures, and this includes Deaf communities in the United States (Ladd, 2003; Scherer, 2013; Wright & Reese, 2015). As with other cultures, members of these collectivist Deaf communities define themselves in terms of their group membership and feel a strong sense of belonging (Scherer, 2013). Deaf people value their connections with others, often discussing them when meeting someone new for the first time (Harmon, 2008; Wright & Reese, 2015). They regard group cohesion, cooperation, and harmony as important qualities with the Deaf community (Wright & Reese, 2015). Victories and struggles are shared, and the entire Deaf community experiences a common sense of pride and joy as its members overcome obstacles with ingenuity and determination and deflect oppression with a sense of humor (Ladd, 2003). For this reason, Deaf clients may prefer to consult with other members of the community or hesitate to say or do something to disrupt the harmony of the group; mental health professionals should first consider their client's behavior from a cultural perspective before declaring it pathological (Wright & Reese, 2015).

Communication in the Deaf Community

Use of Sign Language

It is impossible to overstate the importance of sign language as a feature of Deaf cultures throughout the world. Some might even argue that it is the *key* feature of Deaf culture. Often, researchers lump people with disabilities into a seemingly homogenous category for the purposes

of their studies (see Govindasamy, Amin, & Subhi, 2021; Livneh & Sherwood, 1991; Perkins Nerlich et al., 2021, among others). In fact, because of disability grouping, there is little research regarding Deaf individuals with cognitive, mobility, or other challenges (Ladd, 2003). However, sign language identifies the Deaf community as a linguistic minority, distinct from an ambiguous disability label (Humphries, 2008). From a Deaf perspective, this form of communication separates them from the hearing world as well; in fact, the ASL word for "hearing person" is based on the sign for "talking," not the sign for "hearing," indicating that these visible forms of communication are how Deaf individuals make the distinction between themselves and others (Scherer, 2013).

Students taking ASL classes often expect the courses to be simple, perhaps a direct translation of spoken English to manual versions of those words, and they are surprised by the complexity of the language (Horejes, 2013). In fact, ASL is quite different from English (Wright & Reese, 2015). It has its own grammar, syntax, conventions, and idioms with abstract concepts and linguistic complexities that differ significantly from spoken languages (Knapp & Corina, 2008; Wright & Reese, 2015). As with English, ASL sometimes borrows from other languages, for example, using initialized signs (signs that combine conceptual movements with letters from the English alphabet) and fingerspelling (manually spelling a word instead of using a sign with an equivalent meaning), but these are not considered central to the language (Knapp & Corina, 2008). Many times, native signers who are not fluent in English are dismissed as illiterate or incapable of communication; the same assumption is less likely to be made of someone who speaks English well but cannot sign (Harmon, 2008; Wright & Reese, 2015). Instead, professionals working with Deaf individuals should make the same accommodations for native signers that they would for anyone for whom English is a second language, especially with written communication, as there is no universally accepted written version of sign language

(Wright & Reese, 2015).

There are multiple sign languages in use throughout the world, and each has its own vocabulary, grammar, rules, and conventions (Knapp & Corina, 2008; Padden & Humphries, 2006). There are, however, some similarities. All sign languages are performed by coordinating handshapes (precise ways of positioning the hand and fingers), movements, and hand orientation to specific locations in relation to one's body (Knapp & Corina, 2008). Furthermore, facial expression and body language help to convey grammar and social cues, in addition to signing (Knapp & Corina, 2008; O'Brien & Placier, 2015). Even the position of one's eyebrows can turn a statement into a question or vice versa.

Beyond basic grammar and vocabulary, sign language holds a special significance as a means of storytelling, externalizing, and conveying visual metaphors, all of which are important aspects of Deaf culture (Ladd, 2003; Munro, Knox, & Lowe, 2008). Far from cultivating illiteracy, learning sign language from infancy promotes the Deaf child's ability to communicate with parents and others (Humphries, et al., 2016; Padden & Humphries, 2006). Studies have found that the use of sign language, as opposed to oral communication, also improves academic performance later in the child's life (Padden & Humphries, 2006; Vernon & Leigh, 2007). Thus, it is generally considered the preferred language of culturally Deaf people (Ladd, 2003; Padden & Humphries, 2006; Vernon & Leigh, 2007; Wright & Reese, 2015).

Oral Communication

There is an ongoing debate about which language (ASL or English) is considered normal for Deaf Americans and which leads to the greatest opportunities for success (Horejes, 2013; Padden & Humphries, 2006). For a multitude of reasons, not all d/Deaf people use sign language as a primary means of communication (Feldman, Kluwin, & McCrone, 2006; Harmon, 2008; Horejes, 2013; Leigh, 2008; Padden & Humphries, 2006; Perkins Nerlich, et al., 2021). For

example, most d/Deaf children are born to hearing parents and look to them for modeling and guidance for language acquisition; as ASL requires a great deal of time and dedication to gain fluency, many hearing parents cannot or will not commit to such a task (Harmon, 2008; Leigh, 2008; Padden & Humphries, 2006). Sometimes this is a very intentional choice, as some hearing (and even some deaf) people believe that sign language is outdated, a relic of a time before technology advanced our use of communicative devices (Harmon, 2008). Paradoxically, it is common and popular for hearing parents to teach hearing children baby signs, but hearing parents of deaf children may prohibit their children from signing, fearing that ASL will inhibit the child's ability and motivation to learn oral communication (Horejes, 2013).

Unlike other linguistic minorities in which offspring share common link with their parents to their sociolinguistic heritage, sign languages may not be passed down through generations of Deaf families but acquired or ignored over time, as families with d/Deaf members may consist of mostly hearing members (Ladd, 2003). The communication preferences of the family or the d/Deaf individual will undoubtedly affect the social competence of both, depending on whether they are in a primarily hearing or primarily Deaf environment (Leigh, 2008). When unsure of a d/Deaf person's communication preferences, the most appropriate course of action is to ask them how they would prefer to communicate.

Pragmatic Aspects of Deaf Communication

Deaf communication features a heightened emotional response, particularly for positive emotions (Gala, 2017; Oldale, 2008; Wright & Reese, 2015). As members of a collectivist culture, the emphasis on fostering group harmony may contribute to the prominent displays of joy, pride, and other generally happy feelings, but the degree of the emotional expression tends to be greater in Deaf communities than in other collectivist cultures (Gala, 2017). Facial expressions and exaggerated emotional gesturing reflect grammatical nuances in sign languages,

so what seems to be an overreaction to a hearing person may have significant linguistic meaning and purpose to a Deaf person (Wright & Reese, 2015).

The differences in emotional expression between spoken and signed languages have led to some difficulty in mediation and mental health interpretation (Gala, 2017; Wright & Reese, 2015). In families that have both culturally hearing and Deaf members, misunderstandings sometimes arise because of the subtle implications of a glance or expression (Gala, 2017). A study by Jhai (2017) found that Deaf adolescent males were frustrated by conflicting cultural expectations regarding masculine emotional expression. Mainstream culture portrayed men as dominant, assertive, and stoic; emotional displays are not only normal for culturally Deaf males but required in order to properly communicate (Jhai, 2017). In mental health settings, Deaf people may be misdiagnosed if counselors or other professionals construe emotional expressions that are appropriate in the context of Deaf culture as pathological, for example, as a symptom of impulse control or emotional dysregulation (Wright & Reese, 2015)

According to Wright & Reese (2015), culturally Deaf signers tend to be very direct and may be perceived by others as blunt or rude. Whereas English begins with details and eventually meanders to the main point, ASL has different syntax and often begins with the main point and then adds details. Responses to questions may be explicit and quite meticulous. Conversely, implicative remarks, such as “I see your point, and I would like to propose an alternative,” may be interpreted as passive-aggressive or suspiciously evasive by a culturally Deaf person; simply saying, “I don’t think we should do that,” would be preferable (Wright & Reese, 2015).

Similarly, Wright & Reese (2015) assert that Deaf individuals value directness in eye contact as much as in language. This is as practical as it is cultural, as a clear line of sight is necessary for reception of signed communication. Therefore, Wright & Reese (2015) suggest that breaking eye contact should be prefaced with an explanation (“I’m just going to make a

quick note before we continue") and should not occur when either person is sharing information or asking questions, and under no circumstances should someone obstruct the view of their mouths to intentionally prevent speech-reading, as it is considered extremely rude.

Biculturalism and Multiculturalism in Deaf Communities

Deaf Identity x Racial and Ethnic Identity

A discourse on culture would be incomplete without acknowledging the significance of racial and ethnic identity within any given group. Within the Deaf community, these concepts overlie the entirety Deaf history and the current sociopolitical climate, especially for Deaf people of color (Feist, Saladin, & Hansmann, 2013; Ladd, 2003; Leigh, 2008; Padden & Humphries, 2006; Weifferink, Veremeij, & Uilenburg, 2012). Although few ethnic heritages are represented and supported by international Deaf organizations, there is little doubt that the intersection of Deafhood and ethnic identity has significant implications for illuminating the diversity within Deaf culture (Ladd, 2003). A 2012 study examined the process of cultural merging in a group of Turkish refugees living in the Netherlands (Weifferink, Veremeij, & Uilenburg, 2012). Each family participating in the study was composed of both hearing and Deaf members, and the researchers discovered several levels of acculturation taking place. Another study examined the triple-minority status of Deaf Hispanic women in the United States in the context of vocational rehabilitative counseling and found that obstacles to favorable employment were compounded by each of their minority statuses as well as the various combinations thereof (Feist, Saladin, & Hansmann, 2013). These studies demonstrate the complexity of the multicultural identities experienced by many double- or multi-minority members of the Deaf community. In addition to embracing their Deafhood and potentially maintaining the values and traditions of their hearing families, Deaf ethnic minorities may also be navigating the fusion of their ethnic identity with the mainstream culture.

Much of the history of Deaf Black Americans has been lost or discarded (Padden & Humphries, 2006). Following the Civil War and the end of slavery, Deaf Black children could attend deaf schools, but they were taught separately from white children (Padden & Humphries 2006). Although racial segregation was outlawed in the mid-1950s, not every school complied immediately, and the last segregated school finally merged in 1978 (Padden & Humphries, 2006). Until then, deaf schools, who had total control of and responsibility for the child residents, had labor requirements for Black children, paid Black teachers less than half the salaries of white teachers, and even buried Black children in separate cemeteries, usually without headstones (Padden & Humphries, 2006). The positions of the white administrators varied greatly, with some being moved to advocate for equality for Black children and others resigning en masse when required to treat them equally (Padden & Humphries, 2006). The Union League, a popular Deaf club, actively sought the talents of Black baseball players for their team but would not permit them to join as members (Padden & Humphries, 2006). The vast divergence in the Deaf histories of Black and white Americans resulted in different sign languages and perspectives (Ladd, 2003; Padden & Humphries, 2006). Understandably, Deaf Black Americans in modern times are often hesitant to participate in Deaf communities, especially those that are predominantly white (Ladd, 2003).

Deaf Identity x Gender and Sexual Identities

Only since the 21st century have lesbian, gay, transgender, queer, questioning, intersex, asexual, and other (LGBTQIA+) Deaf groups approached acceptance by either mainstream or Deaf societies (Ladd, 2003). However, the last two decades have been an uphill battle for many gender and sexual minorities striving for equal standing within the hearing and Deaf worlds. A 2022 study by Beese & Tasker explored the experiences of Deaf gay men in their journeys

toward identity development. These participants described the struggle to meet oralist and hetero-centric social expectations during adolescence, the sense of relief from minority stress they found upon entry to the Deaf community, and the fear that they might lose their place among fellow Deaf members by coming out as gay.

The collectivist nature of Deaf culture ties its members' identities to their acceptance by the community, so a threat to that membership is a threat to the person's sense of self. Many would rather suffer in literal silence than disrupt the harmony of the group (Gala, 2017; Wright & Reese, 2015). Additionally, not much has been written about the roles of Deaf women throughout history, but this may change as more Deaf women assume positions of power (Ladd, 2003). As stated by ASL professor Brittany Frederick (2021), "The ability to hear is not related to the ability to lead" (pg 105).

Deaf Mental Health Needs and Barriers to Service

While research guided by the medical model seeks to improve hearing ability, the mental health needs of Deaf people have been largely neglected (Vernon & Leigh, 2007). Researchers have discovered that the Deaf community faces higher risks of mental disorders and psychosocial conflicts than hearing people (Ladd, 2003; Wright & Reese, 2015). Although the genetic risks of mental disorders are the same in Deaf individuals as their hearing peers, the disorders that are traumatic or life-induced are twice that of the general population (Ladd, 2003). The following is a summary of research findings relevant to the mental health problems of Deaf people.

Bias and Discrimination

In a chapter describing the effects of majority perceptions on the treatment and sense of identity of members of the Deaf community, Brueggemann (2008) quotes the French feminist

Helene Cixous: “Hold still, we’re going to do your portrait so that you can begin looking like it right away” (pg 60). Many of the traumas experienced by Deaf individuals are caused or compounded by the prejudices of the hearing world. The dominant narratives are established by those who are not members of Deaf culture and often have little exposure to its members, and these narratives, in turn, shape public views that hearing is preferable to being Deaf. This may be why Deaf people may experience marginalization and are often isolated from each other and from those in the hearing world who fear, despise, or pity them (Boyd, 2007; Munro, Knox, & Lowe, 2008; Oldale, 2008). Microaggressions and implicit biases are inherent in minority stress, and the Deaf community is plagued with ongoing negative social reactions which may range from bizarre curiosity, much like one might have for animals in a zoo exhibit, to unwelcome condolences to active hostility (Beese & Tasker, 2022; Boyd, 2007; Harmon, 2008; Ladd, 2003; Padden & Humphries, 2006; Wright & Reese, 2015).

Most of the discriminatory attitudes within the hearing world stem from a sense of ethnocentricity; when hearing people imagine being deaf, they picture themselves (hearing people) in their (hearing) world suddenly unable to discern the auditory cues on which they have come to rely so heavily (Ladd, 2003). Knocks on shared bathroom doors, oven timers, ringtones, car horns, whistles in various sporting events. . . It seems overwhelming, and they cannot imagine how they would function in this scenario. Some may think of the sounds that they enjoy, like music or laughter, sounds they have learned to isolate in a dizzying atmosphere of harsh noises and distractions, and they feel a little sad at the thought of those beloved scenes taking place in silence. Reflecting in this manner generally prompts them to think of themselves as being lucky to be hearing (Harmon, 2008) without any consideration that others might count themselves blessed to be Deaf.

In a society where arguing couples use silence as punishment, the idea that someone might prefer a soundless culture is described as an oddity by some and as a sickness by others (Harmon, 2008; Ladd, 2003). These views seem to exist on a spectrum with some who see the Deaf community as a "small, different, and exotic group" (Padden & Humphries, 2006, pg 7) and others who think of Deaf people as "passive, sullen, withdrawn, unresponsive, anti-social, stupid, hostile, or, perhaps worse, scary" (Boyd, 2007, pg 93). With the prevalence of audism saturating all aspects of society, both the hearing and the d/Deaf learn to view Deaf individuals as damaged and less than fully human (Brueggemann, 2008; Ladd, 2003).

The historical and contemporary narratives surrounding Deaf culture are not limited to what is said but also how it is said. The social importance of verbal speech powerfully influences majority attitudes toward minority groups (Brueggemann, 2008; Horejes, 2013; Humphries, 2008). In a 2013 study, participants who attended an expert presentation by a Deaf person credited the content knowledge to the interpreter speaking on the presenter's behalf and only transferred that authority to the Deaf expert when they began speaking (Horejes, 2013). The researcher concluded that the audience attributed intelligence, ability, and confidence to the interpreter and speaking presenter because they associate those positive qualities with verbal communication. Often, Deaf individuals become known to hearing individuals only through the lens of sign language interpretation (Young, Napier, & Oram, 2019), so those findings have troubling implications. How can Deaf people assert their competency and legitimacy as a culture and as individuals in a world that largely refuses to acknowledge their system of communication on an equal basis?

One way that signing members of Deaf culture cope with the frustrations of minority stress is to seek opportunities to socialize with other signers (Harmon, 2008; Ladd, 2003; Padden

& Humphries, 2006). Another coping mechanism is to use reflective language when describing members of mainstream hearing culture. For example, most people who are culturally Deaf reject the term “hearing-impaired” as it implies they are incomplete hearing people instead of complete Deaf people (Munro, Knox, & Lowe, 2008; O’Brien & Placier, 2015; Scherer, 2013; Wright & Reese, 2015). At a Deaf exhibition, a visitor called hearing people with no signing abilities or comprehension of Deaf culture as Deaf-impaired as a way of highlighting the discrepancy between the deficit and sociolinguistic perspectives (Harmon, 2008).

Forming alliances and fostering a sense of belonging help to mitigate the effects of minority stress (Beese & Tasker, 2022). Parents of d/Deaf and hard-of-hearing children may be a source of support for the Deaf community, as they tend to express a more positive view of the competencies of and prospects for Deaf adults than does the general population (Crowe et al., 2015). However, many parents also fear the stigma of abnormality that might result from their child’s association with the Deaf community (Ladd, 2003).

Such concerns are understandable, as the consequences of bias and discrimination against the Deaf world can be quite serious. The historical tragedies continue their destructive patterns in modern times. Several studies have noted employment barriers for the Deaf with some stating that Deaf employees must work twice as hard as hearing employees to earn the same levels of respect and authority in their workplaces (Feist, Saladin, & Hansmann, 2013; Frederick, 2021; O’Brien & Placier, 2015). Researchers in 2015 explored the perspectives and experiences of hearing and Deaf teachers at the same school and found that the Deaf faculty resented the oppression, labeling, and disrespect they received from their hearing peers (O’Brien & Placier, 2015). During their own interviews, the hearing educators made aggressive remarks that compared Deaf culture to something foreign and strange, questioned the validity of the culture,

and accused the Deaf instructors of self-segregation (O'Brien & Placier, 2015). Additionally, the metaphorical glass ceiling representing employment barriers for minorities thickens with each marginalized identity, so those Deaf employees who represent double, triple, or multiple minorities face even greater challenges (Frederick, 2021).

Unfortunately, these troubles are not limited to the workplace. Integrating a Deaf identity into a hearing world can be daunting due to the differences in social values and expectations between Deaf and mainstream cultures, especially for those who grew up in an authoritarian atmosphere (like many homes and Deaf schools) where developing a sense of autonomy was suppressed or discouraged (Jhai, 2017). Perhaps the most disturbing form of discrimination is the pervasiveness of modern eugenics. There are laws in place, even in advanced nations, that are aimed at eliminating Deafness altogether by preventing the births of deaf children, and proponents of this movement have gained very vocal support from those who see Deafness as only a medical condition (Emery, Middleton, & Turner, 2021; Ladd, 2003). Proponents of legal eugenics have praised cochlear implants as leading to the "extinction of the alternative culture of the Deaf," (Ladd 2003, pg 160). a chilling echo of the Nazi agenda from the 1940s (Padden & Humphries, 2006). In an article published by the American Psychological Association, Dr. Michael Merzenich plainly stated, "The simple fact is that if [American Deaf culture] could be reliably wiped out, it would be a good thing to wipe out" (quoted in Ladd, 2003, page 160). In addition, there is a pattern of overpathologizing Deafness that extends to the very recognition of Deafness as a culture; in fact, a 1996 article was titled, "Beware the Sick World of Deaf Culture" (Ladd, 2003). Even when the cultural model is used, it is sometimes only as a thin, politically correct veil for a hidden deficit mindset; for example, one might use the term "culturally deprived" instead of "hearing-impaired" (O'Brien & Placier, 2015).

Deaf people are all too aware of these biases against them and the desire to see their culture destroyed. Paradoxically, majority membership typically permits a lifestyle free of even the realization of the traumas endured by minorities; this concept is known as privilege, and hearing privileges include incidental knowledge gained by overhearing information, not being judged for their communication preferences or speech quality, avoiding audism or even having to acknowledge its existence, and the general assumption that they are capable of elementary tasks, such as driving, earning a degree, maintaining employment, and raising children (Frederick, 2021; Harmon, 2008). In addition, some may don a mask of benevolence, the idea that providing accommodations, permitting employment of Deaf people, and granting accessibility to public services are special kindnesses worth of admiration rather than fundamental human rights to which everyone is entitled (Ladd, 2003). That attitude fosters deep resentment in minority populations, and the Deaf community is no exception.

Lack of Support

Even those who mean well do not always provide the quality of support Deaf clients, employees, or loved ones require. Between lack of resources and low expectations, many Deaf children grow up illiterate and may not be able to write their own names (Padden & Humphries, 2006). Those who go to Deaf schools may not be able to do so until they are in middle or high school, and by that time, they have already fallen well behind their hearing peers (O'Brien & Placier, 2015). Qualified faculty are in high demand and short supply, so there may be only one Deaf school in the area or even the state, and the teachers and staff may not be fluent in sign language (O'Brien & Placier, 2015).

After graduation, many Deaf adults turn to vocational rehabilitation programs to find employment. However, these services are often withdrawn prematurely, leaving the Deaf person

to flounder and ultimately fail (Schoffstall et al., 2015). These patterns of limited support that is offered too late and retracted too soon represents a constant struggle for members of the Deaf community. Teetering on the edge of defeat, unable to self-reflect, get constructive feedback, communicate in their own language, or advance in their lives and careers can manifest as lack of self-efficacy or as any of several psychological disorders (Torigoe, 2019; Zaien et al, 2021).

Violence and Trauma

Deaf children are four times more likely to suffer abuse than hearing children, and they are also at greater risk of neglect (Lomas & Johnson, 2012; Padden & Humphries, 2006; Titus, Schiller, & Guthmann, 2008). Child abuse within this population is likely to go unreported due to several factors, including lack of training in identifying signs of abuse specific to Deaf children and difficulties communicating effectively (Lomas & Johnson, 2012). The brutality does not end in adulthood. Deaf and hard-of-hearing college students are subject to greater rates of abuse than hearing college students, and there are significant differences even within subsections of the population (McQuiller Williams & Porter, 2014). Deaf adults experience a higher incidence of intimate partner violence than the general population (Anderson & Leigh, 2010). The prevalence of interpersonal trauma in the lives of Deaf people have been linked to increased risk of substance abuse disorders and higher levels of distress (Anderson et al., 2021; Titus, Schiller, & Guthmann, 2008). However, one study found that in a clinical sample, the traumatic experiences of Deaf clients did not differ significantly from the traumas of the hearing clients (Øhre et al., 2015). More research is needed to determine whether the qualities of this sample are generalizable or consistent with the general population.

Depression and Anxiety

The symptoms of depression in Deaf populations are identical to those observed in hearing people, but Deaf individuals may communicate those symptoms differently, and they are rarely screened for depression (Sheppard, 2008; Sheppard & Badger, 2010). Thus, the exact prevalence of depression among the Deaf is difficult to pinpoint, but a recent study found that a sample of d/Deaf and hard-of-hearing children exhibited more depressive symptoms and selfharm than the hearing children in the study, and among girls, the incidence of peer victimization was higher for the Deaf participants (Butcher et al., 2022). This is consistent with other studies that have linked depressive symptoms, such as poor self-image and suicidal ideation, in Deaf adults to abuse, isolation, difficulty communicating, and other distressing childhood occurrences (Kushalnagar et al., 2017; Sheppard, 2008; Sheppard & Badger, 2010).

A 2008 qualitative study used hermeneutic interviews facilitated by certified interpreters to explore the experience of depression among a sample of Deaf participants. Among the themes that emerged, the researcher found that participants related their depression to the frustrations of trying to find balance between their culture and functioning in a hearing world and defending themselves against the general perception that they are broken (Sheppard, 2008). One might speculate that the expectation of prejudice, rather than any actual existence of bias, is the cause of the depressive symptoms. However, this suggestion was laid to rest ten years later when researchers found that depression among Deaf individuals was not mediated by internalized and anticipated preconceptions but by enacted discrimination experienced by the participants (Mousely & Chaudoir, 2018).

The prevalence of anxiety within the Deaf community is unclear. Around 80% of studies have found that d/Deaf and hard-of-hearing participants have higher levels of anxiety as

compared to hearing control groups (Shoham et al., 2019). A Norwegian study found that Deaf children are far more likely than their hearing peers to be referred for mental health services; one of the top reasons for these referrals was anxiety (Oerbeck et al., 2022). In contrast, a 2013 study found that anxiety disorders were less likely to be diagnosed in d/Deaf or hard-of-hearing outpatients than in hearing outpatients (Diaz et al., 2013). It is worth noting that the absence of a diagnosis may be attributed to miscommunication or inadequate screening (Sheppard & Badger, 2010). A more recent study concluded that d/Deaf and hard-of-hearing children had fewer anxiety symptoms than their hearing peers (Long, Attuquayefio, & Hudson, 2021). However, this study collected its data not from a representative sample but from the parents and teachers of Deaf children who reported observed rather than experienced symptoms. Another study found that reports of symptoms from Deaf children are significantly higher than those observed by their parents (Fellinger et al., 2008). This contrast merits further research.

Studies in Norway and Spain found that symptoms of both depression and anxiety were more common among d/Deaf and hard-of-hearing participants than within the general hearing population, and the symptoms reported were rated as being more severe (Kvam, Loeb, & Tambs, 2007; Peñacoba et al., 2020). This seems to be the case whether the d/Deaf and hard-of-hearing individuals prefer sign language or speech for communication (Øhre et al., 2017). In fact, d/Deaf and hard-of-hearing older adults have almost twice the rate of depression symptoms and more than twice the rate of anxiety symptoms compared to hearing adults of the same age (Simning et al., 2019). Overall, in spite of having comparable social relationships, members of the Deaf community have overall poorer quality of life and higher emotional distress than hearing populations (Fellinger et al., 2005; Fellinger et al., 2008).

A study by Palmer et al. (2013) explored the emotional impact of genetic testing on Deaf individuals. Those participants who discovered they were genetically deaf experienced a significant reduction in anxiety; those whose test showed no genetic link or an inconclusive result reported their anxiety was heightened by the findings. The difference between the groups was not deafness itself but instead seemed to be linked to self-understanding and perceived personal control. Thus, the initial anxiety is less likely to have stemmed from the deafness itself and more likely to have roots in the social environment. The sense of control derived from increased awareness may serve to mitigate the effects of minority stress.

Other Disorders

Many disorders are no more common within the Deaf community than in hearing populations. For example, a 2013 study found no differences in diagnostic rates for psychotic disorders, personality disorders, eating disorders, adjustment disorders, or personality disorders between hearing and Deaf people (Diaz et al., 2013). The same study, however, found that several disorders, including impulse control disorders, attention-deficit disorders, pervasive developmental disorders, and intellectual disabilities were diagnosed significantly more frequently among Deaf samples than hearing samples. More research is needed to determine whether these differences have legitimate genetic or environmental causes or may be the product of bias or a lack of understanding of Deaf norms.

Despite these differences, some studies have shown that Deaf clients have the same potential to develop healthy coping skills as hearing clients. For example, studies of Deaf adolescents have found that they have similar emotional regulation skills, emotional awareness, and psychological adjustment compared to hearing peers (Bizjak, 2009; Eichengreen et al., 2022). Another study found that the mental health of Deaf adolescents with CI may be

comparable to hearing adolescents (Huber & Kipman, 2011); however, this study used only one measure and contrasts with a previous study using the same measure plus others (Fellinger et al., 2008). Furthermore, the 2011 study relied on the input of adults who observed the adolescents rather than direct data collection from a representative sample.

The unique social crossroads of Deaf culture in the hearing world presents a number of problems for its members, and in addition to the practical and interpersonal barriers, these individuals might also face difficulties stemming from bicultural or multicultural identity (Feist, Saladin, & Hansmann, 2013; Jhai, 2017; Oldale, 2008; Weifferink, Vermeij, & Uilenburg, 2012; Wright & Reese, 2015). With these biases being supported at both the personal level and by societal laws and leadership, Deaf adults face multiple barriers to employment, social support, and mental health services (Emery, Middleton, & Turner, 2010; Feist, Saladin, & Hansmann, 2013; Fellinger, Holzinger, & Pollard; 2012; Oldale, 2008; Perkins Nerlich et al., 2021, Torigoe, 2019; Vernon & Leigh, 2007; Wright & Reese, 2015). Although relatively little literature is available on the topic, some researchers have embarked on studies to help improve conditions and outcomes for Deaf people.

Deaf Counseling

Accessibility

Research has clearly established there is a need for counseling interventions targeting issues faced by members of the Deaf community. However, counselors and potential clients alike may experience significant barriers to meeting those needs through counseling services. Several researchers have explored challenges that stem from communication problems (Fellinger, Holzinger, & Pollard; 2012; Geigerich et al., 2020; Oldale, 2008; Perkins Nerlich et al., 2021; Vernon & Leigh, 2007; Wright & Reese, 2015). For example, during the COVID-19 pandemic,

mask requirements obstructed the view of speech-reading clients (Perkins Nerlich et al., 2021). Many Deaf clients would prefer a signing counselor, but the few signing counselors available are distributed over a wide geographical range, limiting the accessibility for the average Deaf client (Oldale, 2008; Vernon & Leigh, 2007; Wright & Reese, 2015). Furthermore, there is no current standard by which a client can determine whether someone is qualified to offer counseling services in sign language, and it is estimated that in some places, there may be over 8000 Deaf clients per qualified signing therapist (Oldale, 2008).

Attitudes

Additionally, a hostile social climate may contribute to a Deaf person's hesitation to seek mental health services. Some arguments against providing culturally-relevant services to Deaf clients include linguistic objections to sign language in favor of oralism, offense at the oppression perceived by the Deaf community, the belief that Deaf people are content to be uneducated so that they do not have to make an effort to thrive in a hearing world, and the denial that Deaf culture exists at all (Ladd, 2003; Padden & Humphries, 2006). Those who challenge the authenticity of Deaf culture often cite the lack of geographical boundaries, mixed genetic outcomes within families, and the bicultural and multicultural identities of many Deaf people as taking precedence over any form of Deaf identity (Ladd, 2003). Some cultural objections are informed by the medical model. Over time, there has been a significant shift in the direction of the public perception of Deafness to a cultural model (Humphries, 2008), but in spite of research that clearly demonstrates the validity of Deaf culture, the medical model persists (Munro, Knox, and Lowe, 2008; O'Brien & Placier, 2015; Wright & Reese, 2015). In these studies, there is generally no differentiation between those who are deafened and those who are Deaf (Ladd , 2003).

Professionals working with Deaf individuals from the medical model perspective have responded to recommendations for a sociocultural approach with defensive indignation (see Spivak, 1982). Others approach their treatment of Deaf clients with an apparent need to direct and control their interactions, and they may even ignore laws and practice standards regarding therapeutic techniques, assessment, and documentation (Lomas, Nichter, & Robles Pina, 2011). Failure to acknowledge sociocultural differences in a professional manner can lead to misdiagnosis and miscommunication, which in turn can lead to mistrust and lack of compliance with treatment plans (Oldale, 2008; Vernon & Leigh, 2007).

Given the combination of hostility and invalidation often present in predominantly hearing settings, it is hardly surprising that counselors may experience rejection from Deaf clients and lack of support from their families (Govindasamy, Amin, & Subhi, 2021). Counselors who work with Deaf populations have also expressed a sense of isolation from their peers who may not understand the complexity of their work (Lomas, Nichter, & Robles Pina, 2011). When working with Deaf clients, counselors and other mental health professionals have reported a range of internal emotions, including pity (Boyd, 2007) and, in the case of Deaf children, a sort of parental countertransference, especially in the absence of actual parental involvement (Lomas, Nichter, & Robles Pina, 2011). The factors that discourage treatment-seeking among Deaf individuals and the on-the-job interpersonal and intrapersonal struggles are only the beginning of the challenges experienced by mental health professionals serving the Deaf community.

Communication

Counselors are ethically obligated to provide services in the client's preferred language or to retain the services of a qualified interpreter (ACA, 2014; ADA, 1990, 1991; Wright & Reese, 2015). As previously established, not all those who identify as Deaf prefer sign language to other

forms of communication (Feldman, Kluwin, & McCrone, 2006; Harmon, 2008; Horejes, 2013; Leigh, 2008; Padden & Humphries, 2006; Perkins Nerlich, et al., 2021). Rather than try to predict a client's choice by asking potentially offensive questions such as, "How bad is your hearing?" or "Can you speak well?" it is best to ask the person how they feel most comfortable communicating (Wright & Reese, 2015).

Culturally Deaf clients tend to prefer signing counselors to the use of interpreters, and some studies have found that this produces a more emotionally impactful session (Munro, Knox, & Lowe, 2008; Oldale, 2008; Vernon & Leigh, 2007; Wright & Reese, 2015). One study attempted to determine whether the counselor's signing ability affected the client's perceptions of competence; the results were inconclusive, though the researchers suspect the differences in outcomes may have more to do with the client's background in sign language (Feldman, Kluwin, & McCrone, 2006). Ideally, signing counselors should have a strong understanding of Deaf culture and approach counseling from a cultural rather than a medical model (Munro, Knox, & Lowe, 2008; Vernon & Leigh, 2007).

When the counselor is not fluent in ASL, the alternative is to hire a qualified interpreter. This is a legal imperative for ethically responsible service provision (Lomas & Johnson, 2012). Each interpreter possesses a unique set of skills, experiences, and insight in the lives and cultures of their Deaf clients (Darroch, 2018; Vernon & Leigh, 2007). Because the quality of interpretive skills varies significantly, it is recommended that counselors retain certified interpreters with ample experience and a good reputation in the local Deaf community (Fellinger, Holzinger, & Pollard, 2012; Frederick, 2021; Vernon & Leigh, 2007). Securing a recognized interpreter does have its downsides though. Depending on the level of familiarity between the interpreter and the members of the Deaf community, the client may not feel comfortable opening up in front of

them, much as they would not want to invite a coworker to the session; thus, it may be necessary to explicitly outline the confidentiality protocols and negotiate boundaries with both the interpreter and the Deaf client (Oldale, 2008; Wright & Reese, 2015). In spite of these potential challenges, the services of a skilled interpreter have been shown to reduce distractions, improve counselor-client communication, and decrease attrition of Deaf clients (Fellinger, Holzinger, & Pollard, 2012; Frederick 2021).

Gaps in the Literature

Cultural Diffusion

Deaf culture, even within a single country, has a great degree of heterogeneity (Livneh & Sherwood, 1991; Munro, Knox, & Lowe, 2008; Oldale, 2008; Wright & Reese, 2015). Signed languages across the globe are as different as spoken languages, and many regional variations exist as well, and the specific grammar structures and word interpretations often have cultural significance (Munro, Knox, & Lowe, 2008; Wright & Reese, 2015). Geographic cultures, too, are very different and may affect Deaf communities in any number of ways. Therefore, Deaf counseling studies from different parts of the world have limited generalizability. The studies I found from Europe (Boyd, 2007; Darroch, 2018; Datta et al., 2020; Oldale, 2008; Weifferink, Vermeij, & Uilenburg, 2012), Africa (Zaien et al., 2021), Australia (Munro, Knox, & Lowe, 2008), and Asia (Govindasamy, Amin, & Subhi, 2021; Torigoe, 2019) may be, in some ways, irrelevant to the issues faced by Deaf clients in the United States.

Emphasis on Deficits

Another major obstacle in the research is the tendency to view Deaf issues from the traditional medical model rather than a sociocultural perspective (Emery, Middleton, & Turner, 2010; Fellinger, Holzinger, & Pollard; 2012; Oldale, 2008; Wright & Reese, 2015). Although the

medical model has its place in fields such as audiology (Spivak, 1982), counselors are to be committed to a multiculturally inclusive approach that embraces the cultural aspects of being Deaf (ACA, 2014). Several studies, however, posit Deafness as a problem rather than as a cultural membership (see Datta et al., 2020; Govindasamy, Amin, & Subhi, 2021; Harvey, 2009; Livneh & Sherwood, 1991; Spivak, 1982; Zaien et al., 2021). Harvey (2009) uses a narrative approach in which deafness is an enemy to be defeated, while another study emphasizes that deafness should be corrected (Datta et al., 2020). Substitute any other cultural group (Christianity, femininity, Blackness, queerness, etc.) in the place of "deafness" in the above statements, and their insulting nature quickly becomes apparent. Additionally, many articles included offensive language such as "impaired" (Spivak, 1982, pg 69), "handicapped" (Spivak, 1982, pg 69), and "disabled" (Govindasamy, Amin, & Subhi, 2021, pg 28), which imply superiority of hearing individuals over Deaf individuals and emphasize the deficit of hearing ability over the incredible diversity, rich history, cultural attributes, and pride of the Deaf community.

Absence of Deaf Input

Echoing this sentiment, researchers often choose to work with hearing participants rather than Deaf participants, even when their research is aimed at helping the Deaf community. Many articles sampled participants or reflected the perspectives of those that were tangential to, but not part of, Deaf culture, such as interpreters and hearing sign language students (Darroch, 2018; Giegerich et al., 2020), parents of Deaf children (Crowe et al., 2015; Weifferink, Vermeij, & Uilenburg, 2012), hearing counselors or counseling students with Deaf clients (Boyd, 2007; Giegerich et al., 2020; Govindasamy, Amin, & Subhi, 2021; Harvey, 2009; Lomas, Nichter, & Robles Pina, 2011; Schoffstall et al., 2015), and audiologists (Spivak, 1982). While these views

are essential for building mutual understanding for interdisciplinary collaboration, the majority of contributions to our understanding of culturally appropriate counseling interventions for the Deaf community should involve Deaf participants. Given the historical and current marginalization of members of Deaf culture, this may be easier said than done. If researchers fail to recruit a diverse sample of culturally Deaf participants, the results may not be generalizable to members of the Deaf community. For example, Livneh & Sherwood (1991) sampled a variety of people with disabilities, some of which may differ significantly from deafness; they also assumed late-deafness, in which someone loses hearing later in life, usually due to aging, and is less likely to identify as culturally Deaf. Some interventions for the Deaf, such as the one described by Whyte & Guiffrida (2011), were developed independently of input from Deaf clients. This indicates a need for more research conducted by or in partnership with the Deaf community.

Often, articles consist of commentary (Fellinger, Holzinger, & Pollard; 2012; Perkins Nerlich et al., 2021; Vernon & Leigh, 2007; Wright & Reese, 2015) or counselor experiences (Boyd, 2007; Giegerich et al., 2020; Govindasamy, Amin, & Subhi, 2021; Harvey, 2009; Lomas, Nichter, & Robles Pina, 2011; Schoffstall et al., 2015) rather than studies examining the perspectives of Deaf participants. Those that conducted original research with a Deaf sample were often limited to specific subsections of the Deaf population, including students (Anderson & Leigh, 2010; Datta et al., 2020; Feldman, Kluwin, & McCrone, 2006; Jhai, 2017; Torigoe, 2019; Whyte & Guiffrida, 2011; Wright et al., 2022), teachers (O'Brien & Placier, 2015); gay men (Beese & Tasker, 2022), Hispanic women (Feist, Saladin, & Hansmann, 2013), or single subjects (Boyd, 2007; Harvey, 2009; Whyte & Guiffrida, 2011). Although an argument could be made that exceptions exist and that those studies listed above may have some generalizability,

mental health counseling for Deaf adults as a broad and diverse group remains largely unexplored (Anderson et al., 2021; Vernon & Leigh, 2007).

Despite the powerful narratives and vivid histories of Deaf people, many regard them as simply a medical group rather than a sociocultural population with their own language, traditions, values, and perspectives. Because of this bias and multiple other factors, Deaf individuals are in great need of culturally-relevant mental health services, which are currently inaccessible to many. With further research, we may be able to better understand the needs, social norms, clinical symptomology, assessment, and treatment of the Deaf. This requires a foundational understanding of the current perspectives of Deaf adults regarding counseling and mental health.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore the perspectives of Deaf adults on counseling using naturalistic inquiry. The overarching research question was, "What are the perspectives of Deaf adults on counseling?" Within that question there were the following sub-questions:

1. How do Deaf adults perceive the concept of counseling?
2. How do Deaf adults perceive counseling services?
3. How do Deaf adults perceive counselors?

Research Design

As previously discussed in Chapter 1, this study followed a naturalistic inquiry design. In this chapter, I will outline the methodology of that design in greater detail. Using a grounded theory method was appropriate to answer the research questions because, rather than seeking to confirm expectations or validate current practices, it solicited the answers to those questions directly from the population of interest without a prior hypothesis.

Naturalistic Inquiry

Traditional positivist paradigms are founded on the ideas of objective realities, generalization, causal relationships, and the importance of maintaining a value-free stance in the name of research. Naturalistic inquiry, on the other hand, acknowledges multiple subjective realities, the inseparable nature of time and context when interpreting findings, reciprocal relationships, and the significance of human experiences, values, and biases in both researchers and participants (Lincoln & Guba, 1985). Beuving & de Vries (2014) describe this paradigm as qualitative research that seeks to examine ordinary phenomena with minimal disturbance on the

part of the researcher. Thus, the purpose of naturalistic inquiry is not to manipulate variables but to understand existing constructed meanings.

Research to guide and direct counselors with Deaf clients is too scarce to begin testing variables and building theories; therefore, it is necessary to establish some understanding of how Deaf people think and what they believe to be true about counseling constructs. Thus, in the spirit of naturalistic inquiry, this study endeavored to solicit from Deaf adults their perspectives regarding counseling services, practitioners, and clients. The challenge was to dive into the diverse subjective realities of the participants, creating as few ripples as possible in the process.

Grounded Theory Methods

Naturalistic inquiry makes use of established grounded theory methods to collect and analyze data (Beuving & de Vries, 2014; Lincoln & Guba, 1985). Although there are many techniques for soliciting information, interviews are a flexible and effective means of amassing data (Beuving & de Vries, 2014; Lincoln & Guba, 1985). Aside from these practicalities, an interview provides opportunities for reciprocal influence and constructing ideographic interpretations *with* the respondents rather than *for* or *to* them (Lincoln & Guba, 1985). The resulting dyad of researcher and participant is empowering both for the investigator who is aided in the study by the participants' unique insights and for the participant who exerts greater authority over the interpretive findings than is typically seen in positivistic research; thus, it forms the perfect basis for generating themes regarding perspectives of counseling from the marginalized Deaf population.

The grounded theory methods used in naturalistic inquiry emphasize the constructed meanings of a given phenomenon by the participants themselves (Suddaby, 2006). Rather than using research data to confirm a pre-existing theory, themes are generated from the data itself

and evolve over the course of the study (Dey, 2004; Suddaby, 2006). Each study begins with broad information gathering (semi-structured interviews, in this case) and narrows to more structured forms (like the follow-up interviews in this study), as directed by the initial findings (Dey, 2004). Simultaneously, data is coded, sorted into categories, analyzed, compared with each successive collection of data, and refined by both researcher and participants until a meaningful interpretation is achieved (Dey, 2004; Glaser & Strauss, 1967). This technique, known as constant comparative analysis, slowly extrapolates a cohesive set of hypotheses until data saturation, a point when no more meaningful concepts or themes emerge (Dey, 2004; Glaser & Strauss, 1967).

Trustworthiness

Unlike positivist approaches, qualitative research is not subject to constructs such as validity, reliability, and generalization (Erlandson, 1993; Lincoln & Guba, 1985; Merriam & Tisdell, 2015; Shenton, 2004). Instead, the trustworthiness of a study is founded in its adherence to established practices for demonstrating its credibility, transferability, dependability, and confirmability (Erlandson, 1993; Lincoln & Guba, 1985; Shenton, 2004). Lincoln and Guba (1985) have suggested multiple methods for establishing the trustworthiness of a study using these four criteria.

Establishing the credibility of the study requires the researcher first to design a study in such a way that the findings can be reasonably believed and then to demonstrate that the interpretation of the data is consistent with the subjective viewpoints of the participants (Erlandson, 1993; Lincoln & Guba, 1985). I accomplished this goal using multiple methods. I practiced prolonged engagement by immersing myself in the Deaf community. Lincoln & Guba

(1985) describe prolonged engagement as an investment of time spent learning about the culture, building trust with the population, and uncovering potential misinformation introduced by the researcher or participants. Although it was not possible to directly engage with each of the respondents in my study prior to the interviews, I took signing classes, made friends at the Deaf community center, and participated in Deaf events, such as Signing Santa (a Christmas event with signed carols, holiday characters played by Deaf adults, and other festivities) and Deaf karaoke, in which songs are performed with sign language and movement. These activities allowed me to explore various aspects of Deaf culture and learn how to build trust within the Deaf community. In addition to prolonged engagement, I reviewed data during its collection and throughout the analysis process, as well as revisiting it multiple times throughout the emergence, consolidation, and dissolution of early themes, a technique known as persistent observation (Erlandson, 1993; Lincoln & Guba, 1985).

Data saturation can be conceptualized as a construct with both a breadth of multiple participants and a depth including follow-up with at least some of those participants (Bowen, 2008). The former was achieved after the fifth participant; this respondent's contributions did not result in the formation of any new themes. The latter was achieved by following up with two participants.

Another means of establishing credibility is triangulation (Erlandson, 1993; Lincoln & Guba, 1985). Erlandson (1993) states that triangulation is "perhaps the best way to elicit the various and divergent constructions of reality that exist within the context of a study" (pg 31). I triangulated data in this study by collecting data at two separate times. The first interview resulted in my initial data sets which let to tentative themes. I then invited participants back for follow-up interviews to review and discuss the emerging results. Lincoln & Guba (1985) also

recommend peer debriefing, in which the researcher discusses the study with individuals outside the context of the study who understand the concepts of the study well enough to provide useful feedback. Erlandson (1993) emphasizes the peer relationship as an essential component and discourages relying on dissertation committee members alone. Therefore, I consulted with a Deaf Studies faculty member at the institution where I teach, discussed the progress of my research, allowed her to reflect on interpretations and findings, and documented her feedback.

During data collection and analysis, as I noticed apparent exceptions to the emergent data, I followed up on those points and attempted to determine whether the inconsistency was meaningful or irrelevant to the study. Relevant discrepancies may lead to a deeper understanding of the participant perspectives regarding counseling; such a process is called negative case analysis (Lincoln & Guba, 1985). In those negative cases, I have offered tentative explanations in Chapter 5.

According to Lincoln & Guba (1985), the single most important technique for establishing credibility is member-checking. This involves discussing elements of the study and the tentative emerging themes with the participants (Erlandson, 1993; Lincoln & Guba, 1985; Merriam & Tisdell, 2015; Shenton, 2004). Member-checking can be a formal or an informal process, conducted after each interview or at the end of the study (Erlandson, 1993; Lincoln & Guba, 1985). In this study, member-checking involved sending transcripts to the participants to verify the interpreter's spoken version of their contributions and soliciting feedback during the follow-up session to collaborate on an interpretation of the findings.

Comparable to the concept of external validity in a quantitative study is the second criterion for trustworthiness: transferability (Erlandson, 1993; Lincoln & Guba, 1967). Studies using grounded theory methods are not typically aimed at generalization (Glasser & Strauss,

1967), and any attempt to generalize findings would be inappropriate for this study. However, this inquiry was not intended for the benefit of the local Deaf community alone. Some aspects of the findings may be transferable to other groups or settings. Because of the complex diversity of potential applications, this was not a quantifiable outcome. Instead, transferability was demonstrated using thick descriptions, detailed enough for others to make a reasonable determination whether some facet of the emergent findings could be applicable to a different location, population, or situation (Erlandson, 1993; Lincoln & Guba, 1985).

The third criterion is dependability, a concept which has been compared to that of reliability within positivist paradigms (Lincoln & Guba, 1985). Ideally, a replicated version of the study should yield similar findings, allowing for individual differences(Erlandson, 1993; Lincoln & Guba, 1985). To meet this criterion, I have preserved an audit trail by tracking the progress of the study, noting the themes that emerge, and documenting any changes required in detailed, chronological notes saved to the same flash drive as the videos.

The final criterion by which the trustworthiness of this study can be judged is confirmability, the extent to which my interpretations reflect the perspectives of culturally Deaf adults regarding counseling rather than my own biases and subjective viewpoint (Erlandson, 1993; Lincoln & Guba, 1985). Evidence for my findings have been confirmed in four ways, two of which have already been mentioned: triangulation and the audit trail (Erlandson, 1993; Lincoln & Guba, 1985). By gathering data at two different points in time, triangulation provided perspectives through which to view the data, reducing the potential for my own predispositions to interfere (Lincoln & Guba, 1985). The audit trail provided not only a means for reviewers to understand the process but also to make judgments about whether my findings are consistent with the data (Erlandson, 1993; Lincoln & Guba, 1985). Additionally, I kept a reflexive journal

documenting my thoughts, emotions, and other reactions throughout the study as well as my actions, my decisions, and justifications for those choices (Erlandson, 1993; Lincoln & Guba, 1985). Finally, I maintained regular check-ins with my dissertation chair and was transparent with her and my other readers about my qualifications, experiences, and background and how those factors might have influenced the study as it progressed (Merriam & Tisdell, 2015; Shenton, 2004).

For well over a century, Deaf mental health has been dominated by hearing perspectives, and the premise of this study necessitated the representation of Deaf participants and the inclusion of their interpretations of the data. Naturalistic inquiry was, then, the most rational choice as a framework for this research. The grounded theory methods endemic to naturalistic data collection and analysis provided an efficient and effective means of soliciting and confirming the contributions of the Deaf participants.

Target Population and Sample

The research question indicated that the target population is Deaf adults. One of the major principles of qualitative designs is that the results of any study cannot be generalized beyond the sample (Dey, 2004). The sample for this study included adults who self-identified as culturally Deaf. Wright and Reese (2015) promote the cultural model of Deafhood in which the Deaf community is characterized by unifying experiences, traditions, and expectations as well as a common language. In keeping with these guidelines and with the purpose of the study, Deaf adults were defined as individuals over the age of 18 who self-identify as culturally Deaf.

Sample

The sample for this study was defined as self-identified Deaf adults recruited from a Deaf community center in the Coastal Bend region of Texas, as well as those who volunteered to

participate via links in ads posted to Facebook groups for Deaf communities. The resulting sample reflected the purpose of the study, which aimed to explore perspectives of culturally Deaf adults. Due to the nature of theoretical sampling, it is not always possible to determine the sample size in advance (Dey, 2004; Glaser & Strauss, 1967; Suddaby, 2006).

Procedures

Participant Selection

When using naturalistic design with grounded theory methods the sample targeted is derived from relevance to the research questions and may be subject to successive recruitment, dependent upon the emerging data (Dey, 2004; Glaser & Strauss, 1967; Suddaby, 2006). In this study, I recruited Deaf adults to fit the purpose of the study until data reached saturation.

I used a Qualtrics survey to screen respondents for eligibility and replied to prospective participants seeking clarification as needed. For this study, the inclusion criteria were selfidentification as culturally Deaf and legal ability to consent. Exclusion criteria included adults who could not act as their own guardians, did not have access to virtual interviews, or resided outside of the United States. After screening, selected participants were scheduled for an interview via e-mail, and informed consent policies were reviewed prior to each interview (with the assistance of the interpreter, if requested in the demographic survey).

Expert Review

Misunderstandings between Deaf and hearing individuals are commonplace and have been cited as one reason for the mistrust between the Deaf community and members of the helping professions (Vernon & Leigh, 2007; Wright & Reese, 2015). To minimize these errors and ensure cultural relevance, I contacted experts at the local Deaf and Hard of Hearing Center

as well as the Deaf Studies department of a local community college to review the guiding interview questions (see below). No changes were deemed necessary.

Guiding Interview Questions

1. What do you believe to be true about counseling?
2. What do you believe to be true about people who seek counseling services?
3. What do you believe to be true about people who provide counseling services?
4. What do you believe to be true about counseling for the Deaf community?
5. Is there anything else you would like to tell me that I have not asked you?

Data Collection

Initially, data was collected via individual interviews lasting approximately 30 minutes each. Each semi-structured interview began with the review of the informed consent document and consisted of five guiding questions with some flexibility. An interpreter was present to aid with both informed consent and the actual interview as requested by the participant in the demographic survey. This minimized communication errors and allowed me to focus on the interview itself rather than the intricacies of sign language (Feldman & Gum, 2007; Hanks & Hill, 2015; Vernon & Leigh, 2007; Wright & Reese, 2015).

Each interview was recorded for later transcription. The video was necessary to capture the actual signs used by the interpreter and the participant and to be referred to later when I had questions about something that was signed or said during the interview. The videos are also considered referential adequacy material (see *Trustworthiness* below). I transcribed the audio from the interviews. Both the videos and the typed transcriptions were stored on my personal laptop in encrypted files; the laptop itself was protected with a password and kept in a locked bag when not in use. The key was kept with my personal keys in my purse.

Glaser & Strauss (1967) emphasize the importance of analyzing data as it is being collected. As themes emerge from data analysis, it is sometimes necessary to revise the interview questions for subsequent participants (Glaser & Strauss, 1967). However, no adjustments were necessary during this study. Participants were sent transcriptions of their interviews to check for accuracy of their interpreted statements.

Following the interview stage of data collection and once my analysis had rendered an interpretation, I invited all participants back for a focus group session to review my findings and provide feedback. However, due to scheduling conflicts, this plan was altered to allow for individual follow-up interviews instead. After this change was permitted by the Institutional Review Board (IRB), invitations were sent via text or email, dependent on the participant preferences indicated in the demographic survey, and two participants accepted. An interpreter was available to facilitate communication for one participant who had indicated she preferred sign language to spoken English.

During these sessions, we discussed the themes that emerged. Participants were invited to confirm, correct, or add to the results. I also asked participants the following questions relevant to the emerging themes:

1. What role, if any, do family members play in the mental health of Deaf people?
2. What role, if any, do other Deaf people play in the mental health of Deaf people?
3. Previous research has suggested that Deaf people are resistant to counseling; that was not what I found. What are your thoughts?
4. Which factors would be most important to you when looking for a counselor?
5. In what ways should counselors be involved in the Deaf community?
6. What role do counselors play in career development for Deaf clients?

7. What other roles might be important?
8. For those in the Deaf community seeking counseling, what information would be most important for them to know?
9. Tell me your thoughts about counseling accessibility for Deaf people.
10. What is most important for counselors to know about Deaf people?
11. What role, if any, should interpreters serve in the counseling process?
12. Is there anything else you would like to tell me that I have not asked you?

As with the first set of interviews, the participants' responses were transcribed and subjected to data analysis.

Data Analysis

In naturalistic studies using grounded theory methods, data analysis takes place simultaneously with data collection (Dey, 2004; Glaser & Strauss, 1967; Suddaby, 2006). Thus, I transcribed and analyzed data using the constant comparison method described by Glasser & Strauss (1967) while analyzing the interviews. The transcriptions were subjected to constant comparative analysis, in which I compared the participant responses, created labels for groups based on similarities in the data, and noted any themes, inconsistencies, or questions that emerge from the data collected (Corbin & Strauss, 2015; Lincoln & Guba, 1985).

Glaser & Strauss (1967) describe their constant comparison method of data analysis as a four-part sequence. In the first, I coded data from the transcripts using keywords, some of which would eventually become thematic categories as they emerged, by adding labels to the data within the documents. With each additional item added to a category, I compared the item to the previous items to ensure fit; this was to prevent a label from assuming multiple meanings during analysis as well as to generate a theoretical set of conditions for each label (Glaser & Strauss

1967). For example, an initial category was labeled *Culture*, and its items consisted of aspects of Deaf culture mentioned by participants. When participants mentioned minority stressors, such as workplace discrimination, I realized that although these experiences directly related to Deaf culture and resulted from conflicts with the mainstream hearing cultures, it did not fit with the other items. Thus, the category *Culture* became more clearly defined, and an additional category was formed from the new items. As themes and their theoretical conditions emerged, I took note of these ideas in a separate document before returning to the data.

Following the initial stage, Glaser & Strauss (1967) indicate that researchers should integrate categories with similar theoretical properties in a process known as axial coding. This, they argue, is one of the purposes of simultaneous data collection and analysis. After each interview, and once the transcripts were coded, I returned to the document on which I had previously listed my codes and their tentative categories. I reviewed the conditions of the categories and sometimes found that two or more were more alike than not. It was often the case that some items could easily fit the conditions of multiple categories and that the phenomenon represented by the categories was likely the same. Therefore, these categories were combined, and the theoretical conditions were redefined. For example, there was significant crossover regarding the concepts of *Discrimination* and *Abuse*. These categories coalesced under a new label: *Struggles and Trauma.* I maintained sections for previous thematic incarnations for reference and reflection.

The third step is delimitation (Glaser & Strauss, 1967). As data emerges and categories merge, the results will need fewer and less significant modifications and will solidify into a stable framework, requiring only minor corrections and reductions in non-relevant details (Glaser & Strauss, 1967). The goal of this process is to achieve what Glaser & Strauss (1967) termed

parsimony of variables and to determine to what extent the findings can be applied to a variety of situations. Therefore, in this study, I aimed to eliminate extraneous variables to come to the simplest and most straightforward conclusions about when and how the emerging themes within my participants' contributions could be applied. As this occurred, I reduced the original categories according to the boundaries of the overall results by eliminating those themes that had too little support, a process Glasser & Strauss (1967) term selective coding. The remaining categories that are central to the findings became theoretically saturated as the interviews progressed.

The final stage in the constant comparison method of data analysis is to organize the resulting themes based on the documentation generated during the previous steps (Glaser & Strauss, 1967). I used the notes regarding the categories and their properties to draft findings backed by the specific incidents as examples. Once generated, the participants were invited to their follow-up interviews to review and provide feedback on my interpretation of the results. These findings and the process that led to it will be detailed in chapter four and discussed in depth in chapter five.

Role and Lens of the Researcher

Role of the Researcher

In qualitative studies, the researcher interprets data through a subjective lens and therefore should be considered an instrument of the study (Lincoln & Guba, 1985). This longheld qualitative assumption was backed by researchers Pezalla, Pettigrew, & Miller-Day (2012) who added that the researcher's personality and unique approach to data collection need not be a detriment and can be beneficial to the study, provided it is subjected to careful reflection. In

keeping with their recommendations, I provided self-disclosure to participants and kept a self-reflexive journal in the same folder as the notes.

Lens of the Researcher

My interest in this population has been strongly influenced by my personal experiences as a person with a moderate-to-severe hearing impairment. Although I have experience within the Deaf community, my connections to Deaf culture are still quite new, and I use speechreading and hearing aids in spoken conversations rather than ASL as a primary form of communication. Therefore, I may be seen as an outsider by the Deaf participants. Furthermore, I am a doctoral candidate in a Counselor Education program at the local university. Just as my interpretations will be influenced by a subjective lens, participant responses may be influenced by my cultural identity, my association with the counseling profession, or both.

Ethical Considerations

To respect the dignity and ensure the safety of all participants, several steps were taken to ensure ethical standards were kept during the research process. Although recruitment efforts were public, potential participants were encouraged to contact me via e-mail to volunteer for the study to keep their participation as confidential as possible. In addition, all documentation, including videos, related to the study was kept in an encrypted file on a password-protected laptop and backed up to a cloud server accessed only through my personal account, which was also protected by a password. The laptop, when not in use, was kept in a locked laptop bag, and the key to the bag was kept in my purse, along with my personal keys.

Certified interpreters assisted with communication to ensure the participants understood the informed consent process and their rights throughout the study. The interpreters facilitated communication to allow the participants to provide responses and feedback in their preferred

language. Community counseling resources were provided to participants at the end of each interview to mitigate the risk of potential traumatization caused by any aspect of the interviews. Every effort was made to respect and empower the participants and the Deaf community as a whole.

Summary

This study began with recruitment in a public location for Deaf community events and on social media with the assistance of an interpreter. Participants contacted me via e-mail or clicked on links in the social media advertisements for screening and interview scheduling. Informed consent was reviewed at the first interview and at the follow-up interviews. The interpreter assisted with the informed consent process and with each interview. Members of the Deaf community contributed to this study in the interviews and by providing feedback in follow-up sessions. The findings are detailed in the following chapter.

CHAPTER IV

FINDINGS

Recruitment via social media and physical flyers posted at a local Deaf community center resulted in five eligible participants who were willing and able to meet virtually for at least one interview. One participant declined to answer any demographic questions. Of the remaining participants, one identified as male, and three identified as female. Two participants were White; one of these indicated Hispanic, Latinx, or Spanish ethnic origins, and the other did not. One participant was of both Asian and Native Hawaiian/ Pacific Islander descent, and one chose *Other* for race. One participant had a high school education, one had some college but no degree, one had earned an Associate's degree, and one had earned a Bachelor's degree. One participant declined to answer any demographic questions.

These participants shared their experiences and perspectives regarding counseling, and from this data, five major themes emerged: *Struggles and Trauma, Importance of Counseling, Barriers to Counseling, Emotional Support Role of the Counselor,* and *Desirable Counselor Characteristics*. Under *Struggles and Trauma*, the subtheme *Interactions with the Hearing World* emerged. Two subthemes were identified under *Importance of Counseling*: *Benefits* and *Personal Openness to Counseling*. Subthemes for the *Barriers to Counseling* theme included *The Search Process, Expectation of Risk, Negative Experiences*, and *Interpreters*. The *Desirable Counselor Characteristics* theme was highly varied, though not contradictory, and one subtheme emerged: *Deaf Fluency*. This chapter will explore in depth the definitions of each theme and subtheme as well as the data from which they emerged.

Table 2

Themes and Subthemes

Themes	Subthemes
Struggles and Trauma	Interactions with the Hearing World
Importance of Counseling	Benefits Personal Openness
Barriers to Counseling	The Search Process Expectation of Risk Negative Experiences Interpreters
Emotional Support Role of the Counselor	None emerged
Desirable Counselor Characteristics	Deaf Fluency

Note. This table depicts the five major themes that emerged and their associated subthemes.

Theme 1: Struggles and Trauma

This theme explores challenges faced by members of the Deaf community that would necessitate counseling services. Four of the five participants provided data from which this theme emerged. The theme was warranted by extensive evidence in the form of both generalizations and numerous specific examples. “There’s a lot of things that we have conflict on [sic],” Participant C stated.

Participant B used the words “struggles,” “trial and tribulation,” and “mental issues” when discussing the shared challenges of members of the Deaf community. As an example, she referenced family conflicts that were unique to Deaf individuals. “Families often take advantage of their Deaf and hard-of-hearing family members,” she said. “I have seen situations where the Deaf person didn’t even realize they were getting a disability check. Their family members steal their benefits.”

Participant C confirmed there were often "issues with the family." She spoke of her own experiences and those she had witnessed in the lives of others. "[There are] conflicts all over," she said, "especially if you're the only Deaf one in the family."

While all families have the potential for conflict, some struggles are unique to families with Deaf members. "I'm the only one in my family that's Deaf and hard-of-hearing," said Participant D. "And I think my parents have always regretted it." Whether or not Participant D judged her parents' feelings accurately, the perception of being unwanted or unaccepted can leave a lasting scar.

In addition to the emotional damage families can wreak, Participant B identified other forms of abuse prevalent within the Deaf community. "Families often take advantage of their Deaf and hard-of-hearing family members," she said. "I have seen situations where the Deaf person didn't even know they have been getting a disability check. Their family members steal their benefits." This form of maltreatment does not occur in families in which no member has a disability, and it may lead to distrust of hearing individuals, anxiety, and shame. "I still have anxiety from [growing up in a hearing household]," Participant B stated. Later she spoke of how those feelings followed her into adulthood and how she was able to overcome them. "You don't have to feel ashamed of it," she said. "Just be proud, and just be, you know, thankful for what you have. It's hard. It is hard."

Participant B also indicated loneliness and isolation as potential mental health risks, stating that Deaf adults often "feel like they're alone," especially without connections to the Deaf community. Participant E agreed. "Some Deaf people are very isolated," he stated. He went on to say that counseling could help those secluded Deaf individuals "be more involved in the hearing world."

Participant B has seen multiple clients who have struggled with violent trauma, and she is also a survivor of violent crime. She stated her belief that culturally-relevant counseling and psychoeducation would be an invaluable asset in those cases. “We have to be able to provide in-depth information for, say, sexual harassment . . . rape! A victim of rape,” she said.

Given the circumstances involving family conflict, isolation, and high rates of victimization, it is unsurprising that participants mentioned depression and anxiety as a common occurrence within the Deaf community. “There’s a lot of depression with being Deaf and hard-of-hearing,” said Participant D. Even when depression does not stem directly from issues related to Deafness, it can be difficult for Deaf people to find services to meet their needs. Such was the case for Participant B when she became pregnant while still recovering from a previous birth. “I was suffering from postpartum depression,” she said. “Obviously, I was pregnant at the time, so that was a high risk, that life I’m carrying inside . . . My hormones were all over the place.” She found it difficult to communicate with mental and physical healthcare providers to meet her needs in a way that was appropriate for her:

> I was kind of stressed out. It was really stressful. I was going through a lot. . . the whole COVID thing, being a mom and having to deal with COVID, having to deal with miscommunications, having to deal with the lack of information. (Participant B)

Regarding her stress, Participant B admitted to an unhealthy coping mechanism. “I’m a smoker,” she said. “I’m trying to quit right now. Like, I’m literally vaping.” However, there was a time when her self-destructive patterns might have proved more immediately lethal. “I told the person [at the hospital] I’d been thinking about killing myself, and I had a plan,” she stated. After this confession, she was transferred to inpatient care, but the lack of communication left her confused, regretful, and cautious.

Subtheme: Interactions with the Hearing World

Four out of the five participants described interactions between Deaf and hearing individuals at school, work, and home when discussing their sense of Deaf identity. This subtheme speaks to the contrast between Deaf culture and mainstream American culture, as well as how the two clash, combine, and coexist. As Participant C stated, "they have to merge for me every day."

A couple of participants talked about being the only Deaf member of their hearing families. Participant B stated she remembered "growing up in the hearing environment." Now as an adult, her husband of eight years is hearing as are their two children. Participant D claimed she was the only "Deaf and hard-of-hearing" member of her family. "Growing up my parents had to pay for my hearing aids," she recalled. For many, hearing aids may seem like a simple solution for those who have some residual hearing, but relying on technology to communicate in a hearing world is not without its drawbacks:

> I could get some financial assistance for them, but it wasn't gonna be totally covered because, you know, oh, you have to be poor to get covered. I'm not poor, not rich . . . It's a little frustrating because they just keep getting more expensive. (Participant D)

Participants also described how they interact and communicate with hearing individuals in a variety of public settings. Participant B mentioned being "mainstreamed in school," meaning she had attended the same classes as her hearing peers as opposed to going to a Deaf school or taking classes consisting of only Deaf students. Participant D discussed her struggles as a Deaf person in predominantly hearing workplaces. She stated in the initial interview:

> Finding a job is always very frustrating, and finding employers that, you know, respect Deaf and hard-of-hearing [employees] is difficult. My current part-time job is working in

> retail, and I feel like I don't get as much respect as I should . . . The managers at the store where I work at, I just think they don't think I'm capable of figuring things out for myself. Or like the way they talk to me, sometimes it's like they don't think I know any better.

She was currently looking for employment elsewhere but said it was "tough looking for a job" because "a lot of people don't understand what it's like to work with a Deaf and hard-of-hearing person . . . I feel like people don't treat me like I'm capable."

Surprisingly, despite the difficulties communicating with hearing individuals, two participants expressed a desire to see more hearing, as well as Deaf, people engaged in Deaf culture. Participant B recommended, "Get involved in the Deaf and hard-of-hearing community . . . We have a lot of events. There's lots of events that's going on." For those who might be a bit hesitant to engage with others in an unfamiliar cultural environment, she confidently added:

> It's important that, you know, we start to put ourselves out there and try to be brave . . . The more you put yourself out there, the more you learn about Deaf culture. You learn about the Deaf and hard-of-hearing community. The more that you put yourself out there, the more you are immersed in the culture.

Participant A stated, "I didn't find any counselors . . . involved in the Deaf community."

Theme 2: Importance of Counseling

All participants expressed general beliefs that counseling is beneficial or necessary, either personally or for the Deaf community, as well as specific issues necessitating counseling services for Deaf people. Thus, this theme encompasses both those statements that support the idea that counseling is not just a preference but an essential service as well as the benefits of receiving that

service. Additionally, four of the five participants indicated they would be open to seeking counseling in the future.

Subtheme: Benefits of Counseling

This subtheme emerged from statements regarding specific or nonspecific benefits of counseling or the perception of counseling as a beneficial service in general. All participants contributed to the data that formed this subtheme. When asked about their thoughts and beliefs regarding counseling, all participants answered that it might "benefit" clients (Participants C and D) or that it "helps" (Participants A, B, D, and E), and some provided further details. "I think it really helps," Participant B stated. This participant did not give any specific instances of support or assistance provided by a counselor but seemed convinced of its merits, nonetheless. Participant A was similarly vague but positive, stating "I think it's a great, like, resource, and it helps, like, improve your life."

Others were more detailed in their explanations. "I think it's a beneficial service," Participant C said. "I've seen how it benefits specific people." She elaborated by describing how counselors offer "another perspective to help them . . . a professional perspective" for their clients and could "help them figure out whatever it is about themselves" that could lead to greater independence and self-efficacy. This participant also noted that clients may experience improvements "with their health" and recovery from "anything that's related to any trauma they may have from childhood to adulthood." She seemed to view the role of the counselor as a source of support for clients "to help themselves get better, feel better about [past traumatic experiences]."

Participant E echoed these healing and recovery sentiments. "I think [counseling] helps people. I think it's good. [Counselors are] helpful." Far from buying into the stigma that

historically presented barriers, this participant stated, “It’s healthy. Counselors would help.” This participant also spoke about the direct benefits to the Deaf community, especially when it comes to navigating the hearing world and communicating with others. “[Counselors would] help us understand more.”

On this point, Participant D agreed. “[Counseling services] would help some Deaf or hard-of-hearing . . . It can be helpful to some people.” After reflecting on her own struggles, the participant made a courageously vulnerable statement. “I personally think I could benefit,” she said. “I think it would be helpful to talk to a counselor about these things. Yeah, it would be nice to be able to.” When told she would be offered a list of free or low-cost virtual counseling resources, she stated, “That would help!” Although her primary interest in counseling was career-related -- she stated she wanted someone to “help me find the right job” -- she was also keenly aware of the value of mental health services. “There’s a lot of depression with being Deaf and hard-of-hearing, and I think a counselor could help with that as well.”

Some participants made statements that indicated counseling was not only helpful but often a necessity. When asked what they thought or believed about individuals who seek counseling services, all participants were very supportive. “They may need it, counseling,” stated Participant D.

Participant C agreed, answering, “People who seek counseling and support like that need it, and they don’t have it in their lives.” This sentiment was echoed yet again when Participant E stated, “They need help. We need counselors.” Participant B, who worked in the Deaf community, bemoaned the fact that those who seek help often have trouble finding “this service that is needed.” She sighed, “We really need counselors.”

Participant A considered the question from their personal experiences as a college student seeking services. “I just knew that I needed counseling,” they said. Despite the concerns about stigma which permeate the literature as an explanation for the hesitation Deaf clients often experience when considering counseling services, it is abundantly clear that Deaf people see counseling services as a critical need.

Subtheme: Personal Openness to Counseling

This subtheme refers to the desire, acceptance, or perceived personal need for counseling services. It emerged from data provided by four of the five participants. Notably, Participant D did not deny openness to counseling but stated that the cost would likely be prohibitive. Each participant was asked if they would like a list of counseling resources at the end of their individual interviews. Their answers are as follows:

“Yes.” – Participant A

“That would be great! Yeah, I would love that!” – Participant B

“Yes, I’m open to that. I’ve had it in the back of my mind for a while. I mean, I would like to, and I know I probably need it. But I’m open to it.” – Participant C

“I don’t know. I probably couldn’t afford it. I just don’t know.” – Participant D

“I’ve been looking for counseling for myself. Yeah, I think I would. Sure, if that would be possible.” – Participant E

While the levels of enthusiasm varied among these participants, this subtheme is warranted as an indicator of the likelihood a Deaf person would be open to learning about counseling resources. This seemingly contradictory finding has multiple potential explanations, some of which will be explored in this and the next chapter and some of which require additional research.

Theme 3: Barriers to Counseling

Participants noted there are practical, social, and psychological barriers to seeking or acquiring counseling services. Four subthemes emerged within this theme. Although not every subtheme contains data from every participant, the overall theme, Barriers to Counseling, encompasses significant input from all five participants.

Subtheme: The Search Process

For the purposes of this study, *The Search Process* refers to difficulties in initiating the search for a counselor and other obstacles to successfully finding suitable counseling services. It speaks to the struggles of Deaf individuals to access information and services that may be readily available to the hearing. This subtheme emerged from statements made by three of the five participants.

One of the major barriers to the search for a counselor was the geographic restrictions some individuals faced. "It's difficult to find counseling," said Participant D. Regarding mental health services that suit the needs of the Deaf community, Participant B added, "We really lack the resource." Participant C was particularly outspoken on this point. "It's really limited here," she said. "There's a few in the local area. Out in the rural area? Not so much. It's even more limited." Her repetition of the word "limited" continued throughout the interview and seemed to emphasize the frustration in her facial expression and body language.

> Just have to really dive in to find out, you know, what access I would have here . . . But I know [bigger communities] have more access, and there's more Deaf counselors available, too. There's more in the Deaf community there. (Participant C)

Overall, though, she admitted that easy accessibility was not an option for most culturally

Deaf clients. “Access to counseling for the Deaf community, for Deaf culture, is very limited.” One thing that stood out about Participant C, aside from her silent exasperation, was that she offered a potential solution to the shortage of counselors who are fluent in Deaf culture and sign language. “I know the counseling services are state-to-state,” she began, “but what we need out there is more openness.” When asked if she was suggesting fewer restrictions on license portability or improvements to insurance options, she indicated she meant both. As it stands, the enormity of the task of finding affordable, culturally-relevant counseling services that are accessible to her is more than she can manage at the moment. “I just don’t have the time to find one,” she said.

Affordability also impacted Participant D’s search for counseling. “The biggest problem with counseling,” she said, “is the cost --[having to take off work] and also having the money to pay the counselor.” When asked if she had considered free, low-cost, or sliding scale counseling services, she replied, “I don’t think that I would qualify.”

Participant B suggested that, for areas that do have access to culturally-relevant counseling for the Deaf community, marketing those services should be done in a way that is also culturally appropriate for this population. “Like a brochure or, like, a list of counselors? I don’t want that,” she said. Given the importance of detailed disclosure in Deaf culture, she indicated that a brief list with simple contact information would leave more questions than answers:

> Which psychologist? The different specialties? I don’t know where to talk to [sic], who deals with that . . . It’s really hard to find out who I need to talk to, which topic would you prefer to talk with them about, what topic you can talk about with each [mental health professional]. (Participant B)

She explained that Deaf individuals might have more difficulties than hearing people when it comes to deciphering the differences in mental health services and what they can expect.

> We have to be able to give in-depth information. They need more information explained. You have to be able to provide information -- simple, easy-to-understand information. What's going on? How do I set up an appointment? What do I do? Where do I set up an appointment? You explain to them. Who do I see? You explain to them. (Participant B)

This participant also spoke about the distinction that hearing people make between self-disclosure in a social environment and in a counseling session, and she stated concern that this type of cultural boundary might be blurred within Deaf populations. "They may not understand the difference between showing your feelings to people. They should be able to understand," she said, but added that it is "a little hard for people who are seeking counseling to know the difference."

Subtheme: Expectation of Risk

This subtheme refers to the belief that many counselors available are unskilled or unsuited to their needs. Three of the five participants expressed the statements from which this subtheme emerged. Its inclusion is warranted by the amount of evidence provided by the three participants and the depth of their observations. All three expressed hesitation about seeking counseling services as well as the contention that hearing counselors would not understand Deaf perspectives.

When asked about her beliefs about counselors, Participant D replied, "I don't think they know everything. I think that because everyone has their own opinions and beliefs and views. So not everything that they're saying is correct." Later, Participant D elaborated about her perceptions of what counselors do not know. "I think it's difficult to have counselors who

understand what people like me are going through," she stated wearily. "I feel like a counselor wouldn't understand the problems that Deaf and hard-of-hearing people go through." Participant A seemed to agree:

> Hearing counselors are going to think . . . they see that as a loss, and that's it. And then, you know, once I lose it completely, you know, there's no helping me, but it's also, you know, access to a new language and a new culture. But we also need to kind of look into the loss and how that's going to affect me emotionally.

"I feel like it's 50/50," Participant C stated. "Kind of hit or miss." When asked to elaborate, she gladly obliged.

> It's hard to find counselors who are really good at their job. About 50% aren't really worth it. They're not good at their job. Their skills aren't and their knowledge isn't where it should be. None of them really understand how this culture impacts my life in the real world . . . the Deaf world. They don't understand the two concepts and how they have to merge for me everyday. So I mean, it's a lot on one person to know. So I feel like they understand that maybe less than 50% or so.

Subtheme: Negative Experiences with Mental Health Services

This subtheme refers to the personal experiences or observations of others' experiences that deter seeking counseling services. The data was provided by three of the five participants. Its inclusion is warranted by the depth and variety of anecdotal evidence used by the Deaf individuals when determining whether they would seek counseling.

When discussing his recent interactions with hearing college counselors, Participant A stated, "They don't understand Deaf community, the culture, and what it means to lose my

hearing." For this participant, it was never a matter of locating services or setting an appointment, but the experiences that followed shaped their perspective.

> Right now, I'm in counseling . . . through my school. I just knew I needed counseling, so I went to my school, and I found that. But there's no captions. There's nothing. It's video, but I have to lipread the whole time, and it's a struggle. . . I think after college, I think I'm not going to be as likely to look for counseling.

"I have been involved in group therapy," Participant B claimed. She described how she mentioned to hospital personnel that she was experiencing suicidal thoughts during her second pregnancy, and they sent her to an inpatient mental health facility. "A group therapy home!" she said. "They really put me in therapy." What unfolded next was confusing and frustrating for this participant as she tried to communicate with staff members and get more information. "I haven't gone back to the group therapy, and I'm not in counseling," she said. "Why did I say that [I was suicidal]? I shouldn't have done it."

"I've never experienced counseling myself," Participant C stated. However, she claimed she had "many friends and family that go to counseling. They'll share with me their experiences with the services. It's not really beneficial for them." She reiterated this information came secondhand from:

> just personal conversations with friends and other people I've met. I'm a visual person, so I've observed some of it. I've also seen, like, what they've struggled through and whether the counselor helps them or not. This is one reason why I haven't gone to counseling before in my local area . . . The benefit to me probably wouldn't be much.

She elaborated on the dissimilarity of hearing and Deaf clients in the counseling setting.

“It’s harder to get, like, breakthroughs,” she said. “It’s different for us than what a normal person would experience.” Given the collectivist nature of Deaf culture, Participant C was asked if these narratives from others would influence a Deaf person’s views and decisions regarding counseling services, and she confidently answered, “Very much.”

Subtheme: Interpreters

This subtheme was somewhat unexpected and yet emerged from statements made by four of the five participants. Notably, the remaining participant, Participant D, used oralist methods of communication (speaking and lipreading with some residual hearing) and did not rely on interpreters. This subtheme refers to objections to or problems with the use of interpreters in counseling sessions.

“Are you a certified interpreter?” Participant B eyed the interpreter facilitating the interview with suspicion. “Deaf people have the right to know whether they’re certified or not, and if they’re not certified, they have the right to, you know, deny that service.” After assuring her that the interpreter was certified and hired from a reputable company, Participant B wanted to know where the interpreter was located geographically, as she was not familiar with this particular interpreter. She added, “I’ve been having some trouble with [different interpreter service].”

Her cautious reaction was supported by other participants. Participant C expressed similar concerns regarding interpreters. “The quality of the interpreting service, you know, it’s not great,” she said. “It wouldn’t be the same interpreter each time. So every time, it would be a different one.” Adjusting to an unfamiliar interpreter’s style could be difficult. “The levels are different,” she stated. “The skills are different. The flow would be different.”

Familiarity with an interpreter could also complicate perceptions of confidentiality and feel very awkward in a counseling session, and there are not very many choices for interpreters in smaller town and rural neighborhoods.

> Like for a bigger community area, maybe. There's just not a lot of interpreters available. The [Deaf] community is a lot smaller, so they tend not to be very comfortable using an interpreter in that small of an area because they know the community. They know everyone, so it's harder to believe the confidentiality will stay there. (Participant C)

All the participants who use sign language as a primary form of communication express ed unease at the idea of an interpreter joining them in a counseling session. Participants described feeling "uncomfortable" (Participant B) or stated that they did not feel comfortable with the third party in the room (Participants C and E). One (Participant A) stated, "It's just not the same." Using interpreters appears to have many drawbacks in the eyes of Deaf clients. In addition to problems with quality and the unease of having a familiar face joining a private counseling session, some Deaf individuals would prefer not to have an interpreter just because there would be someone else in the room.

Theme 4: Emotional Support Role of Counselors

Four out of five participants highlighted the importance of personal disclosure in the counseling process and the emotional supported provided by the counselor. Participant B described the concept as "sharing" thoughts and emotions with the counselor. She stated a desire "to talk to someone about the things I'm going through" and emphasized the benefits of "sharing your feelings" and "sharing your thoughts."

Two other participants expressed a similar disposition. Participant E stated that counseling offered an opportunity to be "able to discuss our emotions," and Participant D spoke

of the prospect of counseling in terms of her current situation, stating she might be able to make some improvements "if I could talk to somebody about that."

Participant C was perhaps the most ardent supporter of this aspect of counseling and said that people in the Deaf community and others who seek mental health "need to open up" in order to progress through the counseling process and find healing.

Theme 5: Desirable Counselor Characteristics

All participants described traits, characteristics, and behaviors that are valued and sought after by Deaf clients. Participant C, who had expressed doubts about half the available counselors, stated, "On the other 50%, I believe that, yes, it's the right person. They're good, and it's, like, a big benefit . . . It's a great match . . . Just, we got to find the right one."

Another common response was a preference for a high degree of empathy and understanding. For example, Participant B hoped to find a counselor who was "able to be there and listen." When asked about her beliefs regarding those who provide counseling services, Participant D stated, "They want to help people," reflecting an optimistic view of the counseling professions. Of the ideal counselor, Participant C said, "They're empathetic. They have empathy . . . Like, they have a good heart . . . They're really there to support you as the patient."

Participant C also mentioned passion and education as key values in the ideal counseling relationship. She described counseling as not only "the right job" but as a "mission," and stated that a good counselor should "love their job." She also stated that a "strong" counselor has an equally strong "knowledge base" from which their techniques and skills are derived and that their background significantly influences their approach. "They've got the knowledge. It's all there," she said. "It's really strong."

However, the participants did express a preference for counselors whose skills and training specifically address the needs of Deaf clients. “We need a lot more who understand the struggles and the perspectives of the Deaf community,” said Participant A. “Someone who understands Deaf culture and the community.” Likewise, Participant B expressed a need for “counselors who are already culturally exposed, knowing the culture of the Deaf and hard-of-hearing community [and who] know what the Deaf and hard-of-hearing go through.”

“How do they understand, for example, different cultures? It’s really important to understand to help people,” said Participant C. “It’s really important to know that and not just feel like [a counseling technique] will benefit a patient in general.” She described the ideal counselor as:

> someone who has a background in that culture, who doesn’t have to have been, like, fully-involved, but has some background to help support [the client] . . . to understand that background and what it’s really like for us, just applied to the counseling service. . . To be really beneficial, you already kind of need to know that, and some do understand that, yes, but it’s different . . . it’s really important for the counselor to have that background and the education to know what would really benefit us versus, like, a non-Deaf person. (Participant C)

Participant C emphasized the importance of a foundational training in Deaf culture rather than relying on the client to educate the counselor.

> I’m looking for someone who has that background knowledge, too. Yeah, I want them to understand the culture a little bit more in-depth, I guess . . . like education to understand how trauma affects the Deaf people, their life, and what that would look like everyday. It’d be really impactful for their life going on. (Participant C)

The participants also stressed the advocacy and psychoeducational roles of counselors in the Deaf community. Participant A stated:

> A counselor can help educate both a Deaf and hard-of-hearing person as well as the hearing workforce or the medical industry on what accommodations may be helpful. How, when, where and why would an interpreter be helpful and useful for me? I only just learned of apps on the phone being possible tools for me. I don't know anything about any of the apps or how to use them. A counselor can help with choosing the right accommodations and how to use them. Also, maybe a counselor can help navigate the legality of certain accommodations or medical coverage? I know my state hearing aids are only legally required to be covered for ages 18 and under. But I don't know what other accommodations are legally required.

Participant B has some experience in education and advocacy, and she had a few recommendations for counselors:

> I think maybe [counselors and other helping professionals] can give a presentation or like a group workshop or a talk to let the [Deaf] community know what services are available, like how to set up an appointment, what the different services mean, what to expect. Provide a presentation . . . that presentation can have a Deaf person, you know, doing the presentation in a language that people who are Deaf and hard-of-hearing understand.

She went on to explain that this could be accomplished with a Deaf presenter or a presentation facilitated by a Certified Deaf Interpreter (CDI), a Deaf person who translates sign language into regional variations.

Subtheme: Deaf Fluency

This subtheme refers to the preference for a counselor who is Deaf or fluent in Deaf culture and sign language. It emerged from statements made by four of the five participants. As previously mentioned, it is important to note that the one participant who did not provide evidence to support this subtheme was Participant D who converses in an oral/ aural manner and does not use sign language as a primary form of communication. Thus, it is reasonable that she might not highlight Deaf fluency to the degree of the other participants, if at all.

"There are not a lot of Deaf counselors," said Participant A. Although they preferred a Deaf counselor to a hearing counselor, it was not an option for them. "I looked in the community in my area, and I didn't find any counselors who were Deaf or hard-of-hearing or even signed."

"What we really need," stated Participant B, "are counselors who are Deaf." She wondered aloud about the options in her state. "Do they have anyone who are Deaf and hard-of-hearing counselors? . . . I want to be able to, you know, be comfortable talking to someone in my language."

Participant C stated in frustration:

> I don't have the energy to try and explain [integration of Deaf culture in a predominantly hearing environment] for them just to get a few services because probably, each time, I would have to explain it all over again about the Deaf world and the hearing world. I'm not super excited to get in and have those conversations, or try to have them, and be their homework, kind of, you know?

Participant E shared his thoughts on the matter, stating, "It's hard to find anyone who can communicate with me… I would prefer a Deaf counselor." When asked for clarification about whether this preference was for a Deaf counselor or one who was fluent in sign language,

Participant E stated, “Both.”

Significant revelations emerged from these interviews and follow-up sessions. They offered unique insights into the development of a Deaf identity and how Deaf culture merges with the hearing world. Participants described overall positive views of counseling, including the benefits of self-disclosure to an emotionally supportive counselor and ways that counseling might be able to help improve certain aspects of Deaf existence. While they expressed concerns based on previous negative experiences and the expectation of risk, they also provided a wealth of information about their preferences, hopes, and recommendations regarding counseling. Their generous disclosures can prove invaluable for counselors who aspire to treat Deaf clients.

CHAPTER V

DISCUSSION

There is a paucity of research investigating the mental health needs and culturally relevant treatments for Deaf adults, (Vernon & Leigh, 2007) and even less qualitative research exploring those concepts with Deaf participants. This study used naturalistic inquiry to address that deficit and provide insight into the perceptions of Deaf adults regarding counseling. Specifically, the research questions asked how Deaf adults interpret the meaning of counseling, how they perceive counseling, and how they perceive counselors.

Themes

Five themes emerged in this study (see Table 2). A thorough examination of the thematic results highlights disparities between policy and practice and calls for reevaluation of current approaches to Deaf counseling.

Theme 1: Struggles and Trauma

Participants in this study described distress, social conflicts, and other challenges unique to the Deaf community. A single subtheme, *Interactions with the Hearing World*, emerged from the diversity of their statements. The variation in their responses aligns with other research that has established that Deaf individuals are at disproportionate risk of certain mental health problems and sources of trauma (Anderson & Leigh, 2011; Butcher et al., 2022; Fellinger et al., 2005; Fellinger et al., 2008; Oerbeck et al., 2022).

Subtheme: Interactions with the Hearing World

Family Conflict. Several participants discussed family conflict. ,Padden & Humphries, 2006). Further complicating existing barriers, Deaf children in hearing families may not have the support they need to develop social competence (Leigh, 2008). Without familial support and the

social skills necessary for interacting with hearing peers, Deaf adults may be at a significant disadvantage in a variety of settings (Leigh, 2008).

The prevalence of interpersonal conflict in hearing families with Deaf children is worthy of further exploration. Family conflict was noted multiple times in previous studies, and at least one study has suggested that parents and other hearing authority figures may be missing important signs of distress in Deaf children (Fellinger et al., 2008). Additionally, Ladd (2003) has observed that many hearing parents feel the bond with their children is threatened by their cultural Deafness, a world they cannot fully enter, while others fear the stigma of abnormality that comes from having a child who cannot hear.

Deaf culture is collectivist (Ladd, 2003; Scherer, 2013; Wright & Reese, 2015), and many Deaf individuals may rely on family members for practical or emotional support (Crowe et al, 2015; Horejes, 2013; Ladd, 2003). The strong emphasis on group membership and natural dependence on relatives may exacerbate the pain of family conflict. Though some may find similar forms of scaffolding in the Deaf community, rejection and betrayal by family members is likely to have a significant impact on a Deaf person's worldview, behaviors, and well-being.

Sociocultural Conflict. One participant shared perceptions of evident prejudicial attitudes, and this seemed primarily concentrated in vocational settings. Another asserted that a lot of these conflicts are due to differences in communication styles, including a more open communication style with fewer personal boundaries. Detailed introductions and transparency regarding Deaf status of oneself and one's family members, whether the person attended mainstream or Deaf schools, and any contacts in the local Deaf community are essential aspects of culturally appropriate communication (Harmon, 2008; Padden & Humphries, 2006).

Research has indicated that Deaf employees often have an undue burden to prove their worth and often must work harder to earn the same levels of regard and authority as their hearing colleagues (Feist, Saladin, & Hansmann, 2013; Frederick, 2021; O'Brien & Placier, 2015). Deaf employees may be labeled or oppressed, and they may experience hostility from hearing coworkers who see them as strange, question the validity of Deaf culture, and accuse them of segregating themselves (O'Brien & Placier, 2015; Padden & Humphries, 2006). Furthermore, multiple minority status may increase these challenges, thickening the proverbial glass ceiling with every layer of marginalization (Frederick, 2021). This form of sociocultural conflict may also manifest as a lack of support in the form of vocational services that are withdrawn prematurely, leaving Deaf employees floundering in an environment where they may be seen as inferior (Schoffstall et al., 2015).

Ladd (2003) attributes this attitude to ethnocentricity, the belief that one's own cultural experiences are the norm and that others are odd or somehow wrong. They imagine their world and their lives without sound, and it is difficult for them to picture someone being happy with that reality. They may consider themselves privileged to be hearing (Harmon, 2008), which implies that those who cannot hear have an inferior existence. Furthermore, when Deaf individuals express being hurt by discriminatory beliefs and practices, the validity of their perceptions may be questioned, despite evidence that the experience of marginalization in the Deaf community is linked to specific instances rather than an ambiguous sense or internalized expectation (Mousely & Chaudoir, 2018).

Loneliness and Isolation. Participants expressed concern over the solitude many Deaf individuals endure due to communication barriers as well as the loneliness they often experience, even within the community, and though they suggested social events, mental health workshops,

and counseling as potential unifiers, they also acknowledged it would require that attendees, Deaf and hearing, have the courage and vulnerability to be open-minded to the language and mannerisms of the Deaf community. Multiple studies have shown that microaggressions, bold discrimination, chronic misunderstandings, and inequitable public policy may serve to isolate Deaf people from their hearing friends and family and from other members of the Deaf community (Beese & Tasker, 2022; Boyd, 2007; Ladd, 2003; Padden & Humphries, 2006; Wright & Reese, 2015). Their hearing peers may have difficulty understanding them except through the lens of an interpreter, keeping them always a step removed from the Deaf people in their lives (Young, Napier, & Oram, 2019). This has led to loneliness and a sense of seclusion for many members of the Deaf community.

Additional Findings Relevant to Struggles and Trauma

These findings were not extensive enough to constitute their own subthemes but warrant additional exploration.

Stress and Anxiety. Some participants mentioned stressors specifically related to Deafness, such as lack of accommodations for public performances. Both Participant A and Participant B described their deafness in terms of a "loss." Other stressors were more universal, such as the struggles during and following the coronavirus pandemic. This data reflects current literature regarding stressors affecting Deaf individuals. In addition to exploring ubiquitous stress generated by the pandemic (Perkins Nerlich et al., 2021), studies have investigated Deaf minority stress (Beese & Tasker, 2022), and entire books have been written about the historical context of those stressors (Harmon, 2008; Ladd, 2003; Padden & Humphries, 2006).

In addition to stress, participants described feelings of anxiety. Participant B was able to link her current anxious tendencies to specific experiences throughout her life. Participant D expressed financial worries, including being able to afford hearing aids and securing satisfactory employment. Studies to determine the exact prevalence of anxiety disorders in the Deaf community have shown mixed results. Some claim that anxiety is less common among Deaf individuals compared to hearing counterparts (Long, Attuquayefio, & Hudson, 2021). Others say it is more common, perhaps even twice the rate of the hearing population (Simning et al., 2019).

Regardless of the true prevalence, if a Deaf person presents for counseling services, it is likely anxiety will be listed among their primary concerns (Oerbeck et al., 2022). Whether or not Deaf individuals suffer from anxiety more frequently than the general population, researchers have noted symptoms of anxiety among their Deaf participants to be of greater severity compared to hearing peers (Fellinger et al., 2005; Fellinger et al., 2008; Kvam, Loeb, & Tambs, 2007; Peñacoba et al., 2020; Shoham et al., 2019). Yet studies suggest Deaf patients may not be sufficiently screened for related disorders (Sheppard & Badger, 2010). Therefore, more research is necessary to understand the complex nuances of Deaf experiences of stress and anxiety.

Depression, Shame, and Suicide. Participant D stated that depression and deafness are deeply intertwined. Participant B, for example, took some time to develop her Deaf cultural identity and accept herself without guilt or embarrassment. At the end of her second pregnancy, burdened with postpartum depression and trying to survive as a Deaf person in the pandemic with two infants, she contemplated suicide.

Unfortunately, her story is not unique. In research conducted by Kate Sheppard (2008), six of the nine Deaf participants had suicidal ideation or attempts. This study linked their depression and eventual suicidality to friction between the Deaf and hearing worlds and the

general perception of Deaf people as broken hearing people. Because Deaf people may express depressive symptoms differently from their hearing counterparts and depression screening relevant to Deaf culture is not yet a healthcare standard, far too many in the Deaf community suffer in literal silence (Sheppard 2008; Sheppard & Badger, 2010).

The implications for Deaf mental health are concerning. Even as children, members of the Deaf community have been found to have higher rates of depression and self-harm (Butcher et al., 2022). Multiple studies have linked this depression, whether diagnosed early or later in life, to childhood experiences of abuse, difficulties communicating, and various other long-term problems (Kushalnagar et al., 2017; Sheppard, 2008; Sheppard & Badger, 2010).

Coping Deficits. Like many other Deaf adults, Participant B reported she had suffered a great deal of interpersonal trauma throughout her life. To cope, she stated she often seeks support from members of the Deaf community. Unfortunately, this coping method is not available to all Deaf adults. Participant D does not have access to a local Deaf community. In her small hometown, she has been able to find no one who understands d/Deaf and hard-of-hearing perspectives to help her navigate various social challenges, such as finding employment, interacting with disrespectful hearing coworkers, and building a Deaf support system.

Studies have shown that trauma and other negative experiences are positively correlated with unhealthy coping strategies, sometimes even much later in life (Anderson et al., 2021; Titus, Schiller, & Guthmann, 2008). However, seeking out opportunities to socialize with other signing, culturally Deaf adults is a very common and effective approach to minimizing the detrimental effects of minority stress (Harmon, 2008; Ladd, 2003; Padden & Humphries, 2006). In addition, a 2021 study by Zaien et al. explored the role of self-efficacy as a potential mediator of psychological distress among the Deaf. Unfortunately, the development of self-efficacy

requires some understanding of personal strengths and challenges, and research has shown that self-reflection might be difficult for Deaf adults, which could in turn lead to trouble with emotional regulation (Torigoe, 2007). Without the development of effective coping skills, the trend of higher prevalence of mental health problems in the Deaf community can be expected to continue.

Theme 2: Importance of Counseling

All five participants described counseling in positive terms like "beneficial" and "helpful." This conflicts with research that seems to imply that Deaf individuals are resistant to receiving mental health services. One study found that Deaf clients were actively hostile toward counselors (Govindasamy, Amin, & Subhi, 2021). This apparent contradiction was exemplified by participants' own conflicted stances and may reflect complex motivations of potential Deaf clients.

Subtheme: Benefits of Counseling

When asked what they believed to be true about counseling services, participants tended to express vague but positive viewpoints, using words such as "helpful" or "beneficial," and occasionally providing examples of its merits. Participant C, who had formed her opinions based on her observations of others, mentioned gaining perspective, potential improvements in wellbeing, the opportunity to learn more about oneself, and assistance in trauma recovery.

The statements about self-discovery call to mind a 2013 study which described the reactions of Deaf individuals who completed genetic testing to determine if their deafness was hereditary or if the results were inconclusive (Palmer et al., 2013). The findings indicated that those whose tests were positive for a gene associated with hereditary deafness.

Participant C's endorsement of counseling for trauma is especially relevant to the Deaf community because, while the prevalence of genetic-based disorders is roughly equal to that of the general population, Deaf people are at a much greater risk of victimization and traumainduced disorders (Ladd, 2003). Unresolved trauma may, in turn, be linked to a higher rate of substance abuse disorders and distress in the Deaf community (Anderson et al., 2021; Titus, Schiller, & Guthmann, 2008).

Subtheme: Personal Openness to Counseling

Recognizing the benefits of a service does not guarantee that someone will choose to pursue the service for themselves. In this study, participants wavered in their own willingness to seek counseling, despite their praise for its benefits.

There was a great deal of variability in responses, often even within the statements of a single participant. One possibility is that as we discussed various aspects of counseling, the participants began to see more benefits and changed their minds. However, when considering the whole of their concerns, it seems more likely the participants were weighing the perceived need for and expected positive outcomes of counseling with the possibility that sessions might entail certain undesirable aspects as well.

The variation in responses indicates that, even if a Deaf person acknowledges potential advantages of seeking counseling services, this decision may be wrought with complexities that have yet to be explored. For example, previous research has suggested that culturally Deaf individuals might be hesitant or even openly hostile to the idea of receiving counseling. A survey of counselors in Malaysia found that they reported being rejected by their Deaf clients; however, no further detail is provided nor are there any follow-up statements from the clients themselves in exploration of this rejection (Govindasamy, Amin, & Subhi, 2021). Boyd (2007) posits that

such perceptions may be due to biases retained by the counselors themselves. Further research is merited to better understand the complexities of the intrapersonal and interpersonal conflicts among both Deaf clients and their counselors.

Theme 3: Barriers to Counseling

Subtheme: The Search Process

For those potential clients who are willing to seek help, the search process itself can be a barrier to service. Participant B stated that those in the Deaf community may need further instruction to successfully search for and initiate counseling services. Written information is widely available, but Participant B indicated that this is not especially helpful as English is not the first language for many Deaf individuals. Without detailed, essential information available in their own language, Deaf individuals may be unable to effectively search for and secure counseling services.

Once a potential client understands how to initiate the search, another hurdle is finding someone who is culturally-attuned and physically accessible. Both Participant B and D stated that there were no counselors in their respective areas that were familiar with the Deaf community (or with whom the Deaf community was familiar). These participants live in very different parts of the country, and this problem exists not only on a national scale but a global one as well. In 2008, Oldale found that the ratio of qualified therapists to Deaf citizens in Great Britain was one to more than eight thousand. More recent studies have also indicated that Deaf clients, who face higher levels of abuse and other traumas, have fewer options for and more barriers to culturally appropriate treatment (Lomas & Johnson, 2012; Perkins Nerlich, et al., 2021; Wright & Reese, 2015). When such services are available for the Deaf community, they may be withdrawn prematurely (Schoffstall et al., 2015). These impossible deficits leave many

Deaf individuals without access to mental health care services and frustrate the search for a Deaf-trained counselor with availability in their areas.

Subtheme: Expectation of Risk

Some participants stated an expectation that the counselor might not have the skills, knowledge, or empathy necessary to treat Deaf clients. Vernon & Leigh (2007) described culturally Deaf people as neglected by mental health research. Although some researchers have begun delving into investigations of assessments and interventions for Deaf populations (Anderson & Leigh, 2010; ; Anderson et al., 2021; Giegerich et al., 2020; Guiffrida, 2011; Harvey, 2009; Munro, Knox, & Lowe, 2008; Whyte & Guiffrida, 2011; Wright et al., 2022; Zaien et al., 2021), there are still plenty of questions and a lot of unexplored territory. Practitioners, therefore, have little guidance in the existing literature when planning treatment of

Deaf clients. The history of psychological assessment of Deaf clients is teeming with misdiagnosis and maltreatment (Blankmeyer Burke, 2008; Feist, Saladin, & Hansmann, 2013; Gala, 2017; Vernon & Leigh, 2007; Wright & Reese 2015). Ethnocentrism continues as assessments normed on hearing populations may over-pathologize behaviors that are culturally appropriate (Lomas, Nichter, & Robles Pina, 2011). Like many marginalized people whose cultures have been overlooked in clinical assessment and treatment, the Deaf community tends to approach mental health services cautiously.

Subtheme: Negative Experiences with Mental Health Services

Both Participants A and B described disappointing experiences with mental health services and they attributed their struggles in these situations to communication and cultural barriers between themselves and their hearing providers. The audio-centric perspective neglects Deaf cultural values and sign language in favor of approaches, such as speech-reading, that are

convenient for the hearing majority and leave Deaf people at a disadvantage; reading lips is difficult and not an especially accurate or dependable way to communicate (Ladd, 2003; Padden & Humphries, 2006). This oralist approach neglects to account for the difficulty and inaccuracy often experienced by those who attempt to read lips and speak to communicate with the hearing (Ladd, 2003) and places an undue burden on the client to ensure the accuracy and effectiveness of the interactions; even those who are proficient at speechreading are unlikely to decipher every important point (Pickens, 2021). Furthermore, given the role of generous self-disclosure in and collectivist nature of Deaf culture, that dissatisfaction with counseling services will affect not only the clients themselves but others in the community as well, as they form opinions based on the clients' experiences.

Subtheme: Interpreters

All participants who used sign language as a primary form of communication expressed discomfort with the presence of interpreters in a counseling session. Participants B and C both commented on the variations in style, flow, and accuracy of the interpreters with whom they had worked. Participant C also pointed out the disadvantages of both rural and urban districts when considering hiring an interpreter for counseling. In the larger cities, the larger pools of interpreters may mean that there would be an unfamiliar person present for each session; this could easily hinder the development of trust and rapport. For more rural areas, the interpreter hired for the counseling session may be familiar to the client but will also likely be a consistent presence in the Deaf community, calling into question the confidentiality of the sessions.

Some studies have shown some success with the use of interpreters in counseling sessions (Munro, Knox, & Lowe, 2008; Vernon & Leigh, 2007; Wright & Reese, 2015). As these participants have indicated, though, the counselor needs to consider several complex points

before securing their assistance. There is also a significant discrepancy in the quality of services provided by different interpreters. Existing research confirms that many interpreters are barely comprehensible by members of the Deaf community and quality may be difficult to ascertain (Oldale, 2008; Vernon & Leigh, 2007). These findings do not completely invalidate the use of interpreters to facilitate services. However, it does suggest that it may not be the best practice for Deaf clients, and the specific concerns regarding interpretation merit further discussion in research.

Theme 4: Emotional Support Role of Counselors

Participants discussed the role of counselors in providing emotional support. Over and over, participants described a process of "opening up" and "sharing" thoughts or feelings with someone whose sole duty was to assist them in their journey to healing. Extensive emotional expression has long been identified as a characteristic feature that distinguishes Deaf culture from surrounding mainstream cultures (Gala, 2017; Oldale, 2008; Wright & Reese, 2015). In particular, males in many cultures have social limitations on their displays of vulnerable emotions, and this clashes with the linguistic and cultural traditions of Deaf culture (Jhai, 2017), so although participants alluded to the importance of emotional expression and feedback, it was interesting to see that the only participant who openly identified as male was also the only participant to specifically cite emotional processing as a benefit of counseling.

Theme 5: Desirable Counselor Characteristics

Even without direct prompting, all participants described characteristics of what they perceived to be an ideal counselor. Many of the preferred counselor attributes, such as fit, passion, advocacy, and empathy, are very similar to qualities that are preferred by the general population. However, when viewed through the lens of Deaf culture, these qualities take on new

meaning. Participant C described the effectiveness of counseling in terms of the "match" between the counselor and the client, provided that the client can find the right practitioner for their specific needs. Participant C also stressed the importance of securing the services counselors who seem to enjoy and find a sense of purpose in their work. Participant E echoed this sentiment by stating that effective counselors should have an innate desire to help others.

The most successful counselors demonstrate the ability to build strong relationships with their clients in ways that honor their cultures (Jennings et al., 2003). Jennings et al. (2003) describes a series of studies of peer-nominated master therapists and revealed several qualities of effective practitioners that are remarkably like those outlined by the participants in this study. In addition to being passionate, these counselors are adept at balancing generosity with appropriate boundaries, quite skilled at engaging with their clients, and multiculturally competent.

In conjunction with these qualities, the participants described the significance of locating someone who could support their rights to public accommodations, provide community education for workplace ethics relevant to Deaf culture, and act as a mediator between the Deaf and hearing worlds. The specificity the participants applied to the duties of the counselor as an advocate speaks to the centrality of this role from a Deaf perspective. Advocacy is an ethical requirement for all counselors (ACA, 2014), and with its history of marginalization and oppression (Blankmeyer Burke, 2008; Brueggemann, 2008; Harmon, 2008; Ladd, 2003; Padden & Humphries, 2006; Vernon & Leigh, 2007; Wright & Reese, 2015), advocacy is especially meaningful for the Deaf community.

The concept of fit, as was described by Participant C, has also been explored as a reliable predictor of successful counseling in other populations (Curtis et al., 2013). Given the participants' emphasis on the need to be understood, both linguistically and culturally, it stands

to reason that fit would be especially important for Deaf clients. Unfortunately, studies have shown that counselors of Deaf clients may experience burnout, pity, and a range of other discouraging emotions (Boyd, 2007; Govindasamy, Amin, & Subhi, 2021; Lomas, Nichter, & Robles Pina, 2011), which may be more apparent to their Deaf clients' eyes than previously realized. Because the Deaf community has incorporated emotional expression into the grammar of their signed languages, they may more readily sense when the counselor is distracted, disinterested, or worse, apathetic, and it logically follows that this observation would affect Deaf perspectives of counseling in general, though more research is required to confirm this hypothesis.

Subtheme: Deaf Fluency

Most participants expressed a preference for a Deaf counselor over a hearing counselor, though Participant E indicated that either would be acceptable, provided that the hearing counselor was well-versed in Deaf culture and sign language. Participant C, too, stated that one need not be a member of the Deaf community but should have some training in Deaf culture and fluency in ASL, and Participant B said she wanted a counselor who could communicate with her in her own language.

These desires echo the Section A.2.c (Developmental and Cultural Sensitivity) of the ACA Code of Ethics (2014), which states "Counselors communicate information in ways that are both developmentally and culturally appropriate." Studies have shown that the use of sign language by the counselor improves the emotional impact of the counseling session (Ladd, 2003; Munro, Knox, & Lowe, 2008; Oldale, 2008; Padden & Humphries, 2006; Vernon & Leigh, 2007; Wright & Reese, 2015). Unfortunately, counselors who are proficient in the use of sign

language are few and far between, rendering such a valued service inaccessible to most Deaf clients (Oldale, 2008; Vernon & Leigh, 2007; Wright & Reese, 2015).

It is a regrettable fact that Deaf clients are often misunderstood, misdiagnosed, and ineffectively treated by hearing counselors (Blankmeyer Burke, 2008; Vernon & Leigh, 2007; Wright & Reese, 2015). Although language barriers undoubtedly play some role, these problems can be partially attributed to ethnocentrism and the deficit approach to Deafness (Humphries, 2008; Ladd, 2003). Lack of training in Deaf culture is likely to blame as well (Lomas & Johnson, 2012).

Implications for Counselors and Counseling Programs

The participants in this study often expressed a desire to be understood and accepted as well as concerns rooted in mistrust of the mental health systems and practices. There is no one solution that will remedy this problem. Instead, I suggest a multifaceted approach that includes changes in the areas of counselor education, research, practice, and policy.

Counselor Education

Multicultural competency – not disability – needs to be central to curricula regarding counseling Deaf clients. Thus, educators should incorporate relevant lessons using a sociocultural model rather than the traditional medical or deficit model. Although certification programs exist for offering counseling in other languages and for other cultures, no such certifications are currently available for Deaf culture. Until one becomes available, counseling students who are interested in providing services for Deaf clients can prepare by immersing themselves in their local Deaf community, attending Deaf events, becoming fluent in sign language, and focusing attention on the growing body of literature regarding Deaf counseling (Giegerich et al., 2020; Gournaris, 2022; Ladd, 2003; Munro, Knox, & Lowe, 2008; Oldale,

2008; Padden & Humphries, 2006; Vernon & Leigh, 2007; Wright & Reese, 2015). Even in the absence of an official certification program, these measures will be an invaluable step toward understanding Deaf clients. Also, students may consider research projects involving Deaf mental health to provide worthy contributions to existing literature.

Counseling programs should consider recruiting Deaf students to improve diversity (ACA, 2014). The concepts of Deafness and aspects of Deaf culture would be an excellent addition to program curricula and should be included in classes focused on multicultural competencies rather than disabilities (Giegerich et al., 2020; Wright & Reese, 2015). Students should also have coursework to prepare them to work effectively with interpreters (Darroch, 2018). With a foundational understanding of Deaf culture and experience cooperating with interpreters, counseling students will then be ready to see Deaf practice clients at their training sites (Giegerich et al., 2020). Counselor educators should also stay abreast of current technology aimed at assisting Deaf clients so that they can properly train their students in its use.

Counseling Deaf Clients

Conceptualizing mental health struggles through the lens of Deaf culture can help counselors establish rapport with and determine the most effective treatments for their Deaf clients. Both Participant A and Participant B expressed a desire to see more hearing people, specifically including counselors, involved in the Deaf community. This sentiment echoes Harmon (2008), who suggested that hearing immersion in Deaf culture and education regarding Deaf history would be an essential step toward a strong alliance between the Deaf and hearing worlds. Like counseling students, current practitioners who would like to improve their multicultural competence can benefit from immersion in the Deaf community and learning to sign.

Hiring an interpreter fulfills legal obligations, though it may interfere with the counseling relationship (Vernon & Leigh, 2007; Wright & Reese, 2015). When one must hire an interpreter, it is best to choose one who is certified, fluent in Deaf culture, respected in the Deaf community, and familiar with Deaf rights (Vernon & Leigh, 2007; Wright & Reese, 2015). Interpreters are especially important for assisting with the informed consent process for those clients whose preferred language is ASL (Wright & Reese, 2015). After sessions, the counselor should debrief with the interpreter to mitigate the effects of potential vicarious trauma (Vernon & Leigh, 2007).

It should be noted that hiring an interpreter can be expensive, and lawsuits for improper practices regarding interpreting can be even more costly (Vernon & Leigh, 2007). Vernon & Leigh (2007) suggest that if federal guidelines are in place to require appropriate service provision for Deaf people, there should be federal funding available to practitioners for their training. I would argue that this funding should extend to hiring certified interpreters as well so that practitioners can be in compliance with the law.

Using technology to facilitate the session may improve both communication and access to services. Videoconferencing has long been recommended as a mode of therapy for Deaf clients (Vernon & Leigh, 2007). An interpreter could join the session if the counselor is not fluent in ASL. Some videoconference technologies employ live captions, but these are not always reliable. Another technology option that can allow practitioners to provide long-distance counseling is a video relay service, or VRS (Vernon & Leigh, 2007). These services allow the session to take place via telephone or computer. The counselor speaks or uses a messaging service to communicate with the interpreter, and the interpreter relays the information in sign language via web camera or other video technology to the Deaf client.

During sessions, it might be helpful for counselors to grant more time for Deaf clients to give in-depth descriptions of their experiences or to reduce expectations for the scope of a given session. For example, if the counselor usually allots one hour for the intake session, they might consider blocking off an hour and a half instead, or perhaps schedule two sessions for intake purposes. Frank communication is likely to be regarded as more sincere and practical for Deaf clients than Socratic questioning and other indirect techniques. When administering assessments, they should be normed for Deaf populations or interpreted with extreme caution (ACA, 2014; Sheppard, 2008; Sheppard & Badger, 2010; Wright & Reese, 2015). Vernon & Leigh (2007) recommend that practitioners seek continuing education credits from courses or workshops that focus on providing counseling services to Deaf clients, such as those that provide up-to-date information on assessments normed with Deaf populations.

Marketing Services

Counselors may find traditional marketing attempts that rely on self-reflection to be ineffective in Deaf populations (Torigoe, 2007). However, the collectivist nature of Deaf culture and the emphasis on uninhibited self-disclosure may promote the services of a skilled counselor as clients recommend practitioners to others in the Deaf community. Practitioners who market services to Deaf clientele should ensure that websites and other materials are accessible by ensuring the accuracy of captions on videos or, even better, providing signed versions of advertisements and information, either as an in-person presentation, per the recommendation of Participant B, or as a video uploaded to the professional's website.

Transparency

All material should use straightforward language and demonstrate complete transparency regarding fees, financial assistance programs, insurance policies, and background in Deaf

culture. In addition to providing standard contact information, Participant B suggested that members of the Deaf community might need instructions for setting up appointments and education regarding the differences in the dynamics between sessions with a professional and conversations with friends. As Deaf people are unable to gain incidental knowledge through overhearing others and may not always have access to professionals with quality signing skills (Frederick, 2021; Oldale, 2008), it cannot be assumed that they have had prior contact with this information or that they will be able to ask questions and get answers as quickly as someone who is hearing.

Transparency when describing consent, payment, and other policies as well as self-disclosure on the part of the counselor may help put Deaf clients at ease. It is important to remember that, as sharing details of private information is common and expected within the Deaf community (Harmon, 2008; Padden & Ladd, 2006), more information will be better received and appreciated than less. Furthermore, according to Participant B, Deaf clients may have more questions than hearing clients. Answering these questions and providing straightforward information, including detailed descriptions of what to expect and explanations of options and rights, are essential to building trust in the Deaf community (Wright & Reese, 2015).

Cultural Competencies

When meeting with a Deaf client, counselors should consider adopting a sociocultural or linguistic perspective of Deafness, as opposed to the traditional deficit model. This may involve reflection on personal views and how they may affect the counseling relationship. Ethnocentrism may evoke pity in counselors (Boyd, 2007), and this may deter potential Deaf clients. As an example, recall Participant A's concern that counselors would see their Deafness only as a loss and without considering the sociocultural implications.

Additionally, it may be best for Deaf clients for the counselor to incorporate counseling strategies that emphasize personal strengths to empower Deaf clients, evaluate the need for skill based psychoeducation regarding social interactions with the hearing world, and aim to improve self-reflection and build stronger social support systems to counteract the effects of minority stress. Counselors should consider including self-advocacy as a major component of treatment plans with Deaf clients in similar situations. Improving a sense of personal control may reduce anxiety and empower the Deaf client (Palmer et al., 2013).

Those who specialize in specific forms of counseling may want to contemplate the role of Deaf culture in their area of concentration. Those who work with children and families, for instance, should be aware of the prevalence of trauma and family conflict in the lives of Deaf children as well as Deaf-specific signs of abuse and encourage early intervention when problems are detected (Lomas & Johnson, 2012). Vocational rehabilitation counselors may need to extend their services beyond the acquisition of employment to ensure the client will continue to be successful after services are withdrawn (Schoffstall et al., 2015).

Advocacy

The participants in this study highlighted the role of the counselor as a pillar of emotional support and advocacy. Most participants indicated that Deaf and hearing audiences alike could benefit from psychoeducation workshops relevant to Deaf culture and mental health. Some focused on the potential to aid Deaf individuals with understanding their options and rights as clients. Others, like Participant D, hoped counselors would promote awareness of Deaf culture in hearing settings, such as workplaces and public events. The findings of this study suggest that families with Deaf members could reduce conflict and improve family relationships by learning

about Deaf mental health. Counseling students and therapists might also improve their practices by attending these events.

On a much larger scale, counselors can serve as advocates by supporting Deaf rights at the polls and in public discussion. They can vote against laws that favor the eugenics movement and back candidates with a history of providing protection against discrimination. They can lobby for affordable mental health programs and improvements in license portability. Such campaigns have resulted in legal improvements (Emery, Middleton, & Turner, 2010). Just as importantly, advocates can support Deaf communities by supporting the enforcement of current laws and ensuring that they are compliant so that they do not unintentionally discriminate against Deaf clients (Vernon & Leigh, 2007).

Practitioners and educators should continually seek new information about Deaf counseling and support research endeavors relevant to this cause. Vernon & Leigh (2007) have suggested that counseling professionals seek federal funding to improve training, assessment, and practice for Deaf clients. There is much to do to further the cause of Deaf mental health, and there is much that counselors can do to help.

Directions for Future Research

In a study by Fellinger et al. (2008), researchers discovered that there were significant discrepancies between the reports of hearing adult caregivers and Deaf children regarding clinical symptoms. Thus, it is essential that research about Deaf populations takes place with the assistance and participation of Deaf people. A critical review of previous studies may call into question their results if data was collected from hearing rather than Deaf participants. As such, it has been suggested that future research follow existing guidelines, such as recruiting a

representative sample, and that older research be deconstructed in order to find these flaws and reconstructed using recommended standards (Ladd, 2003; Vernon & Leigh, 2007).

The concept of Deafness as a culture is still evolving, and we know even less about the complexities of multiple minority identities among the Deaf. One recommendation for future research is a replication of the present study with specific Deaf subcultures. Further exploration of the distinctions between Deaf subgroups should focus on mental health differentiations, such as whether anxiety is associated with powerlessness in all groups or only some. Increasing understanding of the diversity of Deaf populations can help researchers and practitioners alike improve access to appropriate assessments and interventions.

Some studies have suggested that symptoms and prevalence of various disorders might be different in Deaf populations, but there is still a lack of conclusive evidence. Future studies should aim to rectify this as well as exploring phenomena unique to or more common within the Deaf community, such as financial abuse and cultural merging. These topics, mentioned by the participants in this study, had little, if any, research to guide practitioners. Furthermore, the research that does exist regarding mental health risks for Deaf populations may not be based on a representative sample.

As data related to mental health problems among Deaf individuals increases, so too should research evaluating interventions, isolating protective factors, and exploring aspects of the counseling relationship with Deaf clients. As a top priority, researchers should strive to identify appropriate treatments for suicidal ideation among Deaf individuals as well as culturally relevant coping strategies. Studies that investigate locus of control and other empowerment concepts could be especially helpful, as might those that concentrate on family or group

counseling for members of the Deaf community, as those existing counseling models could be congruent with the collectivist nature of Deaf culture.

Researchers have yet to develop an ecological model of Deaf culture. This approach to treatment would include not only the Deaf microsystems, such as their families and workplaces, but the macrosystems and historical sociopolitical contexts as well so that we can fully comprehend the complex challenges Deaf clients face. Such a model could prove invaluable to counseling students and practitioners for developing a greater understanding of Deafness.

Additionally, further attention should be given to the dynamics of counseling Deaf clients, with and without an interpreter facilitating sessions. These should be aimed at identifying best practices regarding the use of interpreters as well as the effectiveness of oralist forms of communication, such as speech-reading or captioned virtual sessions, between the counselor and the client. Likewise, studies should examine the Deaf client's perception of the counselor, including the potential ability to pick up on burnout and other emotions due to the role of emotional expression in Deaf communication. Finally, researchers should investigate fit as a mediator of the effectiveness of Deaf counseling and whether any approaches or traits seem to be more beneficial for Deaf clients.

When conducting Deaf counseling research, there are few guidelines available to provide direction for researchers, though a few principles have emerged from previous research and the current study. First, it is imperative that future research aimed at exploring or evaluating mental health topics for Deaf populations use a representative sample rather than rely on the input of hearing individuals tangentially associated with the Deaf community (Fellinger et al., 2008; Vernon & Leigh, 2007). Recruitment should take place through multiple channels to accommodate the diverse communication preferences Deaf individuals (Leigh, 2008). This may

include use of sign language to invite members of the Deaf community at various events, videos with captions and signed interpretation of the research advertisement posted in Deaf groups in social media, collaboration with those who provide services to Deaf people, and printed flyers left in Deaf community centers and similar locations. Data collection, ideally, should be diversified as well; some participants may prefer face-to-face interviews in ASL to written surveys that may not be in their native language.

Last of all, I and other researchers encourage multidisciplinary cooperative research between Deaf participant-researchers, counseling professionals, interpreters, and others to produce studies that address the full complexity of the Deaf world (Darroch, 2018; Giegerich et al., 2020; Perkins Nerlich et al, 2021; Spivak, 1982). Once new data is collected and new conclusions are reached, this information should be presented at national and international conferences in order to increase saliency among counseling professionals. In time, we may be able to develop a cohesive model of Deaf counseling that can be readily manualized and distributed.

Limitations of the Current Study

The findings of this study must be considered in light of its limitations. Recruitment for the study included flyers and social media announcements written in English, which is not the first language of many Deaf people (Wright & Reese, 2015). Additionally, a collaborator created a signed interpretation of the social media post to include with the written version. However, this announcement would still be viewed only by those in the Deaf community who were active in certain groups on social media. Therefore, the recruitment methods may have lent themselves to sampling bias by not including those eligible to participate who were not local, strong readers in English, or active in the social media groups in which recruitment took place.

Furthermore, as this study took place during and just following the global coronavirus pandemic, the face-to-face interviews that were initially planned were replaced with virtual interviews. This further limited the sample to those who had access to a web camera and the Internet. Therefore, the sample size was significantly limited by the recruitment and data collection methods.

One major limitation of this study involves the use of interpreters. As I am not a native signer, I thought it best to hire certified interpreters to facilitate the interviews and decrease the possibility of miscommunication, as suggested by previous researchers (Darroch, 2018; Fellinger, Holzinger, & Pollard, 2012; Frederick, 2021; Lomas & Johnson, 2012; Vernon & Leigh, 2007; Wright & Reese, 2015). During recruitment, however, I found that some potential participants were uncomfortable with the presence of an interpreter and did not want to participate for that reason. After the initial interview, one of the participants expressed she had no interest in joining a follow-up session due to the presence of the interpreter. Although the participants were generally candid, even regarding their discomfort with interpreters, it seems likely that a researcher with high quality sign language skills who could forgo the addition of an interpreter may attract a wider variety of participants and perhaps provoke different responses from the interviewees.

This study did not explore misconceptions or false beliefs of participants and therefore may have missed important data. Furthermore, the data collection and analysis was completed by a single researcher. Multiple researchers working as a team might not only improve triangulation but could separately analyze themes to increase the credibility of the study.

Finally, one must consider personal biases as a potential limitation in this study. As a member of the local Deaf community, I approached this study with some preconceptions about

counseling perceptions of Deaf adults. Using a journal and reflections with my dissertation committee, I tried to separate my own ideas from those of my participants. However, it is unclear how much of my own experiences have colored my interpretations of the data. Likewise, the participants were aware of my connections to the counseling field when we began our interviews, and this knowledge may have influenced their responses.

Conclusion

To date, little research has been directed toward improving mental health outcomes for the Deaf community. To that end, the study uncovered a wealth of information from five diverse participants who contributed data during five initial interviews and two follow-up interviews. Six themes emerged during data analysis that offered surprising revelations to address the research questions. Deaf adults interpret counseling and other matters through the lens of Deaf culture. As most counselors are hearing, Deaf clients regard them with the same level of caution they reserve for other interactions with the hearing world. They believe that counseling can be helpful, provided that the counselor has the desired characteristics, but their optimism is tempered by previous negative experiences and expectation of risk. However, they are not without ideas for increasing access to culturally-relevant counseling services. With further research, counselors may be able to realize the hopes of potential Deaf clients and offer interventions and treatments that are effective for and reflect the values and strengths of the Deaf community.

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APPENDIX A: GUIDING INTERVIEW QUESTIONS

Initial Interview

1. What do you believe to be true about counseling?
2. What do you believe to be true about people who seek counseling services?
3. What do you believe to be true about people who provide counseling services?
4. What do you believe to be true about counseling for the Deaf community?
5. Is there anything else you would like to tell me that I have not asked you?

Follow-Up Interview

1. What role, if any, do family members play in the mental health of Deaf people?
2. What role, if any, do other Deaf people play in the mental health of Deaf people?
3. Previous research has suggested that Deaf people are resistant to counseling; that was not what I found. What are your thoughts?
4. Which factors would be most important to you when looking for a counselor?
5. In what ways should counselors be involved in the Deaf community?
6. What role do counselors play in career development for Deaf clients?
7. What other roles might be important?
8. For those in the Deaf community seeking counseling, what information would be most important for them to know?
9. Tell me your thoughts about counseling accessibility for Deaf people.
10. What is most important for counselors to know about Deaf people?
11. What role, if any, should interpreters serve in the counseling process?
12. Is there anything else you would like to tell me that I have not asked you?

APPENDIX B: IRB LETTER OF APPROVAL

TEXAS A&M UNIVERSITY CORPUS CHRISTI | RESEARCH & INNOVATION

Date: February 24, 2022
To: Karen Hunnicutt Hollenbaugh
CC: Jennafer White
From: Office of Research Compliance
Subject: Amendment Approval for Exempt Study

Dear Karen Hunnicutt Hollenbaugh, PhD,

On 02/24/2022, the Texas A&M University IRB - Corpus Christi Institutional Review Board (IRB) reviewed and approved the request changes for the following study:

Type of Review: **Amendment**
Title of Study: Perspectives of Culturally Deaf Adults Regarding Counseling
Principal Investigator: Karen Hunnicutt Hollenbaugh
IRB Number: TAMU-CC-IRB-2021-0235
Submission Number: TAMU-CC-IRB-2021-0235-AMD-2.0
Risk Level: Not Greater than Minimal Risk under 45 CFR 46 / 21 CFR 56

Type of Change: Revisions to study documents
Change description: Expanding recruitment to other sites within the community, including audiology offices, Deaf services, and Deaf social gatherings. Modifying original wording of recruitment material to clarify that potential participants need not have actual counseling experience to participate.

On 02/24/2022, the IRB confirmed the study as changed continues to meet exempt category:

Category 2: Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: i. The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; ii. Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or iii. The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by .111(a)(7).
Approved changes may now be implemented.

If you have any questions or concerns please contact us at irb@tamucc.edu.

Sincerely,

Rebecca Ballard, JD
Office of Research Compliance