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How Does an Interpreter Affect the Client-Counselor Relationship with a Client Who Is Deaf?

Vanessa Ivette Rodriguez-Aviles

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**HOW DOES AN INTERPRETER AFFECT THE CLIENT-COUNSELOR
RELATIONSHIP WITH A CLIENT WHO IS DEAF?**

A Masters Thesis

Presented to

The Graduate College of
Missouri State University

In Partial Fulfillment

Of the Requirements for the Degree
Master of Science, Counseling

By

Vanessa Ivette Rodriguez-Aviles

December 2015

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HOW DOES AN INTERPRETER AFFECT THE CLIENT-COUNSELOR RELATIONSHIP WITH A CLIENT WHO IS DEAF?

Counseling, Leadership, and Special Education

Missouri State University, December 2015

Master of Science

Vanessa Ivette Rodriguez-Aviles

ABSTRACT

Few studies have explored mental health services such as counseling that are specifically provided to those who are d/Deaf and hard of hearing (d/DHH). This qualitative study was intended as an early research effort within a young field to investigate the impact of having an interpreter present within the therapeutic context. Qualitative data were obtained from an online, open-ended survey of eight d/Deaf and/or hard of hearing counseling clients in which the counselor was hearing and an interpreter was used in the counseling process. It was found that that d/Deaf cultural competence on the part of the counselor is an important part of the client-counselor relationship for those who are d/Deaf and hard of hearing along with the desire to feel safe, understood and connected. Future research should seek to (a) replicate this study with a broader sample, (b) make adjustments in order to interact with the participants through interviews rather than an online survey, and (c) study topics such as specific therapy styles that may be most beneficial for the those who are d/DHH.

KEYWORDS: survey study, d/Deaf and hard of hearing, counseling, relationship, deaf culture, qualitative study, research, introductory study, mental health services

This abstract is approved as to form and content

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Chairperson, Advisory Committee
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TABLE OF CONTENTS

Introduction.....	1
Research Design.....	2
Definition of Terms.....	4
Literature Review.....	6
Mental Health Issues within the Deaf Population.....	6
Deaf Culture Awareness	12
Interpreter’s Role in the Counseling Sessions	15
Methodology	21
Results.....	25
Discussion.....	30
Conclusions & Recommendations.....	34
References.....	38
Appendices.....	40
Appendix A: Survey Questions	40
Appendix B: NAD-RID Code of Professional Conduct.....	41

INTRODUCTION

This study began with the concern that individuals who are d/Deaf or hard of hearing get little attention in the field of counseling. With no immediate evidence to prove this, this study aims to provide a start to a better understanding of counseling those who are d/Deaf or hard of hearing (d/DHH), specifically when an interpreter is used within the counseling session. By gaining more information about the relationship between d/Deaf and hard of hearing clients with their counselors who are hearing, it can be better understood how the clients view the overall counseling sessions, what effects (if any) an interpreter has on the client-counselor relationship, and what improvements can be made to the counseling process. In order to gain the understanding of what has been done already, the researchers explored the mental health challenges for individuals who are d/DHH, Deaf Culture, and the interpreter's role in the counseling session.

The topic being researched is how to counsel individuals who are d/DHH when interpreters are utilized within the counseling setting. The intent is to conduct an open-ended survey to explore experiences of d/Deaf and/or hard of hearing participants who have received counseling in order to better understand beneficial interaction and engage in meaningful communication, which facilitates improved self-understanding. By receiving feedback from individuals who are d/DHH, this survey study could provide some valuable information to this field and to the counselors working with the d/Deaf and hard of hearing population. It would be beneficial to see if having an interpreter impacts the client-counselor relationship positively or negatively and learn if whether or not there are times when the content becomes lost in translation during the counseling process. The

research could also provide insight if the participant would build rapport faster with the counselor who knows sign language (and be able to use it in a conversational manner) or is rapport built the same if the counselor utilizes an interpreter and is still a competent counselor. By learning about the counseling experiences of individuals who are d/DHH, it can provide great insight on the effectiveness of counseling and what changes could be made to better benefit the clients who are d/Deaf and hard of hearing. This can provide as an exploratory study and show insight to other areas of research that could take place in the near future.

The following are questions that prompted the study:

1. What types of mental health services are provided to the d/Deaf and hard of hearing population?
2. What types of issues are brought up by the d/Deaf and hard of hearing population when it comes to counseling?
3. Are there communication issues between individuals who are d/Deaf or hard of hearing and their family?
4. Do individuals who are d/Deaf or hard of hearing have a family support system to help them through issues as they come up?
5. What is the interpreter's role in the counseling setting? Are there specifics for confidentiality and expertise in this specific field?

Research Design

The research design for this study is a qualitative survey study. The objective is to gather data on how the counselor-client relationship is between the deaf client and their therapist. It would be insightful to learn about how the client satisfaction is within their therapy and see if there are ways the client-counselor relationship can be better improved. This is an exploratory research with the intent to gather information on how the

participants relate to their counselors. In this study, the participants will be chosen through very specific criteria: they are deaf individuals, they have gone through counseling, they had an interpreter present during their sessions, and they are willing to relate his/her experience in a written survey format. Participants will complete a five question open-ended survey to provide feedback about the relationship and satisfaction they experienced in their counseling experience.

The following assumptions were made regarding the research:

1. The interpreter is qualified to interpret within the mental health field.
2. The interpreter is a certified interpreter.
3. The individuals completing the survey have had counseling and had an interpreter present during counseling.
4. The participant is willing to communicate through written language

Several limitations in the design of the research were identified:

1. Bias in purposive and snowball sampling.
2. A small sample makes it more difficult to generalize over the entire population.
3. The communication barrier the participants may experience based on their differing ability to effectively express their counseling experiences and level of satisfaction in written form.
4. Difficulty in finding willing participants that fit these specific criteria.

Definition of Terms

American Sign Language -

American Sign Language (ASL) is a complete, complex language that employs signs made by moving the hands combined with facial expressions and postures of the body. ...

ASL is a language completely separate and distinct from English. It contains all the fundamental features of language—it has its own rules for pronunciation, word order, and complex grammar. (“American Sign Language,” 2014)

Interpreter - An interpreter is “a person who translates the words that someone is speaking into a different language” (“Interpreter,” n.d.).

Convenience sampling - Convenience sampling is “the process of including whoever happens to be available in a sample (e.g., volunteers)” (Gay & Airasian, 2009, p. 600).

Snowball sampling - Snowball sampling is a method that “yields a study sample through referrals made among people who share or know of others who possess some characteristics that are of research interest” (Biernacki & Waldorf, 1981, p. 141) and is used when trying to identify individuals in a very particular group and can be located by those who are within the community or are aware of the community (Biernacki & Waldorf, 1981).

Grounded theory methodology -

Grounded theory is a methodology for the inductive development of theory (Glaser and Strauss 1967). A grounded theory study involves collecting data in a substantive area; analysing data to find concepts, properties of concepts, and relationships between concepts, using a method called ‘constant comparison’; directing further data collection, so as to further develop concepts, properties, and relationships; and developing a theory around a ‘core’ category to explain the process under investigation (Glaser and Strauss 1967, Glaser 1978). (Skeat & Perry, 2008, p. 97)

d/Deaf - The use of small d deaf usually means that the person does not connect with other members of the deaf community, but rather connect themselves into the hearing world, and view their hearing loss solely in medical terms. The term Deaf is used for people who tend to identify themselves as culturally deaf and have a strong deaf identity. The Deaf individuals who identify as Deaf may have attended schools for the deaf while the deaf tend to have attended mainstream schools and/or never attended a school for the deaf and got into public or private schools. “When writing about deafness many writers use a capital D when referring to aspects of deaf culture, and a lower case d when speaking solely about the hearing loss, while others simply use D/deaf” (“What does D/deaf mean?” n.d.).

Deafhood - Deafhood is “the experience of being Deaf. Deafhood is sometimes referred to as the 'life journey' of a deaf person” (Wiley, Egbert, Lapiak, & Vicars, n.d.). This means, the experience of Deafhood varies from person to person. The term emphasizes the ideas that being Deaf has great value for Deaf individuals, for the community and for society as a whole. These individuals see no reason for medical intervention to improve their hearing loss and do not consider their limited hearing as an issue that needs to be addressed (Wiley et al., n.d.).

Hard of hearing - Hard of hearing refers to deaf people who do not use ASL, are unfamiliar with the Deaf community and have little to no understanding of Deaf culture; these individuals interact primarily with and associate themselves with the hearing community and culture (Wiley et al., n.d.).

Pre-lingual deaf - (Also referred to as: early deafened) are individuals of any age who were a) born with a hearing loss or b) developed a hearing loss prior to acquiring a primary language (regardless of signed or spoken); this could mean developing hearing loss prior to one year of age (Wiley et al., n.d.).

Post-lingual deaf - (Also referred to as: late deafened) are individuals of any age, who acquired a level of hearing loss after they already developed a primary language (Wiley et al., n.d.).

Late deafened adult - (Lower case l and d) Also known as “LDA” are individuals who are born with normal hearing who developed a significant hearing loss. Before their hearing loss, LDAs learned and used some form of auditory language, attended hearing schools, associated with hearing people and the hearing community. Most LDAs are not involved with the Deaf community and have little or no understanding of the Deaf culture. They typically go through a natural process of mourning the loss of their hearing and make adjustments to their lives in acceptance of their hearing loss (Wiley et al., n.d.).

LITERATURE REVIEW

Through this review of previous research on the topic of counseling the d/Deaf and hard of hearing population in order to gain insights on what's been done, it is divided into three major divisions: the mental health issues, deaf culture, and the interpreter's role in the counseling session.

Mental Health Issues within the Deaf Population

The articles that were found for this section are a mix between historical, qualitative and quantitative peer-reviewed articles, along with other article styles, such as case studies and literature reviews, to help provide an understanding of what type of mental health difficulties individuals who are d/DHH suffer from along with what treatment options they were provided. The articles describe mental health services and programs being provided for people who are d/Deaf, assessment of depression in pre-lingually deaf people, and abuse of children who are d/Deaf or hard of hearing. Research of these topics and a study of their findings will assist in identifying what topics need to be discussed further and what topics provide valuable insight for this study.

Vernon and Leigh (2007) showed the historical perspectives on mental health services for this population. Vernon and Leigh explained that until the mid-1960s, the Deaf population who were seriously mentally ill didn't have mental health services that were specialized to their needs. With no special services, they were typically housed with the hearing patients and with staff who were unable to communicate with the Deaf and had no knowledge of sign language (p. 374). Vernon and Leigh also share that during the

mid-1960s, psychiatric hospitals began to incorporate inpatient units for the Deaf patients along with researching ways to improve the Deaf patient's psychiatric disorders. In 2000 the National Deaf Academy (NDA) was opened. This was "the first residential treatment center ever established exclusively for individuals who are Deaf" (p. 375). Vernon and Leigh also discussed how personality tests were not valid or reliable because they did not take into account the d/Deaf culture or the influences that could affect the test, such as the age of hearing loss, age of diagnosis, and their access to verbal language or communication. Vernon and Leigh also shared that when d/Deaf children were thoroughly studied by Schlesinger and Meadow in 1972 over a 5-year period, they discovered that "sign language had great value in facilitating academic achievement, parent-child interaction and communication in general, including speech and lip [-] reading" (p. 376). It was expressed that APA was working on developing "guidelines for the assessments and treatment of persons with disabilities, including those who are d/Deaf" (p. 376) along with the concept that misdiagnosis is an issue which can affect the child and have repercussions that could negatively affect the rest of their lives (p. 376).

Ridgeway (1993) presents three case studies of deaf women who were abused at a young age. This article shows the difficulties that Deaf women who have been abused face in seeking treatment. Ridgeway illustrates the range of problems faced by these individuals and the language barriers and communication issues that come with being in this population. The females discussed in this article are women who were either deaf from birth or became deaf at a very young age. Each of these women was abused by a family member. One of the women tried to talk with her mom about the abuse done by her stepfather but was told that she was only day-dreaming and this never happened to

her. With this as a response, it is a wonder how anyone would seek help if family wouldn't even believe them. Another woman was abused by both her stepfather and grandfather for nine years; she didn't combat this because she was under the impression that this was acceptable behavior. It wasn't until this woman was 27 that she learned that this was not acceptable behavior through watching TV. The last woman whose story was shared in this article talked about how she was abused by her uncle from the ages of 10-15. However, since there were no resources for her, she was unable to discuss these issues until she was 35. She was admitted into an inpatient mental health facility due to depression, anorexia and self-harming behaviors.

Ridgeway (1993) examined the development and communication of individuals in the d/Deaf population: "Research suggests that many deaf children have poor psychosocial development (Meadows, 1980), poor self-images and negative self-concepts (Ridgeway, 1992a)" (p. 167). Ridgeway (1993) explained that these deaf individuals began to have these negative self-concepts after they were removed from their homes and realized that they were different from everyone else. D/deaf children may begin to feel that the hearing individuals are smarter and better than they are and start to think they have a disability that can't be overcome. They start to feel a sense of helplessness and hopelessness. Influences in how these children see themselves can be external such as educational experiences but they can also be affected through family experiences. If their family ignores them and pushes them aside because of the communication barrier, the deaf children may feel that they are not welcomed at home and that they need to be someone different to be loved or welcomed.

Through talking with these three individuals, Ridgeway (1993) explained that children who are deaf are more likely to face neglect and abuse along with a lack of emotional development and low self-esteem (p. 168) because of the language barriers and the lack of open communication. In all three of these case descriptions, a close family member molested the females. If open communication was not a problem, they would have been able to share this information with other family members who would have been able to make it stop; however, one of the individuals was “accused of day-dreaming ‘as usual’ ” (p. 168) when she attempted to tell her mother about the sexual abuse. Another individual, Rachel, who survived sexual abuse, was only able to express her pain through anger and continual crying. She was unable to express herself because no one tried to help her or communicate with her to see what was going on.

Willis and Vernon (2002) completed a quantitative study, which took place in 1998-1999, which consisted of a sample of 58 deaf children and adolescents at the Tampa Bay Academy. These 58 were compared to a sample of 168 hearing individuals. “A startling and significant finding was that all of the deaf children admitted at age 12 years or younger had strong or confirmed indications of sexual abuse” (p. 31). The children at the Tampa Bay Academy lived in the residential treatment facility, which was a 24-hour living environment where they received treatment and help. They were given intense structure, protection and psychotherapeutic treatment. This is more extensive work than an outpatient facility could do and can be very difficult, especially if the clients have already been abused in their past, causing them to have a very difficult time trusting individuals. Willis and Vernon (2002) also state, that in most cases the children who were

d/Deaf had dysfunctional homes and were not given appropriate resources such as health insurance (p. 33).

Connolly, Rose, and Austen (2006) wrote a literature review, which provided some much needed insight about the differences between the hearing world and the deaf world. Connolly et al. (2006) discussed the topic of how the assessment methods used to help identify and assess the mental health problems in today's society were "developed as a result of research with White, middle-class, hearing participants" (p. 49). This is something that most people wouldn't even think twice about, but if it were considered, it would be acknowledged that there are so many cultures that have to be considered through the assessment, such as race, gender, ethnicity, socioeconomic status, religious background, family cultures, etc. The Deaf community has also shown that they have created their own culture, their own language, and their own concepts of communication. They have their own way of understanding things. If this population, along with others is pushed to fit in the mold of how the assessments were developed, there will be gaps in the research that would stunt learning about this culture and potentially never be able to provide truly beneficial treatment. The authors noted "a small number of services around the world offer specialized assessment and intervention for deaf people with mental health problems" (p. 50). It should be noted that all of the studies that Connolly et al. reviewed of psychiatric deaf patients that reported prevalence of depression were written between 20-30 years prior which limits how useful and applicable these studies are. Connolly et al. (2006) expressed that these studies only reflected the amount of d/Deaf and hard of hearing who received a diagnosis of depression instead of those who were experiencing depression (p. 50). Within these studies, there was no clear expression of

what percentage of deaf people were diagnosed with depression. Connolly et al. (2006) believed “Differences between studies may be attributable to the fact that the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used in the United States, whereas European countries tend to use the International Classification of Diseases (ICD)” (p. 50).

When completing a retrospective study using mental health case records, Connolly et al. (2006) shared that one of the mental health centers for the community used a sign language interpreter which helped provide services to the d/Deaf population, along with this was shown that due to having the interpreters and having a way to communicate effectively, the d/Deaf population was provided the services needed and showed that it is due to the lack of communication that makes it difficult to help the d/Deaf population (p. 52). Connolly et al. reported “Diagnostic information was reported for 343 deaf and hard of hearing individuals and for the total sample, which consisted of 68,329 individuals. The results showed that 13.7% of the patients who were deaf or hard of hearing were diagnosed with mood disorders, compared to the 14.8% of the total sample” (p. 52). Within this article, it is shared that there is beliefs that due to communication and/or language barriers, d/Deaf and hard of hearing individuals may lead to misdiagnoses or get minimal assessments to receive a complete and precise diagnosis.

Connolly et al. (2006) stated that when using written assessments, there may be concerns about the validity of them due to the reading levels for the d/Deaf participants, or other such obstacles such as English being a second language. The research that Connolly et al. (2006) studied provided information stating that compared to the hearing participants, deaf participants were more depressed as a whole. When looking at the

percentages, 51% of the deaf participants scored 10 or greater on the Beck Depression Inventory while only 33% of the hearing participants held that same score; this indicates at least mild depression. They also explained research that they reviewed, which showed that the percentage for moderate to severe levels of depression, were 7% of hearing participants and 8% of deaf participants (p.54).

The articles found in this research were full of important knowledge about the d/Deaf community. This provides more understanding to the communication issues these individuals may face on a daily basis and that they are tremendously lacking of a support network that should be created by their family. If there was support from their family, they would be better able to share their experiences and potentially even receive help at an earlier age. The studies and specialized treatment for this population appears to be a fairly new and this has helped improve their quality of life. Still, there are struggles that must be overcome. Struggles with effective communication in the home, early treatment for those who have mental illnesses and a better system that could help assess this population that takes consideration of this population's culture and the influences in their lives.

Deaf Culture Awareness

Peters (2007) revealed, through the United States Census, that there were about 1 million people who were deaf in 2002. Peters shares his insight about deaf culture and the groups that come with it. He explained that there were within-groups that affect the Deaf population such as those who are born deaf or became deaf later in life and after they've developed a language, those who have parents who can hear or those who are born to

parents who are deaf, those who use a cochlear implant, or hearing aids or no support, and then within-groups for those who know sign language in comparison to those who rely solely on lip-reading (p. 182). Peters also explains that he's a hearing counselor who interacts with a lot of d/Deaf individuals and reports that "This article provides a general framework for working effectively with clients who are deaf, but counselors must always be aware of the many within-group differences among the deaf population" (p. 182).

Peters (2007) educates his readers on the historical background of how the d/Deaf population was treated in the beginning and how their culture was created. Peters expresses the importance of deaf culture by sharing that the cultural identity is based on many factors, which need to be accommodated by those who are hearing. Peters also states "Hays reported that culture includes language and a history" (p. 184). The Deaf population has both: "Research suggests that persons who are deaf or hard of hearing appear to have more mental health issues than hearing persons. This may be due, in part, to additional stressors that are unique to individuals who are deaf. For example, the obvious language barrier between a client and a counselor is particular to clients who are deaf" (p. 184). Peters shares that Deaf individuals were often misunderstood and even diagnosed with schizophrenia due to their style of communication through gestures and sounds. Peters also explains this when he shared that due to misunderstanding, those who are d/Deaf become misdiagnosed, which then leads to mistrusting those who are in the mental health profession (p. 184).

Peters (2007) explores further some additional considerations to make when working with the Deaf population: awareness of the Deaf culture, attention to nonverbal behavior, and focus on wellness, confidentiality, and sign language interpreters. As

suggested above, understanding the Deaf culture is very important, and may be the most important consideration to have when working with this population. Peters shares that those who decide to work with the Deaf population should either take a sign language class or gain education on the culture of the Deaf population (p. 180). Since most of those who are d/Deaf or hard of hearing don't always rely on verbal language, it is very important to pay attention to the nonverbal behaviors. "Communication via sign language involved a great deal of facial expressions, body and hand movements, and close proximity to others" (p. 186). Eye contact is also very important in this culture. When talking about focus on wellness, the author explains that it is crucial to view the deafness as an identity and not as a disability. Using more strength-based approaches may be more beneficial because it shows care for the client and gives them the ability to improve their self-esteem and self-concept (Peters, 2007). Showing the d/Deaf population that they are accepted will help tremendously. Confidentiality is something that is important in any client-counselor relationship, no matter the population. Just as in small towns, when counseling the d/Deaf population it may be common knowledge within the community that someone is going to counseling. Explaining confidentiality upfront will be helpful when building that trust with the client (Peters, 2007).

Ladd and Lane (2013) shared that "Collective language, collective identity, collective culture, collective history, collective arts, collective epistemologies and ontologies--all are aspects of Deaf ethnicity" (p. 576). They continue to explain the difference between Deaf ethnicity and Deafhood by stating that Deafhood is something that can be learned later in life whereas Deaf ethnicity is something that is learned from birth and can cause struggle for the Deaf individual who is trying to find their place in the

world. “Such persons are left with a struggle to develop their identities, and this leads to what is termed ‘hybrid identities’” (p. 576). Ladd and Lane assert that in Deaf culture there are no boundaries and that if a Deaf person meets another from a different country, city or state, they will make a connection due to the “Deafhood” (p. 577).

Munro, Knox, and Lowe (2008), share some insights by stating,

Deaf people want to be able to communicate with a therapist using their first language and where this is not possible they want to use a skilled sign language interpreter. Those deaf people identifying as culturally Deaf want therapists to recognize them as a part of a cultural group and not as a disabled group. Deaf people want therapists to have an awareness and understanding of Deaf culture. (p. 308)

This provides insight to the importance of viewing this population as their own culture.

This quote also shares the similar views studied above about how important it is for this population to seek help from someone who best understand them and their way of life.

For them, talking to a counselor who speaks their language is important, but second to that would be having an interpreter there to bridge the language gap.

Interpreter’s Role in the Counseling Sessions

Peters (2007) discussed a section about considerations to make while working with the d/Deaf population. One of the considerations was the use of sign language interpreters. In this section, Peters shares, “Research suggests that clients who are deaf prefer a counselor who is also deaf” (p. 187). Peters (2007) further goes on to express other possible options as well when stating, “In the absence of a counselor who is fluent in sign language, the use of an interpreter is the appropriate means of providing counseling, and clients who are deaf are often amenable to use sign language interpreters” (p. 187). Through this study, Peters (2007) also noted that having an

interpreter present during counseling had no negative repercussions in the client-counselor relationship (p. 187).

According to his research, Peters found that there were no issues with having a counselor who was competent in sign language or having an interpreter but that the d/Deaf or hard of hearing client did prefer meeting with a counselor who was d/Deaf as well. However, Connolly et al. (2006) brought up a valid concern when they stated, “The inclusion of an interpreter in an interview introduces two more relationships to the interview: interpreter-client and interpreter-interviewer (Farooq & Fear, 2003). This can have the effect of altering the usual dyadic therapeutic relationship” (p. 53). The authors also stated the following in regards to the topic of confidentiality: “Even though interpreters are bound by rules of confidentiality and impartiality, deaf people may have concerns about confidentiality” (p. 53). With the interpreter in mind and the concerns that may come up, it’s crucial for the counselor to understand that certified interpreters have a code of ethics they too must follow. NAD-RID Code of Professional Conduct is a good reference to see that interpreters must work under their scope of practice and present in a professional manner. A crucial section is the section on professionalism, which can be reviewed in Appendix B. Some of the major statements for understanding the role of the interpreter include:

Interpreters possess the professional skills and knowledge required for the specific interpreting situation. ...

Interpreters are expected to stay abreast of evolving language use and trends in the profession of interpreting as well as in the American Deaf community.

Interpreters accept assignments using discretion with regard to skill, communication mode, setting, and consumer needs. Interpreters possess knowledge of American Deaf culture and deafness-related resources. ...

Render the message faithfully by conveying the content and spirit of what is being communicated, using language most readily understood by consumers, and correcting errors discreetly and expeditiously. ...

Refrain from providing counsel, advice, or personal opinions. (Registry of Interpreters for the Deaf, 2005, p. 3)

Haley and Dowd (1988) noted studies that showed how counselors who were d/Deaf or hard of hearing were more influential than hearing counselors who had the same amount of experience in the d/Deaf population. One such study by Freeman and Conoley (1986) demonstrated that “Experienced deaf and hearing counselors who used sign language were rated higher on social influence and willingness to see the counselor than were hearing counselors who used an interpreter” (as cited in Haley and Dowd, 1988, p. 258).

Haley and Dowd (1988) also conducted a qualitative research study with 106 youth from 3 different state schools for the Deaf. The students were divided equally between male and female (53 each gender) and they were between the ages 14 to 19 (grades 9 to 12). The test was to see if a Deaf counselor was more credible to the students than a hearing individual who used an interpreter or one who used written language as their form of communication. The method used for this study was a simultaneous recording technique and with that, there were three different types of counselor communications used. Six videotapes were the result of the simultaneous recording method and were used to record the counseling session in different formats.

In the first videotape the counselor and the client communicated by the use of sign language. In the second the counselor and client communicated through the use of a nationally certified sign-language interpreter. In the third the counselor and client communicated through writing (with a large pad and pencil that were easily visible to the observer of the videotape). (Haley & Dowd, 1988, p.258)

The participants were picked with the consultation and input of the administrators of the state schools for the deaf. Through the process of finding the participants, 10% of the participants were classified as individuals who had deaf parents. This was an important issue because “These children are therefore likely to have more advanced communication skills than the others” (p. 258).

The Haley and Dowd (1988) study was conducted over a 6-week period where a rationale for the study was presented to students residing in the state school. The participants were asked to complete the Willingness to See the Counselor Scale along with a counselor rating form. The Barrett-Lennard Relationship Inventory was designed to measure the perception of their counselor’s empathetic understanding, level of regard, unconditionally of regard, and congruence and was designed as a six-point Likert-scale with 16 questions/statements that discussed each variable. The participants were then asked to complete the Counselor Effectiveness Rating Scale, which consisted of seven items that connected to the client perception of their credibility as a counselor. A multivariate analysis of variance (MANOVA) was used in this study. The dependent variables were the counselor rating form, the Barrett-Lennard Relationship Inventory, and the Counselor Effectiveness Rating Scale. The Willingness to See the Counselor Scale acted as a pretest and posttest. Then, an analysis of covariance (ANCOVA) was run using the pretest as the covariate and using the counselor, communication method and hearing status used as the variables (p. 260).

Within the study, Haley and Dowd (1988) a manipulation check was completed to determine if the participants correctly understood the status of the counselor (whether Deaf or hearing) and what form of communication was used through the interview (sign

language, use of interpreter, or use of written language). It was noted that the participants understood the status of the counselor and form of communication that was used 93% of the time. The study showed that there was a significant difference between the counselors' use of sign language versus use of written communication. Haley and Dowd (1988) noted that the use of sign language was much more preferable to using the written form of communication: "The subjects tended to perceive the counselor as more influential, effective, and empathetic when sign language was used than when writing was used as the form of communication" (p. 261). Haley and Dowd (1988) also expressed that the counselor effectiveness was higher whenever sign language was used in comparison to the use of written communication:

The subjects rated the counselor significantly higher in effectiveness (CERS) [Counselor Effectiveness Rating Scale] in the sign language condition than in the written condition. For the BLRI [Barrett-Lennard Relationship Inventory] a significant difference was likewise found between the sign language and the written conditions. (p. 261)

It was also noted that the Deaf youth were more willing to see the hearing counselor who used sign language or who used an interpreter rather than going to the counselor who used written communication. There was no major difference with willingness between the Deaf counselor and hearing counselor so long as they used sign language or an interpreter. It was stated that it would be more beneficial to use sign language than rely on written communication because "it appears that the use of sign language by counselors, deaf or hearing, may enhance their social influence, empathy, and perceived effectiveness" (p. 262). Haley and Dowd (1988) further stated "the use of sign language may well be important to the ultimate success of counseling with deaf adolescents" (p. 262).

With the literature review providing insight on the research that has been done before, it is clearer on the concepts that will be focused on through this study. This study of previous work has given us an opportunity to find relevant studies and find ways to incorporate new questions to those that have been addressed in previous studies.

METHODOLOGY

In this study, the goal was to gather information from participants who are d/DHH on their experience with a counselor when an interpreter was used within the counseling session. In this, counselors can have a better understanding of the counseling process for some individuals who are d/DHH. Additionally, information was gathered about how the relationship between the participant and the counselor was developed, which may provide valuable insight as to how connections can be improved.

A 5-item open-ended survey was constructed in Survey Monkey. While participants were recruited in person to participate in this project, their survey responses were totally anonymous as they were able to complete their survey in the privacy of their home or other location; there wasn't a specific site for this research as the individuals were able to go online at their own time and complete the questions. The individuals were selected through purposive sampling and snowball sampling because it was based on if they are deaf, 18 years or older, if they have attended therapy in the past, and if an interpreter was present in these session. Snowball sampling will come up as the study will rely on the participants to recruit other participants for the study. Qualitative survey responses will be subjected to analysis using Grounded Theory methodology. Within this methodology, evaluators both within and across respondents reviewed qualitative responses. While doing so, the evaluators write memos to themselves about themes that appear to be embedded with the responses. After all data were evaluated in this way, the memos are collected and reviewed to evaluate them for emergent larger themes (i.e., the drive to parsimony). This higher-level thematic evaluation continues until the most

parsimonious set of themes reflected in the participant responses is acquired. These become the major emergent themes for the study. Each are presented and described, and representative participant quotes are provided to illustrate the theme.

Participants were recruited through the use of snowball sampling techniques. Within this technique, characteristics of a desirable participant are identified and an initial candidate meeting those criteria is sought. Once that participant has been identified, recruited, and has participated in the qualitative interview, they are asked if they know others who are like them who might be willing to participate. Thus, the current participant nominates additional likely participants. A total of eight participants will be sought to participate in the project. Participants will be purposive in that they will need to fit the “desirable” mold. The participants will (a) be d/Deaf or have a significant hearing impairment of the age of 18 or older, (b) be willing to engage in the research interview through textual means (i.e., responding to open-ended questions within a Survey Monkey survey), and (c) have participated in counseling in the past with the use of an interpreter.

Information was provided upfront about what this study was about and received the participants’ consent before they were able to complete the survey. They were informed of the consent by the survey, which stated “by moving forward in this survey, you are consenting to the study.” There were no participants younger than the age of 18 so there was no usage of a parental consent. Prior approval for this project was obtained from the Missouri State University IRB (July 9, 2015; approval #16-0003). The participants remained anonymous through the completion of the survey. Ethnicity was omitted in order to keep anonymity for the participants.

The survey study will be dispersed via the Internet and will be sent back to the researcher to receive, collect and analyze the data. The researchers used the Grounded Theory methodology to analyze the data and write up the results. Some demographics will be considered to help identify the population as a whole but even with the demographics the participants will remain anonymous. The demographics that were asked consisted of:

1. Age
2. Gender
3. Born d/deaf or lost hearing after birth; if after birth, at what age
4. Had a family member that was deaf
5. What was the schooling situation
 - a. Private School
 - b. Public School
 - c. School for the Deaf
 - d. Homeschooled
 - e. Other

Premade survey questions will be used for the research study through Survey Monkey. The questions will discuss what the impact was in having an interpreter present in therapy, if the client felt understood by the therapist, if the counseling was effective and if there were any setbacks in therapy.

The researcher will be analyzing the data provided by the survey results and will write up the results in a manner that would be beneficial for future studies. Steps in data analysis include (a) having the responses reviewed by evaluators both within and across

respondents, (b) having the evaluators write memos to themselves about the themes that appear to be embedded with the responses, and (c) collecting the memos and reviewing them to evaluate for emergent larger themes (i.e., the drive to parsimony). This process will continue until the major emergent themes for the study are discovered. Each are presented and described, and representative participant quotes are provided to illustrate the theme.

RESULTS

There were eight participants who completed the open-ended online survey that was created. Within this chapter, the researchers examined each of the questions posed to participants and take note of the major and minor themes that came from their responses.

Within this study, there were eight individuals willing to participate in the study. In order to keep anonymity, some demographic information was avoided. The average age of the participants was 41.5. From these 8 participants, 75% were female and 25% male. In response to the question regarding whether the participant was born d/Deaf or hard of hearing, 50% reported that they had been born deaf while the remainder reported losing their hearing sometime after birth. Twenty five percent of the participants had a family member that was also d/Deaf or hard of hearing, where the majority of this sample (75%) did not. From this sample, 87.50% reported they went to a school for the Deaf (at some point in their education), 75% went to public school, and 25% to private school.

There were five open-ended questions asked. After reviewing the responses, the researchers were able to derive some major themes and some minor themes from each question.

Question 1: “What impact did having an interpreter in the counseling session have on your counseling experience?” Within the responses from this question, the major theme of “utility” emerged. Respondents conveyed that it was necessary to have an interpreter to help facilitate the communication process and help the participant understand the counseling process and be able to have functional two-way conversation. Responses that help illustrate this major theme include, “It helps most of times so I could

actually understand the situation,” and, “It was helpful, especially for a first time meeting.” Another participant expressed how important it was to have a qualified counselor and interpreter by stating, “It was a must that the deaf patient have a licensed, qualified interpreter to effective[ly] receive counseling. The counselor must also have knowledge of how to use an interpreter and an understanding of deaf culture.” When going through the responses, the researchers also found that the minor theme of “safety” was noted, as expressed by one participant; “It helped a whole lot...I’d hold back to say anythin[g] until I’m comfortable knowin[g] [that the] interpreter d[o]n’t judge.”

Question 2: “How and how well did you feel understood by your counselor? Do you have examples that might illustrate this?” Within the responses from this question, two major themes were derived. The first was that the participants felt understood due to the communication facilitation of the interpreter: “Interpreter c[a]n understand my body language [and] expressed in wh[at] I’m tryin[g] to explain [and] I believed it helped counselor to understand better.” The second major theme was somewhat the converse of the previous theme; that there was some disconnect with having the three different individuals in the therapy session. One participant stated “There’s plenty of times that the counselor felt that he/she didn’t understand the interpreter not me.”

Question 3: “Was the counseling helpful? If so, how? If not, how not?” Again, the participants’ responses provided two major themes: helpful yet still having a disconnection between individuals. This was shown from question 2 and continued onto question 3. The concern that there was something missing or that having an extra person in the counseling session provided more space for error. The responses that pointed to the helpful aspect of counseling included: “The counseling has help greatly with interpreter

so I am able to understand each other more than one on one” and “...helped me understand in how to live my life without h[a]ving complications.” Some statements were made to provide insight that counseling had its own setbacks. One participant in particular referred back to his/her response from question two when the participant responded, “Our first counselor was also fluent in ASL and deaf culture. She was very helpful with the problems facing deaf persons and understood the unique issues facing the deaf. Another counselor had never used an interpreter before and would ask me to tell the interpreter what to tell my deaf daughter. She had no understanding of deaf culture. I teaching her about deaf culture and using interpreter, more than she was helping my daughter.” This response provided insight in how counseling could be harmful to one with cultural needs. Counseling appeared to be helpful in one instance but harmful in another due to the lack of cultural understanding.

Question 4: “Were there setbacks in the counseling process? If so, what were they? If not, what helped your experience ‘flow’ better?” Participant responses to this question illustrated a major theme related to setbacks - the importance of developing safety, trust, and reliability in counseling. The following respondents’ statements illustrate this theme: “Yes, sometimes I felt it was too personal with the interpreters present” and “Sometime the interpreter will suddenly cancel right before the appointment. Or interpreter will talk to the counselor during the process.” This showed, along with the safety, trust, and reliability, that there is an importance to understanding the role culture plays. Another participant reported “Yes, when a qualified counselor who specialized in helping the deaf, was told she could not see multiple deaf individuals from the same family; even though she was the only one qualified to do so. She eventually quit

counseling, and my daughter was left with a counselor who was not qualified to help my daughter at all.” This participant’s statement clarifies their belief that counseling must be available to all individuals who need counseling services. The setback here was that the participant’s daughter was unable to receive the help she needed due to the lack of cultural competence within the counseling field.

Question 5: “Is there any other information you would be willing to share that could provide this study with more insight into the client-counselor relationship?” This question wrapped up the entire survey and provided insight to what the participants were looking for. A big part of the responses provided insight that culture matters and that it is more than counseling and more than interpreting but that knowing the culture is highly facilitative. “Counselor need to be aware [of] differences w[ith] deaf [and] hearing [because] we both [have] different ways to express [ourselves and] counselor need to m[a]ke deaf feel comfy [and] b[e] open mind[ed] [and] it’d connected between th[e]m.” Another participant reported “The deaf need counselors with an understanding of deaf culture and the uniqueness of their language; use of interpreters, and special problems trying to function in a hearing world. As for my daughter, I have taken her to many different counselors, because of trying to find someone who is qualified to help her. She has no one in SW MO that can do that for her now; at least not that I have found.” This also shows that there is a strong need for counselors who are willing and qualified to work with individuals who are d/DHH. This means that counselors who are hearing need to learn about Deaf Culture to better serve their clients. Another participant provided insight about the time length within the counseling: “I would make it more than just 50 minutes when there is an interpreter involved.”

Through studying the responses and themes derived from participants, it appears that a meta-theme (i.e., a higher-order theme) emerged, that of deaf cultural considerations as critical to helping the d/Deaf and hard of hearing population. Safety, understanding, communication, and connectedness are all deeply rooted in the cultural context.

DISCUSSION

Throughout the research, some valuable information was brought to light about individuals who are d/DHH. Learning about the struggles faced by the d/Deaf population through abuse has been eye-opening and has provided insight that this is a concern that needs more attention; this, along with other mental illnesses such as depression, emphasize the importance of having counselors competent to work with the d/Deaf and hard of hearing population. It was noted that there is a high need for counselors who can help individuals who are d/Deaf and hard of hearing through their difficulties. Participant responses from the survey study supported the idea that there was some dissatisfaction with communication due to some difficulty in understanding the interpreter, the interpreter misunderstanding the counselor, or the overall conversation getting lost in translation. One participant stated that counseling wasn't helpful because "A lot of times....it's because of miscommunications between the interpreters and the counselors." Another participant stated "There's plenty of times that the counselor felt that he/she didn't understand the interpreter not me." Connolly, Rose, and Austen (2006) also provided the information that "The inclusion of an interpreter in an interview introduces two more relationships to the interview: interpreter-client and interpreter-interviewer" (p. 53) which can alter the typical therapeutic relationship.

Secondly, a major aspect for improved satisfaction involves the counselors become culturally competent for the d/Deaf and hard of hearing population. The responses of the surveys and the review of literature provided great evidence that cultural awareness is necessary. This could be seen by a participant who stated: "Another

counselor had never used an interpreter before and would ask me to tell the interpreter what to tell my deaf daughter. She had no understanding of deaf culture. I teaching her about deaf culture and using interpreter, more than she was helpful to my daughter.” If cultural awareness and improved communication were incorporated in the counseling session this would provide for improved client satisfaction within counseling for the d/Deaf and hard of hearing population. By focusing on cultural competence this would provide the d/Deaf and hard of hearing population an opportunity to trust the counselor and the process. Peters (2007) states “The combination of misunderstanding, misdiagnosing, and mistreatment, albeit with good intentions, led to mistrust of mental health professionals” (p. 184).

Communication barriers are evident and that even in their own homes with hearing family members, d/Deaf individuals appear to be strangers. The d/Deaf have no way of communicating their struggles with their own family, and as a consequence they are made to face this world in isolation. Ridgeway (1993) shared how one of the individuals that was in her study was “accused of day-dreaming ‘as usual’” (p. 168) when she tried to share with her mother that she suffered from sexual abuse. With no support group, they find themselves unable to heal from the hurt of their past and unable to learn to trust others to be there for them. By providing them the support through cultural competence and understanding how to utilize the interpreter, this can provide the help they would need.

Based on the responses from the participants in this study, it is suggested that if the counselor is working with a d/Deaf individual and is not fluent in sign language, the next best thing for the counselor to do is to seek a qualified, certified interpreter to bridge

the gap of communication. One participant stated, in regards to what impact the counseling had with an interpreter in the room, "It was helpful, especially for a first meeting." Another stated, "It helps most of [the] times so I could actually understand the situation." Providing a competent interpreter will help build trust in the client-counselor relationship. One of the participants stated "The counseling has help[ed] greatly with interpreter so I am able to understand each other more than one on one." Within the counseling sessions, it was noted that the most beneficial method of therapy is to be visual and hands-on. Using verbal language, and even sign language at times, may be extremely difficult for the client. Using dolls or pictures to help them express the concepts rather than the words will be beneficial to them in their treatment. Peters (2007) strongly encouraged counselors to take the time to learn sign language or learn about deaf culture to help the counseling process. Peters does share "Research suggests that client[s] who are deaf prefer a counselor who is also deaf" (p. 187). Peters does provide an alternative if this is not an option for the client by stating that if the counselor is not fluent in sign language, then an interpreter should be utilized.

Another finding was that there were setbacks in the counseling process due to difficulty within the interactions between all parties and overall feeling of safety to open up in the counseling session. One participant stated, "Sometimes I felt it was too personal with the interpreters present." This shows the importance of providing a safe space for the client by expressing the role of the interpreter and the confidentiality by both the counselor and interpreter, so that the three individual are able to work together in collaboration and will help avoid issues with miscommunication and distrust.

Counseling is a very personal and individualized endeavor, and though therapy styles weren't specifically addressed in the survey study, the idea of researching therapy styles that best suite those who are d/DHH was something of interest. There are therapy styles that are used for different circumstances. For instance, most often when counseling children, play therapy is used because this is a language where the children can express themselves where words are not yet formed. They may not have an understanding of the word "abuse" but when they act out in the playroom with violence or art that has cruelty the counselor can learn to interpret their play to see something beyond what is said. This concept was brought up as a concern because those who are d/DHH may not have the vocabulary for issues of hurt, sadness, anger or struggles. An example of this concern was provided by LaBarre (1998) when she discussed how in her intake paperwork, she found that often the Deaf children would not indicate that they had been sexually abused; however, if she asked them if they were touched in a way they did not want, they would respond yes. LaBarre explained that these individuals have a difficult time with the vocabulary of sexual abuse and typically don't realize it's an issue until adulthood. LaBarre stated, "In some residential school environments sexual abuse had become normalized" (p. 322). When discussing how to help d/Deaf children or adults who had been sexually abused at an early age, she explains that the key is to use visualization. LaBarre continued by stating, "Explaining boundaries should be done in visual ways (i.e., shower curtain, door, teacher's desk drawer, another person's purse. A doll house can be helpful to show the concepts of doors and privacy" (p. 324). She also shared insight that Deaf adults also found it easier to communicate what happened to them by using the dolls and that it is important to not rule this out when working with d/Deaf population. Being

able to provide the Deaf population with a visual form of counseling would be helpful for them to share and express their feelings and emotions in a way that would be understood by the counselor which would lead to the journey of the healing process.

Munro, Knox, and Lowe (2008) report, “The congruence between the changing social construction of Deafness and the therapeutic approach creates an environment that is likely to yield collaborative and productive therapy” (p. 309). They continued to explain that the constructionist approach is more defined by its creativity rather than focusing on predefined pathologies and how the constructionist approach focuses on the strengths and resources of the client. This allows the client more control of their life and control of their treatment. Therapy styles could be further explored and studied to see which would be the most fitting for the participants.

Conclusions & Recommendations

Through reading the literature, it was shown that there were quite a few articles that discussed the mental health treatment and programs for individuals who were or are d/Deaf and hard of hearing. However, there were other areas of research that appeared to be lacking: therapy styles, communication issues/language barriers, and the importance of understanding Deaf Culture.

Conclusions that could be drawn from this study include the importance of addressing cultural competence, understanding the role of the interpreter prior to working with one, working towards better understanding and providing the necessary safety their clients are looking for, and finding a way to incorporate interpreters in the session in the most beneficial manner. Throughout the survey, it was addressed time and time again the

importance of feeling understood by the counselor and feeling a connection. There is an importance to feeling accepted by the counselors and seeing that the culture is not a deterrent for the counselor to provide support through the healing process. This could be started by the counselor understanding the dynamic an interpreter brings into the session and the proper etiquette when working with a client and interpreter. After evaluating the survey responses, the biggest key was that counseling was helpful as a whole, but the focus must be on more than the language of the d/DHH but that the language combined with culture. One participant in the survey study reported “The deaf need counselors with an understanding of deaf culture and the uniqueness of their language.” Munro, Knox, and Lowe’s study also supported this when they shared “Deaf people want therapists to have an awareness and understanding of Deaf culture” (2008, p. 308). One of the participants stated “Counselor need to be aware [of] differences w[ith] deaf [and] hearing [because] we both [have] different ways to express [ourselves and] counselor need to m[a]ke deaf feel comfy [and] b[e] open mind[ed].”

There are several possible recommendations for improving research on this topic. The first recommendation would be replication of this study with a broader sample by conducting the five question open-ended survey to a larger group of participants could help provide more information and make it easier to generalize for the population. By replication with a broader sample, the limitation of having a small sample size could make it more difficult to generalize could be addressed. Another way to make this study more interactive would be conversing with the d/Deaf and hard of hearing participants through interviews which could provide more insight and provide the participants the ability to utilize sign language to better express their experiences. By interacting more

with the participants in a manner outside of written language could provide future researchers the ability to finding more willing participants with the specified criteria needed. Thirdly, though therapy styles were not specifically addressed by the participants, it does appear to be a concern for the effectiveness of therapy. To see if other forms of therapy would be more beneficial, such as play therapy versus talk therapy, could provide necessary insight to improve the client satisfaction, therefore empirical research on various modalities with the deaf is warranted. Finding ways to educate the insurance on the importance of providing this population with a longer counseling session as discussed by one of the participants when they stated “I would make it more than just 50 minutes when there is an interpreter involved.” Lastly and more broadly, more research in all aspects is warranted due to the paucity of current research.

When working with individuals who are d/DHH, it would be necessary for the counselor to have some knowledge of Deaf culture and are either able to interact proficiently through the use of sign language or provide the client with an interpreter who is certified and qualified for working in the counseling setting. In addition, it might be beneficial for the counselor and the interpreter to discuss the therapy style that would be used and how they expect to interact with the client previously to give the interpreter the big picture of what to look for and how to help the communication flow without any barriers. Lastly, taking the time to build rapport and safety between the three parties by openly and clearly discussing confidentiality and other safety matters could provide the clients with the ability to become comfortable with both the counselor and the interpreter and be more willing to open up about concerns they wish to address via therapy.

The purpose of studying Deaf culture and using an interpreter or being proficient in sign language is to help provide the support and guidance needed to provide the client with beneficial counseling and help them through their struggles. With this information, it is recommended that the therapist become fluent in sign language and/or Deaf Culture. In connection to this, it is recommended that interpreters become specialized with working in the counseling field, where they are able to understand the terminology and provide the information specifically and clearly to the client. Building the rapport with the client is crucial and would be destroyed with the incompetence of the counselor with the d/Deaf population. This could only damage the client on a further level and make it more difficult for the client to trust another counselor or seek help in the future. Consider this participant's response from the survey: "Our first counselor was also fluent in ASL and deaf culture. She was very helpful with the problems facing deaf persons and understood the unique issues facing the deaf. Another counselor had never used an interpreter before and would ask me to tell the interpreter what to tell my deaf daughter. She had no understanding of deaf culture. I [had to] teach her about deaf culture and using interpreter, more than she was helping my daughter." She goes on to say, "My daughter was left with a counselor who was not qualified to help my daughter at all." Finally she states, "I have taken her to many different counselors, because of trying to find someone who is qualified to help her. She has no one in SW MO that can do that for her now; at least not that I have found." As you can see from the concepts and from the participant's perspective, counselors need to be culturally competent to be effective counselors within the individuals who are d/DHH, which is the same that has been found with other studies of diversity.

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APPENDICES

Appendix A: Survey Questions

1. What impact did having an interpreter have on your counseling experience?
2. How and how well did you feel understood by your counselor? Do you have examples that might illustrate this?
3. Was the counseling helpful? If so, how? If not, how not?
4. Were there setbacks in the counseling process? If so, what were they? If not, what helped your experience “flow” better?
5. Is there any other information you would be willing to share that could provide this study with more insight into the client-counselor relationship?

Appendix B: NAD-RID Code of Professional Conduct



CODE OF PROFESSIONAL CONDUCT

Registry of Interpreters
for the Deaf
333 Commerce Street
Alexandria, VA 22314
703/838-0030 (V)
703/838-0459 (TTY)
703/838-0454 (Fax)
www.rid.org

NAD-RID CODE OF PROFESSIONAL CONDUCT

Scope

The National Association of the Deaf (NAD) and the Registry of Interpreters for the Deaf, Inc. (RID) uphold high standards of professionalism and ethical conduct for interpreters. Embodied in this Code of Professional Conduct (formerly known as the Code of Ethics) are seven tenets setting forth guiding principles, followed by illustrative behaviors.

The tenets of this Code of Professional Conduct are to be viewed holistically and as a guide to professional behavior. This document provides assistance in complying with the code. The guiding principles offer the basis upon which the tenets are articulated. The illustrative behaviors are not exhaustive, but are indicative of the conduct that may either conform to or violate a specific tenet or the code as a whole.

When in doubt, the reader should refer to the explicit language of the tenet. If further clarification is needed, questions may be directed to the national office of the Registry of Interpreters for the Deaf, Inc.

This Code of Professional Conduct is sufficient to encompass interpreter roles and responsibilities in every type of situation (e.g., educational, legal, medical). A separate code for each area of interpreting is neither necessary nor advisable.

Philosophy

The American Deaf community represents a cultural and linguistic group having the inalienable right to full and equal communication and to participation in all aspects of society. Members of the American Deaf community have the right to informed choice and the highest quality interpreting services. Recognition of the communication rights of America's women, men, and children who are deaf is the foundation of the tenets, principles, and behaviors set forth in this Code of Professional Conduct.

Voting Protocol

This Code of Professional Conduct was presented through mail referendum to certified interpreters who are members in good standing with the Registry of Interpreters for the Deaf, Inc. and the National Association of the Deaf. The vote was to adopt or to reject.

Adoption of this Code of Professional Conduct

Interpreters who are members in good standing with the Registry of Interpreters for the Deaf, Inc. and the National Association of the Deaf voted to adopt this Code of Professional Conduct, effective July 1, 2005. This Code of Professional Conduct is a working document that is expected to change over time. The aforementioned members may be called upon to vote, as may be needed from time to time, on the tenets of the code.

The guiding principles and the illustrative behaviors may change periodically to meet the needs and requirements of the RID Ethical Practices System. These sections of the Code of Professional Conduct will not require a vote of the members. However, members are encouraged to recommend changes for future updates.

Function of the Guiding Principles

It is the obligation of every interpreter to exercise judgment, employ critical thinking, apply the benefits of practical experience, and reflect on past actions in the practice of their profession. The guiding principles in this document represent the concepts of confidentiality, linguistic and professional competence, impartiality, professional growth and development, ethical business practices, and the rights of participants in interpreted situations to informed choice. The driving force behind the guiding principles is the notion that the interpreter will do no harm.

When applying these principles to their conduct, interpreters remember that their choices are governed by a "reasonable interpreter" standard. This standard represents the hypothetical interpreter who is appropriately educated, informed, capable, aware of professional standards, and fair-minded.



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www.rid.org

CODE OF PROFESSIONAL CONDUCT

Tenets

1. Interpreters adhere to standards of confidential communication.
2. Interpreters possess the professional skills and knowledge required for the specific interpreting situation.
3. Interpreters conduct themselves in a manner appropriate to the specific interpreting situation.
4. Interpreters demonstrate respect for consumers.
5. Interpreters demonstrate respect for colleagues, interns, and students of the profession.
6. Interpreters maintain ethical business practices.
7. Interpreters engage in professional development.

Applicability

- A. This Code of Professional Conduct applies to certified and associate members of the Registry of Interpreters for the Deaf, Inc., Certified members of the National Association of the Deaf, interns, and students of the profession.
- B. Federal, state or other statutes or regulations may supersede this Code of Professional Conduct. When there is a conflict between this code and local, state, or federal laws and regulations, the interpreter obeys the rule of law.
- C. This Code of Professional Conduct applies to interpreted situations that are performed either face-to-face or remotely.

Definitions

For the purpose of this document, the following terms are used:

Colleagues: Other interpreters.

Conflict of Interest: A conflict between the private interests (personal, financial, or professional) and the official or professional responsibilities of an interpreter in a position of trust, whether actual or perceived, deriving from a specific interpreting situation.

Consumers: Individuals and entities who are part of the interpreted situation. This includes individuals who are deaf, deaf-blind, hard of hearing, and hearing.

1.0 CONFIDENTIALITY

Tenet: Interpreters adhere to standards of confidential communication.

Guiding Principle: Interpreters hold a position of trust in their role as linguistic and cultural facilitators of communication. Confidentiality is highly valued by consumers and is essential to protecting all involved.

Each interpreting situation (e.g., elementary, secondary, and post-secondary education, legal, medical, mental health) has a standard of confidentiality. Under the reasonable interpreter standard, professional interpreters are expected to know the general requirements and applicability of various levels of confidentiality. Exceptions to confidentiality include, for example, federal and state laws requiring mandatory reporting of abuse or threats of suicide, or responding to subpoenas.

Illustrative Behavior - Interpreters:

- 1.1 Share assignment-related information only on a confidential and "as-needed" basis (e.g., supervisors, interpreter team members, members of the educational team, hiring entities).



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- 1.2 Manage data, invoices, records, or other situational or consumer-specific information in a manner consistent with maintaining consumer confidentiality (e.g., shredding, locked files).
- 1.3 Inform consumers when federal or state mandates require disclosure of confidential information.

2.0 PROFESSIONALISM

Tenet: Interpreters possess the professional skills and knowledge required for the specific interpreting situation.

Guiding Principle: Interpreters are expected to stay abreast of evolving language use and trends in the profession of interpreting as well as in the American Deaf community.

Interpreters accept assignments using discretion with regard to skill, communication mode, setting, and consumer needs. Interpreters possess knowledge of American Deaf culture and deafness-related resources.

Illustrative Behavior - Interpreters:

- 2.1 Provide service delivery regardless of race, color, national origin, gender, religion, age, disability, sexual orientation, or any other factor.
- 2.2 Assess consumer needs and the interpreting situation before and during the assignment and make adjustments as needed.
- 2.3 Render the message faithfully by conveying the content and spirit of what is being communicated, using language most readily understood by consumers, and correcting errors discreetly and expeditiously.
- 2.4 Request support (e.g., certified deaf interpreters, team members, language facilitators) when needed to fully convey the message or to address exceptional communication challenges (e.g. cognitive disabilities, foreign sign language, emerging language ability, or lack of formal instruction or language).
- 2.5 Refrain from providing counsel, advice, or personal opinions.
- 2.6 Judiciously provide information or referral regarding available interpreting or community resources without infringing upon consumers' rights.

3.0 CONDUCT

Tenet: Interpreters conduct themselves in a manner appropriate to the specific interpreting situation.

Guiding Principle: Interpreters are expected to present themselves appropriately in demeanor and appearance. They avoid situations that result in conflicting roles or perceived or actual conflicts of interest.

Illustrative Behavior - Interpreters:

- 3.1 Consult with appropriate persons regarding the interpreting situation to determine issues such as placement and adaptations necessary to interpret effectively.
- 3.2 Decline assignments or withdraw from the interpreting profession when not competent due to physical, mental, or emotional factors.
- 3.3 Avoid performing dual or conflicting roles in interdisciplinary (e.g. educational or mental health teams) or other settings.
- 3.4 Comply with established workplace codes of conduct, notify appropriate personnel if there is a conflict with this Code of Professional Conduct, and actively seek resolution where warranted.
- 3.5 Conduct and present themselves in an unobtrusive manner and exercise care in choice of attire.



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- 3.6 Refrain from the use of mind-altering substances before or during the performance of duties.
- 3.7 Disclose to parties involved any actual or perceived conflicts of interest.
- 3.8 Avoid actual or perceived conflicts of interest that might cause harm or interfere with the effectiveness of interpreting services.
- 3.9 Refrain from using confidential interpreted information for personal, monetary, or professional gain.
- 3.10 Refrain from using confidential interpreted information for the benefit of personal or professional affiliations or entities.

4.0 RESPECT FOR CONSUMERS

Tenet: Interpreters demonstrate respect for consumers.

Guiding Principle: Interpreters are expected to honor consumer preferences in selection of interpreters and interpreting dynamics, while recognizing the realities of qualifications, availability, and situation.

Illustrative Behavior - Interpreters:

- 4.1 Consider consumer requests or needs regarding language preferences, and render the message accordingly (interpreted or transliterated).
- 4.2 Approach consumers with a professional demeanor at all times.
- 4.3 Obtain the consent of consumers before bringing an intern to an assignment.
- 4.4 Facilitate communication access and equality, and support the full interaction and independence of consumers.

5.0 RESPECT FOR COLLEAGUES

Tenet: Interpreters demonstrate respect for colleagues, interns and students of the profession.

Guiding Principle: Interpreters are expected to collaborate with colleagues to foster the delivery of effective interpreting services. They also understand that the manner in which they relate to colleagues reflects upon the profession in general.

Illustrative Behavior - Interpreters:

- 5.1 Maintain civility toward colleagues, interns, and students.
- 5.2 Work cooperatively with team members through consultation before assignments regarding logistics, providing professional and courteous assistance when asked and monitoring the accuracy of the message while functioning in the role of the support interpreter.
- 5.3 Approach colleagues privately to discuss and resolve breaches of ethical or professional conduct through standard conflict resolution methods; file a formal grievance only after such attempts have been unsuccessful or the breaches are harmful or habitual.
- 5.4 Assist and encourage colleagues by sharing information and serving as mentors when appropriate.
- 5.5 Obtain the consent of colleagues before bringing an intern to an assignment.



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6.0 BUSINESS PRACTICES

Tenet: Interpreters maintain ethical business practices.

Guiding Principle: Interpreters are expected to conduct their business in a professional manner whether in private practice or in the employ of an agency or other entity. Professional interpreters are entitled to a living wage based on their qualifications and expertise. Interpreters are also entitled to working conditions conducive to effective service delivery.

Illustrative Behavior - Interpreters:

- 6.1 Accurately represent qualifications, such as certification, educational background, and experience, and provide documentation when requested.
- 6.2 Honor professional commitments and terminate assignments only when fair and justifiable grounds exist.
- 6.3 Promote conditions that are conducive to effective communication, inform the parties involved if such conditions do not exist, and seek appropriate remedies.
- 6.4 Inform appropriate parties in a timely manner when delayed or unable to fulfill assignments.
- 6.5 Reserve the option to decline or discontinue assignments if working conditions are not safe, healthy, or conducive to interpreting.
- 6.6 Refrain from harassment or coercion before, during, or after the provision of interpreting services.
- 6.7 Render pro bono services in a fair and reasonable manner.
- 6.8 Charge fair and reasonable fees for the performance of interpreting services and arrange for payment in a professional and judicious manner.

7.0 PROFESSIONAL DEVELOPMENT

Tenet: Interpreters engage in professional development.

Guiding Principle: Interpreters are expected to foster and maintain interpreting competence and the stature of the profession through ongoing development of knowledge and skills.

Illustrative Behavior - Interpreters:

- 7.1 Increase knowledge and strengthen skills through activities such as:
 - pursuing higher education;
 - attending workshops and conferences;
 - seeking mentoring and supervision opportunities;
 - participating in community events; and
 - engaging in independent studies.
- 7.2 Keep abreast of laws, policies, rules, and regulations that affect the profession.