Mental health provision for and needs of British Sign Language users: practitioners’ perspectives

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Glossary/Abbreviations

*AMHS*: Adult Mental Health Services

*BSL*: British Sign Language

*BSL users*: people who have BSL as their first language, despite hearing status

*CAMHS*: Children and Adolescent Mental Health Services

*coda*: a methodological element of Dialogical Narrative Analysis that is used in the present research (not to be confused with CODA)

*CODA*: Child of Deaf Adult

*CR*: Critical Realism

*CYP*: children and young people

*deaf/ deafness*: audiological deafness, a pathological condition where an individual is considered to have lack of the ability to hear. They normally use spoken English, and/or have hearing assistive devices.

*Deaf/ Deafness*: a cultural and linguistic identity, an individual who resonates with a minority cultural and linguistic group (the Deaf Community), and normally utilises BSL as their primary language. They normally hold negative beliefs towards hearing assistive devices and they hold a Deaf identity.

*DMH*: Deaf Mental Health

*DMHS*: Deaf Mental Health Services

*DNA*: Dialogical Narrative Analysis

*Hard-of-hearing/HOH*: people experiencing mild to severe hearing loss, who are usually able to communicate by using an assistive device.

*Hearing impairment*: a general term which is most commonly used to describe individuals who experience any degree of hearing loss. Might be used interchangeably with hearing loss.

*MHP*: Mental Health Practitioners
MHS: Mental Health Services

NA: Narrative Analysis

NDCAMHS: National Deaf Children and Adolescent Mental Health Services

NHS: National Health Service (UK)

QI: Qualitative Inquiry

SJ: Social Justice

RQ: Research Questions
Abstract
The University of Manchester
Doctorate in Counselling Psychology

Mental health provision for and needs of British Sign Language users: practitioners’ perspectives

Aliki Vasiliadou

Background and objectives: Despite a large amount of theoretical literature on best practices in deaf mental health, empirical research concerning hearing mental health professionals working with d/Deaf service users has been limited, with the majority of literature written in English and originating from the US. This study aimed to explore how UK-based mental health professionals speak about their professional experiences and training in deaf mental health, and their perspectives on deaf mental health provision. The goal was to identify areas of development for deaf mental health provision based on deaf specialists’ reported experiences. The foundational basis of this study is social justice and intersectionality theory as understood within counselling psychology, as well as multicultural and diverse therapeutic practice.

Methods: a qualitative research design was employed, informed by Critical Realism. Semi-structured interviews were utilised with eight participants who are deaf specialists in mental health (clinical psychologists, counsellors, psychotherapists), and their accounts were analysed using Dialogical Narrative Analysis. Analysis: None of the participants reported receiving formal training in working with d/Deaf clients, however, all identified informal sources of learning, and all were trained in British Sign Language. All participants reported challenges in their work in deaf mental health. Those were related to aspects of deafness (but not d/Deaf clients per se) such as cultural differences and conducting appropriate psychological assessments, as well as with liaising with (hearing and d/Deaf) professionals. Nevertheless, the main reported challenge was socio-political aspects of deafness, such as deaf education, poor mental health provision, lack of Deaf awareness in the community and historical oppression. Participants recommended best practices for deaf mental health practitioners, with some of them reflecting multicultural competencies and social justice practice, and they identified areas of development for deaf mental health services and public services. Conclusion and implications: Despite practitioners adapting practice to meet clients’ needs, there is a significant number of challenges originating outside deaf mental health that need to be addressed.
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Dedication

In memory of my grandparents.
Acknowledgments

My deepest affection and love to my family, and especially my parents, who apart from their practical support, they have never stopped believing in me and encouraging me to continue reaching my goals.

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Chapter 1: Introduction

1.1. Overview

The present study explores hearing therapists’ experiences in working with British Sign Language (BSL) users, their perspectives on mental health provision for BSL users, and finally, their deaf-related training. Hearing therapists who *routinely* work or have worked with BSL users were interviewed, and hence, ‘hearing therapists’ or ‘deaf specialists’ are used interchangeably to refer to the participants. The study aims to fill the gap in the literature in understanding what is like for deaf specialists to work with BSL users.

The term BSL users is adopted, firstly, as I consider it to be more inclusive since it allows people to identify BSL as their first or preferred language despite hearing status (Young et al., 2017) and secondly, as it focuses on the language and cultural aspects of service users (rather than on the hearing and speaking ability) which brings attention to the wholeness of the person, and on the interplay of intersections as manifested in the therapeutic relationship. Nevertheless, the terms deaf (and deafness), Deaf (and Deafness), and Hard-of-Hearing (HOH) are also used as they appear in the literature and/or participants’ accounts.

In this introductory section, I firstly provide my socio-politico-legal rationale for the study, by narrating about the reasons that render this topic worth exploring. The literature review chapter serves as my academic rationale. A separate chapter is dedicated to reflexivity in this research, where I expand on my personal interest on researching Deaf Mental Health (DMH). I consider, however, important to state early on that I am hearing, and I do not use any sign language. I then move into discussing the current UK Deaf Mental Health Services (DMHS) for adults, and Children and Young People (CYP). Following this, I present the debate on deafness being a disability or a cultural identity, alongside relevant terminology. Finally, the theoretical background of counselling psychology, and more specifically, multiculturalism and diversity, intersectionality and social justice (SJ), are discussed to set the lenses through which this study approaches DMH.
1.2. Socio-politico-legal rationale for the study

As members of society, we are expected to follow social norms and ideally, live in harmony, a state of well-being that was secured by the Universal Declaration of Human Rights published in 1948 (United Nations, n.d.). Article 1 states that “all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood” (p. 2). The Human Rights Act published in 1998 and applicable to the UK, also stresses the right to equal access, through Article 14 ‘Protection from discrimination’ which refers to a position of disability, but also a national minority status.

According to the Equality Act of 2010, deafness is considered as a protected characteristic that ensures anti-discrimination for d/Deaf in the workplace and the wider society. Scotland is the only country in the UK to have established the BSL (Scotland) Act (2015), making the promotion and support of BSL, and the publication of relevant plans by public bodies, a legal responsibility. Unfortunately, literature suggests that d/Deaf people still face discrimination in multiple areas in their lives, such as in the workplace (Hasanbegovic & Kovacevic, 2018), and educational settings (Brennan, 2003), since they are not given equal access. An example of d/Deaf people struggling to function in the hearing world due to its structure, is the recent global pandemic, during which people are required to use face masks, which makes lip reading impossible. Deaf people have been discussing their experiences of this issue on web blogs and social media, which I understand to have contributed to the production of transparent face coverings (Whitbread, 2020).

In the UK, deaf and HOH individuals have been estimated to be 11 million, and BSL users to be 151,000 (Government Digital Service, 2017). In the group of people that would perhaps find DMH relevant, are people with acquired hearing loss or ‘deafened’ as the literature refers to this position (British Deaf Association - BDA, n.d.), as well as mental health practitioners (MHP) involved in the support of deafened individuals. Indeed, research shows that age is still the stronger predictor of hearing loss (Hoffman et al., 2017), which renders the topic relevant to all of us. The disability literature discusses the idea of being temporarily able-bodied, as Breckenridge and Vogler (2001) state:

> no one is ever more than temporarily able-bodied. The designation *temporarily able-bodied* [emphasis in original] invites us to consider different sorts of vulnerability,
different points of frailty, as features of our common lot and accordingly to shift our understandings of flourishing, social justice, and embodiment (p. 356).

Further to the idea of humans being able-bodied only temporarily, the authors discuss the concept from a social perspective; how we think about justice in society, and the opportunities we provide to people to thrive and achieve their potentials.

Another socio-political reason for conducting this study is the actual frequency of mental health difficulties that UK d/Deaf people face, which are reported to be about two times higher than the hearing population (Government Digital Service, 2017; Hulme, 2017; Fellinger et al., 2012). Yet, despite the higher mental health difficulties rates, it is questionable whether mental health services (MHS) are ready to address the needs of this group, with literature actually suggesting that d/Deaf people face barriers in accessing MHS even before reaching a mental health professional. Some of those barriers are the lack of interpreters, cultural ignorance, inappropriate diagnostic tools, and d/Deaf people’s ignorance of the MHS available to them (Steinberg et al., 1998). Nonetheless, difficulty in communication is claimed to be the main cause (I would say maintenance factor too) of mental health issues from the time of booking an appointment, to the clinic’s reception, to the therapeutic room (Steinberg et al., 1998; Fellinger et al., 2012; Cabral et al., 2013). Wright (2020), the clinical lead of National Deaf Children and Adolescent Mental Health Services (NDCAMHS) writes on the particularities of BSL concluding that “The UK system is not well prepared for this variability” (p. 9).

The higher rate of mental health difficulties faced by d/Deaf people as well as the unpreparedness of the UK system to address the particularities of BSL users are expected to influence the work of mental health providers, and the wider socio-political and legal matters are thought to be of further relevance to our work. In addition, the idea of developing hearing loss at some point during our lives, and the discrimination that d/Deaf people face presents a socio-political and legal matter that is relevant to d/Deaf\(^1\) and hearing people alike. Hence, equality of access to MHS reflects equality of human rights, the right to well-being, and access to societal public services, and renders working therapeutically with d/Deaf people contemporary.

\(^1\) Includes audiological and cultural positionings
1.3. Deaf Mental Health Services in the UK

I here present the MHS available to d/Deaf people, followed by a brief critical reflection on them.

1.3.1. Adult mental health services

In the UK, there are only three National Health Service (NHS) providers which offer inpatient services for deaf adults, interestingly, all of them located in England (Greater Manchester, Birmingham, and London) whilst also accepting patients from Scotland, Wales, Northern Ireland, and the Republic of Ireland (National Health Service Commissioning Board, 2013-4; Hulme, 2017). The first of those units was built in Manchester in 1968 (Young et al., 2001). Additional forensic settings offering inpatient services also exist in the private sector, and are commissioned by the NHS; three of them are located in Greater Manchester, and two in East Midlands (Hulme, 2017). In the community, there are eight services across England. There are also organisations such as SignHealth (charity) that offer psychological support to adults who live in England or Wales, and which advertise that they provide therapy only in BSL. SignHealth is the largest provider of counselling services to d/Deaf people in the UK (A. Young, personal communication, February 14, 2018). BSL - Improving Access to Psychological Therapies (IAPT) through BSL Healthy Minds is a psychological therapy service for Deaf people and part of SignHealth. Community services for d/Deaf adults are also available in Scotland (NHS National Services Scotland, 2020). For an overview of DMHS readers could access the guidelines document of Joint Commissioning Panel for Mental Health - JCPMH (Hulme, 2017), the BPS’ (n.d.) guidelines on psychometric testing for hearing impaired clients, and NHS Lothian (2020) for Scotland.

1.3.2. Children and young people mental health services

Unlike MHS for d/Deaf adults, services for d/Deaf children are developed nationally. NDCAMHS were founded in 2009, after a successful pilot from 2004 to 2009 that involved London, York and Dudley (Ackroyd et al., 2018; Wright et al., 2012). With their establishment, an additional service in Taunton was developed to cover a broader geographical area.
Therefore, there are currently, four teams in England\(^2\) (Northern Arm, Central Arm, South East Arm, and South West) (National Health Service Commissioning Board, 2013-4), with only one NHS inpatient NDCAMHS service, in London (Sessa & Sutherland, 2013), with six beds available. NDCAMHS supports d/Deaf children, and hearing children of d/Deaf parents, and their families, and they typically consist of multi-disciplinary professionals, both hearing and d/Deaf, such as psychologists, family therapists, child psychiatrists, nurse specialists, specialist d/Deaf outreach workers, family support workers, child mental health workers, occupational therapists, speech and language therapists, and BSL/English interpreters (Ackroyd et al., 2018). To my knowledge, no private (non-NHS) services exist for d/Deaf CYP that specifically offer mental health support. For a detailed review of NDCAMHS please see Wright et al. (2012).

1.3.3. Critical discussion on deaf mental health services

It appears that DMHS are more developed in England, compared to the rest of the UK where services are limited to adults, and do not include Tier 4 services. Practically, that would mean that d/Deaf people would need to be hospitalised away from home, or travel to another country. The same would be true for d/Deaf CYP who do not live close to the only inpatient service, in London. Despite DMHS not being particularly developed in Scotland, the government is aware of the gap and the need for a strategic plan, and they have developed the BSL National Plan in effect until 2023 which covers a range of domains (e.g., education) (Scottish Government, 2017). Regarding mental health, they state the need for prompt and accurate support, without discrimination or stigma.

It is beyond the scope of this research to discuss commissioning DMHS; for a brief review, please refer to the JCPMH (Hulme, 2017). It is, however, important to consider the services’ effectiveness and impact. Recent research comparing the effectiveness and cost-effectiveness of BSL-IAPT and standard IAPT services accessed by d/Deaf people has indicated no significant differences, concluding that there is currently uncertainty regarding which, if any of the two, is more effective and cost-effective (Young et al., 2017). However, some studies report that d/Deaf people face communication barriers in accessing MHS (e.g., Cabral et al.,

\(^2\) some authors such as Hulme - JCPMH, 2017 only refer to three teams as they consider the South East and South West as one service.
2013) and Deaf communities and organisations advocate for d/Deaf people’s right in accessing therapy in their preferred language (e.g., National Association of the Deaf, 2020). Feldman & Gum (2007) found that deaf clients preferred therapy in sign language, but that younger people were somewhat more willing to have therapy through interpreters.

Another step that reflects development is the endeavours to translate and standardise assessment tools to be used with d/Deaf people, for instance, the Strengths and Difficulties Questionnaire (SDQ) (Roberts et al., 2015). Researchers from the University of Manchester and as part of BSL Health Minds, have also developed the IAPT’s tools in BSL; the Patient Health Questionnaire- 9 (PHQ-9) and the Generalised Anxiety Disorder-7 (GAD-7) (Rogers et al., 2012), whilst also testing their clinical cut-offs (Belk et al., 2016).

Finally, NDACMHS seems to produce significant research, at least in comparison to d/Deaf adult services, in which they also explain steps they take to improve their services. For instance, Ackroyd et al. (2018) present the development of ‘The Communication Profile’ which aims at assisting clinicians’ understanding of families’ language and communication needs, as well as screen for further linguistic assessment needs, explaining their goal of sharing skills and educating staff as part of induction. Hence, some steps towards improving DMH in England and Scotland are evident.

1.4. Deafness in the disability discourse

As already mentioned, under the Equality Act of 2010, deafness is considered as a disability, and therefore, as a protected characteristic, aimed to promote anti-discrimination for d/Deaf people in the workplace and the wider society. Despite that, the view of deafness as a culture exists for the last 50 years and was launched after the ineffectiveness of oral education, the acknowledgment that sign languages are languages, and the movements for minority civil rights (Glickman & Gulati, 2003). As indicated in the glossary, deafness with a lower ‘d’ signifies an understanding of it as a pathology; the lack of the ability to hear, whereas Deafness with a capital ‘D’ indicates a cultural identity, a sense of belonging in a community, and pride (Walker, 2013). The term ‘deaf’ can also be used to refer to those with an acquired hearing loss or who use spoken language (Ladd, 2003). Hence, people who identify as Deaf tend to not
identify as disabled/impaired, and they are also typically part of the Deaf Community, follow cultural norms and customs, attend events, and use sign language (Ladd, 2003). In the UK Deaf Community, their preferred or first language is BSL (BDA, n.d.; signed culture, 2018). The Deaf Community campaigns “for cultural and linguistic recognition” and the capital D signifies this political endeavour (Inclusion London, n.d., p. 2).

The debate on whether deafness is a disability is critical in mental health, as it appears to determine how society would treat d/Deaf individuals, for instance, in terms of financial support or prejudice (e.g., Equality Act 2010). Darling (2013) states that “certainly not all disabilities are the same, and societal reactions vary greatly from one disability to another” (p. 1). Chapman and Demmeyer (2017) found that facing discrimination led to lower well-being levels despite hearing-related identity (hearing, deaf, bicultural – both hearing and deaf, marginal – neither hearing nor deaf). Therefore, experiences related to deafness as a disability or culture are expected to determine the mental health needs of service users (Hulme, 2017). The debate is also expected to influence how d/Deaf individuals construct their identity and personal narrative. It has been well established that the concept of identity, that is, the development of a stable understanding of how we are as individuals and in relation with others, is associated with well-being both in hearing adults (e.g., Karaś & Cieciuch, 2018) as well as in deaf adults (e.g., Chapman & Dammeyer, 2017). Interestingly, Chapman and Dammeyer (2017) found that adults with hearing loss who identified as having a deaf, hearing, or bicultural identity, presented with significantly higher levels of psychological well-being compared to those who identified as marginal. Although, this finding does not make claims about whether considering deafness as a disability relates to well-being, it does claim that having a ‘clearer’ hearing ability-related identity does.

The debate is also relevant to psychological therapists as their understandings of d/Deafness are expected to be present in a therapeutic encounter and influence how effectively they will relate to d/Deaf service users, for example, through their own biases of ability, disability, deafness, and culture. In support of that, challenging discrimination is an ethical responsibility of practitioner psychologists (Health and Care Professions Council, 2016) and to “critically reflect on the use of self” is an area of competency for counselling psychologists (HCPC, 2015, p. 12). Glickman and Gulati (2003) have published a book on ‘The Culturally Affirmative

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3 For the purpose of this thesis, disability and impairment are used interchangeably
Approach’ through which they clearly state that they do not view Deafness as a disability, and they further challenge oppression and marginalisation against Deaf people. They, therefore, write about service users who identify as culturally and linguistically Deaf (without though promoting cultural Deafness for those who do identify with it), and they suggest how to be culturally affirmative with Deaf clients through cross-cultural psychology (versus disability psychology) (Glickman & Gulati, 2003). This book could be seen as an example of how therapists’ positioning of Deafness as an identity, guides their work with those service users.

Authors of Deaf Studies have, traditionally, been disapproving the overlap of deafness and disability, which led the two growing apart (Scott-Hill, 2003; Kusters 2011). Mackenzie and Smith (2009) have characterised deafness as “the neglected and hidden disability” (title), referring to the society’s lack of awareness of deafness’s impact on an individual, and therefore the lack of action in responding to potential difficult experiences. Brueggemann (2010) acknowledges a shift in how the two fields relate, which began in about 2000, and states that they have grown to have commonalities. They borrow from each other their interests, even though the level of emphasis is not always the same (Brueggemann, 2010). Examples of commonalities are discussions on i) access (to services, public spaces, information, education) and employment, and ii) audism and ableism as constructs that oppress and limit d/Deaf and disabled people respectively (Brueggemann, 2010).

Kusters (2011) described the distance with which Deaf Studies approach Disability Studies, and even characterised it as hostile. Doe (n.d.) who identifies both as a “marginal” member of the “Deaf World” and the “Disability Culture” (p. 1) claims that Deaf people “oppress and marginalize Disabled people” (p. 2). She attributes it partly to the fact that Deaf people do not consider being Deaf as a stigma; “[Deaf people] are proud of their culture and do not want it to be ‘‘contaminated’ by the enormous stigma associated with lower case disability and impairment” (p. 3). Personally, when I was first involved in the topic of d/Deafness in research, I had not included the disability discourse in my writing because I had never thought of the two being associated, as deafness would not fit into my understanding of disability as visual. Nonetheless, Doe’s (n.d.) statement about the need to recognise our social and biological existence “without denying the importance of political or cultural stances” (p. 5) provoke some thought. This allows for flexibility when thinking and speaking about, as well as researching,
d/Deafness, a flexibility that could possibly support discussions in the counselling room. For the purpose of this research, Deafness is considered as a cultural identity rather than a pathological condition, which appears to be in line with contemporary understandings of Deafness (e.g., the culturally affirmative approach), as well as ethical guidelines for psychologists, as described above. Nevertheless, echoing Doe and taking into consideration Brueggemann’s (2010) claims about the two fields’ commonalities, my view of Deafness as a cultural identity does not exclude people and readers who do not (always or at all) identify as such, and I do not hold a ‘right or wrong’ position. I, therefore, often use the term d/Deaf and/or d/Deafness to include both positions, where relevant.

1.5. Theoretical background in Counselling Psychology

I here discuss how d/Deafness is relevant to the discipline of psychology, and the division of counselling psychology more specifically. Concepts that characterise counselling psychology and distinguish it from other psychology divisions are multicultural and diverse practice, as well as intersectionality theory and SJ practice. The concepts are introduced and their use in this study is explained.

1.5.1. Multiculturalism and Diversity

Multiculturalism is widely discussed and valued in psychology since the mid 70s, following the acknowledgment of interacting with culturally diverse clients without training as unethical (Ridley & Kleiner, 2003), however, some authors place this interest between the 40s and 60s. Even though multiculturalism and diversity are sometimes used in academic journals as synonyms, they are claimed to have differences. Diversity is “quantitative” and refers to “who we are” (National Association of Independent Schools - NDIS, 2005, para. 1). It includes, but not limits to, culture, sexual orientation, sexual identity, religion, age, gender, and disability status (American Psychological Association – APA, 2017; Ade-Serrano et al., 2017). Contrary, multiculturalism is “qualitative” and exists only when we make an informed commitment to change” (NDIS, 2005, para. 1). Multicultural competency goes beyond mere acknowledgement of diversity, and refers to the ability to work with people from different cultural backgrounds, ethnic groups, and languages (Frisby, 2018) in an effort “to challenge the current state of mental health practice, theory and training” (Liu & Pope-Davis, 2003, p. 98).
According to Liu and Pope-Davis (2003), multiculturalism and diversity conceptualise and use power in different ways, claiming that what distinguishes multiculturalism is the recognition of power alongside taking action to diversify. To become multicultural, the first step is recognising the role of power in people and contexts (Liu & Pope-Davis, 2003), whereas, diversity “exists in spite of, and sometimes because of, the action we take” (NDIS, 2005, para.1). It is my understanding that multiculturalism relies on the existence of diversity, and both terms are used in guidance documents such as the HCPC’s ones. Multicultural competency and diverse practice are not set as ethical responsibilities for practitioner psychologists according to the HCPC (2016) yet, authors within BPS’ division of counselling psychology claim lack of awareness of race, culture and difference as “unethical” (Ade-Serrano et al., 2017, p. 3). Challenging discrimination is an ethical responsibility (HCPC, 2016) and being aware of culture, equality and diversity is a standard of proficiency for safe and effective practice, which practitioners should meet, to be registered in the UK (HCPC, 2015).

Multiculturalism has a special place in counselling psychology (Ridley & Kleiner, 2003) both in the USA (Vera & Speight, 2003) and the UK (Parritt, 2016) but also in Canada, Australia and New Zealand (Pelling, 2004). In the UK, the BPS (2019) expects counselling psychology doctoral trainees to be able to work with diversity and multiculturalism as presented in Figure 1.

It appears that the centrality of multiculturalism within counselling psychology is because the most well-known framework of multicultural competency was developed within counselling psychology by Sue et al., in 1982. Sue et al. stress that multicultural competency comprises of three dimensions; beliefs/attitudes, knowledge, and skills, as presented in Figure 2 (as cited in Sue, 2001). Beagan (2018) further explains that skills for cultural competence comprise of “effective communication, rapport building across differences, respect, active listening, advocacy, use of open-ended inquiry, use of culturally appropriate assessments and interventions, and working with interpreters” (p. 124). Reflexivity is at the heart of counselling psychology (HCPC, 2015; Donati, 2016), and as one can see, is an integral part of multicultural practice too (e.g., “able to acknowledge own racist attitudes, beliefs and feelings” in Figure 2). Gerstein and Ægisdóttir (2007) write that when interacting with people from different cultures “one must necessarily practice a high degree of self-awareness, awareness of others, and awareness of the surrounding environment and context” (p. 126)
Figure 1: Diversity and cultural competence in counselling psychology doctorate programmes

7. **Working with diversity and cultural competence**

By the end of their programme, trainees will be able to:

a. develop knowledge and understanding of equality of opportunity and diversities and how to work affirmatively to promote social inclusion in their clinical practice;

b. value social inclusion and demonstrate a commitment to equal opportunities;

c. understand issues of power, discrimination and oppression, the psychological impact of these, and how to work with these issues psychologically;

d. develop an understanding of the importance of cultural and ethnic backgrounds and an awareness of difference including visible, less visible, and mixed backgrounds, and be able to work from a knowledge base of different cultural frameworks;

e. have an understanding of the major religious beliefs and practices, spirituality, and how to work with these in clinical practice;

f. understand the diversity of forms of relationships and families in gender and sexual minority clients; be knowledgeable of the diversity of sexual and gender minority identities and practices; work affirmatively with gender and sexual minority clients, understanding contemporary models of gender and sexuality, internalised oppression, and the impact of stigmatising beliefs; and recognise that attitudes towards sexuality and gender are located in a changing socio-political context, and reflect on their own understanding of these concepts;

g. be mindful of the impact of socioeconomic status and disadvantage and limited access to resources and services;

h. be aware of attitudes towards disabled people and the social construction of disability, and appropriate models for practice;

i. understand the principles and requirements of safeguarding of children and vulnerable adults; and

j. understand human development across the lifespan and the issues of discrimination and disadvantage that can arise.

www.bps.org.uk/partnership
Figure 2: Framework of multicultural competency

TABLE 1: Components of Cultural Competence

<table>
<thead>
<tr>
<th>Belief/Attitude</th>
<th>Knowledge</th>
<th>Skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Aware and sensitive to own heritage and valuing/respecting differences.</td>
<td>1. Has knowledge of own racial/cultural heritage and how it affects perceptions.</td>
<td>1. Seeks out educational, consultative, and multicultural training experiences.</td>
</tr>
<tr>
<td>2. Aware of own background/experiences and biases and how they influence</td>
<td>2. Possesses knowledge about racial identity development.</td>
<td>2. Seeks to understand self as racial/cultural being.</td>
</tr>
<tr>
<td>psychological processes.</td>
<td>Able to acknowledge own racist attitudes, beliefs, and feelings.</td>
<td>3. Familiarizes self with relevant research on racial/ethnic groups.</td>
</tr>
<tr>
<td>3. Recognizes limits of competencies and expertise.</td>
<td>3. Knowledgeable about own social impact and communication styles.</td>
<td>4. Involved with minority groups outside of work role: community events, celebrations, neighbors, and so forth.</td>
</tr>
<tr>
<td>4. Comfortable with differences that exist between themselves and others.</td>
<td>4. Knowledgeable about groups one works or interacts with.</td>
<td>5. Able to engage in a variety of verbal/nonverbal helping styles.</td>
</tr>
<tr>
<td>5. In touch with negative emotional reactions toward racial/ethnic groups and</td>
<td>5. Understands how race/ethnicity affects personality formation, vocational choices, psychological disorders, and so forth.</td>
<td>6. Can exercise institutional intervention skills on behalf of clients.</td>
</tr>
<tr>
<td>can be nonjudgmental.</td>
<td>6. Knows about sociopolitical influences, immigration, poverty, powerlessness, and so forth.</td>
<td>7. Can seek consultation with traditional healers.</td>
</tr>
<tr>
<td>6. Aware of stereotypes and preconceived notions.</td>
<td>7. Understands culture-bound, class-bound, and linguistic features of psychological help.</td>
<td>8. Can take responsibility to provide linguistic competence for clients.</td>
</tr>
<tr>
<td>7. Respects religious and/or spiritual beliefs of others.</td>
<td>8. Knows the effects of institutional barriers.</td>
<td>9. Has expertise in cultural aspects of assessment.</td>
</tr>
<tr>
<td>9. Values bilingualism.</td>
<td>10. Knowledgeable about minority family structures, community, and so forth.</td>
<td>11. Educates clients in the nature of one’s practice.</td>
</tr>
<tr>
<td></td>
<td>11. Knows how discriminatory practices operate at a community level.</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: Adapted from D. W. Sue, Arredondo, & McDavis (1992).
Multiculturalism and diversity are relevant to DMH either we speak about d/Deafness as an identity or disability; acknowledging the “otherness” of d/Deafness (diversity) and moving into understanding d/Deaf norms (multiculturalism). The components of cultural competency proposed by Sue (2001) are applicable to interacting with Deaf service users, for instance, through valuing bilingualism (beliefs/attitudes), knowing our own social impact and communication styles, such as signing or speaking (knowledge) and being involved with minority groups outside the therapist role, e.g. through Deaf clubs (skills). Nevertheless, there are specific areas of competence in DMH that literature typically refers to and that could come under multicultural practice. Those are: being Deaf aware, learning BSL, and knowing how to work with interpreters.

Deaf awareness refers to i) communication, for example, learning some basic signs and how to get someone’s attention using our face and body, ii) learning about deaf history and the debate on deafness-Deafness, and iii) how to work with interpreters (Royal Association for Deaf People - RAD, 2020; Royal National Institute for Deaf People - RNID, n.d.; SignHealth, n.d.; Remark, 2019.; Deaf Umbrella, 2017). Literature recommends specialist training prior to working with Deaf clients (e.g., Glickman & Harvey, 2008; RAD, 2020) and BSL interpreters (BPS, 2017). Despite Deaf awareness being highly recommended, no formal institutional training for MHP in working within d/Deaf clients exists (Glickman & Harvey, 2008). Nevertheless, some individual trainings on Deaf awareness and BSL are being advertised. Bodies such as RAD advertise offering Deaf awareness training, but mainly, for organisations instead of individuals (Remark, 2019.; RAD, 2020; 121 Captions, n.d., Clarion UK, 2020). By looking at the advertised Deaf awareness programmes, one can see that some aspects overlap with BSL training, although, very basic, and likewise BSL training includes some Deaf awareness, for instance, Level 3 (BSL Level 6 is the highest) includes knowledge about Deaf Culture and Community (Signature, n.d.). Deaf awareness training further overlaps with working with interpreters training, however, the depth of working with interpreters training is not clarified. I did not come across any ‘working with interpreters training’ being advertised online. Nevertheless, the BPS (2019), in accrediting counselling psychology doctorates, expects trainees to understand how to communicate effectively with interpreters and be aware of the limitations of such communication. Hence, training in working with interpreters within

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5 where Deaf people gather to access information, attend events, and engage in activities
6 BSL Level 6 is the highest
counselling psychology doctoral courses is expected, though, this is not specified to BSL interpreters. It appears that some opportunities to be trained in working with d/Deaf clients are available in the UK, yet, they are perhaps fragmented.

1.5.2. Social Justice and Intersectionality

Further to multiculturalism and diversity, the concepts of intersectionality and SJ are key to counselling psychology, and as I will discuss here, to DMH. Those terms are related to multiculturalism and diversity, but they also have a socio-political extension and therefore, I present them separately to highlight this distinction.

Authors have been writing about the relationship between SJ and multiculturalism, and Lewis and Arnold characterised them as “two sides of the same coin” (as cited in Ratts, 2011, p. 26). Ratts (2011) claims that what connects the two is the focus on diversity, and the recognition of oppression’s implications on mental health. Arredondo and Perez (2003) agree with the latter point and add that it is also the realisation of how injustice, discrimination, marginalisation and privilege related to social and cultural dimensions, affect our lives, that distinguishes SJ. Another aspect of both ideas is the recognition of the limitations of counselling theories for those service users who do not fall into the category for which the theories were developed (e.g., white, male), and therefore, the need for adaptations (Crethar et al., 2008). Essentially, Crethar et al (2008) write, they both emphasise promoting individual and social changes. Nevertheless, and what seems in contrast with Crethar et al. (2008), a difference is that SJ is fundamentally about social changes because social contexts are identified as the sources of psychological difficulties, rather than individuals creating them (Goodman et al., 2004). For example, SJ is often accompanied by the term ‘advocacy’ “as a mechanism to address systemic barriers that hinder clients’ ability to achieve optimal psychological health and well-being” (Ratts, 2011, p. 24). In my view, multiculturalism does not speak about advocacy, at least, not to the same extent as SJ does.

Although there is not a universal definition of SJ, it could be considered as “the realisation of people’s potential in the society in which they live” (James, 2016, p. 406) and as “one way of thinking about addressing social inequalities and encouraging inclusion” (Tribe & Bell, 2018, p. 2). Constantine and colleagues (2007) write:
Social justice reflects a fundamental valuing of fairness and equity in resources, rights, and treatment for marginalized individuals and groups of people who do not share equal power in society because of their immigration, racial, ethnic, age, socioeconomic, religious heritage, physical ability, or sexual orientation status groups (p. 24).

SJ and counselling psychology share the view that people are impacted by their contexts and environmental systems (Vera & Speight, 2003; James, 2016), which is also a view of multiculturalism (Crethar et al., 2008). BPS’ (2020) division of counselling psychology states its commitment to “fairness, equality, and social justice” (Our vision section). Fouad et al. (2006) write that SJ has been a “hallmark of counselling psychology since before it was a fully recognized speciality” (p. 3), with the interest being revitalised in the late 1990s. Winter (2015) has argued for the more apparent inclusion of SJ perspectives within the American Psychological Association compared to the UK, where ethical guidelines do not make reference to it. Indeed, either in the ‘Standards for the accreditation of doctoral programmes in counselling psychology’, the BPS (2019) makes reference to ‘social justice’, ‘justice’, ‘fairness’, ‘advocacy’, ‘equity’ or ‘empower/-ment/-ing’. This is surprising taking into consideration the profession’s long-term interest in SJ, the extended dedication to diversity and multiculturalism as previously seen in Figures 1 and 2, and the links between SJ and multiculturalism.

Literature suggests models of practicing SJ (e.g., Crethar et al., 2008; Goodman et al., 2004). Lewis et al.’s (2003) model is the one followed in this study as it addresses multiple aspects (e.g., individual, public) and levels (e.g., client’s involvements, practitioner’s role) of SJ and I, therefore, consider it to be more comprehensive. Nevertheless, I acknowledge what other models have to bring, for instance, Crethar et al. (2008) appear to emphasise clients’ empowerment and offer ways of achieving this, and Goodman et al. (2004) speak about self-exploration as a SJ competency. Lewis et al. (2003) introduced the ‘ACA (American Counseling Association) Advocacy Competencies’ model. They proposed that advocacy can be conducted with clients or on their behalf, which will determine the focus of therapists’ energy; to support clients or to directly influence the system. They add that advocacy can focus on issues faced by the client as an individual, or by communities, or the broader public. Thus, they say, advocacy competencies are organised in two dimensions; extent of client involvement
in advocacy, and level of advocacy intervention, clarifying that advocacy on both dimensions can co-exist and actually increase effectiveness. When therapists advocate on both dimensions, six domains of advocacy are met: empowerment, client advocacy, community collaboration, systems advocacy, collective action, and social/political advocacy. Figure 3 represents the relationship between the two dimensions and the six domains.

**Figure 3: The ACA Advocacy competency framework**

For Lewis et al. empowerment resembles Crethar et al.’s (2008) one, and is about supporting clients to identify and address barriers, evaluate their coping strategies and facilitate their reflective process. Client advocacy refers to therapists addressing systemic issues on behalf of clients, by directly addressing the system where the problem exist or where the solution is to be found. Next, community collaboration is about identifying and addressing barriers by supporting groups that are considered as experts on the issue of concern. Therefore, therapists
here act as allies or contributors of professional skills. Systems advocacy refers to therapists advocating on behalf of groups of clients and taking the role of investigating situations that come to their awareness. Therapists aim to change the status quo. Collective action is advocating on even a broader level, to influence policies and public beliefs, for instance, through awareness raising. The therapist acts as a group member/collaborator who lends their knowledge to achieve change of public perception or policies. Finally, political advocacy refers to therapists acting independently (and on behalf of clients) to address injustices they observe. They speak on behalf of an issue and aim for system change. They proposed specific skills, knowledge, and actions that therapists could follow to address each principle, and hence, those acts as guides to advocacy. Those skills for each domain could be found in Appendix 1.

Considering the historical oppression, discrimination and prejudice that d/Deaf people have faced, what is being known as ‘audism’, d/Deafness is fundamentally a matter of SJ. A major event that proved this oppression, was the famous Milan Conference back in 1880 where 163 hearing people and one deaf were met to decide about the best way to educate the deaf, with no further involvement of the people mostly concerned. BSL users or d/Deaf people are considered as a minority in the UK, since BSL (although an official language in the UK as of 2003, with not, however, legal status) is not the primary language used, and since people often speak about belonging to the Deaf Culture.

Intersectionality is also a relevant term, and as with social justice, it is also interlinked with diversity and multiculturalism (e.g., APA, 2017). It takes into account how ‘identities’ intersect, to produce power relations, and either be a burden or an opportunity for people (Burman, 2003). The term was introduced by Crenshaw in 1989, within the context of feminist theory and antiracist politics, who claimed that Black women face greater racism because of the intersection of sex and culture (Tang et al., 2020). Since then, intersectionality grew to include other types of marginalised identities, such as disability (Tang et al., 2020). May (2015) defines intersectionality as:

a form of resistant knowledge developed to unsettle conventional mindsets, challenge oppressive power, think through the full architecture of structural inequalities and asymmetrical life opportunities, and seek a more just world. It has been forged in the context of struggles for social justice as a means to challenge dominance, foster critical imaginaries, and craft collective models for change (p. xi).
May (2015) speaks of intersectionality as the means to achieving SJ, where SJ is therefore, understood as the goal. Tang et al. (2020) explain that intersectionality goes beyond challenging systemic oppression and is interested in exploring the “social, political and ideological context in which these identities intersect” (para. 8). Therefore, they conclude, intersectionality is not about offering a solution to inequalities, but the lens to explore the complexity that those different contexts bring in how people are marginalised. Burman (2003) suggests the use of the term as an alternative to the discourse on ‘difference’ to highlight the need to i) consider power and oppression, ii) understand that not all differences provoke oppression (but rather privilege), and iii) that differences are linked to the personal, interpersonal, systemic and structural. Hence, those differences that intersect to produce privilege or oppression are a situated and relational matter, rather than something fixed or unchanging. Applying intersectionality theory in the context of DMH, being d/Deaf (either this is a disability status, or a cultural minority one) might intersect with characteristics such as gender, ethnicity and skin colour, to produce oppression or privilege.

Authors have already linked intersectionality with DMH. For instance, Chapple (2019) discussed Black Deaf feminism through intersectionality and SJ theories, claiming a unique positionality of those women, that shape different experiences of the world, and proposed questions such as “Which identities become more salient in certain social contexts, race, gender, or deafness? What happens when the identities converge simultaneously? What if there are more than three marginalized identities?” (p. 194). Schaad (2015) considered sexual identity, and deafness, as two marginalised identities with limited information to sexual health, but also greater vulnerability to sexual abuse. They interviewed Deaf lesbians and found that the participants reported oppression by both hearing and heterosexual individuals. Furthermore, Brenman et al. (2017) approached intersectionality within DMH, from the perspectives of clinicians conducting autism assessments within the NDCAMHS, to explore how MHS interact with Deaf culture in the way they conduct this specialised assessment.

In the present study, intersectionality theory is utilised as a concept within SJ, to consider characteristics/identities of participants and those they work with, and considers relationship dynamics between them such as privilege, oppression, and sense of belonging (as unfolded in the participants’ accounts). MHP are encouraged to be change agents (Motulsky et al., 2014), and qualitative inquiry (QI) has been claimed as a SJ practice (Lyons et al., 2013). This study is an endeavour of this commitment.
1.6. Chapter Summary and thesis outline

In this chapter, I have presented my socio-political-legal rationale for this study referring to human rights, equality acts, and the concept of the ‘temporarily able-bodied’ people, claiming that understanding deaf specialists’ professional experiences is both contemporary and needed. I have provided an overview of the MHS for deaf adults and CYP in the UK, and I discussed the debate on deafness being a disability and/or an identity. I have further examined the relevance of DMH to counselling psychology, through diversity and multiculturalism, as well as intersectionality and SJ. Those concepts are utilised as lenses through which the participants’ accounts are understood, and the specific models followed are Sue et al. (1992) for cultural competency and the ACA (Lewis et al. 2003) for SJ practice.

The next chapter explores literature on DMH, which points to my academic rationale for conducting the study. Chapter 3 discusses my methodological decisions, and Chapter 4 presents my reflexive engagement with the study. In Chapter 5, the analysis of the participants’ accounts is presented. Chapter 6 discusses the interpretation of the accounts, implications for mental health practitioners as well as d/Deaf service users, and provides limitations and future directions. Finally, Chapter 7 offers a conclusion of the study’s main points.
Chapter 2: Literature Review

2.1. Overview

The literature on mental health service provision for d/Deaf people and/or sign language users is growing. The vast majority of relevant research originates in the US, and particularly, the Gallaudet University which is specialised on the education of deaf and HOH people. Nevertheless, UK-based and European-based research are currently developing. Here, I present both UK-based and international work, and more specifically, literature on i) the mental health difficulties that d/Deaf people and/or sign language users face, and ii) the experiences and perspectives of parties involved in care provision. Literature has been accessed mainly through the University of Manchester’s database which directs to a variety of further databases such as the APA and Project Muse. Google and Google Scholar were further searched. Terms such as ‘mental health’, ‘mental health services’, ‘experiences’, ‘therapists’, ‘mental health providers’, ‘psychologists’, ‘deaf’, ‘Deaf’, and ‘BSL’ were utilised.

2.2. Mental health needs of d/Deaf people

Literature suggests that the percentage of d/Deaf people’s mental health difficulties is higher than in the hearing population, with studies reporting discrepancies in the specific mental health concerns that are found to be more frequent in this population. The JCPMH (Hulme, 2017), by summarising four studies, reports that the prevalence of those difficulties varies between 30% to 60%, whilst clarifying that it is difficult to determine the actual prevalence of mental health difficulties within the Deaf community. Lack of access in MHS might be one reason for that. Another reason might be that Deaf people are geographically spread out in the UK, which renders them hard-to-reach (Hulme, 2017).

2.2.1. Adults

A study conducted in the US found that deaf adults who were cared for by the same community mental health centre as their hearing counterparts were more frequently diagnosed (in accordance with DSM-IV-TR criteria) with pervasive developmental disorders, attention
deficit hyperactivity disorder, intellectual disabilities and impulse control disorders, (Diaz et al., 2013). The researchers reported that the reasons for the difference in rates remain unclear but clarified that even though the participants were cared for in a mainstream centre, clinicians were American Sign Language (ASL) users (except for the psychiatrist) and culturally competent, which potentially minimised miscommunication and problems with assessment, whilst however, acknowledging the limitation of not assessing service users’ fluency in ASL to ensure communication was not a barrier. By relying on previous research, Diaz and colleagues (2013) speculated that the reasons for the higher mental health rates were due to etiological-medical factors rather than cultural bias.

Whereas Diaz et al. (2013) found that hearing people were diagnosed with anxiety disorders more frequently, Black and Glickman (2006) found that deaf and HOH inpatient deaf adults actually had higher rates of anxiety disorders. In agreement with that, Shoham and colleagues (2018) through a systematic review of the literature, found that UK HOH individuals were more frequently diagnosed with anxiety disorders than their hearing counterparts. Moreover, deaf people reported feeling depressed twice as frequently as hearing people (SignHealth, 2014). A study with ASL deaf people found that not only depressive or anxiety disorder diagnoses were most frequent in deaf individuals, but they also occurred earlier in life (Kushalnagar et al., 2019). In one study, the prevalence of anxiety disorders was attributed to the hearing impairment’s severity, as anxiety levels were reduced after surgical treatment (Shoham et al., 2018), which could be debatable.

Studies on the prevalence of psychotic experiences are controversial. Some report that deaf and HOH individuals present psychotic symptomatology equally to hearing people (e.g., Black & Glickman, 2006; Landsberger & Diaz, 2011), where other studies, especially older ones, report an ‘overrepresentation’ of psychotic disorders in deaf people (Cole & Magis, 2011) with ‘psychosis not otherwise specified’ often being given (McEntee, 1993). Cole and Magis (2011) explain that this might have been due to a lack of knowledge and skills in working with this population, that might have led to bias. Substance misuse also divides the research community, as according to Black and Glickman’s (2006) literature review, those are almost not prevalent. Nevertheless, Guthmann and Graham (2004) state that only a few studies provide “reliable information about the prevalence of substance abuse in the d/Deaf and hard of hearing community” (p. 50) and characterise substance abuse as the “hidden problem” (p. 49) within
those communities. Interestingly, studies report a lower prevalence of personality disorders in deaf people, both in the USA and Belgium (Black & Glickman, 2006; Cole & Magis, 2011).

Cole and Magis (2011) divided studies on the epidemiology of mental illness among deaf people, as run by ‘unspecialised teams’ and ‘specialised teams’, highlighting the discrepancy in the focus of those studies; more specifically, the first studies emphasised the presentation of psychotic disorders in deaf people, whereas more recent studies, undertaken by specialised teams, show a low frequency of those difficulties. Additionally, Post-Traumatic Stress Disorder (PTSD) was a frequent diagnosis given to deaf inpatient adults, and according to Black and Glickman (2006) was the most frequent one, with Cole and Magis (2011) adding that around a third of deaf individuals has a diagnosis of PTSD.

In addition to mental health disorders and disabilities, American Deaf and HOH people, are sadly, more likely to experience relationship violence, through isolation, intimidations, shame, and manipulation, as the most common tactics (National Domestic Violence Hotline, n.d.). A literature review of abuse in UK deaf adults and children revealed that all abuse types explored (emotional, physical, sexual, neglect, and intimate partner violence - IPV) were more frequently experienced by deaf people (Wakeland et al., 2017). However, the researchers caution readers to interpret data considering sample characteristics (e.g., tendency for educated, young and white women in studies examining IPV), and the lack of interpreters or translation materials. Lastly, a literature review exploring suicide risk in deaf people concluded that the existing research is unrepresentative and limited, and conclusions about suicidality in deaf people cannot be made (Turner et al., 2007).

2.2.2. Children and Young People

When it comes to deaf CYP, the frequency of mental health difficulties in the UK community population, has been estimated to be approximately 40% (Hindley, 2005). The same percentage is also reported in Australia (Remine & Brown, 2010; Brown & Cornes, 2015), with the most common difficulties reported to be internalising problems such as somatic complaints and withdrawn behaviour (Brown & Cornes, 2015). The above authors also reported that the main factor contributing to those difficulties was the mode of communication used at home, with those using signed English or Australian sign language to face more mental health difficulties.
compared to those using spoken English. Roberts and colleagues (2015) found that the probability of deaf CYP who did not attend MHS, developing a mental health problem was 57%. Schenkel and colleagues (2014) reported that American deaf and HOH children experience depression and PTSD more frequently than hearing peers. Interestingly, they added that being an active member of the Deaf community acted as a protective factor, with those CYP reporting fewer depressive and PTSD symptoms, which might be understood as the importance of belonging.

Schenkel and colleagues (2014) further explored deaf and HOH child maltreatment, including neglect, physical and sexual abuse, which was 25% higher than hearing children, with children with more severe hearing loss, reporting more frequent and severe maltreatment. As expected, children who were maltreated, reported higher rates of negative beliefs about themselves. A systematic review exploring emotional and behavioural difficulties in CYP with hearing impairment, using the strengths and difficulties questionnaire (SDQ) found that the area with the most significant difference was ‘peer problems’ which explores relationships with other young people, such as how liked they feel, if they experience bullying, and if they spend their time with other children. ‘Peer problems’ was indicated an area of high difficulty by all parties who completed the tool; CYP, parents and teachers (Stevenson et al., 2015). McCullough et al., (2000) stated that the relationship with peers in puberty highly influences risk behaviour, and that being rejected by peers increases the possibility of emerging mental health difficulties.

A North American study examined the psychosocial risk behaviours for adolescents and compared the results of deaf/HOH and hearing individuals utilising measures of risk and behaviour (Youth Comprehensive Risk Assessment; The Conduct Disorder Checklist). The researchers found that deaf/HOH adolescents presented with higher risk to others, difficulties with social and adaptive functioning, aggression towards people and animals, and total risk to self and others (however, risk to self was not significantly different from hearing counterparts when measured in isolation). Violations of rules was significantly lower in deaf/HOH adolescents (Coll et al., 2009).

A great interest in the literature on deaf CYP is psychological assessment and differential diagnoses. Krouse & Braden (2011) examined the validity and reliability of WISC-IV for American deaf children (although they refer to HOH children too, the majority of the sample were classified as profoundly deaf), by recruiting psychologists who provided archival data on
CYP who were administrated the WISC-IV. They concluded that the tool is valid in terms of internal consistency, however, the researchers calculated the internal consistency reliability only of 8 out of 15 tests and 2 out of 5 indexes (excluding the full IQ scale). The results showed that the test is not valid.

Moreover, a numerous body of literature discusses deafness and autism, with research estimating that 3.5% of CYP with Autism Spectrum Condition (ASC) are also Deaf/HOH (Beers et al., 2014) which is a higher percentage than in the hearing CYP. Hansen & Scott (2018) conducted a systematic review on CYP with both diagnoses (autism and deafness) and explored evidence on language development, assessment, challenging behaviour, and instruction. They concluded that research on the topic is limited and of poor quality, and appropriate assessment and intervention means for ASC deaf CYP do not exist. In the UK, Brenman et al., (2017), examined how NDCAMHS MHP as well as professionals from generic services who administrated at least one autism assessment in deaf CYP, incorporate cultural-linguistic aspects of deafness when assessing for autism. Most participants were hearing, but some were also Deaf. They found that those specialised staff utilised intersectionality understandings to diagnose autism in deaf CYP, which means that they took into consideration cultural, linguistic, sensory, and social factors altogether. Interestingly, participants stated that the diagnostic system focuses on hearing CYP’s norms which do not apply to deaf CYP and which they appraised as frustrating.

2.2.3. Section summary

It is evident that deaf adults and CYP face a variety of mental health difficulties, which are estimated to be at a higher prevalence than in the hearing population. Some common mental health struggles and experiences that deaf adults face are multiple types of relationship abuse, depression, anxiety disorders, ADHD, PTSD, psychotic disorders, impulse control disorders, pervasive developmental disorders, and intellectual disabilities. Some common difficulties in deaf CYP are depression, PTSD, maltreatment including sexual harassment, ASC, risk to others-aggression, internalising problems, relationship difficulties with peers, withdrawn behaviour, and difficulties with social and adaptive functioning. Given the challenges in using mainstream tools to assess those difficulties, as well as lack of Deaf awareness in some services, it is important to interpret those outcomes with caution.
2.3. Experiences of and Perspectives on Mental Health Services

2.3.1. Service users

Optimistically, a large number of studies have been interested in investigating the experiences of both deaf adults and CYP regarding the support they receive by MHS. Research that involves service users is an essential source for clinicians and the government in identifying what works and what needs improvement.

2.3.1.1. Adults

Cabral et al. (2013), conducted a qualitative study to explore Deaf and HOH people’s perspectives on MHS in the USA, including peer support. Participants identified as someone with a mental health difficulty, and spoke about their experience of accessing services, support within the Deaf community, and recovery. Participants reported feeling more comfortable reaching out to their community because they share culture, but this did not apply when the topic was mental health, particularly due to confidentiality concerns and lack of understanding of mental health within the Deaf/HOH community. The main obstacle reported in accessing MHS was communication. Participants highlighted that written communication could be ineffective since English is not their first language and authors spoke about “unequal access to health education materials” (p. 653). A second barrier reported was not enough services suitable to Deaf and HOH people as well as very few support groups that consist of Deaf people only. For that reason, when a Deaf and HOH person struggles with mental health, the hospital is the most popular option; this is also because, according to the authors, hospitals in the USA are obliged to provide interpreters. Participants further spoke about their experience of working with interpreters, and some struggles reported include not being provided an interpreter, discomfort in opening up, and fear of misinterpretation.

Storch (2010) found that clinical outcomes in psychotherapy delivered in ASL improved over time compared to therapy facilitated through interpreters. More specifically, those individuals’ scores on symptom distress scale (emphasis on depression and anxiety), interpersonal relations, and social role (workplace, school or home duties difficulties) indicated that therapy was
beneficial. Nevertheless, other factors than working directly or through interpreters were not taken into consideration to explain the results.

Interestingly, deaf/HOH adults mentioned that they would reach out to mainstream MHS, however, only if they are able to build a trusting relationship with their clinician (Cabral et al., 2013). In a study where Deaf/HOH adults were asked to talk about their experiences of psychotherapy (both with hearing and deaf therapists) in the USA, they highlighted communication/linguistic matching as an integral part of the therapeutic alliance, including eye contact (Cohen, 2003). Participants also expressed discomfort with the therapists’ silence and half of them interpreted silence as lack of interest. Other factors reported to benefit the therapeutic relationship were; i) therapists’ positive attitude and sensitivity, for instance, empathy and unconditional positive regard, ii) therapists’ endeavour to accommodate clients’ needs, such as additional therapeutic time, iii) therapists’ cultural understanding of being deaf, including understanding of oppression and willingness to challenge their own behaviour and biases, and finally, iv) therapists’ use of self through sharing their own experiences (Cohen, 2003).

2.3.1.2. Children and Young People

Greco et al. (2009) examined CYP’s experiences of NDCAMHS, including standard therapeutic procedures as well as ‘telelink’ practice which refers to the use of teleconferencing technology to allow CYP to access the deaf psychologist working in another NDCAMHS. The majority of the participants reported positive views of their care, and all of them reported positive feelings about their clinicians, despite feeling helped by them or not. BSL CYP expressed appreciation for being able to communicate in their first language, either through signing clinicians or interpreters, but stated their preference for clinicians to be able to communicate in BSL. Interestingly, CYP who were offered sessions with both hearing and deaf clinicians, stated their preference for deaf clinicians due to communicating more easily, and to sharing similar experiences. Most CYP valued the ‘telelink’ service, but some reported feeling that online communication was unnatural, and one reported difficulty with ending the online session, and inability to use body language. It is important to mention that 40% of the participants expressed concerns around confidentiality, and authors reported that an explicit agreement was found to address this concern. Factors that CYP appraised negatively were appointments being postponed, ending the sessions in ways which felt abrupt, not being able
to emotionally disconnect from the session for the rest of the day, difficulties with communication (for instance, clinicians/interpreters using different signs, signing too quickly, or their expertise in signing), and lack of information about aspects of the service including why they were using it.

This study was part of a project that also examined how parents evaluate NDCAMHS (Beresford et al., 2008). Parents expressed their trust in the clinicians as experts in mental health and deafness and valued their experiences on the area. Those parents who had previously used generic Child and Adolescent Mental Health Services (CAMHS) highlighted the higher expertise of NDCAMHS, and parents whose children were BSL or Sign Supported English (based on the English syntax) users, reported their appreciation for clinicians who were able to sign and considered this as a contributing factor to the therapeutic relationship, and to children’s level of attention during the session. In addition, parents valued the presence of interpreters and marked the interpreting level as high. Obstacles that parents reported had to do with practical issues, for instance, traveling to their appointments, inappropriate environments (non-child friendly; non-confidential), and needing more information about the services provided and the progress of their children.

2.3.2. Mental health providers and interpreters

Empirical literature on the experiences and knowledge of MHP in working with d/Deaf individuals or BSL users is scarce. Existing literature on the training mostly consists of theoretical papers and books on ethical and practical considerations, including ethical guidelines and recommendations for best practices (e.g., Boness, 2016; Filer & Filer, 2000; Gutman, 2005; Glickman & Gulati, 2003; Williams & Abeles, 2004). Despite this area of research vastly contributing to professional practice, it does not seem to adequately explore MHP’s perspectives on possible challenges and needs.

Cornes and Napier (2004), a social worker and an Australian sign language interpreter respectively, conducted a literature review on challenges faced by therapists and sign language interpreters when working with deaf CYP and their families. According to their own experiences, one challenge Auslan (Australia’s sign language) interpreters face is the lack of Auslan vocabulary for mental health concepts, which means that they will use more signs to
interpret, and therefore, more information. They identify that this process has implications for therapy and therapists, as the exact meaning of a phrasing might be lost, and a phrase might come across as too leading, or too literal. Another challenge sign language interpreters might face is working out of their depth, whether linguistically, which might be due to not having enough information about their assignment, or emotionally due to the nature of counselling. Both cases would impact on the accuracy of interpreting. They give an example of a therapist who used the word ‘rape’ but the interpreter, due to feeling uncomfortable, used the sign for ‘molest’ instead, which the service user did not understand, and this did not allow for the exploration of the issue.

Another issue that appears common to both interpreters and therapists, is role dynamics which happens when interpreters are ‘stepping outside’ their roles, without however, expanding on it. A final challenge that Cornes and Napier (2004) discussed is that of the therapeutic alliance, with the role of the therapist being confused by deaf clients. Unfortunately, they do not expand on their experiences of this matter either. de Bruin and Brugmans (2006) wrote about their positive experience of collaborating as therapist and (Dutch) sign language interpreter, and also stated that clients are not preoccupied with communication when involving interpreters. They spoke about challenges they needed to overcome, for which the answers were not to be found in the literature, and they clarified that the only way for the collaboration to be effective is when they both “have succeeded in building a rigorous collaborative partnership based on a keen sensitivity to each other’s meanings” (p. 368). Moreover, they emphasised the importance of consistently having the same interpreter, and of sharing “identical conceptions about the status and role of the interpreter” (p. 368).

Thomas and colleagues (2006) studied the perspectives of “mental health workers” (p. 302) working within Community Mental Health Teams – CMHT, in supporting deaf adults with severe mental health difficulties. Importantly, some participants’ experience of working with deaf people was limited. The researchers concluded that CMHT’s mental health workers felt deskill ed in working with deaf people due to their limited experience; and more specifically, lack of BSL knowledge, Deaf awareness, and working with interpreters. This was in contrast to Brenman et al.’s (2017) study who examined specialist teams’ understanding of Deaf cultural aspects when assessing CYP for autism. Participants of Thomas and colleagues’ (2006) study reported that deaf services did not provide them with enough information on how they work, and how CMHT could support deaf people. They further reported that this lack of
communication interfered with their clinical competency, clients’ engagement, and clinical assessment. Deaf clients dropping out of therapy due to ineffective communication was a factor also indicated by Willimas and Abeles (2004).

CMHT staff members spoke of interpreters’ presence as a barrier in developing relationship with the client, as they tend to relate with the interpreter instead (Thomas et al., 2006). They also referred to Deaf services being located far away which made communication between services and meeting service users difficult, especially during an emergency. In terms of Deaf awareness, the participants reported inadequate knowledge about mental health and deafness, which would impact on their understanding of the presenting difficulties. This is line with Bartlett (2017) who found that MHP had limited understanding of deafness, and some held negative attitudes toward it. Finally, Thomas and colleagues (2006), spoke of practical difficulties, such as not knowing how to book an interpreter, and questioned the suitability of providing care for d/Deaf people through generic services. Nevertheless, the researchers highlighted the danger in treating d/Deaf people only in specialised services as that might send the messages that those individuals do not belong in the mainstream services.

2.3.3. Section Summary

Literature on d/Deaf adults’ experiences of MHS suggests mainly a negative appraisal, with participants referring to challenges around communication and lack of understanding of their culture. They spoke of communication (including eye contact) as a barrier both to accessing services, but also to engaging with therapists and building an alliance. Additionally, they stated that there are not enough services suitable to their needs, including peer support groups, they are not always provided with an interpreter, they do not necessarily understand therapists’ silence, and they expressed concerns around comfort and misinterpretation when interpreters are involved. Contrary, CYP appraised MHS positively, however, studies included here were targeted to NDCAMHS which is a specialist service. Parents of CYP using the NDCAMHS, were also satisfied with the services, and expressed positive views about interpreters’ skills. Nevertheless, around 40% of all CYP expressed some concerns about confidentiality (Greco et al., 2009), and parents of NDCAMHS clients also express some struggles related to traveling, suitability of environment for children, and requiring more information (Beresford et al., 2008).
Literature on therapists’ experience in working with d/Deaf service users is almost non-existent. Such a gap might suggest that therapists interested in working with d/Deaf individuals or BSL users have limited clinical and academic resources to refer to, in order to ensure that they work within the limits of their knowledge and skills which is deemed by the HCPC (2016) as an ethical responsibility. Specialist staff reported being Deaf aware when assessing CYP for ASC and struggling with mainstream understandings of this diagnosis. On the contrary, non-specialist staff stated feeling deskilled in working with deaf people, as they lack knowledge about Deaf culture, working with interpreters, communicating with deaf people, and what specialist services do and how they can support them. Two studies on working with sign language interpreters referred to challenges in this triad that affect all parties - clients, therapists, and interpreters, and made suggestions for a smooth collaboration.

2.4. The present study and the research questions

The study has three areas of interest. The first area follows on from the discussion that renders DMH contemporary, and from the identified gap in the literature on therapists’ experiences in working with BSL users. Hence, research on the experiences of hearing therapists working with this population is expected to equip us with ideas and options in addressing possible barriers, and eventually “promote and protect the interests of service users and carers”, which is certainly, another ethical responsibility of psychological practitioners (HCPC, 2016, p. 5). The first area of interest is therefore, to examine hearing therapists’ accounts on how they experience working with BSL users.

Given the lack of specialised training in working with d/Deaf service users and the recommendations in the literature for such steps (e.g., Glickman & Harvey, 2008), as well as the reported practice of therapists working with d/Deaf clients, outside their competence, participants’ d/Deafness training is also explored.

Finally, as DMH is understood in context of multiculturalism and SJ (and therefore, on the societal level), the third area is therapists’ views on the current DMHS, therapists’ training, and areas of development for DMH.
It should, however, be noted that training was initially given primary focus in this study, following recommendations on specialist training being developed, and relying on my experience as a counselling psychologist trainee identifying a lack of training on how to work with d/Deaf clients. The initial aim was to give training recommendations for bodies and therapists. Nonetheless, training shifted to be only briefly considered, following from participants’ accounts, and hence, their accounts on their professional experiences, and on their views about contemporary DMH issues constitute the primary areas of research. The ultimate goal of the study shifted to be the identification of development steps for DMH based on participants’ experiences and views.

Two research questions (RQ) were formed, one concerning ‘the individual’; participants’ personal journeys, and one concerning ‘the social’; participants’ views on aspects of DMH. In this study, ‘therapists’ (and hence, ‘participants’) refers to practitioner psychologists, counsellors, and psychotherapists. The RQ are:

i. How do hearing therapists who work therapeutically with BSL users speak about their experiences, training and competence in this area?

ii. How do hearing therapists who work therapeutically with BSL users speak about the current mental health services provided, therapists’ training in working with BSL users, and the future of deaf mental health?

2.5. Chapter summary

In this chapter, I explored the literature on DMH, considering the reported mental health needs of d/Deaf adults and CYP, as well as the experiences and perspectives of parties involved in DMH (service users, MHP, and interpreters). I presented in that way, the academic rationale for the study, considering a research gap in professionals reported experiences and training. I finally, stated the two RQ, also explaining how they are linked to both academic and socio-political rationales (the individual and social aspects).
Chapter 3: Methodology

3.1. Overview

In this chapter I discuss the methodological decisions that I took to design this study. I begin by speaking about the research design including the research paradigm. I then present the participants, and I move into explaining how I recruited and interviewed them, and how I transcribed their accounts. Next, I present the analysis method, the rationale for it and the analytic steps. Finally, I speak about how I ensured the research’s quality, and I present the ethical considerations.

3.2. Research Design

3.2.1. Research paradigm: Critical realism

In QI, it is typical for researchers to speak about ideas such as ‘ontology’, ‘epistemology’, and ‘research paradigm’. Those terms are related to philosophical branches, and decisions relevant to philosophical branches support researchers to decide how to design their study. Ontology is a term widely used within the social sciences and serves as the way researchers set and communicate the philosophical foundations on which they build their studies. Ontology is “concerned with ‘what is’, with the nature of existence, with the structure of reality as such” (Crotty, 1998, p. 10). To put it simply, it refers to what we believe is the nature of being and what can be known in the world. My ontological belief is that there is one single reality which we can only partially and imperfectly perceive “because of basically flawed human intellectual mechanisms and the fundamentally intractable nature of phenomena” (Guba & Lincoln, 1994, p. 110). Where ontology refers to what is the nature of being, epistemology raises questions on how we gain knowledge of the world (Hughes, 1997), of what we consider as the truth. My epistemological position is that people hold their constructs of knowledge, which are constantly alternated and reconsidered through dialogue, and therefore are context- and person-informed. Within the field of research, I hold the view that researchers and participants cannot be considered as entirely separated as the views and beliefs of the one influence the constructions of the other.
When ontological and epistemological positions are grouped together, they create what is known as a research paradigm. A research paradigm is understood as “a set of assumptions” about the phenomena under investigation (e.g., DMH) and the ways we approach and study them (Donmoyer, 2008, p. 591). Different ontological and epistemological positions lead to different research paradigms over the same phenomenon under investigation (Scotland, 2012). For instance, if we believe that there is only one truth about DMH independent of our existence, and that we can discover absolute knowledge about this objective truth, it will lead us to approaching DMH aiming to find this absolute knowledge (positivism). Contrary, if we believe that each person has their own truth about DMH and only unless we know about it, this truth exists, will shape a different research (social constructivism). It has been argued that there is a linear relation between ontology and epistemology and between epistemology and methodology and, hence, that they both influence the decision upon a research paradigm (Guba & Lincoln, 1994). Methodology is understood as how we go about accessing knowledge (Guba & Lincoln, 1994), it is the plan we make about what data to collect and analyse, how, when and why (Scotland, 2012). Scotland (2012) added that “research methods can be traced back, through methodology and epistemology, to an ontological position” (Scotland, 2012, p. 10), and, hence, another term is added to the equation (ontology – epistemology – methodology – methods). A method describes the specific tools we utilise to collect and analyse our data (Crotty, 1998). Gorard (2004) has criticised the “adopting a method automatically means also adopting an entire paradigm” way of thinking (p. 2), and Bhaskar referred to this idea as the ‘epistemic fallacy’ (as cited in Fletcher, 2017).

Despite the claim for the linear relations, the way I appraise what is the nature of being and how knowledge can be accessed are not linearly linked, and therefore, my ontological and epistemological beliefs do not fit under one of the traditional research paradigms as explained by Guba and Lincoln (1994). The framework informing the present study is Critical Realism (CR), which emerged from the conflict between positivism and constructivism in the 1980s (Fletcher, 2017) and is heavily relied on the work of Roy Bhaskar (Fairclough, 2005), a philosopher, who is actually considered the originator of CR. CR combines both paradigms and more specially, it integrates a realist ontology (positivism), therefore, believing that there is one single reality which is independent from our perceptions, with a constructivist epistemology, holding the view that we understand that reality or world, based on our perceptions of it (Maxwell & Mittapalli, 2010; Maxwell, 2012; Fletcher, 2017). Thus, CR embraces the belief that multiple perspectives of reality exist (however, it is not committed to
naïve relativism, or pluralism), constructed socially either by people, or societies more broadly (Maxwell, 2012). According to CR, the natural and the social worlds are separate in the sense that we have incomplete understanding of what is real, but at the same time, they influence each other. This means that “the meanings people attach to things have consequences for their actions and for the physical world” (Maxwell, 2012, p. viii). Fletcher (2017) explains that CR “treats the world as theory-laden, but not theory-determined” (p. 182) meaning that it does not reduce reality to human knowledge. In accordance with CR, and in context of the study’s topic, I hold the view that there is one single reality which I understand to be that of working with d/Deaf clients as one distinct therapeutic speciality that differs from practicing with hearing individuals (e.g., specialised training, professional experiences due to working with d/Deaf clients). The differences are unique to each person/therapist/participant and their emotions, beliefs, values and experiences are part of reality, rather than mere “abstractions from behavior or constructions of the observer” (Maxwell & Mitapalli, 2007, p. 158). Hence, the way to access this reality is by conversing with those individuals and be a listener of their experiences.

Maxwell and Mittapalli (2007) state that CR could support qualitative research’s goals which include understanding participants’ perspectives as real phenomena, and which are of primary value in social science. What CR brings in research is: i) the incorporation of causal explanation, ii) the view of mind as part of reality, iii) the clarification of the relationship between participants’ views and the actual situations, and iv) the understanding of diversity as a real phenomenon (Maxwell & Mitapalli, 2007). Regarding causal explanation, CR does not aim to merely describe causality in terms of a variable producing or not producing another one, but instead takes a phenomenon’s context into account and is interested in explaining the processes by which an event happens. In that sense, it is further interested in understanding particular situations rather than producing general patterns. Fletcher (2017) expands on the benefit of causal explanation and states that this allows researchers to explain social events and therefore, to recommend ways to address social problems. The way causal explanation is incorporated in this study, is by taking into consideration the context of DMH (e.g., historico-political practices) in interpreting participants’ accounts. The second benefit of CR, viewing mind as part of reality, refers to the consideration of multiple perspectives of reality “as part of [emphasis in original] the world that we want to understand” (Maxwell & Mitapalli, 2010, p. 158) and therefore, of the causal influence that the social and physical contexts have on our beliefs. CR claims that both our situations and our perspectives are real phenomena, which are though separate but interact with one other to cause effects. Hence, it allows us to understand
the relationship between people’s perspectives and their actual situations, which is its third claimed benefit. In this process, CR emphasises the role that culture and personal characteristics play in how people interpreter their situations. In practicing the second and third benefits, I emphasise the participant’s personal characteristics (e.g., demographics) and reported experiences as possible factors in how they narrate about their experiences. The last advantage, considering diversity as a real phenomenon speaks about CR’s appreciation of individual factors and complexity rather than shared themes. I understand this to be an expansion of the three previous points.

3.2.2. Methodology: Qualitative Inquiry

QI has been growing rapidly in the field of psychology, especially in the UK, where policy making and funding bodies favouring research proposals that encompass both qualitative and quantitative methods (Stainton-Rogers & Willig, 2017). Traditionally, QI values constructing knowledge and supports that objective reality is impossible. It approaches a phenomenon holistically, emphasising deep understanding, (Maxwell & Mittapalli, 2010), and it is typically, but not merely, inductive in nature (Surbhi, 2016). Inductive reasoning in research means that researchers endeavour generalising a theory derived from the data, rather than testing a preconceived theory, therefore, they do not form a hypothesis (Gabriel, 2013). Hence, they normally seek exploring, describing and interpreting participants’ personal and social experiences (Smith, 2015). Smith (2015) states that QI in psychology is not “homogenous” (p. 2), with a number of different approaches relying on different methodological and/or philosophical understandings.

CR could be considered as in conflict with QI due to the dissimilar ontological positions. Nevertheless, Maxwell and Mittapalli (2007) see CR as “quite compatible with the way most qualitative researchers think about their work, and incorporates the key characteristics of qualitative research” (p. 3). According to Fletcher (2017), CR is not connected to any particular set of methods, and it is therefore, a methodological framework generally used. Maxwell (2012) argues for the promising position of CR in social science, and states that its value is beyond its compatibility with different methodological approaches, or its pragmatic stance towards research methods.
3.2.3. Method: Interview-based Research

Interviews were utilised to gather participants’ accounts, as they are the most popular way of gathering data in qualitative research, due to fitting well with a number of analysis approaches (Willig, 2008), and they, therefore, provide flexibility to the researcher. In interview-based research, the researcher acts as an active participant since the answers are shaped by the RQ, however, a balance should exist between this directive stance and the participants’ agency to lead the discussion. The way this was achieved in this research was by being flexible in the order in which I asked the interview questions, and by following the participants’ responses to form the next questions/comment. Reflexivity then becomes relevant in this process, as the researcher is encouraged to be aware of how their intersections influence what is being said. For example, my position as a trainee and an ‘outsider’ of the experience of working with BSL users led me asking ‘the obvious’ or led the participants ‘educating’ me about DMH.

Semi-structured interviews were more specifically used, which allow exchange of dialogue between interviewer and interviewee, and hence, the experiences of the participants are unfolded, and situated and contextual knowledge is produced or constructed (Mason, 2002). Willig (2008) states that semi-structured interview guides, should have the following characteristics; i) limited number of open-ended questions, ii) general questions should be first and more personal topics later on to allow for rapport to be built, iii) participants’ comments to be incorporated into further questions to demonstrate active listening and maintain coherence, iv) the researcher should maintain a naïve stance and ask the obvious to obtain detailed and comprehensive accounts, and v) questions should be formed in four different types; descriptive, structural, contrast and evaluative as introduced by Spradley (as cited in Willig, 2008). Descriptive questions aim for general accounts of what happened. Structural questions prompt participants to speak about how they organise their knowledge, how they make meaning of the world, for example, why they decided to do something. Contrast questions prompt comparison between events and experiences, and lastly, evaluative questions seek participants’ emotions. I have endeavoured to incorporate those suggestions in my interview guide and I briefly speak about how I demonstrated this. Willig (2008) does not state how many open-ended questions are considered as a “limited number”, and I would argue that this depends on the length of the interview, the research topic, and on how vague or specific a question is. I incorporated 12 open-ended questions, four in each topic of interest (training, experiences, views/perspectives), to answer the RQ. I also placed the more general questions
first (how interviewees were trained) followed by questions about their professional experiences and perspectives on DMH. Nevertheless, it should be noted that some interviews followed a different structure (e.g., discussed their perspectives of DMH first) in accordance to participants’ narratives. The third point, incorporating participants’ comments into further questions could be evident through the audit trail (Appendix 2). In maintaining a naive stance, I would ask participants ‘the obvious’, what is already spoken about in the literature, for example, if working with DMH is challenging or different. Some examples of the four different types of questions are:

- How do you experience your role in a BSL session? (descriptive)
- From where does your interest in working with BSL users derive? (structural)
- Is [a BSL session] challenging, fulfilling, not different from working with other client groups? (contrast)
- How do you feel about your competency in working with BSL users and/or interpreters? (evaluative)

The interview guide can be found in Appendix 3.

3.3. The participants

Eight participants from England and Scotland were recruited for this study. Table 1 shows participants’ demographics. Participants were asked how they would like to be identified in the research and encouraged to share information that felt comfortable and relevant. Gender, age, ethnicity and sexuality were recommended by me as relevant information, whereas occupation, area, working sector and BSL level were collected throughout the interview. As one could observe, counties instead of specific areas or cities are included and this is to ensure participants’ anonymity. Participant 1 referred to her education level when asked about how she would like to be identified, and therefore, this information was added to respect her request. The same is true for participant 2 who referred to his working class. The boxes include only the information shared by participants; when information was not provided this is indicated by Not Disclosed (N/D).
Participants are identified using an identification code (for example, P1 for participant 1). It has been argued that our names tend to be associated with specific characteristics, and therefore, they have power within them to affect our futures, for example, our career opportunities. Alter (2013), a marketing author, writes at The New Yorker and summarises relevant study findings to prove this point. Zwebner et al. (2017) found that our names are associated with specific appearance characteristics as well, and therefore, people create certain expectations of how people should look according to their names. Taking into consideration those socio-political understandings of names, I chose to refrain from using pseudonyms for the participants in order to encourage readers to focus on what each participant has said and creating their own understandings of them.
<table>
<thead>
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<th>Identification Code</th>
<th>Gender</th>
<th>Occupation</th>
<th>Working Sector</th>
<th>County</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Sexuality</th>
<th>BSL Level</th>
<th>Social Class</th>
<th>Education Level</th>
</tr>
</thead>
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<td>NDCAMHS</td>
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</tr>
<tr>
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<td>Private Sector and Forensic Services</td>
<td>North West</td>
<td>50s</td>
<td>White British</td>
<td>N/D</td>
<td>Level 6</td>
<td>N/D</td>
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<tr>
<td>P5</td>
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<td>Counsellor</td>
<td>Private sector adult deaf services</td>
<td>Scotland</td>
<td>30s</td>
<td>Dual heritage</td>
<td>Heterosexual</td>
<td>Level 6</td>
<td>N/D</td>
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<td>P6</td>
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<td>Clinical psychologist</td>
<td>N/A (past adult and CYP sectors)</td>
<td>Greater London</td>
<td>40s</td>
<td>N/D</td>
<td>N/D</td>
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<td>Heterosexual</td>
<td>Level 6</td>
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3.4. Data collection

I here speak about the eligibility criteria, how I recruited the participants, the interviews’ means and particularities, and how I transcribed the accounts.

3.4.1. Sampling

For people to participate in the study, the following eligibility criteria were chosen:

- mental health practitioners of any discipline (e.g., counsellors, psychotherapists, practitioner psychologists, PWP's)
- either qualified or in training
- of any therapeutic approach
- hearing
- either past or current experience of working with BSL service users
- either practicing directly in BSL or via BSL interpreters

Participants’ age, gender, ethnicity, sexuality and any other demographics were not included in the eligibility criteria. Nevertheless, they were taken into consideration when interpreting the narratives. This form of sampling is called purposive as participants were chosen based on the purpose of the study; people who would have ‘rich’ experiences in working with d/Deaf individuals in order for the RQ to be answered (Guest et al., 2013). For the purpose of this study, rich experience was not strictly defined (e.g., extensive DMH experience), but is understood as the course of intervention with a BSL user. Only professionals who routinely work with d/Deaf people expressed interest in the study, which resulted in forming a sample of deaf specialists.

Palys’ (2008) term that would best describe my sampling would be ‘criterion sampling’ a subtype of purposive sampling, reflecting the common characteristics among potential participants. In addition to purposive sampling, snowball sampling was used, as participants would circulate my advertisement email to colleagues who would then get in touch with me. Morgan (2008) explains that snowball sampling carries the risk of recruiting a biased sample as eligible participants would not be accessible but adds that the best solution to that is to firstly

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Please note that the eligibility criteria have been slightly rephrased compared to the study advertisement, for clarification purposes, but they remain the same.
recruit participants who are as diverse as possible. To answer to that argument, snowball sampling was secondary to purposive sampling and a number of organisations were contacted, with diverse focus (e.g., adult clients, children and families, psychologists, counsellors and psychotherapists). Hence, potential participants would have the opportunity to contact me directly. Having said that, I am aware that half of my participants come from a certain area of practice, which might pose implications for the RQ.

3.4.2. Recruitment

To recruit participants, a study advertisement was prepared and disseminated electronically between 21st March and 15th April 2019 (Appendix 4). I firstly contacted a number of organisations enquiring if they would be interested in disseminating my research to their members. On most occasions if the answer was positive, the participant information sheet was provided, however, I would sometimes send out the information sheet in the first contact. The organisations contacted were either related to d/Deaf counselling to reach out to practitioners in specialist services or counselling and psychology more broadly (The BPS for practitioner psychologists, and the British Association for Counselling and Psychotherapy - BACP, for counsellors and psychotherapists). As previously explained, some organisations would also disseminate my advertisement email in other trusts/colleagues.

Six organisations were contacted, but only three responded, excluding the BPS and the BACP. Eight participants were recruited, which was the aimed number. Participants contacted me on my email address and a date and time for our interview was agreed. We also agreed whether we would meet in person or electronically, based on geographical concerns. One participant asked me to test our Skype communication prior to interviewing, and another one asked “to speak to you about your study prior to agreeing”, and both requests were facilitated. During the initial conversation with the latter participant, we discussed about my interest in deafness. The recruiting and interviewing took place between March and August 2019.
3.4.3. Interviewing

The interviews lasted between 45-100 minutes. Two participants were interviewed face-to-face whereas the remaining six were interviewed through Skype, due to geographical disparity and time-constraints. One of the face-to-face interviews took place at the University of Manchester’s facilities, whereas the other one at the participant’s working office, as mutually agreed with the participants in both cases. Interviews were audio-reordered with the participants’ consent, using a recorder provided by the University of Manchester. No other means of recording were used, such as mobile phones or recording through Skype, for confidentiality purposes.

The use of online interviewing is often challenged by authors as it requires additional ethical considerations, a discussion worth noting in this study. One issue discussed is data accessibility, for which literature does not seem to give absolute answers, which is understandable since the online environment is very difficult if not impossible to be controlled. “The issues raised [are] ethical problems precisely because they evoke more than one ethically defensible response to a specific dilemma or problem. Ambiguity, uncertainty, and disagreement are inevitable” [emphasis in original] (Ess and the Association of Internet Researchers, as cited in James & Busher, 2009, p. 60). People nowadays, appear very familiar with using technology either in their free time or for the purpose of their work. Even though we probably do not like to think about who can access our information, we do use technology being aware of possible threats to our privacy. In the present research, participants did not express any concerns regarding being interviewed through Skype, and to add to that point, therapists working with d/Deaf clients are probably even more comfortable with communicating online as this means seems to be preferred by d/Deaf people (Akamatsu et al., 2005; Power & Power, 2004). To conclude, the flexibility of technology goes hand-in-hand with its threat to privacy, yet people choose to access it.

3.4.4. Transcribing

All the interviews were transcribed by me, to ensure confidentiality and familiarity with the accounts. Transcribing was selective, filtering out information that I did not consider relevant to the study, such as discussions about needing to take a break. Transcripts further included
non-verbal communication, such as pauses, sighs, laughter, and signing, as those are considered to be additional sources of information, especially in DMH where communication is mainly non-verbal. Those non-verbal indications were included in the main text, in brackets, bringing the two together, and endeavouring to make transcripts as practical and theoretical as possible (Ochs, 1979). When participants were mentioning the word ‘deaf’, this was noted with a small ‘d’ (since a hearing disability or cultural position was unclear) unless clearly indicating an identity position, for instance, when followed by words such as ‘culture’, ‘clubs’, and ‘community’. All participants were offered the opportunity to be sent the transcript and amend/add/delete information as necessary. Two participants accepted the offer, from which only one responded to my email and returned the transcript with alterations.

It is relevant to say that this study was initially designed as a mixed-methods study, using Grounded Theory (GT) as the analysis method. Nonetheless, the quantitative part’s (questionnaire) contribution was understood as limited and therefore it was removed. It became apparent that it was unrealistic to analyse every interview before proceeding to the next one (as GT implies), due to the thesis’ timescale. This shift impacted the transcribing process only. More specifically, I heard back each interview, reading simultaneously the transcripts already produced, and I incorporated another level of transcribing, that of notation (pauses, tone of voice) as this did not seem to be emphasised in GT. Additionally, I was required to adopt narrative language, and move away from the idea that each interview should be structured based on what is missing from the previous one.

3.5. Analysis method

I here explain how I analysed the interviews through Narrative Analysis (NA), and more specifically, Dialogical Narrative Analysis (DNA). I firstly speak about their theoretical background, followed by the rationale for using them.

3.5.1. Narrative Analysis

The term NA “refers to a family of methods for interpreting texts that have in common a storied form” (Riessman, 2008, p. 11). In NA, researchers are interested in how people gather and structure an event, and how they use, language or vision to communicate the event’s meaning.
Its interest goes beyond the content and structure of a storied event, and explores why a story is being told, for whom, and what is achieved by it (Riessman, 2008). What is considered as key characteristics of NA, is its focus on the details; the context of a story, the intention of the storyteller and its agency, and the way a story is unfolded. Therefore, narratives are analysed as a whole rather than through common themes that favour general statements. Nonetheless, NA can still produce general themes (as in theoretical, and not statistical, propositions) and prompts readers to think beyond the obvious (Riessman, 2008).

Writers often discuss the ‘narrative turn’, referring to the moment narratives were considered for careful study in the human sciences (Riessman, 2008). Some locate the ‘narrative turn’ in the 1960s as a challenge to realism (Riessman, 2008), but it is also linked to liberation movements, the civil rights, and feminism movements, in expressing stories of marginalised groups during the 1960s and 1970s (Holstein & Gubrium, 2015). Holstein and Gubrium (2015) claim that narratives have been an essential part of social sciences since their inception. However, NA seems to have flourished during the 1980s following some notable publications from Mishler, Sarbin and Bruner, all three published in 1986 (Riessman, 2008; Hiles et al., 2017).

It is claimed that narrative is associated with identity (Hiles et al., 2017), and therefore, NA is often used in studies preoccupied with some form of identity (e.g., Stephens & Breheny, 2013). Nevertheless, Holstein and Gubrium (2015) refer to NA that focuses on identity as a “variation” (p. 6) of thematic NA and explain that it is used mainly in psychology and has a therapeutic element. The approach to NA employed in this study, considers some aspects of the participants’ professional identity formation, but it is not therapeutic, and identity is not a research aim. It is, therefore, apparent that the ‘field’ of NA is not unified (Holstein & Gubrium, 2015); “we draw insights from many traditions and have disagreements” (Riessman, 2008, p. 13). Thematic NA and structural NA are probably the most common forms of NA. The first one emphasises what is being told and is perhaps mostly developed by Catherine Riessman (2008), a professor of sociology in the United States who writes extensively on narrative methods in the human sciences. The latter, also called Labovian structural analysis, focuses on how a story is told. Thematic NA focuses on events rather than on storytelling as a performance and takes limited account of the context in which the story is produced (Patterson, 2013). Contrary, Labov, a sociolinguistic, argues that stories are typically structured in a particular

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8 narrative and story are used interchangeably, as further discussed under DNA’s analytic steps
format; abstract (A), orientation (O), complicating action (CA), result (R), evaluation (E), and coda (C) (as cited in Patterson, 2013). Briefly, the abstract introduces what the story is about, orientation answers questions such as ‘who’, ‘where’ and ‘when’, complication action is the part of the story that unfolds the plot, evaluation gives information about the narrator’s appraisal of the story, result refers to what finally happened, and coda, is the part where the narrator returns to the present, the moment the story is told (Patterson, 2013). The specific NA approach in this study incorporates elements of both narrative and structural approaches and is called DNA.

3.5.2. Dialogical narrative analysis

Arthur Frank, a US professor of sociology, appears to be the founder of DNA and explains that DNA is based on what he refers to as socio-narratology, which is in turn founded on narratology, the study of narrative (Frank, 2010). The adjective ‘social’ is added to reflect that “being human, and especially being social, requires the competence to tell and understand stories” (p. 13). Hence, no one comes up with a story that solely belongs to them, and no one creates a story by themselves. The ultimate aim of socio-narratology is the “symbiotic work of stories and humans creating the social” (p. 15), and the means to practise it is DNA. DNA places particular focus on the multiplicity of voices that are enacted within a single narrative, and on the effects of a story being told (Frank, 2010), and ‘dialogical’ refers to the relationship between the story, the storyteller and the listener, as the one influences the other, which is fundamental in the analytic process. Other theoretical influences also inform DNA, such as symbolic interaction theory, partly, conversation analysis, as well as literary theory, and more specifically, Mikhail Bakhtin’s work on dialogue (Riessman, 2008), who was a Russian literary theorist and philosopher of language of the 20th century.

According to Riessman (2008), DNA introduces elements such as the influence of the researcher, the setting, and social circumstances on both the production and interpretation of a story. Frank (2012) adds that “storytelling responds to others – whether actually present or imagined – and anticipated future responses, including the retelling of the story, with variations” (p. 33). Hence, the audience of a narrative plays a particular role in how storytellers shape their identities. Of particular significance is intersubjectivity and reflexivity which due
to the dialogue between “researcher and researched, text and reader, knower and known”, readers participate and give meaning through their interpretations (Riessman, 2008, p. 137). Apart from the researcher’s influence on what is said and how it is understood, storytellers also influence the listeners in a sense of learning. Listeners learn how to use the stories appropriately to achieve what each story is capable of achieving (Frank, 2010). “The primary lesson from storytellers is that they learn to work with stories that are not theirs but there [emphasis in original], as realities” (Frank, 2010, p. 17)

Five “commitments” (Frank, 2012, p. 34) or ideas as I prefer to view them, are central in DNA. The first idea is, of course, the understanding of any individual voice as “actually a dialogue between voices” (Frank, 2012, p. 34). Two concepts are used to further explain this idea, polyphony and heteroglossia. Polyphony refers to specific people’s voices whom the speaker listens to and value, and as a result, the speaker’s voice always resonates with those specific others. On the other hand, heteroglossia refers to voices from generalised others rather than specific individuals, such as communities, and their intersections. The second idea is to constantly remain sceptical about monologue, which is the opposite of dialogue, and the third one is to conceptualise stories as having their own “independent lives” (p. 36), meaning that they exist outside us, which we borrow and adopt, and at the same time, they shape our sense of self. The fourth idea refers to the “unfinalized nature of persons” (Frank, 2012, p. 36) which is based on the premise that as long as people live, their last word has not yet been said, which brings up a dilemma since the purpose of a report is to be finalised. This leads to the last idea which is DNA’s aim to enhance reflexivity in participants. The purpose of DNA is not to summarise findings which implies an ending of a conversation, but rather to i) allow “continuing possibilities of listening and responding to what is heard”, ii) allow people to hear themselves and others, iii) enhance ‘people’s sense of responsibility in how they might respond to what is heard’ and iv) ‘to show what is at stake in a story as a form of response’ (Frank, 2012, p. 37).

3.5.3. Rationale for Narrative Analysis and Dialogical Narrative Analysis

Hiles and Čermák (2008) have characterised NA as “the new kid on the block” (p. 147) stating that within psychology, its establishment is very recent. Despite this, NA appears to have made a strong presence as more theoretical and empirical material is being written on this approach
One of the benefits of NA is the power that narratives are claimed to have beyond the convention of experiences. More specifically, narratives “offer pragmatic and persuasive responses to deal with life’s events” (Hiles & Čermák, 2008, p. 149) and NA, in that sense, is linked to social action. Indeed, the authors further claim that “narrative seems to be in a unique position to promote human empowerment, and to challenge oppression, unnecessary suffering, and discrimination” (Hiles & Čermák, 2008, p. 149). Even though the authors do not expand further on that point, considering the historical development of NA (civil rights, liberation movements, and feminism movements) its “resistance to existing structures of power” is long established. (Squire et al., 2013, p. 4). Bruner (1991) has stated that people’s narratives give access to specific cultural rules of social relationships, that means, how we should interact, but also access to who we can be. Squire et al. (2013) put it this way:

By focusing on narrative, we are able to investigate not just how stories are structured and the ways in which they work, but also who produces them and by what means; the mechanisms by which they are consumed; how narratives are silenced, contested or accepted and what, if any, effects they have. For many of us, problematic as they are, narratives carry traces of human lives that we want to understand (p. 2).

NA’s strong positioning toward SJ acts as one reason why I have chosen to utilise it in this study. The second reason is NA’s value for people’s stories as their realities and for their context as influencing their stories, which leads to accounts being analysed and presented as unique and diverse as they are (not in themes).

In addition to the two benefits of NA, the particular reasons for choosing DNA are firstly, its view of dialogue as the multiplicity of voices, either those voices are the listeners’ or people’s by whom participants’ views and beliefs are affected. This idea allows me to consider the relation of the topic under investigation (e.g., political discourse on DMH – heteroglossia), with the participants’ beliefs and perceptions of the topic, and hence, it is, in my view, a more holistic approach. Furthermore, I understand DNA’s aim of increasing reflexivity in participants (Frank, 2012) as a specific proposition of how to use stories to initiate social change, that goes further to a study’s readers, and includes all of us. As a last point, both NA and DNA through their emphasis on social change and resistance to oppression, are compatible with the study’s theoretical bases (multiculturalism and SJ), and are further in line with CR, which also highlights social action.
Despite CR’s recent inclusion in qualitative studies, to my knowledge, there are no narrative analyses conducted through CR. This might suggest that it is not common to combine the two and I could only speculate that this could be due to NA emphasising dialogue and language, which can be well supported through the constructivist paradigm. Nevertheless, O’Mahoney (2011) not that long ago wrote about the application of CR to the study of “selfhood, identity and psychology” (p. 122) where they speak about the “fertile ground” for CR in the study of self, as providing “richer and more ontologically coherent analyses” (p. 127). They add that “there is an opportunity for critical realism to act as a bridging mechanism by examining how phenomena such as discourses and texts interact with and limit the self, without resorting to mere correlative studies” (p. 124). Despite O’Mahoney (2011) not making reference to narrative analyses, they rather clearly speak about the benefits of CR to discourse and conversation analysis. In more recent years, it appears that the links between CR and discourse analyses have been well established, and theoretical papers support the link between those two areas. For instance, Joseph and Roberts (2004) writing from the fields of politics and sociology respectively, discuss the contribution of realism in understanding “how discursive and other social practices produce real effects” (p. 17), and how this knowledge helps us change the world. Like discourse analyses, NA has historically been concerned with issues of difference, rights, and discrimination, and it essentially, tackles power relationships, oppression and social injustices. Discourse analyses and narrative analyses are further similar in the sense that both consider language as key in meaning making and in constituting and reconstructing identities (Burck, 2005). We could then, claim the benefits of CR for discourse analyses as applied to NA.

Important to clarify is the difference in how NA, DNA and CR speak about reality or realities. NA considers stories as realities (in accordance with social constructivism). Interestingly and in my understanding, DNA does not seem to follow this rationale as “reports present stories not as transparently accurate descriptions of what is…but rather as storytellers’ presentations of what they perceive” and “people’s stories report their reality as they need to tell it” (Frank, 2012, p. 37). In accordance with DNA, CR speaks about stories as perceptions of reality, and in this study DNA’s and CR’s understanding of reality and stories is followed.
3.6. Analysis steps

Frank (2010) explains that there are no particular steps in applying DNA, however, he recommends seven steps, on which I build to inform, rather than guide, the analysis process as they seem to limit creativity and flexibility of understanding and presenting stories. The seven steps are as follows; i) animating interest, ii) varieties of fieldwork, iii) deciding what is a story, iv) collecting stories, v) selecting stories for analysis: practicing phronesis, vi) opening up the analysis, and vii) building a typology.

As a reminder to the reader, the two RQ are:

i. How do hearing therapists who work therapeutically with BSL users speak about their experiences, training and competence in this area?

ii. How do hearing therapists who work therapeutically with BSL users speak about the current mental health services provided, therapists’ training in working with BSL users, and the future of deaf mental health?

3.6.1. Animating interest

The first step of DNA is having an interest on the topic and be clear about it. For Frank (2012) “interest proceeds from a standpoint” where “standpoint begins with someone’s personal troubles” (p. 37) but it is also located in between personal troubles and social issues. A personal trouble that I could reflect on, is the wish to work therapeutically with d/Deaf clients and the realisation of a specialist training not being offered to prepare me for such work. A standpoint I hold would, therefore, be that MHP are not adequately trained to work with d/Deaf clients which would impact on their professional experiences. This, however, could be understood as a bias, and Frank (2012) warns DNA researchers “to begin research without a preconception of what ought to change; that would foreclose dialogue” (p. 36). The study’s shift in focus from training needs to staying close to the participants’ accounts could be considered as the acknowledgment of, and response to, this bias.
3.6.2. Varieties of fieldwork

Frank (2012) believes that narrative dialogue can happen only when the researcher “has sufficient proximate experience of the everyday circumstances in which people learn and tell their stories” (p. 38), which acts as the second analytic step. Hence, he says, researchers should endeavour to experience what their participants experience, as this shared experience would be the only means through which the researcher would comprehend their stories. This step is not followed here, as I do not have experience in working with d/Deaf people. Nonetheless, I have experience in working with individuals from cultures different to mine, with different language, and norms. The way I developed my understanding of DMH was through the literature including previous studies of Deaf identities, Deaf culture and guidelines on working with d/Deaf people and BSL interpreters. Furthermore, multiculturalism, intersectionality theory, and SJ theory supported my learning not only of what might be for hearing people to work with d/Deaf people, but also, of how d/Deaf people might experience the hearing-dominant world.

3.6.3. Collecting stories

DNA researchers are called to decide how, and which stories to collect, reflecting their animating interest. As a trainee interested in working with d/Deaf service users, collecting stories from professionals already in the field reflects my interest, and the way this was done was through interviews. As the benefits of interviews have already been explained, I move on to the next step.

3.6.4. Deciding what is a story

Next, DNA researchers should decide what counts as a story. Narrative is often used interchangeably with story (e.g., Riessman, 2008) but Frank (2010) distinguishes between the two, and describes narratives as including “multiple stories” (p. 199), referring to no specific characters, and having causality as an ingrained principle. Squire et al. (2013) suggest that there is no single universal definition of narrative, and even within everyday conversations, there is
diversity in how narrative is understood, adding that definitions change even year by year. Riessman (2008) states that within psychology and sociology, narrative is understood as encompassing “long sections of talk – extended accounts of lives in context that develop over the course of single or multiple research interviews or therapeutic conversations” (p. 6). Interestingly, Frank (2010) appears to use ‘story’ in favour of ‘narrative’ as this is understood by the title of his book, his approach (socio-narratology) and even the steps of DNA where he invites us to ‘collect stories’ and ‘define what a story is’. Nevertheless, he uses ‘narrative’ to refer to the analytic approach (DNA). He acknowledges himself that maintaining the “distinction in consistent usage proves impossible” (p. 200). As I consider the distinction of the terms as unfortunate, for this study’s purpose I use ‘narrative’, ‘stories’, and ‘accounts’ interchangeably, to refer to the audiotaped interviews (and transcripts).

3.6.5. Selecting stories for analysis: practising phronesis

After deciding on what is a story, researchers are encouraged to select which stories to analyse by practising ‘phronesis’, a concept used by Bent Flyvbjerg, a Dutch economist and professor, and which is understood in three ways. The first one is “the practical wisdom gained through analytic experience” (Frank 2012, 43); the ability to choose among the collected stories, which ones to write about. The second one is choosing those stories based on values and interests; what is considered as good or bad. The third aspect is revising the selection of stories as we move on with building arguments. Even though I appreciate that this very specific way of choosing stories could enhance the focus on the RQ, this step is not followed as it is against my view of each story’s worth. Thus, all interviews collected are analysed and presented.

3.6.6. Opening up the analysis

In opening up the analysis, certain types of questions are proposed; resource, circulation, affiliation, identity questions and questions about what is at stake, meaning how the stories that people tell convince them of what they need to do to protect themselves from potential risks to their identities. Riessman’s (2008) explanation of DNA (as well as of thematic and structural NA) was combined with Frank’s (2012) steps to form 21 questions (Appendix 5). Hence, those
questions echo the thematic, structural and dialogical aspects of DNA and were used in no particular order, depending on whether they would be acknowledged. The first step of the analysis process was reading a few times the transcript and familiarising myself with it. Then I would start asking myself the questions whilst reading the transcripts. In addition to those questions, Labov’s six structural elements of story; abstract (A), orientation (O), complicating action (CA), result (R), evaluation (E), and coda (C) were also followed.

3.6.7. Building a typology

Once the analysis is completed, DNA researchers are asked to ‘build a typology’. It is my understanding that typologies refer to ‘titles’ given to participants’ accounts to describe the overall message that the researcher perceives. They are used to explain how narratives limit people in becoming their “fate” (Frank, 2010, p. 48). Frank (2010) holds the view that typologies help people remain unfinalised, whereas their narratives are considered as finite, and they also demonstrate how people are allowed to be themselves through their available narratives. He adds that the ultimate goal of DNA is helping participants “to become more reflective narrators of their lives” (p. 48). It is not the purpose of a typology to be used as labelling. “Thus DNA circles back, repeatedly, to asking this question: How well served are people by their stories?” (Frank, 2010, p. 49)

The way I build typologies in this study, is by summarising what I perceive to be the meanings of participants’ accounts, as I divide those accounts in the three areas of interest of this study for each participant. This summarising is reflected by naming each section, through using the participants’ words, that I would understand to be the main meaning of each section. For instance, when P1 was speaking about her training and background (first area of study’s interest), she would often refer to her qualifications, and thus the title I chose for that section was “I am qualified” which were her words. This will become clearer in the analysis chapter.

3.6.8. Bringing the stories together

The final step, which is not proposed by Frank, but which I incorporated, was to bring the stories together; to consider commonalities and differences in order to allow for some synthesis
of my interpretation. This step was conducted after reporting the selected sections of all the analysed narratives. More specifically, guided by the interview guide, I noted how many participants spoke about specific difficulties such as working with interpreters, or how many made specific suggestions such as educating MHP. This process can be seen in Appendix 6.

3.7. Research quality

Another concept to consider is how to ensure that QI is of quality. Tracy’s (2010) “criteria for excellent qualitative research” (p. 837) inform this study as they appear to provide a relevant and thorough approach in applying and presenting principles which strengthen the meaningfulness of a study. Those principles are the following eight: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical, and meaningful coherence. I now briefly explore how I embed each one.

3.7.1. Worthy topic

A worthy topic according to Tracy is one which is relevant, timely, significant and interesting. I argue that a study on working therapeutically with d/Deaf clients meets all four aspects. It is relevant to therapists of any discipline who are interested in understanding and reflecting on the challenges of DMH and receiving ideas regarding strategies to respond to those challenges. DMH is and will always be timely and significant, as is counselling broadly. It falls under the discourse of SJ, and therefore, it contains a strong political aspect which goes beyond the profession. Hence, it is of interest to people who care enough about equality as a social phenomenon.

3.7.2. Rich rigor

A study of rich rigor means that the researcher is well prepared to acknowledge complexity in terms of theoretical foundations, data, time in the field, number and diversity of the sample, data collection and analysis processes. In response to that, chapter one explores multiculturalism and SJ theories which offer the lenses to interpreter participants’ narratives.
DNA also adds lenses to interpretation, that expand to sociolinguistics. The sample could be considered as diverse and appropriate as participants come from different disciplines (counselling, psychology, psychotherapy), working environments (CAMHS, forensic, adult services), working practices (e.g., working with interpreters or not) and identities (hearing, CODA). I here follow Guest et al.’s (2006) claim who, by referring to the ‘Consensus theory’ recommended that a small sample of experts (specific result for four participants) on a field “can be quite sufficient in providing complete and accurate information within a particular cultural context” (p. 74) because of their tendency to agree with each other compared to novices. The evidence for time spent in the field can be reflected in chapter one (introduction) and five (reflexive analysis).

3.7.3. Sincerity

Sincerity refers to reflexively discussing values, biases and inclinations of the researcher, and being transparent about the methods used, how they were used, and challenges encountered. Chapter four is dedicated to reflexivity in all the aspects of the research.

3.7.4. Credibility

Credibility is proven through audit trails for how narratives were collected, analysed and presented. Another aspect is thick description which is providing enough details for readers to develop their own understandings, and also going beyond the surface of participants’ meanings. Extensive quotes from participants’ accounts are incorporated, following which my own understanding is provided and it is made clear whether this understanding belongs to me. Furthermore, awareness of cultural differences between myself and participants is also discussed in chapter four, which Tracy (2010) names ‘multivocality’.

3.7.5. Resonance

Resonance refers to the ability of the report to influence readers. One aspect of it is the aesthetics of the report. This is hopefully achieved by using simple language, clear structure and personal narrative in the form of reflexive writing which is generally considered as a way of engaging the audience. Through allowing critical thinking rather than imposing my
understandings and recommendations to readers, transferability and naturalistic generalisations are also hoped to be achieved. Transferability is linked to aesthetics and the use of personal narratives to provoke emotional responses and resonance to the readers. Nonetheless, I am aware that it also refers to readers’ resonance with the story of the research, which is highly dependent on their interests and experiences, and therefore, out of the researcher’s control.

3.7.6. Significant contribution

I would argue that the present study contributes practically and heuristically, by developing ideas that can be adopted by a variety of audiences such as psychological therapists, interpreters, d/Deaf people and policy makers, and by providing participants with another way of seeing the world (in context of DNA’s principle of enhancing reflexivity in participants). This is endeavoured through focusing on social change and encouraging participants to share their views of what needs to be improved.

3.7.7. Ethical

The ethicality of the research is addressed in the following section.

3.7.8. Meaningful coherence

The last quality criterion is met when a study answers the proposed questions and achieves its goals, analyses, and presents material in accordance with theories and paradigms, and links literature back with the methods and findings. The present chapters explained the fit of CR to DNA in an endeavour to justify the link between the goals, the paradigm and the analysis employed. Chapter five (analysis) and six (discussion) serve as evidence of the compatibility of the methodology with the presentation of the findings, and the literature, respectively.
3.8. Ethical Considerations.

I here discuss the ethical decisions made, and some dilemmas faced. James and Busher (2009) write that research ethics serves two purposes; the first refers to the outcomes of the research being trusted, and the second that society is benefited by the research not at the expense of the participants. A number of steps have been taken to ensure both the trustworthiness of the data and the fair treatment of the participants. As trustworthiness has been discussed above, this section focuses on the latter aspect, ethics.

Importantly, ethical approval has been obtained by the research ethics committee of the University of Manchester prior to data gathering. Once participants would contact me, a participant information sheet (Appendix 7) was provided, stating the purpose of the research, any potential risks to themselves, audio recording, how data would be stored and their right to withdraw from the study. A consent form (Appendix 8) was also provided and a signed copy from both parties was given to them. The purpose of both documents was to ensure informed consent to the research. Before commencing the interview and audio recording, participants were prompted to ask any questions regarding the research, to ensure their understanding of the process and ethicalities. In addition, they were offered the opportunity to review their transcripts, to make sure they agree with sharing what has been said. The transcripts were sent to the two participants who asked for them, encrypted, using two different passwords (sent in a different email).

The audio recordings and transcripts were kept confidential in the University of Manchester’s Research Data Storage. Electronic data and paper copies were kept in encrypted files and in locked storage respectively. Data in all forms were solely accessed by me as the researcher. No identifiable information was mentioned throughout the writing of the study. The above steps mirror the Code of human research ethics (British Psychological Society, 2014) and the General Data Protection Regulation (European Commission, 2018).

Some ethical dilemmas were faced related to DMH being a small speciality. For instance, the probability of the participants’ anonymity being compromised was higher. To respond to that issue, I refrained from disclosing information that might have been identifiable; I provided counties rather than cities, age range rather than specific ages, and the working sector (e.g., NDCAMHS or deaf adult services) instead of specific organisations. In relation to the small
speciality, the second ethical dilemma was including literature in which participants have contributed. Only when literature was publicly accessible, was included in this study.

Other dilemmas were related to online interviewing, and more specifically to giving consent and maintaining privacy and confidentiality. As consent should be taken prior to the start of the interviewing, consent was provided as an electronic copy, apart from one participant who was audiotaped reading out loud and consenting to the form. After the interviews’ completion, a copy of the consent form signed by me was sent back to the participants.

Finally, technical problems were also present with some participants. During the interview, one participant would struggle hearing me, therefore I would use the chat, and communication was also lost for a few seconds. Those difficulties clearly impacted on the interview process, and this was taken into consideration when interpreting the participant’s narrative.

3.9. Chapter summary

The study is a qualitative piece of work, and CR serves as the research paradigm. Semi-structured interviews were used to gather narratives from eight participants (conducted face-to-face and through Skype), and DNA was chosen to analyse their accounts. DNA was chosen as it emphasises social change and is compatible with CR and social aspects of DMH. Participants identified as clinical psychologists, psychotherapists, and counsellors and were contacted through three organisations. DNA’s steps as outlined by Frank (2010; 2012) were followed, with some exceptions. Tracy’s (2012) steps to ensure quality and ethicality of the research were also discussed extensively, and ethical considerations including ethical issues and how I responded to them were mentioned.
Chapter 4: Reflexive analysis

4.1. Overview

In this chapter, I endeavour to add to the quality and trustworthiness of the study, by exploring contextual factors that have influenced how I designed the study, conducted and interpreted the interviews, and produced this thesis. To achieve that, I critically reflect on i) my personal positioning as a researcher, for instance, the knowledge, feelings, and values that I bring into the research, as well as on ii) how the study has changed my understandings and views of DMH. Attia and Edge (2017) refer to those two ideas as ‘prospective reflexivity’ and ‘retrospective reflexivity’, respectively. I begin by theoretically locating reflexivity in counselling psychology, QI, and NA, to establish its meaning for my research. I then move into prospective and retrospective reflexive concepts in relation to every step of bringing this piece of work into life, and more specifically i) the development of interest in the topic, ii) my understanding of the relevant literature, iii) the process of collecting narratives, and iv) the process of interpreting/writing them.

4.2. Reflexivity in Counselling Psychology

Reflexivity has a long tradition within counselling psychology (Donati, 2016), and the concept of the ‘reflexive practitioner’ has been argued to be its distinctive characteristic (Hanley & Amos, 2017; Donati, 2016). Donati (2016) explains that for counselling psychologists, reflective practice is a ‘way of being’, on which other important elements are based, such as the humanistic value of uniqueness and difference, and the scientist practitioner model which refers to the ability to be critically aware in research. Counselling psychologists in the UK draw on both the scientist-practitioner and the reflective-practitioner models to inform their practice (Jones-Nielsen & Nicholas, 2016) and the HCPC (2015) has clearly incorporated the ability to evidence both as a standard of proficiency. Schön (1983), whose work is closely associated with reflective practice, spoke about experiential learning (reflection-in-action) and the ability to critically evaluate practice (reflection-on-action). Expanding on the reflective-practitioner, Hanley and Amos (2017) write that to be reflective means to approach our inner processes (thoughts, feelings, assumptions) as an external observer, and to develop an awareness of how
those impact on our decisions. In this sense, being reflective requires openness and willingness to re-consider situations and our identity as counselling psychologists (Donati, 2016). As with psychological practice, counselling psychologists engage in reflexivity in the research process (Kasket, 2012), which I discuss below.

4.3. Reflexivity in Qualitative Inquiry

Kasket (2012) claims that it might be counselling psychologists’ value for reflexivity that leads them to favour qualitative inquiry. In qualitative research, reflexivity is of high value (e.g., Dodgson, 2019; Patnaik, 2013), as it has been argued to encapsulate the quality of a study, and has been characterised as the “gold standard for determining trustworthiness” (Dodgson, 2019, p. 220). Elliott (2005) writes that “reflexivity might be understood as a heightened awareness of the self, acting in the social world” (p. 153), and Etherington (2004) has defined reflexivity in QI as:

an ability to notice our responses to the world around us, other people and events, and to use that knowledge to inform our actions, communications and understandings […] We also need to be aware of the personal, social contexts in which we live and work and to understand how these impact on the ways we interpret our world. (p. 19)

What appears to be common then, between reflexivity in psychological practice and research, is the emphasis on the use of self, on self-awareness. Attia and Edge (2017) narrate about it as: “this focus on ‘self-awareness’ that gives reflexivity its hallmark” (p. 36). Mann (2016) further writes on the importance of being committed to ongoing reflexivity to respond to aspects of qualitative interviews that might be taken for granted. In context of adopting a reflexive approach early on in my study and sustaining it as Mann (2016) suggests, it is important to mention that I have kept a research journal, in which I was noting my responses to methodological processes, the participants, as well as the process of interviewing, and interpreting the narrative accounts. I now move on discussing how reflexivity is conceptualised within the broader field of NA.
4.4. Reflexivity in Narrative Analysis

As reflexivity involves self-awareness, and hopefully shapes our understandings of our sense of self, it could be considered even more central within NA taking into consideration the analysis’ emphasis on identity formation. Elliott (2005) clarifies that identity is nowadays understood to be both flexible and individualised, which is known as the ‘reflexive modernisation thesis’, and states that “the notion of identity as a reflexive achievement emphasizes the autonomy of individuals in making choices and shaping their own lives” (p. 153), making the case for reflexivity and narrative as integral parts of identity formation. By citing Richardson, Elliott (2005) further speaks about language as the means to articulate our ideas and convince the readers and adds that “an approach to qualitative analysis informed by an interest in narrative is therefore frequently accompanied by a more reflexive methodology” (p. 152). They explain that “in the context of research methodology, the notion of reflexivity is used more specifically to indicate an awareness of the identity, or self, of the researcher within the research process” (p. 153).

In the context of DNA, I understand reflexivity to additionally manifest through the emphasis on the multiplicity of voices. This appears to be a concept relevant to the researcher too, as reflected in the following DNA question: ‘what resources shape how listeners comprehend the story?’ I, hence, respond to this question in this chapter, rather than during the analysis chapter per se, as I understand it to be a reflection of personal experiences, professional experiences, and intersections.

In summary, reflexivity is central for this study, because it is written within the profession of counselling psychology, it is qualitative, and it further utilises DNA for which being aware of oneself is key. I now bring those values together and speak about how I demonstrate reflexivity in this thesis.

4.5. Reflexivity in the present study

Reflecting on the discussion on reflexivity within counselling psychology, QI, and NA, for the purpose of the thesis, Berger’s (2015) definition of reflexivity in research is utilised as I consider it to be rich and concise: “the process of a continual internal dialogue and critical self-
evaluation of researcher’s positionality’ as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome” (p. 220).

In unpacking this definition, I am going to speak about my personal responses to the participants’ accounts, and to the literature on the topic (for instance, in relation to the discussion around deafness being a disability), and how I used this awareness of my responses to design the study and to interpret the accounts. Additionally, I am going to reflect on how my personal context influenced the narratives’ interpretation, what was referred to as intersectionality previously. Hence, ‘identities’ or positions such as being a woman, a trainee, hearing, and a non-British, among else, are discussed. I finally speak about how my professional experiences (social context) have further influenced my interpretations. Prior to this discussion, my interest in DMH is explored. Patnaik’s (2013) questions as formed through the literature are further utilised as a guide throughout the following sections, as relevant (Appendix 9).

4.5.1. Background

4.5.1.1. Interest in deaf mental health

As mentioned earlier, I identify as hearing, I do not have knowledge of any sign languages, neither do I have the lived experience of being d/Deaf or growing up with d/Deaf significant others. My interest in this topic derives from personal values around SJ, fairness, diversity and inclusion, alongside personal interest in verbal and non-verbal communication (and creativity in language), as presented through different languages, cultures and cross-lingual/cross-cultural therapy. In relating those interests with psychology, working therapeutically with individuals across languages and cultures, and being able to be creative in communication, constitute career goals. Those therapeutic interests are also evidently linked to research, taking also into consideration the evidence-based practice, and practice-based evidence, central in counselling psychology (Hanley & Amos, 2017). Therefore, in combining the two above-mentioned interests (diversity and languages), and as part of my doctoral studies, I am interested in working therapeutically with d/Deaf clients (and BSL users in the UK context) which led me investigating DMH through hearing professionals’ eyes.
4.5.1.2. *Engaging with the literature*

Being hearing and not personally involved in deafness, means that the knowledge I develop about d/Deafness more generally, and DMH in particular, is gained through the literature, as well as my views on the experiences of others, hearing or d/Deaf in positioning. I would argue that the absence of the lived experience does not prevent me from positioning myself in relation to the discourse of d/Deafness, and from holding a view of what appears to be fair. I would parallel that experience with psychological practice, for instance, when practitioners work with service users with whom their lived experience is significantly different, such as when a male therapist works with a female service user who is pregnant. Hence, I would argue that by accessing the literature and professionals who either have the lived experience (e.g., CODA) or have worked with people with the lived experience, I enhance my ability to empathise with the participants and to gain an understanding of their experiences. In this process, my role as a trainee psychologist with experience of working with clients and within teams, is relevant.

Further to developing knowledge through the literature, I would argue that part of my understanding of DMH comes from my lived experience of belonging in a cultural minority group which includes the position of the ‘outsider’. More specifically, coming from a small island, Cyprus, and speaking a dialect of Greek, renders me aware of my minority status, not only when it comes to living in another country with a different culture and language, but also in positioning to the rest of the world since this is a language spoken only on that small island.

Apart from being hearing and Greek-Cypriot, I also identify as a white, middle class, heterosexual woman in my mid-twenties. Those aspects of my identity do not appear to have overtly influenced my understanding of the DMH literature, and I would be cautious in speaking about how they might have impacted on the participants’ narratives. Nonetheless, they have shaped my understanding of the SJ discourse in psychology, by considering power relationships based on people’s intersections and positions/roles, for example, the ‘white privilege’, the equity of genders, and the high prevalence of women in the psychology profession. Those understandings constitute lenses in capturing some aspects that d/Deaf people might be experiencing within a hearing world, such as social inequality, discrimination and oppression, as discussed in chapter one.
I consider important to mention that I do not classify deafness as a disability, but as a cultural minority position, adopting the notion of holism; the belief that a person is more than the sum of its parts, which informs my view of the world, and which is emphasised within counselling psychology (Bugental, 1964). This statement might allow for both positive developments of the study, as well as limitations. A possible development might be that conceptualising deafness and DMH holistically and multi-culturally, allows for more contemporary understanding of d/Deaf people’s mental health needs, and moves away from a more medicalised approach. This firstly, offers lenses to critically reflect on the literature, and secondly, to interpret the participants’ accounts. As a result, it locates the research in a field of studies that are interested in SJ, diversity, and power relations, and adds to it. A possible limitation of positioning deafness outside the disability discourse, which is however the mainstream wave in the relevant literature, is that some deaf people would identify as disabled, or some psychological practitioners would consider deafness as a disability, and therefore, the need for flexibility in interpreting the literature and the participants’ accounts is deemed appropriate, for instance, by critically reflecting on what a disability model might have to offer.

4.5.2. Reflexivity in methodology

Further to reflexivity in theory, I now consider particularities of the methodology that have influenced the study.

4.5.2.1. Collecting narratives

In this section I speak about factors that have influenced the process of interviewing the participants, and more specifically, i) similarities and differences in our positionings and associated power roles, and ii) the use of the interview guide in collecting stories, in the context of ‘the notion of the self-fulfilling prophecy’.

4.5.2.2. Similarities and differences in positionings

As already stated, I do not hold either the lived or the professional experience of d/Deafness, which renders me as an ‘outsider’ in its discourse. As a position, it can be understood in context
of power relations between me and the participants (who are not only qualified psychological therapists, but experts in DMH), and therefore, it manifested during the interviews. This was particularly evident when participants would come across as educating me in terms of how BSL works, what types of interpreters can be introduced in deaf counselling sessions, or about the specificities of their job roles. My position as an outsider, might have further influenced the participants’ interactions with me as the researcher. For instance, I recall one participant who enquired about my personal interest and the reasons I only recruited hearing therapists prior to agreeing to take part, which might suggest an understanding of my interest as being compromised due to my positioning. As a result, I found myself expanding on my interest in SJ and languages, to prove my intentions were relevant. Despite this, I also acknowledge that some participants might consider themselves as outsiders in working with d/Deaf clients as they too do not share the lived experience. In that sense, the hearing position was a commonality between me and the participants that might (or might not) facilitated a discussion on the topic under study.

In addition to lacking professional experience, another difference between me and the participants was my trainee position. Reflecting on that position, I am aware of my inner reactions when one participant would speak about working with trainee interpreters as difficult due to their trainee role. I remember disagreeing with this statement and how I would respond to the participant was a challenge. I decided to allow the participant to express themselves and follow their flow, without sharing my discomfort. Another aspect of being a trainee therapist, was the difficulty of adopting the researcher position which I understand to be as facilitating the dialogue through clear guidance and direct questioning. Rather, I found myself sometimes reflecting on what I understood to be the meaning of the participants’ words which is a therapeutic skill. That might have firstly extended the length of some interviews, and secondly, diverted briefly the focus of the research. Nevertheless, the semi-structured interview design supports some diversion, and we were able to follow the interview guide where relevant. Holding the trainee and outsider positions appears to have eliminated any power that the role of the researcher might hold, as the participants hold more knowledge about the topic through professional experience, lived experience, or educating themselves over the years.

Apart from being a trainee, and an ‘outsider’ in the discourse of d/Deafness, other differences between myself and the participants that I have acknowledged are those of age, nationality, native language, and therapeutic speciality. As expected, all participants were older than I am,
which is another dimension of power relationships, where the older, in that case, the participants, hold more power. I do not consider this to be problematic, taking into account that it was the participants’ experiences that I was seeking, and some agency over what and how they communicate it is, therefore, expected. Having said that, I have not experienced the participants ‘overpowering’ me, for example, by talking over me, and both of us were active agents in the interviewing process. Another example that I consider as sharing power, was one client providing me with resources on DMH, in an endeavour to support my writing.

In terms of nationality and native language, the majority of the participants identified as White British, and all were fluent in English. The fact that I am not White British and a non-native English speaker, further allowed participants power as I would not necessarily have access to every word shared. I would be cautious in saying how me being a non-native English speaker might have influenced how the participants communicated with me, and I would only speculate that they would adjust their register based on their expectations of my language competency. From my experience of the interviews, some participants would be interested in finding out about my nationality whereas others would not acknowledge it. For instance, one participant enquired about my cultural background, and then used my foreigner position to refer to examples of cultural and lingual differences, as a parallel of working with BSL users. I perceive this acknowledgment as a genuine attempt to enhance my understanding of their experiences, and as a form of connection between me and the participant. I recall another participant who when I asked about their experiences of signing, they seem to direct the question back to me:

\[P: \text{signing}\]

\[R: \text{is it tiring? Is it more work? How do you experience it?}\]

\[P: \text{no I think it’s like any language. Once you get, I don’t know, do you find it more tiring to speak in English than in your first language? (softly laughs)}\]

This is another example of acknowledging my difference in terms of language, drawing on my experience of practising in a second language, and bringing it into the discussion as a parallel
example of being hearing and practising in BSL. I would argue that language did not appear to be an obstacle in understanding the key meaning of the participants’ speech.

Interestingly, none of the participants were counselling psychologists, which constitutes another difference between us, and which was unexpected, being aware of my expectation of counselling psychologists having a greater interest in DMH than other mental health professionals due to its focus on diversity. From my point of view, my counselling psychology position did not appear to have influenced the content I introduced, or how I related to the participants, taking into consideration that I acknowledge more similarities than differences among the mental health professions. I was therefore, oriented into viewing the profession of mental health as a unitary one for the purpose of working with d/Deaf clients. Nonetheless, it might have made a difference to some participants. For instance, one participant who is a psychotherapist, briefly referred to psychology as coming from a medicalised background and expressed a disagreement with this perceived positioning. Being a counselling psychology trainee might have influenced the participants’ understandings of what beliefs I might hold, based on their views of counselling psychology as a profession.

Nevertheless, being mental health ‘professionals’ constituted one of our similarities, that I would argue, allowed us to maintain the relevance of our discussion to this broader field. Another similarity is gender, as the majority of the participants were women. Gender did not come into the discussion with any of the participants, either in terms of our interviews, or their work with clients and colleagues. I would be cautious in stating how me being a woman might have influenced the participants, however, I could argue that it was not an obstacle in how I related with either the male or the female participants. The fact that most participants, including myself, were women, might reflect or represent, the widely acknowledged dominance of the mental health professions by women.

4.5.3. Interpreting narratives

In this final section, I speak about factors that influence the interpretation of the participants’ accounts, with particular emphasis on utilising DNA, and my professional experiences that are shared with the participants.
4.5.3.1. **Initial thesis’ focus**

As already mentioned, the study was designed to emphasise training recommendations for therapists working within DMH, based on my understanding that limited relevant training is provided to MHP. This understanding was based on literature (e.g. Glickman & Harvey, 2008) suggesting that such training does not exit, and personal experience as a doctoral student. Nevertheless, in this process I did not consider any other relevant training such as multicultural and diversity for MHP and that might constitute a bias in how I designed the study to focus on training. During the interviews it became apparent that when participants would be asked to provide recommendations, they often narrated about things that need to change in the society for DMHS to be improved, rather than training MHP. As a result, I was drawn to follow participants’ narratives, and emphasis on training recommendations was removed. This was a learning I took with me and could be understood as part of ‘retrospective reflexivity’. The change of the thesis’s title witnesses that shift.

Mann (2016) cautions researchers about ‘the notion of self-fulfilling prophecy’ as “a particular challenge for the social sciences” (pp. 13-14). He refers to the ‘Thomas theorem’, a theory of sociology developed by Thomas and Thomas in the early 20s who stated that ‘if men define situations as real, they are real in their consequences’, to explain self-fulfilment; “where the researcher and the research subjects behave in a way to fulfil the prophecy of the research” (p. 13). I would argue that the way I abstained from ‘the notion of self-fulfilling prophecy’ is by adhering to the semi-structured design and allowing for topics to emerge, and by making the changes in the focus as explained above.

4.5.3.2. **Utilising DNA: analysing and writing**

Richardson (1990) stated:

> In our work as researchers we weigh and sift experiences, make choices regarding what is significant, what is trivial, what to include what to exclude. We do not simply chronicle what happened next, but place the next in meaningful context. By doing so we craft narratives; we write lives (p. 10).

As a researcher, and in echoing Richardson (1990), one way in which I have influenced this study is by choosing to analyse the accounts through DNA, and the particular ‘adjustments’ I
have made. DNA allowed me to approach the accounts through multiple aspects; on the language level, in terms of how stories are structured, and based on the dialogical concepts of heteroglossia and polyphony. Therefore, a particular focus was given to all three levels. Initially, I found incorporating thematic and structural interpretations challenging, as I considered them to be more evident that the dialogical aspects, and I dedicated most of the analysis in what I understood to be the dialogical part. Adopting the narrative language was another challenge, with the first analysis draft reflecting assumptions and claims about intentions. In revising the analysis, equal emphasis was given to the thematic, structural and dialogical parts, and I utilised narrative language free of claims and assumptions.

The specific choices I have made regarding the analysis and representation steps further informed the study. For example, I have stated that I did not follow the ‘practising phronesis’ step, which resulted in a significant number of rich material to be incorporated. Nevertheless, the response to the struggle of incorporating all narratives was to dedicate a certain space to each participant, to make justice to their accounts. To address this, I was referring back to the interview guide in order to ensure that the quotes respond the RQ. The interpretation of the accounts continued throughout the writing process, and the re-writing of the analysis. This reforming strengthened the richness of the analysis, as quotes and interpretations were presented in a more structured and precise manner. I further included quotes to support the analysis (Appendix 10).

4.5.3.3. Shared Professional experience

It is important to refer to those professional experiences that I seem to share with some participants, and that provided lenses in how I interpreted their accounts (but not in how I conducted the interviews). One particular experience is practising with (hearing) CAMHS as part of my doctoral course. I used this experience to develop my understanding of the participants’ experience, for example in terms of working within teams, as well as in terms of challenges related to the referral system. For instance, one participant spoke about adopting an ‘emotion-based approach’ to work with d/Deaf children as the dominant cognitive approaches do not seem to respond to their emotion regulation needs. This is an observation I made within hearing CAMHS, which allowed me to more deeply consider where the differences stand between d/Deaf and hearing children when it comes to emotion regulation, attachment and
attunement (those are terms that the participant used), concluding that difficulties in emotion regulation might happen for the same reasons in both groups.

Another experience is that of working with language interpreters, which I used to understand some of the difficulties that the participants would mention, especially of one participant who dedicated her interview in discussing her experiences of working with BSL interpreters. More specifically, I could acknowledge the frustration of having a third person in the room in terms of relationship dynamics, as well as the gratitude for mediating communication and rendering the sessions feasible.

A third experience was that of practicing in a second language and within a different culture, that offered me lenses in considering the experience of those who practice within the dominant culture (without ignoring how they might identify, for example as part of the Deaf culture or as native BSL users), but with clients from a minority group and native BSL users.

4.6. Chapter summary

Reflexivity is an integral part of counselling psychology’s practice and research, QI, and NA, and hence, a key in the present study which belongs to all these categories. I utilised the concepts of ‘prospective reflexivity’ and ‘retrospective reflexivity’ (Attia & Edge, 2017) and I therefore referred to factors that I brought into the study, as well as what I took from it. I further followed Patnaik’s (2003) questions/prompts of reflexive engagement as a guide. In applying reflexivity, I critically referred to i) my interest in DMH, and engagement with the literature, and to ii) the methodological design: collecting narratives, and interpreting (including writing) them.
Chapter 5: Analysis

5.1. Overview

In this chapter, I present my interpretation of the participants’ narratives which constitutes the analysis. The term ‘analysis’ is favoured (versus findings) to enhance critical realism’ relativistic epistemological position which supports the idea of constructing perspectives of reality, rather than finding them. In accordance with NA’ philosophy, each participant’s story is presented separately to highlight the uniqueness of people’s experiences. For each interpretation, I briefly introduce the participant and the particularities of our interview, then I interpret their accounts, and I finally provide a brief summary of it. The analysis is informed by my RQ as outlined in chapter one, and therefore, professional training, experience of working with deaf clients, and future suggestions are presented in this order. As a reminder, the RQ are:

i. How do hearing therapists who work therapeutically with BSL users speak about their experiences, training and competence in this area?

ii. How do hearing therapists who work therapeutically with BSL users speak about current mental health services provided, therapists’ training in working with BSL users, and the future of deaf mental health?

Nevertheless, the analysis goes beyond a mere reflection of the interview questions and offers a specific analysis of each story. Following the presentation of each account, the eight stories are brought together to highlight commonalities and differences in the narratives of hearing therapists working with BSL users in the UK at the moment of writing.

5.2. Interpretation of narratives

The 21 questions formed through literature on DNA, and which reflect thematic, structural and dialogical aspects, were utilised to guide the analysis. Labov’s six structural elements were also employed. Hence, the three levels of analysis (structural, thematic, and dialogical) were conducted simultaneously. Narratives are presented in the order the interviews were conducted. I now present each narrative.
5.2.1. Participant 1

My interview with participant one (P1) took place through Skype. Prior to our interview, P1 requested some further information about what we were going to discuss so she could prepare in advance, and hence, an email was sent with a few points summarising the interview guide. During the interview, I observed that she had prepared some notes to which she was referring. Additionally, she suggested that we test the quality of our connection prior to our scheduled interview, and therefore, we had a brief skype communication about a week in advance. The connection on both our trial and the interview was poor, and the communication was difficult for both of us, but especially for the participant. As a result, I would often type my responses, which was time consuming, and limited communication effectiveness since it was not immediate. We would also have a few brief pauses as the participant had a workman around (not in the room). P1 identifies as a systemic and family therapist who works with NDCAMHS.

"I am a qualified..."

P1 was prompted to commence her narrative by speaking about the route she followed to qualify as a therapist, which could be referred to as the ‘abstract’ of her story, in Labov’s terms.

Okay so I am a qualified systemic and family psychotherapist…I’m also a qualified systemic supervisor…so yeah I’ve got some qualifications in my teaching, right. Umm and I am also a qualified play therapist umm and umm I am a qualified teacher of the deaf. (8-15)

In addition to a systemic and family therapist, P1 identifies as a supervisor, play therapist, and teacher of the deaf. She repeats the word “qualified” which could be read as confirming her professional identity as a competent and ethical practitioner.

She continues by speaking about her sign language skills and perceived purpose:

…years ago I passed the level 2…which means (sighs) that umm I’m adequate… So…I know enough to be able to tell if the interpreter is umm is interpreting what I want them to say umm and to keep track of the deaf person’s responses…I’m more or less on track
and can tell, just about, if umm I don’t quite think it’s the same sense, so you know if I disagree. Umm yeah so that’s helpful, to be able to do that yeah. (15-23)

P1 states that she utilises her knowledge of BSL to keep track of the clients’ responses, and to tell whether interpreters transmits the meaning she tries to communicate. In that sense, she appraises herself as “adequate”. A sense of power imbalance between herself as the therapist and the interpreter, might be suggested when she says “what I want them to say”.

She stated that she had not received Deaf awareness training within her service as “I didn’t have much of an induction for very specific reasons” (127-8), clarifying that they do offer Deaf awareness training now, delivered by a deaf colleague, but “it’s not a package” (133) and “it’s not formal though” (138). She speaks of the current situation with Deaf awareness training as “a bit of a fudge” (140). Following that, I further asked whether she had training in working with interpreters to which she responds negatively, by outlining the historical evolution of deaf education:

…my training in teaching deaf children was about umm 20 years ago, 25 years ago, and it was very oral...Umm so it’s very old-fashioned (brief laughter). So, no there wasn’t much talking in working with interpreters. (154-158)

“That’s the other downside of having an interpreter”

Regarding her experience of working within deaf counselling, P1 early on spoke about struggles in working with interpreters, especially trainees:

And we only work with qualified, well, try to only work with qualified... (communication lost for 15 seconds)…they’re not necessarily using qualified interpreters, they might send a trainee, and then it’s difficult if I’ve travelled a long way, and a trainee turns up, I can’t really not do the session. So, you know, I’ll note it, in fact, I’ll usually ask the deaf person whether they mind that the person isn’t fully qualified, we might have to do a bit more conversation about confidentiality, make sure that they, accept. Whereas normally, with a qualified interpreter I don’t need to, to check with them...Because deaf world is such a small world, it’s really important to talk about confidentiality. (55-64)
P1 states that in the NDCAMHS she is part of, “we” only try to work with qualified interpreters, but explains this is not only the case as “they” sometimes sent a trainee. Through the pronouns used, she communicates the common goal of her team in endeavouring working with qualified interpreters, whereas the interpreting services will not always comply to the team’s requests, therefore, are considered as the outgroup. She expresses the importance of the interpreters being qualified by referring to confidentiality in the “deaf world” because it is “small”, which might suggest a rapid dissemination of information and hence, a danger to confidential information. She states how she overcomes this perceived risk, by bringing the concern into the room and involving the clients into that discussion.

P1 continues by identifying the struggles’ roots in working with BSL interpreters, which she attributes to the interpreters, deaf CYP’s communication experience, and her “style of working”:

…and asking lots of kind of reflexive questions and so on, so for interpreters, it can take them a while to adjust to my style of working...if the question is too open-ended and too complicated or too much umm circularity where you are asking them to think about someone else’s point of view, which doesn’t naturally lend itself to umm, well not so much in sign language but the experience of deaf people umm that, that kind of empathy, that switching of roles, especially for children is umm, is sometimes quite hard to get across, so, I need to do a bit of prepping of the interpreter...and to, for us to have a conversation in front of the clients, and that might be a bit weird for them...I don’t want the interpreter to take on too much of the role of explaining things...And umm, and I want the clients, to know, that I care (brief pause), greatly, about everything they are communicating to me. So, I want that relationship to be between me and them, via the interpreter...so there is a word that doesn’t make sense. They often step in and say ‘well it means this’. Well I want to be, part of that. (192-225)

There is a number of aspects which P1 narrates as influencing her experience of working with interpreters; interpreters’ experience and understanding of reflexive questioning (which she refers to as her style of working), deaf clients’ experience of empathy and switching roles, clients’ age, and interpreters’ agency over the session. She states wanting to have a direct relationship with the client, where the interpreter would act as the mediator to it (“via”). Her
story might be read as a confirmation of her professional identity as the therapist in the room who cares deeply about her clients, whereas interpreters appear to be positioned as a threat to that sense of professionally competent self, and the therapeutic alliance. Her affirmative tone of voice (for example when she says “well, I want to be part of that”) might suggest that she addresses the interpreters.

She continues by mentioning a further “downside” of working with interpreters:

You know there is a downside to needing an interpreter and what would’ve been even better, what would’ve been perfect is if I could sign fluently. If I could sign at level six, umm then I could have my direct relationship with the deaf people. However, I would still need an interpreter there, to voice, the deaf people for, it wouldn’t be for me, but they would be voicing for any hearing people in the room who aren’t fluent in sign language. (299-305)

She appears to acknowledge her own limitation of not being able to sign fluently, and says signing fluently would be ideal in being able to have “my direct relationship” with the clients, which could be understood in terms of direct communication, and direct therapeutic relationship. Despite this direct relationship and language fluency as the ideal, she further realises that she would still “need” an interpreter for other hearing people in the session. This appears to be a specificity of family therapy as the client’s family members are present.

She adds on the challenge of having interpreters, by referring to power imbalances arising both from age and (what she calls) “engagement”:

That’s the other downside of having an interpreter of course, especially for a child, it’s another adult in the room, which can be, another stranger usually as well. So, you know, it can get in the way of engagement. (583-6)

Apart from confidentiality, and translation barriers, P1 considers an interpreter being “another adult” and “another stranger”, as an additional barrier to deaf clients-children being involved in therapy sessions. When she repeats the word “another”, she seems to acknowledge that she might be perceived in the same way in the deaf children’s eyes, and therefore, she does not appear to be blind to the power imbalance between herself and the clients.
“be transparent about what is obvious in the room”

When P1 was asked if she is interested in SJ, she responded by explaining that it is extremely important in family therapy training, and moved into discussing SJ in working with deaf clients:

Umm so part of my job, even before we get into the therapy really is to have some conversation about their experience of working with hearing professionals. Because I need to know if they’re full of rage, and hurt, and distrust, and suspicion…to give them permission to say they’re feeling by me, they’re feeling patronised, or feeling that I’m taking control too much…do they need my help to make things more fair?…do they want to use me, to help them to communicate their frustrations? (725-740)

P1 narrates about her “need” to know how the clients feel about their experience of a hearing-dominated world, which she appraises as part of her job. She narrates about how she gets that understanding by asking deaf clients about their experiences with hearing professionals. She strives for power balance through being transparent and seeking information, and considers herself as entitled and willing to advocate for the deaf clients.

Regarding service development, she suggests only working with qualified interpreters, this time, by giving a further explanation of how the trainee role influences her work:

…Because they’re not qualified. And because it’s probably harder to make a complaint [R: stops typing] against a trainee than it is about against a qualified person. (867-875)

Lastly, in responding to the prerequisites for therapists to work with deaf people, she refers to transparency, as an additional suggestion:

My request to all training of anybody who is going to work in mental health or in counselling is the people should be transparent about what is obvious in the room. You know you can’t not talk about the fact that the person is deaf and we’re hearing and the fact that there’s an interpreter there. You know, you would be failing in the engagement process if you didn’t talk about that. (832-6)
She locates transparency in all mental health training rather than merely deaf counselling, but also highlights the importance of transparently discussing hearing positions (deaf service users and hearing service providers) that transparency for engagement to happen. Her use of the words “my request” reflects the importance she places on those skills as well as a sense of a power position. Additionally, she speaks in the second person (“you know, you would”), possibly speaking to fellow MHP and making a generalised statement about the importance of transparency on these matters.

P1 narrated about her qualifications, relevant to deaf counselling. She extensively spoke about her experience of working with deaf clients in the presence of (mainly BSL) interpreters, both qualified and trainees, specifically within a family therapy setting, and she appraised this experience as mostly challenging. She spoke about struggles she faces regarding confidentiality, translation and transmission of meaning, the power imbalance between clients and interpreters (possibly herself too) due to age differences, and roles and boundaries between herself and the interpreters. She recommended that therapists endeavour working only with qualified interpreters, and they also be transparent in acknowledging hearing positionings and how they manifest themselves in the therapy room.
5.2.2. Participant 2

In the email expressing his interest in the study, participant 2 (P2) asked “to speak to you about your study” prior to agreeing to be interviewed, and suggested a video call, which was facilitated. During this video call, P2 enquired mainly about my interest in the topic. He agreed to take part, and an interview date was scheduled, prior to which I emailed him with a few questions based on my interview guide, in case he wished to prepare. He identifies as a counsellor, who works as a private practitioner with deaf adults.

“I feel more comfortable with working with deaf clients”

P2 spoke about undertaking specific training in working with deaf clients, communicating an agency which is also apparent through the use of “I” pronouns and the active voice of verbs:

Yes, so I specifically went out and found a course...So, most, I mean my counselling course for example was incredibly broad umm we didn’t touch on deafness at all really. Umm there was sort of a tokenism of diversity and equality types of, but nothing specifically about working with deaf people anyway. Umm and sort of I felt that I needed something extra. Because I think it’s a complexity, or adds a complexity to it, in particular in relation to people who have got diagnoses. (46-54)

P2 refers to “a sort of tokenism” to possibly communicate that equality and diversity were part of his counselling course’s philosophy but not its praxis. He further refers to an added complexity, which I understand as a complexity regarding the understanding and application of equality and diversity when working with d/Deaf people, who especially have mental health diagnoses.

Following a conversation where he appraised his masters course as “quite driven from a psychology...a medical perspective” (86-7), I asked if he would, therefore, consider further training:

umm. I think, you know honestly, I feel more comfortable with working with deaf clients than I’ve ever have in working with hearing clients. And I think a part of it is definitely the cultural difference. (96-98)
Even though P2 does not answer the question directly, he explains his comfort with working with deaf clients which he partly attributes to “the cultural difference”, possibly communicating an affiliation with the Deaf culture. From that moment, he moves into narrating about his experience of working with d/Deaf clients, as interpreted below.

“that role boundary gets blurred”

P2 speaks of practical differences between working with d/Deaf and hearing clients:

…because we did quite a traditional psychoanalytic course, of course they talk about being a blank screen, not interrupting your clients…in their culture, if you don’t interrupt, then you’ve got nothing to say so they’ll carry on talking…but also, I think the visual aspect of it. So, I think my personal approach as a therapist is perhaps quite dependent on things like metaphors, quite dependent on visual abstract constructions of internal processes…with a deaf client, the visual metaphor is really, really useful…Whereas with a deaf client in the first five minutes they will tell you their full story…And that’s the other thing as well, is in Deaf culture there is definitely this culture of almost narrative storytelling, and these visual stories that are passed out from generation to generation, and you know forms a huge part of the culture. And that can be really useful in therapy, and I’ve used a lot of techniques around umm things like narrative therapy and looking at sort of using different elements or things like that to work with the Deaf clients. Because it really fits with their cultural norms and behaviour really. (99-139)

P2 identifies particularities of working with d/Deaf clients and how those link with his working style; i) not interrupting them as having nothing to say versus his “traditional psychoanalytic course”, ii) Deaf clients opening up quickly and his choice of using of narrative therapy techniques, and iii) using metaphors and visual abstracts, which once again, links to the Deaf culture. Considering the pronouns that he uses (e.g., “their culture”), in this extract, he appears to locate himself within the hearing culture, but communicates an affiliation with Deaf clients as his working style matches their cultural norms.
He speaks extensively about context-related difficulties, and here he refers to the physical aspects, such as visibility, of the therapeutic environment, and how he adapts his practice:

…because I use rooms in GPs some of them are less than suitable umm and one of the biggest issues I find is you need light, you need enough light to be able to see each other...I mean at one point I was carrying around my own lamp with me. (375-9)

He further speaks about having to inform GP staff that the client he expects is “profoundly deaf” (350), and I prompted him to expand on it, to which he gives a strongly emotional response:

And it offends me, it offends me when they call me an interpreter, it offends me when they call me like the brother of the person. “It’s just like no, no. Just because I can sign it doesn’t mean I’m his family, I’m just here as a professional”. And I feel that I often, do not get professional courtesy in some of these GPs…But also, they’re often, in my mind, very vocal about that they know who the client is. And that sometimes really bothers me. Because it’s like they almost talk about the client in front of them, without them knowing, and without them understanding. (480-9)

P2 speaks about how other professionals do not treat him with respect because of him being able to communicate in BSL and therefore, they make assumptions about his role. Their approach appears to threaten both his professional identity, and sense of fair treatment of his clients. The staffs’ conduct also appears to be in contrast with values he holds because of the emotional reactions in him (“offends”, “really bothers”). He further gives an example of how “cultural nuance” can create miscommunication and misdiagnosis (which can be found in Appendix 10, extract 1). P2 extensively speaks about how historico-political decisions toward d/Deaf people, influence his work, for instance, by having to “swallow” clients “moaning” about hearing people (Appendix 10, extract 2), and by exploring identity concerns and empowering clients (Appendix 10, extract 3).

Apart from how other professionals perceive his role, P2 narrates about how deaf clients, as well as therapists might also blur boundaries. Nevertheless, he seems to understand that keeping the boundaries he uses with hearing people would not work in d/Deaf counselling, and there is a sense of dilemma:
And I think that role boundary gets blurred by the deaf clients, gets blurred by other staff, and gets blurred by some therapists. Because I know therapists who work as interpreters half the week and therapists half the week. And I think that’s inappropriate. Because there is a role confusion there…In my mind is unethical and unprofessional and shouldn’t be allowed, but I don’t make the rules, so (brief laughter). But I think there is a hell of a lot of that in the deaf world as well; these, these blurred boundaries, these blurred roles. And you know people being interpreters, therapists, community support worker, everything…And I think I have to, in particular for myself with deaf clients, I have to have very, very strict boundaries…In the hearing world I wouldn’t work with somebody I had a prior relationship with in any way. In the deaf world if I didn’t work with people that I had a prior relationship with in some way, I wouldn’t work with any deaf people. (527-558)

P2 repeats the word “blurred” to what appears to be an endeavour to emphasise this ‘phenomenon’. He says that boundaries get blurred within DMH by deaf clients and other staff, but also within the deaf world too. It is unclear if that is due to its small size as he states later on, or if there are other reasons. He characterises therapists’ dual roles as “inappropriate”, “unethical” and “unprofessional” due to the role confusion that it causes, and all three words used indicate an absence of a conduct. He refers to how he himself keeps “strict boundaries”, distancing in that way himself from those professionals who practice without professionalism. Nonetheless, he acknowledges a limitation to those strict boundaries, caused by the Deaf community being small.

“deaf mental health is political”

P2 expressed an interest in politics and SJ. He reports having strong opinions about how to support d/Deaf people and choosing to vocalise them:

So, I would say in my mind SJ is a huge part of the work I’m doing. And in particular with Deaf clients, and I would argue because I work in a way that is culturally and linguistically affirmative. So, I’m not neutral, not in any way. And I advertise the fact that I’m not neutral, in terms of my view of how best to support Deaf people. (599-602)
He claims a very strong positioning on the inevitable political aspect of DMH and how it comes into the therapeutic work:

…and I think it is political, DMH is political, you can’t escape it, you really can’t. And in particular because of the way mental health was used politically to incarcerate, not just deaf but deaf people in this context, in my mind you can’t work in DMH without being an advocate, without being a voice, without standing up and doing something about these misconceptions… (693-7).

P2 uses the pronoun “you”, addressing all professionals in deafness, including himself. He justifies the need to be an advocate by linking DMH to historical oppression of d/Deaf people. His position might serve as a confirmation of his way of practicing, and also influences readers in considering political aspects of DMH.

I prompted him to speak about what needs to improve in DMHS. This political stance he holds is apparent throughout his whole account and it always seems to serve as a maintenance of his professional identity:

I think the main issue overall with the entire sphere of DMH, in particular in deaf counselling, I would say it’s based on the dominant hearing medical culture that controls the discourse around what deafness is…until we have that shift in attitudes and in the discourse, to include the deaf voice, to include the deaf perspective, and to actually prioritise, the way that deaf people see themselves, as opposed to prioritising the way we see and understand deaf people, then I don’t think any of these bigger changes are going to have a huge impact on the everyday lives of deaf people. (942-51)

He characterises the changes in the discourse of deafness, and the shift from how hearing people understand deafness to how deaf people experience their deafness, as the basis for “bigger changes” for which he narrated about before; deaf people running deaf services and adopting a linguistic cultural minority approach as opposed to a medical one.
The second change he identifies, is deaf people running DMHS:

...a lot of deaf people will never engage with them, never engage with them. Because in the back of their minds they know it’s the hearing who run the service, and it’s horrible. (730-2)

In this section, he appears to speak on behalf of the deaf clients, stating how they think about the current DMHS.

His final suggestion is having a personal interest in d/Deaf counselling:

But I think, for me, (brief pause), you have to have some kind of personal interest. And I think one of the most common question anybody working with deaf will ever get asked, is why. (793-5)

I understand this statement as linking back to his request for a conversation prior to our interview, in which he enquired about my interest, and therefore, he comes across as adopting this question himself. He appears to claim that hearing people having a “story” on their motivations, is important not only for himself, but for deaf people as well.

P2 spoke about his experience of working with d/Deaf people as more comfortable for him, and expressed some affiliation with the Deaf culture, for instance, his working style matching Deaf clients’ cultural norms and behaviour. He extensively referred to challenges regarding boundaries that are not respected by d/Deaf clients, hearing colleagues, or hearing GP personnel. He spoke of the need to adopt a cultural minority approach, involve d/Deaf people in the delivering for DMHS, and suggested that therapists should have a personal interest in d/Deaf counselling. In that sense, he expressed a strong opinion about DMH being political, about him holding specific views against the medical model, and he identified his role as an advocate and a voice for d/Deaf clients.
5.2.3. Participant 3

My interview with participant 3 (P3) took place face-to-face. She presents herself as a clinical psychologist who got into the profession “a little bit later than lots of people” (11) as she had previously been working in a different sector. She speaks of having been practicing with CAMHS for most of her career and a few years ago, she joined the NDCAMHS service.

“unless I was a fluent BSL user”

After discussing how her interest in working with d/Deaf people was developed, I prompted her to speak about whether she had any training on DMH or working with interpreters:

no so, I did, well I did, I’ve done training in working with interpreters during my doctorate training, but it didn’t include BSL interpreters…Umm but no nothing on BSL, there’s nothing in my training about working with deaf people. Umm so when I started in the job…I had a long sort of induction process within our service which is a kind of national service. (53-60)

R: were those formal or mostly informal? (63)

P: mostly informal yeah, yeah, yeah. And obviously my supervisor who is a consultant clinical psychologist, [they’ve] been working in deaf CAMHS for a long time, [they’ve] been working with interpreters for long, and with the Deaf community, so I’ve learnt lots through supervision with [them]. (65-58)

P3 narrates about receiving informal training in working with d/Deaf people through NDCAMHS, and with working with language (but not BSL) interpreters through her doctorate course. She clarifies that “our” service is a “national” one, suggesting its high status, and therefore, despite the training being informal, the narrative can be read as maintaining the training’s quality. She affiliates with her team (“our”), and she identifies supervision as an additional source of learning.

P3 identifies a third source of learning for her; the team interpreter.
So, umm I’ve learnt an awful lot from [interpreter’s name] who’s our team interpreter. (85-6)

I asked P3 if she works directly in BSL to which she appears to have a quick reaction, repeating the word “no” three times, communicating her strong opinion, and supporting her sense of “right” practice:

no, no. no. I’ve done my level two BSL but I don’t you know, I realised that I’d had to be, full on level 6 interpreter ‘til I get any kind of, you know. I mean I think, which is quite right, apart from you know, and really unless I was a fluent BSL user, I would never even think about doing it really. Umm because I just think, I would miss so much you know. Certainly, the level that I am at now, there’s no way I could do therapy in BSL, no way. (140-145)

When asked P3 if she would consider additional training, she referred to lack of time in the NHS, as well as further training not being a priority by them, to justify the difficulty of undertaking one (Appendix 10, Extract 4).

“I’m really lucky with our interpreters”

When asked about her clinical experience with d/Deaf CYP, P3 spoke about her collaboration with interpreters. She structures her narrative in a chronological order, referring to the changes she observed over the course of her employment within NDCAMHS, which could be read as her sense of growth:

I think at first, I was very focused on making just the basics of working with an interpreter you know, making sure I was going at the right pace…I think more and more, as I’ve relaxed more, then I’m worrying less about “am I going too fast?”…and obviously these are children as well, so you are adjusting for their developmental level as well…before maybe I would have just said “it’s called CBT, cognitive, that’s thinking”…But then I work with children who are BSL users where [interpreter’s name] had to explain those terms that I thought I took for granted that they would know (questioning tone). So, there’s a whole other level of explanation. So now I’m much
more focusing on the kind of subtleties of the therapy and the relationships (questioning tone). (95-112)

P3 speaks about how she moved from worrying about the practicalities of working with interpreters, to currently considering the “subtleties of the therapy and the relationship”, as well as those amendments in therapy due to clients’ age, and pre-existing conceptual knowledge. I have observed that throughout the whole interview, P3 refers to her colleagues by their names, which gives those people hypostasis, and perhaps echoes her sense of connectedness and belonging.

She speaks of her collaboration with the team interpreters as positive:

I mean I’m very, I’m really lucky with our interpreters, they’re very good [indistinct], they’re very collaborative. So, I’ve had no, honestly, I’ve had no bad experiences where I’ve been frustrated with the interpreter or felt like they’ve not taken you know, it’s not been my session, you know? And I always have felt like that child has had, the services of a clinical psychologist, and made accessible, do you know what I mean? (620-5)

She appears to speak of the interpreters and herself as one team since she appraises them as “collaborative”. She uses questions and the word “honestly” which can be read as emphasising her statement.

Another challenge she speaks about is how clients respond to her due to her hearing position:

Umm those, a lot of those parents and those families are more big D deaf so there’s much more of that cultural identity as a Deaf person. And obviously, I can, I can learn and listen and read and have conversations with people about how it is for a deaf person in the hearing world but I’m obviously, I can’t, I have not lived that so. And I think, there is quite a sort of, there can be quite a sort of, umm idea of “how do you know? you are not deaf” kind of thing umm. And sometimes that can be challenging…and usually that’s easily overcome you know umm, by just (brief pause) doing the work and showing them “actually I can help” you know. Umm but some…I think right from the beginning they’ve been quite switched off…and then [name of deaf colleague] does the work and I just supervise her. (405-420)
P3 presents as aware of how her hearing position influences both her understanding of d/Deaf experience, and the therapeutic engagement of some Deaf families. This barrier specifically applies to “big D” families. Interestingly, she assumes my familiarity with the term as she does not attempt to explain it, which might suggest a sense of a shared communication. She appraises the big D families’ stance as “challenging”, but also states how she overcomes it; by proving she can help. She further speaks of other families which are “switched off” and refuse to work with her, and she once again states the resolution; passing the case to her d/Deaf colleague. Interestingly, she narrates about the absence of the lived experience, but nevertheless, she refers to her source of understanding and knowledge; reading and liaising with people, which might be understood as her endeavour to fill this gap and practice effectively.

She speaks of a third difficulty, “one of the things that I’ve really struggled with” (421), which is linked to the mainstream education system and how that relates to the referrals her organisation receives:

And we’re getting more referrals now for those kids, who aren’t quite, they are not suicidal, they’re not self-harming but they’re so slowly going down and down and down…it’s frustrating because those children are being pushed into having mental health problems…deaf education is just not good enough…and, umm we’ve done as best as we can to try and influence the system around them so that people can see this is not the right environment for them you know…But then I also know, our time is limited, and we have to see the children who are having those mental health problems, and really for us, it’s not our business about the education, so. (438–460)

P3 appraises the inappropriate referrals as “frustrating” which might communicate a sense of unfairness for those children. She speaks of “deaf education” as not being good enough, where “deaf education” in that context appears to point to the hearing-mainstream education system, which is not supporting the “only deaf child” (250) “educationally but socially and emotionally” (437) as well. She narrates about trying to influence that system, which is read as educating hearing people, and serves as a resolution. She, however, acknowledges the limitation of their role as education “it’s not our business”, but it is unclear how she evaluates that. Interestingly, she uses the pronoun “I” only in the first sentence, and then moves into using pronouns to refer to her whole team (“we”, “our”, “us”), once again suggesting a sense
of affiliation. She often chooses to finish her stories by referring to actions/resolutions, which might strengthen her sense of a responsible professional, who takes a pragmatic stance toward difficulties.

“in education and in local authorities”

P3 was prompted to share her opinion on the effectiveness of current DMHS. She briefly speaks about the importance of NDCAMHS’ existence, and how well they are working compared to generic CAMHS which “are under-funded, over-stretched and have huge waiting lists” (650-1). Nonetheless, she goes on to identify the gap in services provided to d/Deaf individuals:

I think where services are really lacking for children is in education and in local authorities…as deaf children become deaf adults, that ongoing support in terms of how you negotiate this hearing world and how you negotiate all the processes and all the systems to get the things that you need. And I think particularly for deaf adults who are BSL, I think that’s really hard you know. There’s a huge, big problem with interpreting services now in this country I’m not sure well, this is what I’m picking up from the interpreters I’m working with…And the way they do it is a bit like just getting a taxi or whatever you know, you put your things in. But half of the time they don’t turn up, you don’t know who’s coming, it becomes very difficult to book the same interpreter you know…we can’t be chopping and changing...So, it’s mostly people who are newly qualified or. And then the standards are going off you know. (656-685)

P3 speaks of deficiencies in three areas: i) education for deaf children and local authorities, ii) support for deaf adults in negotiating their needs, and iii) interpreting services. She expands on interpreting services and uses the visual metaphors of “getting a taxi” and “chopping and changing”, to challenge their lack of quality, and refers to trainee interpreters as providing mediocre services due to lack of skills and experience. She appears to hold a strong opinion about consistency of interpreters, which is in line with guidelines on working with interpreters.

I asked P3 to tell me about training therapists:

…I mean obviously I can only talk about clinical psychology, but I don’t think, all my whole training I never got any teaching on working with deaf people umm or deaf
culture or anything. Umm I think there’s still a big gap, actually a big misunderstanding (questioning tone) in MHS, about umm the differences in working with deaf people in terms of mental health…There’s still unfortunately I think that sort of ‘deaf and dumb’ kind of attitude. (691-702)

Those considerations were formulated in response to my SJ questions, which for P3 is “probably a lot about access and making sure that…nobody is unable to access the services they need because of something about them, culturally, or identity-wise or whatever” (775-8). She does not appear to give a solution this time and hence, she comes across as not holding strong views on therapists’ training or as not feeling able to say.

As a synopsis, P3 identifies as hearing, and as lacking the lived experience of being d/Deaf. She spoke about how she works collaboratively with the team interpreters and located the difficulties she faces in working with d/Deaf CYP as related to i) mainstream education making inappropriate referrals to NDCAMHS, ii) some Deaf families challenging her understanding of d/Deafness due to her being hearing, and iii) some adaptation she (and the interpreter) needs to make due to concepts not being translated or d/Deaf CYP not being educated the same way as hearing ones. She further identifies barriers in accessibility of the existing services, deficiencies in deaf education, as well as interpreting services. She does not appear to make specific recommendations, but based on the identified gaps, improving interpreting services, only making appropriate referrals to NDCAMHS, improving deaf education, and considering how to make services accessible to BSL users might be considered as areas for development.
5.2.4. Participant 4

Participant 4 (P4) identifies as a clinical psychologist who qualified “a long time ago” (p. 10). At the time of the interview, P4 was working in forensic settings and the private sector. Our interview took place face-to-face.

“I was very involved in the Deaf community”

P4 speaks about how she developed her interest in DMH:

So, I was very involved in the Deaf community, went to Deaf clubs, went to Deaf events, that kind of thing, before I did the clinical training. So, by the time I’ve got to clinical training, I knew that I needed to bring those two things together, the psychology and the deafness, and that’s how it looked like. (48-51)

P4 speaks about her involvement in the Deaf community early on in her life, suggesting that she has been proactive in learning about d/Deafness. She uses first pronouns and active voice of verbs reflecting her agency. She acknowledges that she has been “very involved”, which serve as a clarification of a real interest in that field.

After she reported that she has been trained as a BSL interpreter, I further enquired if she received any d/Deaf awareness training, bearing in mind historical influences, and indeed, P4 clarified there was no such a training when she qualified. She however, moved into explaining that she offers Deaf awareness training herself, reflecting once again her agency and confirming her identity as a practitioner who is “very aware”:

I think it’s, I do a lot umm promoting Deaf awareness training...So, I’m very aware of Deaf awareness now, but at the time when I started, I think we were right at the beginning, of things like Deaf awareness, so we would kind of making it up rather than being (indistinct) end of it. (128-132)

She repeats the pronoun “we” perhaps referring to DMH provision/organisations, which might suggest a sense of involvement with those decisions, and a common goal, promoting Deaf awareness. She speaks of “making it up”, which I understand as experimenting to an extent.
Based on that statement, I asked if it would have made any difference for her to have Deaf awareness training when she started:

umm, I think at the time when I started practising, I’d already got it, because I’d already done my level 2, I was familiar with the Deaf community, so I don’t think for me it would have made a big difference. One of the things I’ve done over the years, is that I’ve put on workshops for clinical psychology trainees on various courses around the country, which has provided Deaf awareness and basic psychology and d/Deafness training…Umm, so obviously I would say yes, it would be a totally good thing to psychology trainees to have that… (137-148)

The statement of being Deaf aware in the beginning of her training, might be read as contradictory with this point. Hence, what remains unclear is to what extend she felt confident in working with d/Deaf people back when she started. Interestingly, she shifts from discussing her own level of knowledge, into the dissemination of knowledge to others, highlighting her agency, as well as the role of the educator.

“we have to be really careful”

P4 speaks about differences in working with d/Deaf clients, as linked to their background knowledge and cultural norms. She gave as an example delivering a group when she realised that deaf clients did not have knowledge of genetics which delayed the group intervention (Appendix 10, Extract 5). In the following extract, she expands on gaps in deaf education:

… Umm I think what I find is, umm, we have to be really careful with deaf people is that they’re not just telling you what they think you want to hear…I found over the years that become much less directive, when I’m talking to somebody…Umm so, I don’t want to give the person my signs, if they’ve got, if their experience is different from that, because too often what the deaf person would do is they’ll learn the signs without the internal understanding of what you’re talking about…Because otherwise I think there’s a risk that we just playing a duff game, where they’re coping what I’m signing. And again, all that relate back to the fact they’ve missed stuff and also you know, deaf people are very used to hearing people telling them what to do, and being
in charge, and knowing the answers, so to have someone as a therapist, just say to them ‘you tell me’ can be you know, quite a major thing. (450-466)

P4 states that deaf people tend to adopt signs without necessarily having an understanding for them and warns about playing a “a duff game”, indicating a lack of purpose. She speaks about deaf people missing “stuff”, perhaps referring to non-inclusive education, as a reason why they tend to adapt signs. Nevertheless, she further relates adopting signs to deaf people being used to being told what to do, suggesting what I understand to be a power imbalance and privilege linked to the hearing positioning. Additionally, she encourages us (“we”) to be really careful with deaf people not to tell “you” what “you” want to hear. She also uses the pronoun “I”, to possibly suggest her own experience of deaf people coping her signs. Interestingly, P4 refers to struggles but always follows that with a resolution which is her initiative as well, for example, adapting her style of working. Therefore, the story appears to serve as a confirmation of being agentic, competent, pragmatic, and also comfortable in what she is doing.

She appraises using BSL as “work[ing] quite well therapeutically” (119) because of “mak[ing] BSL the first language” (118), and further speaks of the struggle of being “expected to know everything” (256) which she appraises as “another issue of inequality” (257) (Appendix 10, Extract 6). It appears that inequality in that quote is toward clinicians.

“proper training and supervision”

Following from her previous point about the expectation to know everything, I asked her if BPS has a role, to which she responds by softly laughing and saying that she has initiated some work with them, which might be read as disappointment (Appendix 10, Extract 7). She adds being “cynical about them” (299) (Appendix 10, Extract 8). I prompt P4 to share her views on the current services provided to d/Deaf people:

well I think that MHS anyway, for hearing and deaf people, are quite (softly sighs) variable aren’t they? There is some really good practice out there, but there’s some massive gaps, you know, if you talk to people who try to access MHS it’s really hard umm and it massively depends where you live, that’s not right, is it? (232-5)
P4 highlights geographical location as one factor for DMHS being “variable”, and their quality as another one. She forms both her sentences as questions, which might serve as drawing attention to, and perhaps confirming, her statement.

P4 explains that she is not very familiar with SJ and hasn’t used this concept before to reflect on her work. This appears compatible with the historical developments of psychology in the UK, and the time she was trained. She however states that d/Deaf counselling “is a matter of SJ”:

…the simple answer is; if hearing people can get counselling, deaf people should be able to get counselling, equitably, which means in their own language, that’s it really isn’t it? Umm but I think even more so, if you add in the fact that are barriers at all levels of services, then perhaps it needs to be that extra effort, to make it accessible…and in the deaf world, what happens is, you pick up quite low-level problems because there is no [indistinct] of underneath you…So that means, either they have to be end up seeing a psychiatrist when really they just need a bit of support, and that shouldn’t be, that shouldn’t happen, or their problems just incubate and get worse and worse and worse, until they are really serious (soft laughter) and they so see someone in a mental health team. So, so, I guess the answer is yes (soft laughter) I do, it’s a matter of SJ, isn’t it? It’s not right that that group of people who have more to cope in life, generally, have fewer services to help them. (203-218)

She narrates about the necessity for Deaf people to receive counselling in BSL, and to have services accessible to them, to accurately represent each level of the stepped care model. She thus, claims that “equitable” services means being delivered in BSL, which suggests an area of development. She refers to “the hearing world” and “the deaf world”, emphasising the discrepancy in how accessible MHS are for those two populations, and stresses the difference of d/Deaf people having more mental health difficulties.

She identifies the following practices as key for working with deaf people:

…go and learn sign language. That’s the number one thing, even if over the first few years you’re gonna have to work with an interpreter, the more language that you understand, the more that makes it safe. Because you get to know what the interpreter’s
doing, you get to see where the difficulties arise…The second one would get some supervision from someone who knows about deaf people. Maybe have your normal kind of supervision as well, but maybe like myself that can provide you know, maybe once every two or three months, someone you could use with those questions about deafness. And I do a lot of work, I work with a lot of trainees…in different settings, I work a lot with colleagues who are new to deafness, and that’s supervision and support, and help at the same time that they’re learning to sign it’s, it’s really important. (576-87)

P4 claims the importance of learning BSL and accessing a supervisor who is familiar with deaf people. Interestingly, she structures this narrative by moving from recommendations, to highlighting her own compatibility as a supervisor. Considering her previous statement of not needing specific supervision for deafness, the current statement might be read as a need she had identified in herself.

In a final question, I invite her to add anything she had not spoken about. This is the first time she clearly refers to other people’s voices as an influence of her views. This is understood as polyphony, in Bakhtin’s terms.

hmm (long pause) umm (pause) I think, I mean this is from my peer group as well, I think one of the things that all of us find very stressful, is this thing about people taking on deaf patients, or clients, without the proper training and supervision. And it’s very difficult to know what to do about that, you end up kind of firefighting. So for me, it’s mainly in a legal setting, whereas some would’ve done assessment on deaf people, on a deaf person, on a deaf couple. And it’ll be frankly appalling, and I end up having to kind of rescue that situation. This is where something like the BPS would be helpful if they would take it on about people working within their competence, but again it relates to it being such a small speciality that umm. (547-554)

In that extract, P4 speaks about the importance of appropriate training and supervision, which is a repetition of her previous statement. She uses pronouns such as “my” to refer to the peer group, as well as “we” which represents an affiliation (which becomes plural as in “all of us”), but also the pronoun “you” in her statement; “you end up kind of firefighting”. This statement possibly suggests a shared experience with MHP in deafness. She evaluates this “firefighting”
as “difficult” and as a result of other professionals no having appropriate training and supervision. She moves into applying this polyphonic element to her own experience when she says: “I end up having to kind of rescue the situation”. She concludes in a somehow pessimistic tone about the speciality being small and seems to leave an uncertainty as to the role of the BPS. This struggle links back to her recommendation for therapists to have specialised training and supervision, which reads as the solution to this problem.

Overall, in her narrative, P4 spoke about her work as focusing mostly on assessments and highlighted the benefit of making BSL the first language when working with d/Deaf people. She stated that she is becoming less directive in her work with d/Deaf people and also notices how they might easily adopt signs that of which the meaning might not understand. She did not appear to refer to specific challenges she faces in her work with d/Deaf clients. Nonetheless, she narrated about professionals working with d/Deaf people not having the appropriate training, and therefore, she has to intervene to save the situation, and appraises those colleagues’ practice as stressful. She, at various points, voiced her role as a person who raises Deaf awareness and disseminates her knowledge to trainee psychologists and others, emphasising her role as an educator.
5.2.5. Participant 5

Participant 5 (P5) identifies as a deaf counsellor who at the time of the interview was working in Scotland, with hearing CYP, and deaf adults. The interview took place online. A couple of days before the interview, I emailed P5 with some “ideas” of what we were going to discuss. Our internet connection was good, and we had not experienced communication loss or intentional breaks.

“but to be a deaf counsellor”

P5 presents herself as a “deaf counsellor”, suggesting a professional identity:

I’m, I qualified as a counsellor for in my degree in psychotherapy, psychotherapeutic counselling. But to be a deaf counsellor, cause the question you asked about preparation, I have my level six BSL and I’m a qualified counsellor. (14-16)

When asked about her interest in working with “deaf people or learn sign language” (240-1), she responded by referring to her childhood:

…I think when I was 13, my friend had asked her friend, if she wanted to learn sign language, she said “no” so she asked me and I said “yes, let’s do it”…it brought me out of my shell a lot more, cause you have to, do your face expressions, and be more assertive in yourself, and when I was 13, I was the polar opposite of that, and I think sign language really helped me be more confident in myself, and I did it for myself, not for anybody else, and that was a really big thing for me to do…Umm and I thought “yeah, this is what I want to do, and I wanna work with deaf people, and I want to be able to create access for them”…yeah it was just really nice, just to do, to do something that nobody else could do. (249-265)

P5 narrates about the benefit of learning sign language when she was a teenager, and acknowledges that “nobody else” could sign, which might suggest a sense of uniqueness. In this extract a sense of personal growth could be conveyed.
P5 shared her experience of working as a BSL interpreter, and how back then, she was getting “affected” (53) by the material brought by clients. She relates that experience to boundaries. Following presenting the example of her being an interpreter, she returns to the here and now (coda) and explains that as a therapist, she is not working with interpreters, which leaves unspecified whether she does not do so, to save them the emotional burden, or for example to keep the boundaries clear:

…but I don’t use interpreters. So I’m, I just sign. Which I find is a lot better than using an interpreter. (58-9)

I prompted her to discuss how she experiences her BSL sessions:

It wasn’t as hard as what my friend who is Polish was saying. I don’t think it was that, it was surprising to me that how easy it was for me to counsel with a deaf person in sign language. It’s challenging, because in a counselling session, face-to-face you have silences, so you just allow that person to feel, to think, just to be with that thought. And I can, at appropriate times, I can interrupt and I can talk to them, whereas a deaf person, you can’t do that…and kind of have to wave to the camera or see if you can get, whether they’re looking at somewhere else, you can’t get their attention. (128-135)

In that account, we could identify two voices contesting each other; the participant’s and her friend’s. The participant’s voice wins over her friend’s voice, as she comes to realise that “it wasn’t as hard” for her to counsel in BSL, which she appraises as “surprising”. From that general statement, she moves into mentioning a practical difference in working online versus face-to-face with deaf people, concluding that online counselling with deaf people does not allow for silences to come naturally, which requires her (“kind of have to”) to wave at them.

She expands on online counselling, self-care and boundaries:

…sometimes when it’s face to face, I’ve learnt obviously techniques of not umm, umm, absorbing people’s feelings. And there’s, that’s, even online I don’t do that, because sometimes it’s like, you’re not with them face-to-face, so in a way that’s really
good…But…perhaps to set a lot of boundaries with deaf people, because…I have people sometimes texting me on my work umm tablet to say “oh I need your help, I need to see you now” and I say “no, you wait until your next session”. So sometimes, I had to put my foot down and be direct with them…the experience that they’ve had with trying accessing information, “I need to get in, I need to do this” so boundaries is a big thing, I think with any client but I find, I feel I have to push in more with deaf people, to, to kind of present more and kind of make them more aware that you can’t, I can’t just make myself available. (165-182)

Keeping emotional boundaries is presented as very important for P5 who narrates that this seemed easier online. Having previously stated that working online is difficult in terms of silences and interrupting, this might suggest that she experiences a dilemma as to her preference for online versus face-to-face counselling with deaf clients. She narrates about how she responded to a client asking for an urgent session by denying making herself available, which reflects her resolution part of the story. She evaluates herself as ‘pushy’ and “direct”, and gives a visual metaphor of putting her foot down, which emphasises her active role in setting boundaries.

She spoke of additional particularities of working with deaf people:

…I think I might seem to be more patient with deaf people (soft laughter) and that’s really bad. Okay, I think I’m a patient therapist. But because I think I learnt, I didn’t learn sign language like at university, I learnt it in a deaf club, so I was brought up really, in the Deaf community, but like in Deaf clubs, and signing in clubs. And then I went to, obviously I learnt it in college, I was always around deaf people, so I learnt to kinda be more, I don’t know, gently in your face…I think there’s an aspect of not wanting to offend, I think even as a hearing culture, we are very kind of, we kind of skew the truth a little bit. But I think me as a therapist, I’ve learnt to overcome that, and kind of gently, challenge the clients. (287-303)

P5 makes an interesting distinction between hearing and Deaf cultures, as to ‘directiveness’. She states that she grew up in the Deaf community, and was “always” around deaf people, which in turn, informed how she communicates as a person (being “gently in your face”), and her therapeutic professional positioning (being “more patient”). Growing in Deaf clubs appears
to be a powerful claim for a hearing person to make that could suggest an affiliation with the Deaf culture. Despite her arguing that she ‘overcame’ the tendency to “skew the truth”, located in the hearing culture, there is still a sense of belonging into the hearing community as reflected by the choice of pronoun “we”.

A further challenge of the therapeutic boundaries is time, as deaf clients do not use the full session:

R: Why is it so you think? (368)

P: (pause). I can’t figure out the answer…sometimes with deaf people, talking personally, they’re very loud and they’re very kind of, they’re signing, and they will say whatever is on their minds…deaf people are more open…Or…when I’m counselling them and a family member walks into the kitchen, and I’m like “but they’re in the kitchen”, and they’re like “yeah yeah that’s fine, they don’t really sign”, “but they’re still there”…So I think that sometimes with having to lay boundaries, cost a lot of time. I think sometimes they want us to be more flexible with I don’t know, with access to information. And because I have, deaf clients used that card on me quite a few times, “well, I’m deaf, you need to give me this access”, “but you need to expect the boundaries that if I’m not available at this time…”. There’s probably a few dilemmas that I actually face more with deaf people, than I have with hearing. (370-392)

P5 stated that she finds it difficult to understand why deaf clients do not use the full session and turns into the concept of boundaries to give a possible explanation about it, referring also to specific examples of her professional experience. She, however, speaks about deaf people being more open which might suggest that she considers this (culture) to be a possible reason for them conceptualising boundaries differently. Types of boundaries that were mentioned just within this narrative are time keeping, availability, and confidentiality, situating those challenges as arising from deaf clients’ experience of the hearing world. When P5 speaks about deaf clients wanting more flexibility, she utilises the pronoun “us”, which might suggest that this is a shared view of fellow MHP (polyphony). She uses the metaphor of “that card” to possibly emphasise how deaf clients relate to hearing people (or herself in this context), and how she as a therapist, has to set boundaries constantly, which she appraises as time consuming.
"the awareness is there, I think there’s a lack of access”

I asked P5 to share any interest in SJ, and she responds by referring to equality, and accessibility. She appears critical of how DMH is promoted:

…And I said it’s like with equality a lot of the time, people think that they, they’re providing that access for deaf people with mental health. And you know they’re all like “we have this, we have that”. And it’s like really big at one time and it comes in waves. But then everything is quiet nothing really happens…Umm, so I think the support is out there, is just kind of pushing it a bit more. (473-480)

She adds:

…I think the awareness is there, I think there’s a lack of access…I think it’s just a thought, but there’s not a lot of action. (494-5)

P5 states that there is mental health support for deaf people but acknowledges that it needs more “pushing” which I understand as promoting. She speaks of those people that “think they are providing” as the outsiders, based on the pronoun “they”. She concludes that accessibility requires action and speaks of it as one step ahead of Deaf awareness.

Regarding therapists’ skills and knowledge, P5 said:

umm (pause) I think (brief pause), at least level six. Go up to level six, the highest level because if you’re, you can then adjust your register to see someone who’s at lower level in sign language…As long as you’re comfortable doing it, then do it’…cause you’re not interpreting, you’re counselling. And I think it would be nice to have training for deaf and hearing therapists who work with deaf children and young adults, cause there’s a lot of deaf adult training, but not a lot of children and young people… (542-550)

It is interesting that she claims a distinction between counselling and interpreting and taking into consideration what appeared to be a worry in delivering BSL therapy when she first started,
as narrated earlier on, she possibly speaks through this experience as she came to realise this difference.

In conclusion, P5 spoke about the constructive element of learning BSL as a teenager, and her sense of identifying as a deaf counsellor. She narrated extensively on how she experiences deaf clients relating differently regarding boundaries (time, confidentiality, privacy) and how she responds by becoming more explicit. Nevertheless, she described herself as being more patient with deaf clients, and also spoke about affiliating with the Deaf community in terms of being more assertive as a person. She considers speaking BSL to the highest level as necessary to become a deaf counsellor but calls attention to counselling as separate to interpreting. Finally, she highlights a gap in training to work with deaf CYP.
5.2.6. Participant 6

Participant 6 (P6) identifies as a clinical psychologist who at the time of the interview was working as a BSL interpreter. During his practice as a clinical psychologist, he gained experience in working with deaf adults in clinical settings as well as deaf children in educational settings. Our interview was conducted online, and some questions and topics were sent to P6 prior to our interview for his consideration. Our communication was good, with no signal interruptions or intentional breaks.

“So, it was part of the qualification for me, by choice”

P6 identifies primarily as a clinical psychologist, as he is an interpreter for “now” (6), which might suggest a secondary professional identity. Nevertheless, his interest in deafness preceded his interest in psychology as “I became a psychologist in order to work with deaf people” (20). He explained that he learnt sign language whilst undertaking his psychology degree.

I asked P6 to speak about whether he had d/Deaf relevant training:

not formally, no. but, I suppose my clinical psychology doctoral training course, did give me the space to research and train myself, as far as you can do that. So, one of my placements…where I was getting supervision and learning things there. And also doing a literature review and writing essays…so, it was part of the qualification for me, by choice. Umm and then, just by working in the service, what I had was a deaf member of staff as a buddy…So it’s nice little fine ground cultural things, which is sort of specialised DMH awareness training on the job, but there was no formal…because there’s no such qualification for it, then. (497-513)

P6 refers to historical dimensions of DMH training and appears to claim a development in specialist training through the existence of DMH awareness now. He speaks of undertaking placements with d/Deaf clients, accessing supervision and d/Deaf colleagues, as well as engaging in literature reviewing and writing as the sources of his knowledge, and therefore, his training “by choice”, which further conveys his agency. He refers to those experiences – sources of information as “nice little fine ground cultural things” which possibly indicates the
significance of those – separate but when come together, powerful – experiences in getting to learn about deaf people.

“BSL therapy is...the vehicle for more effective, therapeutic change”

I prompted P6 to speak about the differences between practising with deaf and hearing clients which he appraised as a “huge” (79) topic:

I suppose one of the main differences would be that deaf people because of access tend to have more outstanding problems by the time they get to services...basically because there’s many more therapists for hearing people and the waiting list is shorter...because...often, historically communication has been bad...(85-93)

The first, and one of the main, differences he speaks about barriers in service accessibility which causes more significant mental health difficulties. He appears to suggest that deaf people suffer for longer before being able to access a professional with whom they can effectively communicate. Nevertheless, he does not narrate on how the “outstanding problems” affect his psychological work, suggesting a gap in his story.

Another difference he identifies is a “technical” (102) one, the use of the empty chair technique:

…and that’s weird to hearing people to do, and because it’s weird it feels like a thing, yeah, to teach a hearing person to do this...it works with deaf people as well but it’s much less of a thing because it’s basically the same as how BSL works...So on the one hand, deaf people are so accustomed to that and there is nothing new, so they just wanna do it straight away, but on the other hand it’s not a new, different and interesting thing so it may have less of an impact, it’s kind of an interesting mixed, mixed bag I think. (104-115)

He talks of the empty chair technique and states that it might not have the desired therapeutic impact as it is similar to BSL and therefore, not new, which might suggest that the empty chair technique does not require deaf people to adjust how the think and use language visually.
Interestingly, P6 is the only participant who refers to the implications of research and therapy-specific tools to deaf counselling:

So, they are not great guidelines for doing say, CBT in BSL, in so far as one can do CBT in BSL or whatever the model of therapy it might be. Umm so (brief pause), hearing therapies are (brief pause) better set-up…Umm, and it’s written in a language that they understand natively, because they’re mostly English native speakers reading English journals about hearing people, about hearing English-speaking patients so, everything is relevant. Umm, whereas, even the best deaf research, umm, you have to define your deaf group which already is basically impossible cause there’s no point researching everybody with any sort of level and type of d/Deafness because that’s such a massive group of people and they’re all different…(378-389)

In the extract above, P6 compares the accessibility of research and guidelines for “hearing therapists” (therapists working with hearing people) and claims that accessing and conducting research about d/Deaf counselling is “impossible”. He speaks of guidelines and research as not relevant to his clientele, and by repeating “English”, he emphasises the language as what makes it inaccessible. However, when he speaks about readers being natively English speakers, it is unclear if he refers to deaf therapists, hearing therapists or both. By the statement that “hearing therapists are better set-up”, he seems to suggest that maintaining professional standards as a psychologist working with deaf people is burdensome.

He concluded his interview by claiming the superiority of BSL as a therapeutic medium:

…I’d quite like to say that I think BSL is a really good, effective language to have therapy in, or to undertake therapy in. Because (brief pause), because spoken English is a thin sheet. You can hide behind a stream of words, you can kid yourself that what you mean to say is this and in fact, is something else. And because BSL is three-dimensional and happens in time…is all there. Umm, you can really properly, I think, that’s why I love it, more effectively express what you’re trying to express…so, I think that’s why face-to-face BSL therapy is so great and the vehicle for more effective, therapeutic change, rather than speaking therapy or therapy through an interpreter. Cause obviously going through an interpreter, they’re having the amount of therapeutic experience, but the therapist isn’t so he’s not having it. (646-682)
He expresses “love” about BSL and appears to resonate with the ‘particularities’ of BSL, as to how up-front and expressive he wants to be in communicating with others, including clients. This exceeds the professional identity and indicates a personal stance. A second statement is about the effectiveness of therapy being achieved when it happens face-to-face and directly in BSL. He speaks of interpreters as allowing the “therapeutic experience” for the d/Deaf clients, and he, hence, approaches the presence of interpreters as beneficial for the client, but not the therapist, which is a different stance than those taken by other participants.

“Just ask the deaf people”

I asked P6 to talk about the quality of the MHS provided to deaf people:

…I think that umm, (sighs), they’re brilliant in so far as they are much better and more effective than generic hearing services, because generic hearing services, for deaf people, because they don’t have the background, knowledge…Umm only of a hand, I have worried in both places that hearing professionals in deaf services working with deaf patients rest on their laurels a bit, and they feel good about themselves cause they can sign a bit and they might not be very clinically effective…So, there’s a danger for the clinical quality to be unchecked and may be deteriorate, at the time. (414-326)

He makes a clear statement pro deaf services, explaining it is not merely about communication skills, but also about the knowledge to work with deaf people, which in my understanding, could be called Deaf awareness. He uses the metaphor of “rest[ing] on their laurels a bit” to emphasise how hearing professionals are unaware of the need to clinically adapt practice, in addition to learning BSL. This tendency of hearing professionals, he states, can be dangerous as the quality of the services might be unchecked or get worsen.

He identifies an area of development for deaf services:

But the danger with little isolated specialist services is because they are little isolated, it’s very hard to maintain like a kind of national level of quality. (336-7)
He adds:

So, as a deaf specialist trying to maintain a professional standard, it’s easy to be dismissive of everything that’s available to you to maintain your level of expertise cause its often just not relevant. So, you have to kind of maintain your own…and so all these little services become, potentially, weird little places that they’re doing it their own way, and they’re getting an expert, not an expert, an external person come in…and they go ‘what are you doing? Why are you doing it this way and not that way? (343-351)

Here, P6 refers to a lack of robustness and power of deaf services in coming together and represent a coherent and competent national service. He characterises DMHS as “potentially, weird little places”, and a lack of communication could be conveyed as they are “isolated”. His claimed struggle to maintain a professional standard could be read as in line with his previous claim on research as inaccessible and irrelevant. He speaks of maintaining “your own” professional standards as what “you have to” do, which however, might suggest an arbitrary solution as people who would check on the services’ quality will question “their” practices. He repeats the pronoun “you”, perhaps claiming a shared struggle and identified resolution, amongst DMH practitioners, and does not appear to resonate with the services preferred practices (“their”).

He further makes suggestions for trainees or new therapists who want to work with deaf clients:

(pause) ‘Do it’. What I wouldn’t say, sorry for answering the opposite of the question, but what I would say is don’t do it without a training, cause that would be, that would be terrible!…Just ask the deaf people, generally speaking, and that's the best training you’ll get out. Cause the training you’ll get otherwise, is usually from hearing people that think they know better about d/Deaf people, you really want to ask d/Deaf people. (520-547)

P6 emphasises service users’ inclusion into the decisions of how to work with them, which he evaluates as “the best training”, and which I understand as an endeavour to balance power and change the perception that hearing people know better.
A final area he puts forward for consideration, is his understanding of deaf counselling as a SJ matter:

You are right, I’m naïve to the area of SJ. But I would, my answer is ‘no’ in so far as when I’m somebody’s therapist, I’m not also their advocate, or their legal representation or anything, umm, I’m just a therapist, because the boundaries that we’ve talked about are quite important, wherever you put them. Umm so, I wouldn’t be the agent of SJ to the client…So, all those inequalities, and problems of SJ, are part of the therapy, but not a part of the therapist’s role…So, I think it’s vital, but not a part of the role I think (questioning tone). I think. (605-613)

P6 holds a clear perspective in the beginning of the answer, referring to roles and boundaries, but appears sceptical at the end of it, whilst he summarises his points, as he repeats the phrase ‘I think’ three times. He speaks of deaf counselling as a SJ issue when it comes to theory, and therapy content, but not to action towards social equality and advocacy, since he portrays his primary responsibility to be the therapeutic process of and with the client. Therefore, a distinction between being the role of the therapist and the role of the advocate is made.

P6 narrated about the superiority of BSL in representing communication creatively, and characterised it as the means to effective therapeutic change. He further spoke about the difficulty of therapists who work with deaf clients in maintaining standards of proficiency as research is not relevant or accessible, and he highlighted the lack of communication among services for deaf people, since they do not share quality standards. He distinguishes between being a psychologist and an advocate. He holds a distinctive understanding of the link between SJ and deaf counselling, as well as of the presence of interpreters as beneficial for clients, but not for therapists.
Participant 7 (P7) identifies as a clinical psychologist. She works for NDCAMHS and identifies as a native BSL speaker. Our interview took place online, and communication was good. It was observed that during the interview P7 was at her workplace, and a colleague could be heard talking briefly, however, there were no interruptions or breaks. Prior to the interview, I emailed her with a few points about what we would discuss.

“BSL is my first language”

P7 was prompted to start by speaking about the language of her sessions:

So, for my individual therapeutic sessions I use BSL umm both with parents and children and young people, and for large meetings where a deaf young person is present, we have an interpreter there. (9-11)

Later on, she adds:

So, in family sessions we’ll definitely have interpreters, but I will usually use BSL, and then I’m voiced over by the interpreter. Umm, yes. But there is something in there about a professional that’s working with deaf kids, being able to communicate in the language that they prefer. I know that’s not always possible, but I think it’s really important. (252-5)

P7 reported that she works directly in BSL in individual sessions, either those are with young people or parents, and through interpreters in family sessions and large meetings. She speaks about how in the family sessions she delivers, the main language is BSL. It is unclear which is the first language in the large meetings. She highlights the importance of working with “deaf kids” in their first language, and appears to be talking to fellow colleagues, informing them what they need to do, or continue doing. The affiliation with her team is apparent by the pronoun “we” used. She also does use first pronouns and shifts from the “we” to the “I” when she speaks about interpreters in family sessions, to communicate her own practice, which confirms her position about the importance of communicating in the clients’ first language.
In terms of her language competency, she explains:

> umm well BSL is my first language, so I’m a child of deaf parents, so I’d always use BSL throughout my life and so it feels quite natural for me to be using it in therapeutic sessions. (24-5)

She identifies as a Child Of Deaf Adult (CODA), which as a very particular position, suggesting language competency as well as from where her interest in deafness derives, and therefore, no further questions were asked about those two areas.

> “trial and error”

Despite working in BSL feeling “quite natural” (24) for P7, she narrates about particularities of BSL sessions:

> well for me it’s about a cultural, thing, it’s to do with the language, it’s to do with the type of difficulties that young people present with so by the time a young person and their family get to be, … they’ve got significant emotional and psychological problems…but there’s not a lot of that around for deaf children. (35-41)

In speaking about differences in working with deaf “kids”, P7 identifies three aspects; “a cultural thing”, “language”, and the “type of difficulties” they present with, which she associates with the lack of mental health support in lower steps of care. She uses the pronoun “my” which suggests a sense of affiliation with the setting she is working at.

She expands on attunement, and she identifies the consequence of its absence between parents (hearing or deaf) and deaf children, for deaf children, and for her work:

> Cause that’s mostly what we struggle with, or what they struggle with, is they don’t have the vocabulary…they don’t have the links between what is this feeling, what’s that thought, what do I do with it, how do I then manage it…It’s more of an emotional-based approach, than a thinking-based approach…They don’t get access to the emotional talk that hearing kids get, they respond to emotional triggers differently to hearing kids. So, we need to keep that in mind when work with deaf kids, cause they’re
different. And so, all I do here is help kids express what they’re feeling, understand what they’re feeling, and therefore, regulate and manage what they’re feeling. That’s what most deaf kids that we see here struggle with, is emotional dysregulation. (224-238)

In the extract above, P7 speaks through her clinical experience, and narrates about deaf children’s difficulty in identifying, expressing, and managing how they feel. She speaks of a lack of “emotional talk” and how that then affects the responses to emotional triggers, comparing with the emotional education of hearing children. She concludes that emotion dysregulation is the most common struggle of the deaf children in her service and identifies an emotional-based approach as the intervention used. Interestingly, she moves from “we” to “they” when she refers to struggles, which might suggest a sense of a shared challenge between clinicians and clients, and which could be understood as attunement to the clients’ experiences and identified needs.

One last challenge she speaks about, is adapting her sessions to fit the needs of deaf children, which she appraises as “tricky” and “tiring”:

Umm, I think more of the challenge for me, is having to adapt all of the therapeutic interventions for each child, so that’s the tricky thing. So sometimes, I do dream of getting a manual (soft laughter) a therapeutic manual for deaf children that I could pick up the shelf and go “brilliant! I’ll just do this as it is”. And I think that’s part of a fantasy really, because I don’t think anyone is able to do that, but I do dream of that cause I think “oh my God, if I only had a manual of how to do this and I would have to adapt CBT, or DBT, or MBT, to meet the needs of the child that’s sitting with me”…So that’s a challenge because it’s tiring…(280-290)

She explains that she makes adaptations to the therapeutic interventions for each child she sees, which might suggest that those amendments are not to reflect the use of a different language, but rather, to individual needs, without though specifying them. She continues by speaking about adapting specific interventions (CBT, DBT, MBT), and how she “dreams” about a manual that she could use with deaf children, which might be linked to deaf children’s lack of access to the emotional talk, and therefore, it remains unclear if she adapts to further personal needs, such as developmental conditions.
Expanding from that extract, she gives an example of when she was delivering a manual-based MBT group for deaf children, to highlight her experience of adaptation:

…And I didn’t really think about it too much, cause I was just too excited…and I asked the kids to watch the DVD…And they were like “oh we couldn’t follow it, it was just too hard to follow, there was so much talking in it”. And “of course. How long I’ve been doing this job? ...” … Umm, so that was just a reminder of you know, the challenge really of working with deaf kids…So, in the end it was okay but that’s all trial and error, and that’s all sort of working out and umm yeah. So that for me is the challenge, is the constant adaptation of it, to make it fit, and to make it accessible to deaf kids. (299-316)

She mobilises a personal example to enhance how challenging and tiring adapting an intervention is even when a manual exists. Nevertheless, she states that she was able to find a solution which she evaluates as “okay” and speaks about “trial and error” as possibly inevitable. In the last sentence, she returns to the here and now of her work (coda) to underline that this is still a challenge for her.

“a national strategy for deafness”

P7 states that Tier 2 work is missing for d/Deaf CYP, but when asked how it could be improved, she comes to acknowledge that more services in all tiers are necessary, but funding is an obstacle (Appendix 10, Extract 9). I encourage her to make further suggestions:

I think everybody needs to be working together…it’s about how we as in the deaf world, if you like, we that hold the knowledge about mental health and deafness need to support the schools in understanding how to be with deaf kids, and what deaf kids struggle with, socially and emotionally…but also, we’re tiny, you know, we’re a tiny group of professionals working in this country so, there needs to be some input to the cochlear implant teams, and the medical professions that are diagnosing these babies as deaf…and ideas about preventative type of work. But I don’t know who’s gonna do that and how that could happen…Unlike the things, you know, abroad…in Finland and in Holland, they’ve got a different, or they used to have a different system where they have teams around the child much earlier on…because they insisted that deaf parents have better communication with their children…So, there’s much more work done at
the early stages, whereas us, it’s all fragmented, and there’s bits here and bits there and, you know, they might sort of only where it gets really serious, do they end up with us, cause it’s nothing earlier on, except for the charity based stuff. (321-339)

She narrates about the need for collaboration between all the services for deaf children, including schools, the cochlear implant teams, as well as the medical professions. She identifies the role of “we that hold the knowledge about mental health and deafness” in educating the above-mentioned professionals, but at the same time she acknowledges the small size of the group of those professionals, leaving a pessimistic tone. Additionally, she comes back to preventative work, and she once again, speaks of obstacles to the implementation of this work, but does not seem to name those obstacles. By referring to how professionals work with deaf children in Finland and Holland, she comes back to her initial point about family communication, but actually concludes with the “fragmented” communication between services in the UK. It is interesting how P7 speaks about lack of communication between parents and deaf children, as a factor that influences mental health, and at the same time, she speaks about lack of communication and coordination between MHS, as a factor that maintains or does not prevent those mental health difficulties. Furthermore, she expresses negativity about BPS’ work (Appendix 10, Extract 10).

I prompt her to speak about SJ:

…I mean when you say SJ, I think of oppression and discrimination, and so obviously that features very much when you’re working with deaf people because that’s their life, mostly, and let alone coming into question, you know, race, culture, ethnicity…Umm, I think it’s their lived experience isn’t it?...Umm and if you think about what psychology is sort of moving into now, with the whole power threat meaning framework, that is quite nicely, cause that’s about using a trauma-based model to understand psychological problems. (438-446)

P7 speaks of her understanding of SJ by referring to oppression and discrimination, and states that it is relevant to deaf counselling, as oppression and discrimination are “their life, mostly” and “their lived experience”. Interestingly, she refers to the power threat meaning framework which is a document published by the Division of Clinical Psychology of the British Psychological Society, in 2018, and which speaks about the “assumption” (p. 8) that emotional
distress and unhealthy behavioural responses are the result of “social and relational adversities and their cultural and ideological meanings” (p. 8). It, therefore, suggests an understanding of mental health difficulties as threat responses essential to our survival, “as an alternative to psychiatric diagnosis and clarification” (p. 5). Hence, further refers to other positionalities of deaf people other than hearing ability, it what appears a claim that they might face additional forms of oppression.

Lastly, I encourage her to specifically suggest best practices for MHP. Apart from BSL skills and Deaf awareness, she spoke about acknowledging “your” language limitations:

…knowing your limitations really in language and not being afraid to ask for support because you really do need to understand what the child is trying to communicate to you. (489-490)

Acknowledging the limitation to practice constitutes part of practitioner psychologists’ ethical responsibility, according to HCPC (2015). The pronoun “your” seems to serve as a generalisation and normalisation of having limits in practice.

In conclusion, P7 referred to her position as a CODA to speak about her interest in DMH, knowledge of BSL, and Deaf awareness. She narrated about the lack of community support for deaf children, problems with attunement and attachment between parents and deaf CYP, as well as about the lack of emotional education. She spoke of this as a challenge both for the children and herself as a psychologist. She further spoke about the inapplicability of therapeutic manuals and specifically referred to CBT, and MBT, using personal examples. She identified lack of attunement between MHS for deaf children too, and highlighted the importance of communication between them, to ensure a national strategy. Lastly, she referred to oppression and discrimination as causing traumatic experience for deaf people.
5.2.8. Participant 8

Participant 8 (P8) identifies as a clinical psychologist and has been working with NDCAMHS for nearly 10 years. Our interview was online, and communication was good, but we faced some connection troubles and we had to reconnect. The interview guide had been sent prior to the interview. The interview began in a less structured way, following a casual discussion on the outline of NDCAMHS over England, and P8 referred to equality of access, to justify NDCAMHS’ development. Despite that fluidity, I here follow the interview guide structure to keep consistency with the rest of the accounts.

“I’m not deaf and I’m not part of the Deaf culture”

P8 states that she has a lot of clinical experience in working with deaf people, but does not affiliate with the Deaf community:

I have a lot of experience in working with deaf people and deaf culture, I’m level 6 BSL but I’m not deaf and I’m not part of the Deaf culture. (339-340)

This statement suggests a distinction between experience and lived experience, where she identifies the lack of the lived experience for her.

I prompted her to speak about her BSL skills, and she explains how she uses the language:

…if I’m working clinically, I always work with an interpreter…I use it as an engagement tool but it’s not, but it’s not my, I don’t use it as my language…Because even though I’m level 6, my sign language is just not good enough. Also, it’s not flexible enough to be able to adjust my register. Umm and also, if I’m thinking about being a psychologist, and I’m thinking about the word (indistinct-connection trouble) … can’t also think about working in a second language. Umm, I think that’s really difficult so, umm unless you’re fluent in the language, I think it’s really hard, so. (42-50)

P8 states that delivering therapy in a second language would interfere with her psychological thinking. She appears to generalise that difficulty, as she uses the pronoun “you”, stepping
outside of her own experience, and concludes that language fluency is required to practice in a second language. This statement might be read as contradictory to her being ‘technically’ fluent since she is trained to the highest level and might suggests that she does not consider BSL training as rendering her fluent.

In terms of specific training in working with interpreters, she states:

  Umm, our service will provide training on working with interpreters, through our team interpreters, so when I first started…but not anything more than a couple of hours. I think it’s more being about learning and immersion. (78-82)

She adds:

  …I think that my knowledge has come through experience and immersion as much as being taught anything so. (95-6)

P8 states that she received training in working with interpreters when she first joined NDCAMHS which she appraised as short. She then adds that another source of her knowledge was her clinical experience and immersion, but it appears unclear which source of knowledge she evaluates as most significant, if any. She appears to affiliate with her organisation, reflected in the pronoun “our” she utilises.

“the challenges lie more in our culture”

I invited her to speak about her work, enquiring specifically about her experience of the possible presence of others such as interpreters and parents:

  …interestingly now, I don’t think about it so much because it’s more common for me to work with an interpreter than without, often…you have to trust the interpreter that you’re working with….Umm, I think is a different, (brief pause) there’re a couple of different dynamics, depending on your fluency in BSL…so I can access what that young person is saying to me, but the interpreter will always voice over…but I’ve not always been level 6 BSL, so I think then you have to trust the interpreter. (104-124)
Interestingly, P8 answers one part of my question; working with interpreters, distinguishing between her current and past experience of it. She narrates about the shift in her sense of trust on interpreters and locates that to her fluency in BSL and associated ability to understand what the client is communicating, without having to depend on the interpreter. In that sense, it appears unclear if her sense of trust was developed because it became more “common” or because of her BSL skills. She shifts positions, using the second pronoun to advice colleagues about the need to trust interpreters, she then uses the first pronoun to speak about how her sessions work, and concludes with the second pronoun again, repeating her initial advice.

She expands on her view about working with interpreters:

But the main thing for me is how you set communication at the start of the therapeutic intervention; it’s not a barrier if you set it up well umm and if you have a good interpreter cause that’s the other thing you know, it’s really important to have a good interpreter. In fact, it’s far, it’s the opposite to being a barrier…so I think interpretation opens doors…But I don’t find it a barrier anymore. Umm I think the only barrier that I found at the beginning, was that I just wasn’t used to it, the third person in the room. But it feels much natural now. (124-138)

She introduces the words/sentences “barrier”, “opens doors” and “natural” to highlight once more the shift in her experience of working with interpreters, from a barrier to a process that allows communication. She further identifies that having a third person in the room felt unnatural which made it a barrier for her. She, however, says that having interpreters is not a barrier only “if” “you” set the communication right at the beginning, and therefore, suggesting that it is an action she took herself, considering that she speaks of it as not a barrier “anymore”. Hence, in the previous and current extracts, she speaks about i) her BSL fluency, ii) setting the communication with the interpreter, iii) having a good interpreter, and iv) being exposed to this different therapeutic setting, as factors that have influenced her experience of working with interpreters.

I asked P8 to speak about any challenges in working with NDCAMHS:

Massively…because we’re multicultural, multilingual. Umm I think that can often cause communication breakdown, umm tensions, umm (brief pause) about power,
there’s often a lot of under tense of how are dynamics, deaf people have historically been very umm ostracised and have not held sort of more senior job roles umm…So, I think they can sometimes when emotions are high and that can sometimes bring feelings in teams. I think hearing clinicians or hearing people don’t often understand if they’re not familiar with working with deaf people, they don’t understand umm BSL, Deaf culture and that’s really problematic… (220-229)

The first challenge she refers to has to do with group dynamics within multicultural and multilingual teams of hearing and deaf professionals. She locates those power dynamics and tensions in the history of deaf people having been “ostracised”, and how hearing people still (she uses present tense) are not familiar with the Deaf culture and BSL, which she appraises as “problematic”. It is interesting how even though she is hearing herself, she refers to those hearing people as “they”, which suggests that she does not consider herself as being part of this group.

She further identifies two more challenges, related to the client group:

…similar challenges, that are communication, miscommunication umm, often the challenges aren’t to do with the deaf young people themselves, it’s to do with the system supporting them…it’s about schools and families and the environment don’t support that young person in the way that they need to be…Having said that, the challenges in terms of therapy, are about adapting therapeutic interventions. You can't just pick up a, you know, CBT manual and deliver CBT. You can't pick up a cognitive assessment and assess a child using a cognitive assessment because it’s not valid on a deaf child. A lot of the WISC for example has lots of language questions which disadvantage deaf children. So, in assessments and in interventions you have to be creative and you have to be, you have to work harder to think about that assessment and the intervention for the deaf person. So…challenges lie more in our culture than they do in the deaf person. (231-249)

She speaks of “similar challenges” and hence, parallels the miscommunication within her team, with the work with deaf children. However, she explains that “often” those challenges are due to the supportive system of the clients, and more specifically, schools and families, without expanding on this issue. The word “often” might suggest that there are difficulties related to
working with deaf children per se, but those are not the main ones. She speaks about the
difficulty in delivering assessment and interventions that are valid and relevant to deaf children
and generalises this experience since she is utilises the second pronoun. The resolution she
identifies is being creative and flexible. Finally, she summarises with a strong statement, that
“challenges lie more in our culture than they do in the deaf person”, which suggests an in-
group/out-group positioning accompanied by responsibilities.

“people with the lived experience”

After a discussion about SJ, P8 spoke about “equality and diversity” in the profession of
psychology as limited by the professions’ academic and financial requirements for doctoral
degrees (Appendix 10, Extract 11). She links that to an area of development:

…you can have a deep understanding of something, but you cannot ever be truly part
of something if you aren’t, so, I will never be deaf. So, I will never, ever have that
experience. Which is part of the reason we work with deaf people in our service,
because they bring the experience. I don’t think that means you can't say that you have
an understanding or a deep understanding, but I think it’s important that they’re people
with the lived experience, in order to guide an influence and learn from, within our
profession, and within our services. And that also promotes equality and diversity.
(348-354)

Even though she bases her response on my definition of SJ, she appears to broaden SJ to
clinicians’ lived experience, rather than knowledge and skills in working with deaf people. In
that way, she identifies social injustice at the core of the profession, suggesting that changes
need to happen as for who enters the profession, for justice to be achieved. She refers to her
hearing identity and lack of lived experience, which might suggest a sense of powerlessness in
doing justice, because of who she is; hearing. In support of the lack of diversity and equality
in the profession, she towards the end of the interview when I asked how she would like to be
identified in this study, she quite sarcastically said:

…I am one of those terrible people that fall into the majority of clinical psychologists.
(448)
By that, I infer, she meant white, British, female, middle-classed, heterosexual and cisgender.
I further prompt her to speak about BPS’ role, for which she expresses negativity and refers to “cracks in the BPS” (281) (Appendix 10, Extract 12).

On a final note, I encouraged her to make suggestions to therapists or trainee therapists who want to work with deaf people, BSL users, or interpreters:

(brief pause) first point of call is to learn BSL from a deaf person…Umm, going to Deaf clubs umm although, that could be quite daunting as a hearing person if you’ve got no connection…Reading blogs…reading things about the Deaf culture and Deaf community umm…So, I think not immersing yourself in all of it but educating yourself about the history and culture to a certain extent…And then if you’re a trainee, I would be looking for placements if possible… (370-383)

P8 distinguishes between educating and immersing in Deaf culture, and states that educating is necessary.

P8 highlighted the distinction between experience and lived experience, and clarified that she positions herself as hearing, not part of the Deaf community, and having English as her first language. She extensively narrated about the need for diversity and equality in the profession of psychology, which can be achieved by including people with the lived experience. She appears to greatly use herself in her narrative, speaking of an awareness of roles and how they influence power dynamics and her work with her clients. She also spoke about power dynamics and hearing/deaf status within her team and appraised that as a challenge. She advises psychologists interested in deaf counselling not to immerse themselves in Deaf culture, but certainly to educate themselves.

5.3. Accounts’ synthesis

I here briefly bring together the eight participants’ narratives in the three areas of interest of this study.
5.3.1. Specialist training

Five participants identify as clinical psychologists, one as a counsellor, one as a psychotherapist, and one as a family therapist. All of them position themselves as hearing which was an eligibility criterion for the study. However, three of them identify as growing up in both the hearing culture and the Deaf culture, for instance, through Deaf clubs, and one of those three also identifies as CODA. One participant, even though they don’t state growing up in the Deaf community, claims to share a sense of belonging in it, while the remaining two distance themselves from the lived experience of being deaf. Half of the participants reported working with NDCAMHS, three of them reported working with adults, whereas one reported having worked with both populations.

Only two stated that they have received training in working with interpreters, either during their studies (focusing on language interpreters) or through their services, which were however, brief or informal. None of them identified specific Deaf awareness training, but they were all able to name their source of knowledge about deafness, DMH, and/or Deaf culture; those sources were personal encounters with deaf family members, specific masters’ degrees, through deaf colleagues, hearing supervisors, or interpreters, through teaching others, attending Deaf clubs, and accessing relevant websites.

Additionally, six said they are trained to level 6 BSL, which is the highest level, but one of them shared a preference in working in spoken English through BSL interpreters. Three participants spoke of choosing to always work with interpreters, two of which stated to be trained to Level 2 and one to Level 6. Two participants talked of working with interpreters only on specific occasions, such as group settings, clients’ additional mental health needs, and non-BSL users present in the session. The remaining three participants have never worked with BSL interpreters before, or only once or twice.

5.3.2. Professional experiences

All eight participants identified challenges in working within DMH; six of them talked about therapy-related difficulties, but all of them talked about context-related difficulties, including access and provision limitations. Therapy-specific difficulties had to do with: i) cultural differences and the need to adapt practice, ii) clients’ reactions to hearing therapists, iii)
maintaining roles and boundaries with deaf clients, iv) the difference in how deaf clients reach out to therapists and how therapists respond, v) how therapists use (and need to adapt) metaphors, therapeutic manuals, and assessment tools, and finally vi) gaps in clients’ education and therefore the adaptation of preparing and delivering therapy. Context-specific challenges had to do with i) working with interpreters, other organisations and its personnel, and within multicultural teams consisted of both hearing and deaf colleagues ii) role boundaries and expectations from colleagues, iii) lack of deaf education DMH provision, iv) conducting and accessing relevant research, and v) making and receiving appropriate referrals.

Out of the three participants who stated always working with BSL interpreters, one appraised this collaboration as negative, one as overall positive but highlighted some negative points about dynamics, and the third one expressed mixed views, identifying a shift from negative to positive through the years of their practice. Four of the remaining participants who reported not usually working with BSL interpreters, appraised it as negative, or having negative aspects; interestingly, two of them being interpreters themselves either at the time of the interview or at some earlier point during their lives. One participant did not express views on working with interpreters. Overall, the majority of participants appraise working with interpreters as challenging in terms of relationship dynamics, and confidentiality.

5.3.3. Emerging Recommendations

All participants suggested, either explicitly or implicitly, a high BSL level and knowledge of the Deaf culture, as best practices with BSL users. Other suggestions included being transparent and reflect on practice, work only with qualified interpreters, or work directly in BSL, have the right motives, access appropriate supervision, involve d/Deaf colleagues and ask for support, always involve d/Deaf clients in decision making, and educate ourselves about DMH and relevant news.

Despite not all participants claiming familiarity with the term SJ, they all reported identifying a link of SJ to DMH. Nevertheless, only six referred to being involved in SJ practices and either explicitly or implicitly, considered themselves as SJ agents. To justify their SJ positions, participants referred to the following practices: liaising with professionals and advocating for
deaf clients, empowering clients, providing Deaf awareness training, making therapy accessible by speaking BSL, and working through a trauma or linguistic and culture minority model. All the participants who were asked about the BPS, expressed lack of trust and disappointment in it. They expressed mixed opinions on the current MHS provided, and they were all able to identify what needs to change for those services to improve. This is further explored in the next chapter.
Chapter 6: Discussion

6.1. Overview

In this chapter, I discuss the meaning of this study based on the participants’ accounts and their interpretation, and I locate this discussion in the current literature on DMH, multiculturalism and SJ. I make reference to the areas of interest of this study (training; professional experiences; perspectives on current service provision and recommendations for improved practice) in order to respond to the two RQ. Following that, I address the limitations of this study, I recommend where future research could move to, and I address the contribution to, and implications for, counselling psychology and beyond.

6.2. Summary of findings

I here present the main claims of the study. Those claims go beyond the interview guide and DMH, and hence, I consider wider social implications of deafness as they have been constructed based on participants’ accounts.

6.2.1. Informal opportunities to educate themselves and personal initiation

None of the participants reported receiving Deaf awareness training as a discrete, formal process either through their working places where applicable, or a private provider. This finding concurs with studies which suggest that 61% of UK-based qualified and unqualified MHP were not trained in working within DMH (Bartlett, 2017). Thomas and colleagues (2006) found that UK-based non-specialist mental health staff felt deskilled in working with d/Deaf people, due to lack of Deaf awareness, not knowing how to work with interpreters, and not having BSL skills. Furthermore, studies on multicultural training found that both university predoctoral and doctoral clinical psychology students and academics would benefit from further multicultural components in their professional training curriculums (Geerlings et al., 2017), as well as SJ advocacy that exceeds theoretical input (Collins et al., 2015). Pieterse and colleagues (2009), examining masters and doctoral counselling and counselling psychology
syllabi from all over the US, found that only 29% contained statements about training students on working with people with disabilities, and only 7% on ableism. Another study found that most doctoral programmes included multicultural input (and more specifically, sexuality training) but that counselling psychology programmes had significantly higher input compared to clinical ones (Sherry et al., 2005). The finding is also in agreement with research claiming that BSL users in Scotland identified an absence of Deaf awareness within health and MHS, with clinicians being perceived as not knowing what to expect and what to do, and what “Deaf issues” (p. 15) clients might face (BDA, 2012). It is unclear if those experiences refer to specialist DMHS or mainstream ones, but given the very recent development of the only NHS deaf service in Scotland, it is possible that those experiences refer to mainstream MHS.

Unlike the lack of Deaf awareness reported by mainstream MHP (Barlett 2017; Thomas et al., 2006), and despite participants of this study reporting not having received formal Deaf awareness training, all participants (as specialists) were able to identify their sources of learning about deafness, as follows: personal encounters with deaf family members, deaf colleagues, hearing supervisors or interpreters, specialised educational courses on deafness, through teaching others, accessing and conducting relevant research, attending deaf clubs, and accessing relevant websites. Importantly, educating themselves was sometimes their initiation. This is in agreement with Leigh et al.’s (2004) study of which participants (despite participants’ identified disability status) indicated ‘personal experience with people with disabilities’, rather than training, as the main success factor in their work.

Whilst the importance of Deaf awareness is established in DMH (e.g., BPS, 2017) and as part of multicultural competency (e.g. Sue et al., 1992), a question arises regarding the necessity of formal, institutional training on Deaf awareness. Glickman & Harvey (2008) claim that therapists should have specialised training in working with d/Deaf clients and holds the view that conversations on how to qualify clinicians in DMH are inevitable. Nevertheless, Leigh and colleagues (2004) found that training was not the main source of successful practice, but experience with clients was. In support of that, participants in the present study who were personally involved with deafness, were assumed to be Deaf aware by lived experience and I did not necessarily ask whether they received Deaf awareness training. Clinicians might potentially have different training needs depending on their professional and lived experience of deafness, and Glickman and Harvey’s (2008) suggestion of specialised training might be better understood as flexible and contextual. Sivanandan (1985), has criticised race awareness
training as unsuccessful, due to racism being authorised by the State, rather than individual attitudes. More recent literature has further criticised the effectiveness of diversity training emphasising ‘unconscious bias’, characterising it as a “quick fix” (p. 206) and claiming that no evidence of changing our behaviour due to knowing about biases exist (Noon, 2018). Thus, this study suggests that self-perceived development of awareness and knowledge of DMH can be achieved through multiple professional or personal experiences, other than formal training, and it prompts to a more flexible training, considering personal circumstances and needs.

Only two participants reported receiving working with interpreters training either through their institutions or working environments. Both participants reported working regularly with interpreters. A third participant who works regularly with interpreters, reported not receiving such a training due to being qualified when oralism was imposed. This finding is in accordance with studies which found that psychologists do not typically receive training in working with interpreters (Frandsen et al., 2019; D’Alba, 2020), with training in working with sign language interpreters possibly being even less common (e.g., Barlett, 2017; Thomas et al., 2006). Interestingly, both groups of participants in Leigh et al.’s study (2004) reported having particular difficulty in supporting service users with hearing loss, but not in supporting clients with any other type of disabilities as defined by the Americans with Disabilities Act, with the researchers stating that this might be due to the reported lack of access to sign language interpreters, with no reference, however, to their knowledge in working with interpreters. Both participants of the present study who had received training in working with interpreters, expressed mainly positive attitudes towards this collaboration, with the participant who had not received training reporting significant challenges in that area. Nevertheless, this participant’s narrative focused on interpreters’ behaviour (confidentiality, role boundaries) so that conclusions about the relation between training in working with interpreters and experiences of that cannot be drawn.

Unlike the lack of Deaf awareness training, and the limited training in working with interpreters, all participants reported having undertaken BSL training, two of them being trained to Level 2, and six of them to Level 6. It, therefore, appears that BSL knowledge is emphasised amongst deaf specialists-participants. This responds to research claiming that BSL users wish to access health and MHS in their first language, assuming that clinicians would know more about Deaf culture (Gill & Fox, 2012), and reporting being satisfied with the specialist services received, mainly due to the clinicians utilising BSL (Beresford et al., 2008).
Participants in this study who were prompted to speak about additional training, reported that they would not consider additional training on DMH because i) it would not solve their problems, ii) they felt confident and competent enough in their area, and iii) they lacked time within the NHS. This finding is in agreement with Leigh and her colleagues’ (2004) study where the majority of non-disabled psychologists reported that no additional support in serving clients with disability was needed. This study does not attempt to parallel the participants’ perspectives with those of the non-disabled participants of Leigh et al.’s study as, even though all participants are hearing, some reported identifying with both hearing and Deaf cultures, and therefore, making such parallels might be unfortunate. Nevertheless, participants of both the current and Leigh et al.’s study are considered specialists in their areas, which possibly justifies a reported lack of need for additional training.

The majority of the participants who were prompted to speak about the current mental health professionals’ training in deafness, narrated about the lack of a standardised and applicable training for clinical psychologists and counsellors (as those were their areas), which is not a priority not only of training institutions but also registration bodies and MHS. One participant emphasised that there is a greater lack in working with deaf CYP training, which might be better understood in context of the participant’s geographical location, and more specifically, the lack of NDCAMHS in Scotland. Furthermore, participants referred to a gap in working with interpreters training which is further in line with existing literature (e.g., Costa, 2016). Lastly, one spoke of clinical psychology not providing training on working with cultural minorities, and of (prospective) financial and academic requirements for counselling and clinical psychology as a barrier to diversity and equality. Research reports mixed findings about psychologists’ multicultural competence, with some studies from the US suggesting that psychologists are trained to be multiculturally competent, and they report feeling satisfied with their level of knowledge and skills (e.g., Benuto et al., 2019), whereas elsewhere is reported that both clinical psychology doctoral and predoctoral students as well as academics request further cultural competence training (Geerlings et al., 2017).

6.2.2. Historical societal oppression and relationship dynamics

Not surprisingly, most of Sue et al.’s (1992) multicultural competence areas were discussed by this study’s participants, reflecting how those attitudes, knowledge, and skills are present and
needed in DMH. More specifically, participants spoke about the interplay between their own hearing status and that of their clients, knowing when to ask for support in communicating in BSL (recognising the limits of competency and expertise), the value of BSL, the need for transparently discussing power dynamics, seeking specialist training in DMH or seeking to learn through other sources, acknowledging their negative reactions to boundaries shifting without judging such practice, understanding discrimination of d/Deaf people on the societal level, familiarising themselves with DMH research, working to eliminate bias, prejudice and discrimination, and acknowledging cultural aspects of Deaf people. Expanding on those multicultural aspects, participants further discussed social and political dimensions of DMH and more specifically, the historical oppression from hearing to deaf people as being manifested in therapeutic encounters, and an existing lack of Deaf awareness amongst hearing people as further impacting practice.

Participants stated that clients share negative feelings towards hearing people, resulting in therapists having to “swallow” this and reminding clients that they are hearing themselves. They further spoke about how clients might refuse to work with them because they are hearing, and deaf clients assume them not to be able to support them, or they had negative experiences with hearing professionals before. Both situations appear to originate from historical oppression from hearing to deaf people which creates feelings towards each other. Interestingly, relationship dynamics also being influenced by hearing positions were further reported, between hearing and deaf colleagues, which derive from societal oppression resulting in “feelings” in teams. This is line with reported struggles in multicultural settings, both within mental health (Constantine et al., 2004) as well as outside mental health (Howland, 2008). Literature confirms this historical impression, for instance, through promoting audism and actually banding the use of sign language (Lane, 1999; Ziebart, 2016). Some participants spoke about the importance of being reflexive and acknowledging own possible power position due to hearing ability, or how clients (and deaf colleagues) might feel and relate to them because of their hearing position. They added that they seek to discuss how their hearing position might influence the therapeutic relationship, as well as prior experiences with hearing professionals. Those actions reflect the ‘client advocacy’ domain of the ACA model (Lewis et al., 2003).

Another example of how societal oppression manifests in mental health sessions, is clients’ tendency to copy therapists’ signs without the internal understanding of what they mean, which participants explained by referring to deaf people being used to hearing people telling them what to do, but also “missing stuff”, that I understand as gaps in their education. Literature
confirms that some deaf people do agree with statements in psychological assessments, without necessarily understanding the statements, due to lack of education, and proposes that in those instances a preparatory class prior to evaluation and intervention might be beneficial (Vernon & Miller, 2001). The danger of that is misdiagnoses, lack of appropriate support, and deterioration of one’s perceived inferior status. As a result, participants explained how they become less directive, giving space to clients to explain themselves in their own signs, which they characterised as very powerful for d/Deaf people. This further concurs with literature claiming that many deaf people have limited knowledge of their rights and do not advocate for themselves (Steinberg et al., 2006). Participants also spoke about acknowledging oppressing behaviours by hearing to Deaf people and stated that they adapt the cultural and linguistic minority approach (Glickman & Gulati, 2003) (e.g., promoting a healthy stance towards their Deaf position), encouraging clients to kick “back against the oppressor”. This is also an advocacy skill, and it more specifically comes under empowering clients.

6.2.3. Lack of Deaf awareness in the wider population: Educating others and advocacy

In DMH, challenges and obstacles go beyond the therapeutic room, or even MHS. Participants narrated about lack of Deaf awareness of hearing professionals and services who take decisions about deaf people as interfering with the support provided to d/Deaf service users. For instance, participants spoke about receiving inappropriate referrals from mainstream schools about CYP who do not present with mental health difficulties, misinterpreting Deaf culture for disruptive behaviour. They further added that GP staff do not show understanding of, and respect for their role, referring to them as the client’s relative because they can sign, and asking them to translate irrelevant to their role information. As a result of the wider lack of Deaf awareness, d/Deaf clients are treated unfairly, and participants-clinicians often liaise with GPs, other NHS services, social services and schools to explain Deaf culture and clients’ needs, for instance, their right for an interpreter. Those challenges appear to have in common the lack of hearing people’s understanding of d/Deaf individuals’ needs and rights and are in line with d/Deaf individuals’ reported experiences of medical staff lacking Deaf awareness (London assembly - Health committee, 2015; BDA; 2012). Those actions (e.g., explaining Deaf culture) can be considered as client advocacy under the ACA model (Lewis et al., 2003) where therapists advocate on behalf of their clients, through addressing systems, to find solutions to identified
problems. Additionally, the majority of participants identified SJ advocacy as part of their roles and are in line with literature on oppression from hearing services and individuals to d/Deaf people (Lane, 1999; Ziebart, 2016) as well as with the value of such actions within the mental health professions (Vera & Speight, 2003; Tribe & Bell, 2018; Toporek & Suyemoto, 2014).

Finally, participants reported disagreeing with their hearing colleagues’ practices of working with deaf clients without the appropriate training, and of working as interpreters in addition to clinicians. In both cases, no particular implications for the clinicians’ work were discussed, but it was rather an expression of contrasting values and opinions. However, both cases appear to have an ethical consideration of keeping within the scope of practice in the first example, and of boundaries possibly being crossed in the second (HCPC, 2016). This reflection concurs literature suggesting that MHP work with d/Deaf service users without the necessary training (Glickman & Harvey, 2008; Bartlett, 2017; Thomas et al., 2006) and that professional boundaries are conceptualised differently in the Deaf community due to its small size, and therefore, clinicians might have to adapt their practice (Gutman, 2005).

6.2.4. More colleagues present in sessions

Another challenge that characterises DMH is the presence of additional colleagues in sessions, such as d/Deaf colleagues, BSL interpreters, and relay or language interpreters being in sessions, sometimes resulting in four professionals being with one client. This gets even more complex in systemic therapy, where parents and/or a reflexive team might also be there. Participants mentioned that interpreters’ presence interferes with power dynamics and clients’ engagement, especially when clients are CYP, because of therapist and interpreter being two adults and strangers. In that context, deaf clients’ age is an additional consideration for clinicians. Literature on therapy with CYP speaks about this group as lacking power in making choices for themselves, such as seeking mental health support (Prout & Fedewa, 2015). Additionally, some literature suggests that interpreters’ presence interferes with trust from clients to interpreters (Resara et al., 2014). This was not, however, a consistent view among participants, as others reported that deaf people are used to working with interpreters, and it is rather, a facilitator in communication. Participants also spoke of deaf colleagues being in the session as engaging clients as those colleagues are highly specialised.
6.2.5. Mixed views on liaising with interpreters and interpreting services

Related to more colleagues being in sessions, participants expanded on their experiences of working with interpreters. Despite the multiple types of interpreters in DMH (BSL, language, relay), issues faced by participants due to interpreters’ presence match those mentioned in the literature on cross-lingual therapy. For example, the view of a change in relationship dynamics was mentioned by participants, regardless of typically working with interpreters or directly in BSL. Interestingly, all participants who worked directly in BSL observed how clients would maintain eye contact longer, or only, with the interpret. As literature suggests, it is often a risk that interpreters become involved in therapeutic dynamics, in general therapeutic contexts, beyond DMH (Resara et al., 2014; Cornes & Napier, 2005). Moreover, change in the dynamics was attributed by participants to interpreters’ tendency to step outside their roles and explain concepts themselves, or acting as a role model for the deaf child. Cornes and Napier (2004) further suggested that sign language interpreters decline from their traditional roles either because of personal feelings, or cultural norms related to the Deaf culture. Nevertheless, stepping outside their role applies to language interpreters too, as interpreters often use the technique of ‘expansion’, where they will need to explain a term in depth (Vernon & Miller, 2001). It is hence, widely accepted that when an interpreter (language or BSL) enters the therapeutic room, the relationship stops being that of a dyad, which will inevitably change the dynamics (e.g., Tribe & Thompson, 2009). The finding is further in line with literature on the experiences of interpreters in mental health settings (Resara, et al., 2014) who reported that sometimes they do step outside their roles as translators, explore the mental well-being of clients, and albeit rarely, offer emotional support. Despite the challenges, some participants spoke about the benefits of having interpreters in the room and appraised their presence as the means to communicating with the service users. One participant identified interpreters as a source of learning about deafness and characterised them as a “co-therapist”. Literature supports this collaboration, for instance, de Bruin and Brugmans (2006) writing from both professions, spoke about how to achieve a positive collaboration.

Participants spoke about difficulties with interpreting services, referring to a number of challenges that they attributed to interpreting services’ endeavour to minimise costs: not providing interpreters consistently, interpreters not showing up, not informing clinicians about who is coming, and being newly qualified. The last point might be understood in relation to the discussion on trainee interpreters and limited expertise in mental health interpreting. This
finding is in agreement with literature suggesting that in an endeavour to minimise costs, agencies and individual clinicians either refuse a sign language interpreter or “providing services that are substandard because of lack of communication” (Gutman, 2005, p. 175). Further, the Department of Work and Pensions of the UK government (2017) in a review of the communication support for hearing impaired people, stated that registered interpreters are significantly less for the number of BSL users in the UK, and further claimed that geographical sparsity and travel costs are additional barriers to booking BSL interpreters. However, not providing interpreters is reported to also be common for foreign language speakers in the UK primary care (Gill et al., 2011; Barron et al., 2010).

Another challenge reported was in relation to interpreters’ maintaining confidentiality and trust. This is line with research on d/Deaf clients’ worry about confidentiality due to their community being small, and their significant need for trust (Alexander et al., 2004). Despite some research reporting language interpreters’ upholding confidentiality as part of their professionalism (Resara, et al., 2014), the majority of this study’s participants expressed doubts regarding interpreters adhering by this ethical responsibility. One participant expressed a greater difficulty in ensuring confidentiality with trainee interpreters. Walker (2013) a consultant psychiatrist within the NDCAMHS at the time of publishing, recommended that only qualified BSL interpreters with mental health experience should be involved with signing children, and the Association of Sign Language Interpreters (2018), further states that it is the mental health practitioner’s responsibility to book and involve a registered interpreter, who also has expertise in “mental health interpreting” (p. 8). Finally, the Mental Health Act Code of Practice of 1983 (Department of Health, 2015) makes reference to the engagement of qualified interpreters, but only for psychological assessments.

6.2.6. Lack of mental health support and deterioration of difficulties

Another concern discussed was d/Deaf people’s lack of access not only to mainstream MHS but also to specialist DMHS. Participants referred to the absence of appropriate-to-risk-severity (stepped care approach) deaf services as resulting in service users’ needs either not even being acknowledged, or being exaggerated. Another reason is that unlike hearing services, DMHS are not presentation-specific (e.g. eating disorders for deaf people) causing clinicians to being
expected to know how to work with every mental health difficulty. Interestingly, participants also stated that specialist services further depend on geographical location, as some areas have more NHS and private facilities. They expressed an overall positive attitude toward the existence of NDCAMHS, acknowledging however, that they do not cover all areas and some parents need to commute. Indeed, research states that parents of CYP accessing NDCAMHS identified traveling to their appointments as an obstacle to their access (Beresford et al., 2008). Contrary to the positive views about NDCAMHS, participants spoke of services for deaf adults as scarce and not robust, criticising the ‘withdraw’ of support once deaf CYP become adults. They expanded on the lack of communication between specialist services, without clarifying if referring to both adult and CYP services, characterising them as “isolated”. Hence, they concluded that specialist services do not maintain a national standard of practice. This is further linked to the lack of research to provide evidence of interventions’ effectiveness, as discussed later on in this section.

A final obstacle in accessing mainstream MHS this time, is hearing professionals lack of Deaf awareness and knowledge about working with d/Deaf people, resulting in delayed assessments and interventions, misdiagnoses, and an deterioration in mental health. Hence, by the time that d/Deaf clients reach the participants, they already present with more persistent psychological symptoms compared to hearing clients. Literature confirms a lack of Deaf awareness in mainstream MHS (Thomas et al., 2009) as well as in health services based on deaf people’s testimonials (London Assembly - Health committee, 2015), and a greater number of mental health difficulties among d/Deaf people, particularly, BSL users (Hulme, 2017).

On a positive note, participants identified positives of specialist DMHS; for instance, they stated that NDCAMHS operate quicker than CAMHS with CYP being seen within 4-5 weeks unless an emergency, compared to CAMHS where the waiting list might be one year. Research on the experience of users of NDCAMHS claims for a self-reported positive experience of those specialist services (Greco et al., 2009). Moreover, they added that deaf CYP can access both CAMHS and NDCAMHS, therefore, they have more options, and that deaf adults receive a psychological assessment at the first point of contact which is not the typical practice for a hearing adult accessing MHS.
6.2.7. Poor deaf education: the need to adapt mental health interventions

Apart from poor MHS, participants suggested that deaf people’s poor education interferes with their work as MHP, and gave as examples, CYP’s difficulty in understanding psychological concepts such as emotions and thoughts, and adult’s difficulty with basic knowledge about genetics. This has as a result the need to adapt their practice by devoting additional sessions to prepare clients for an intervention, and constantly altering the delivery of an intervention to be applicable to their knowledge. The use of interventions that are considered as appropriate for the clients’ age group, culture, and educational level (e.g. emotion-based vs cognition-based approach) reflects an advocacy action under the ACA model (Lewis et al., 2003), that of empowering clients (“share resources and tools that are appropriate for the client/student’s developmental level and issue”), which results from the acknowledgment that deaf education is not good enough (“recognize signs indicating that an individual’s behaviors and concerns reflect responses to systemic or internalized oppression”).

Literature suggests that the majority of deaf children currently attend mainstream schools, following schools for the deaf closing down (Berry, 2017) between 2015 and 2016. Squires (2012) discusses steps that have been taken to promote inclusive practice for UK children with special educational needs in mainstream schools, such as continuing professional development programmes for teachers, as well as training for CAMHS staff. The author however states that children are still labelled, and teachers are not provided with adequate support to develop skills in supporting children with special educational needs, and they are approached instead, as “experts who treat conditions” (Squires, 2012, p. 24) Participants expressed disagreement with ‘mainstreaming’ d/Deaf CYP and spoke of a lack of financial, emotional and social support. This concurs with literature claiming that support provided to deaf CYP in mainstream schools is through staff who have limited experience of deafness and/or have received inadequate training in that domain (Berry, 2017), and even when communication happens through an educational interpreter, full access to classroom material and social life is not achieved due to interpreters’ poor service (Schick et al., 2005). Additionally, d/Deaf children are distributed in different numbers across the UK, resulting in educational services supporting them in a wide range, from less than ten to 200 (Berry, 2017). It is, hence, widely accepted that education for deaf people is insufficient, resulting in deaf CYP under-attaining, facing unemployment or being employed in a hearing environment and experiencing exclusion, and having a higher rate of mental health difficulties in adulthood (Schick et al., 2005; Berry, 2017). The results are
further consistent with literature suggesting that deaf people report feeling inferior when clinicians use concepts not directly translated in BSL, and due to lacking skills and knowledge in the spoken language (Gill & Fox, 2012).

6.2.8. Utilising psychological screening and assessment tools

A challenge more closely related to psychological work, was conducting psychological assessments utilising mainstream tools. One participant specifically referred to the WISC being invalid for this population, however, they did not expand on what outcome measures they use or how they adapt the mainstream cognitive tests. Krouse and Braden (2011) found that WISC-IV was indeed invalid for deaf children, although, reliable in terms of internal consistency for 8 out of 15 subtests and 2 out of 5 indexes examined. Not surprisingly, the BPS (n.d.) states that verbal subtests of the WAIS-IV are invalid and unreliable and should “never” (p.8) be used for the Full-Scale IQ.

The finding is further in line with d/Deaf clients’ reporting that clinicians do not know how to undertake psychological assessments without delays (BDA, 2012). Several attempts have been made to translate and/or standardise screening questionnaires to BSL, such as the SDQ (Roberts et al., 2015), the Short Warwick-Edinburgh Mental Well-Being Scale (Rogers et al., 2018) and the Patient-Health Questionnaire-9 and Generalized Anxiety Disorder-7 (Rogers et al., 2012; Belk et al., 2016). These endeavours reflect the need for an adaptation in the delivery of such tools for BSL users.

Nevertheless, participants characterised BSL translated measures as inappropriate for d/Deaf people as those are English-based, and they are not standardised for use with this group. They gave the example of “feeling down” as not making sense in BSL and clarified that when utilising a screening tool, they explain the items using “a real person” to ensure that deaf clients understand. Literature further discusses that, due to the variations within deaf groups, for instance, regarding the preferred language, even tools specifically designed for deaf people might not be appropriate for all subgroups (Morere et al., 2009).
6.2.9. Conducting and assessing research

In context of academia, accessing and conducting relevant research for both hearing and deaf clinicians was indicted as a difficulty. This is firstly because of the diversity of d/Deaf individuals, for instance, regarding the level of hearing loss and the affiliation with the Deaf community, and secondly, due to lack of support from their employment services in conducting research, and an emphasis on their roles as clinicians, without though, expanding on the type of support they would require. Nevertheless, they added that even when research is conducted, it is distributed in written English which makes it difficult for deaf practitioners to access. Indeed, it has been argued that DMH research “is behind hearing mental [health] research by at least 40 years” (Glickman & Pollard, 2013, p. 360) because during the last 40 years, research on that domain simply focuses on challenging biased research being undertaken until the 1970s. Inability to access or conduct research is very problematic. It could be considered unethical practice since utilising research to evaluate practice and inform our actions, but also conducting research, are both standards of proficiency for practitioner psychologists in the UK (HCPC, 2015). Hence, deaf specialists are not able to be guided by research, use evidence-based or evidence-informed interventions, and ensure the quality of their service, which might further exacerbate d/Deaf individuals’ mental health difficulties.

6.2.10. Cultural differences: boundaries and cultural-informed interventions

Last but not least, participants acknowledged differences related to cultures, such as d/Deaf clients’ understanding of confidentiality, ways of addressing people, role boundaries and time boundaries. They spoke about how their deaf clients might: refer to/describe them by referring to a unique characteristic of physical appearance, open up more quickly, have therapeutic sessions in public or in front of family members who do not sign, understand the concept of therapeutic time differently by not utilising the full session time or asking for urgent sessions, being persistent in accessing services (even when they endeavour to find the therapy room) and expect the hearing therapist to advise on and support with non-therapeutic matters because of their ability to hear. Some of this is in line with descriptions of the American Deaf culture’s valuing of collectivism and connecting with people quickly, refraining from withholding information, and remembering a person’s appearance “because it is the landscape for all signed communication” (Rochester Institute of Technology – Northeast Technical Assistance Center,
Despite those claims being for US hearing and Deaf cultures, it is consistent with the experiences of this study’s participants. Moreover, participants spoke about the difficulty of keeping boundaries as they would do with hearing clients, due to their involvement with the Deaf community where they often encounter their clients. This results in them acknowledging the need to maintain different than their expected boundaries. This is supported by literature stating that “self-care activities can be difficult to initiate and maintain for clinicians whose work and lives are in the Deaf community and who may simultaneously feel swamped and isolated” (Gutman, 2005, p. 173).

Finally, another aspect of the Deaf culture discussed was the use of therapeutic modalities and techniques that appear to match Deaf clients’ values in communicating. Two participants spoke about how they utilise metaphors, visual techniques and more specifically the empty chair technique, and aspects of narrative therapy to facilitate the sessions. This is in agreement with literature that suggests that narrative therapy would assist deaf service users to change their internal narrative of being the problem, to an externalising language of how the problem affects them instead (Glickman & Harvey, 2008). Additionally, Isenberg (1996) drawing from their professional experience, further argues that storytelling, metaphors, and NA are very effective with deaf clients, because storytelling offers comfort, a shared experience and new ways of approaching problems and finding solutions.

6.3. Implications for deaf mental health and beyond

Participants discussed best practices for MHP interested in working with BSL users, and changes for DMHS and supporting services broadly.

6.3.1. Clinicians

Participants spoke about what they considered as important for MHP to know in order to work with d/Deaf clients (Table 2). Their recommendations include personal interest, language competency, Deaf awareness, liaising with colleagues (supervision, d/Deaf colleagues, qualified interpreters), engage clients in therapeutic decisions, and be transparent.
Table 2: Recommended best practices for clinicians

1. Be deaf aware; educate yourself about Deaf culture and history
2. Adopt a cultural minority model (rather than the medical model of disability)
3. Learn BSL
4. Acknowledge your limitations in BSL and seek support
5. Endeavour working directly in BSL
6. If you are working with interpreters, ensure they are qualified and registered
7. Engage d/Deaf clients in decision making (including discussions about confidentiality)
8. Access appropriate supervision
9. Seek support from d/Deaf colleagues
10. Be reflexive and transparent, and bring hearing status and feelings into discussion
11. Ensure a personal interest in deaf mental health

Participants’ recommended practices are in line with literature on d/Deaf service user involvement, for example with fighting oppression (Williams & Abeles, 2004), being Deaf aware and self-aware (BDA, 2012; BPS, 2017; Leigh et al., 2004; Fusick, 2008), working with registered interpreters, discussing about confidentiality with clients, receiving training in working with BSL interpreters (BPS, 2017), adapting a cultural minority model (Glickman & Harvey, 2008; Walker, 2013), and working with qualified interpreters with experience in mental health (Walker, 2013). It is further in line with multicultural competencies, such as being (Deaf) aware (Sue et al., 1992). Relational practice is at the heart of counselling psychology, as well as the ability to reflect on and use ourselves, and constantly endeavouring to enhance our self-awareness (BPS, 2019). Self-awareness has been further linked to multicultural (Ægisdóttir & Gerstein, 2010) and SJ practice (Gerstein & Ægisdóttir, 2007).

Even though recommended best practices are further in with literature on the need for specialist knowledge in DMH (Glickman & Harvey, 2008), participants of this study felt competent in their work considering their sources of learning. Hence, this study claims the benefit of a flexible and contextual training (rather than a formal institutional one) in responding to clinicians’ circumstances and needs, also respecting in that way their uniqueness (e.g., prior experiences, how they identify with a hearing position).
It is of relevance to consider to whom those recommended practices refer to since the term ‘deaf specialists’ is broad, as is ‘clinicians’ or ‘therapists’. As mentioned earlier, participants of this study were mainly clinical psychologists, who in their majority worked in clinical settings, with the rest coming from other mental health professions, or working in other settings (e.g., forensic). It is, hence, apparent that participants constitute a diverse group of professionals, who might, or might not identify with some terms used in the study to refer to them, such as ‘therapists’, ‘clinicians’, ‘mental health professionals’ or ‘deaf specialists’. Additionally, some might not find all the recommendations applicable to their work, for instance, generating a discussion about hearing status-related feelings might not be relevant to a mental health professional working mainly or solely through assessments. Despite the tension on how participants and readers who are mental health professionals resonate with the above terms to refer to their job title, there is still some homogeneity in their job roles, through sharing common challenges and concerns, goals, and responsibilities for instance, a counsellor might face challenges similar to a clinical psychologist when working with deaf people. At the same time, mental health practitioners not represented in this study, such as counselling psychologists, forensic psychologists, or CBT therapists, might resonate with some of the terms and some of the recommended practices, taking into consideration those similar aspects of their job roles. It is hence, acknowledged that mental health professionals do identify professionally in different ways and it is recommended that they interpret and adopt practices as suits these identities and associated needs.

Another aspect of the diverse group of professionals who participated in the study, and which appears to complement the discussion above, is the work area that participants chose to narrate about. For instance, some participants spoke about therapy models or techniques that they use, others referred to assessment tools and procedures, yet others spoke about consultation/professional liaison and advocacy. The choice of the narrative’s focus does not appear to be related to their professions, as for example, both a counsellor and two clinical psychologists spoke about models of therapy and/or techniques. Having said that, some traditional differences exist between helping professions, such as UK-based counsellors and counselling psychologists not typically offering psychological assessments due to this practice being a form of labelling or diagnostic categorising, potentially leading to discrimination against clients, and therefore, being at odds with the humanistic philosophy (Van Scoyoc, 2004). More recent understandings of counselling psychology do recognise the multifaceted
nature of the profession, and the possibility for counselling psychologists to work in broader settings, as reflected in the HCPC standards of proficiency (2015). Authors have been discussing counselling psychologists’ role (and adaptations) in forensic settings (Sims, 2016), primary care (Kennedy & Arikut-Treece, 2016), secondary care (Fairfax, 2016), and medical contexts (especially about engaging with diagnoses and formulations) (Pilgrim, 2016), which highlights that boundaries between the mental health professionals are blurred. This statement is not an attempt to claim a reductionistic view of the mental health professions’ diversity but rather, an acknowledgment of those grey areas between them, and an appreciation of this diversity. It is then possible for future studies to identify differences in work-related topics that participants discuss, as related to their profession and associated traditions and philosophies, that possibly shape models of therapy and values.

6.3.2. Mental health services

In addition to recommendations for MHP, participants suggested developments for MHS as presented in Table 3.

Table 3: Recommended developments for mental health services

| 1. Employ more d/Deaf clinicians in deaf mental health services |
| 2. Develop more deaf mental health services (to cover additional geographical areas) |
| 3. Develop specialist-to-presentations deaf mental health services OR employ a pluralistic approach to therapy |
| 4. Develop deaf mental health services to respond to all levels of risk (from Tier 1 to Tier 4) |
| 5. Current deaf mental health services to foster communication and collaboration among them |

Those recommendations refer to developing more DMHS to respond to greater geographical locations, specific presentations, and levels of interventions (stepped-care approach). Specialist-to-presentations services might be considered as another way of diagnosing and therefore, as contradictory to counselling psychology’s values. An alternative might be the use of a pluralistic therapeutic approach with a focus on the clients’ needs and the therapists’ knowledge and experience (Cooper & McLeod, 2011). Furthermore, participants
recommended that more d/Deaf MHP are employed in DMHS, and also staff of different DMHS communicate between them. Despite participants not clarifying if those recommendations refer to specialist or general services, and adult or CYP services, I here present them as referring to all, due to them being applicable to all contexts.

6.3.3. Supporting public services and societal practices

Actions to be taken on a societal level, beyond what individuals and MHS can address were also identified (Table 4).

<table>
<thead>
<tr>
<th>Table 4: Recommended developments for public bodies and citizens</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Citizens (including professionals) to develop Deaf awareness</td>
</tr>
<tr>
<td>2. All services supporting d/Deaf people to work together; “a national deaf strategy”</td>
</tr>
<tr>
<td>3. Schools and local authorities to seek advice from deaf specialist in how to support d/Deaf children and young people</td>
</tr>
<tr>
<td>4. The cochlear implant team and medical professionals to seek advice from deaf specialist, when diagnosing children, to support them and their families</td>
</tr>
<tr>
<td>5. Interpreting services to maintain consistency in interpreters provided</td>
</tr>
</tbody>
</table>

It is important to mentioned that this discussion was initiated by participants which reflects a wider political aspect of DMH, that however, affects clinicians and clients alike. Those recommendations had to do with services supporting d/Deaf clients such as educational institutions, diagnosing teams, and interpreting services. Participants identified actions to be taken by each service, but also the need for all services to work together as “a national deaf strategy”. They also referred to MHP but also people outside mental health not being Deaf aware which impacts, for instance, decision making, and deaf people’s experience in the world. Those recommendations are in line with literature suggesting lack of Deaf awareness by hearing professionals (BDA, 2012, Thomas et al., 2006), public negative attitudes toward deaf people (National Deaf Center, 2019), and guidelines for practitioner psychologists on working with interpreters (BPS, 2017). However, it should be noted that some US literature claims positive attitudes of undergraduate students toward the deaf (Hankins, 2015).
6.4. Methodological limitations

Identifying and reporting a study’s limitations should be prioritised and utilised as a vehicle for future theoretical progress that would enhance contribution to knowledge (Brutus et al., 2013). Here, I discuss the identified limitations of this study and how they have influenced the interpretation of the data.

6.4.1. Sampling

Despite advertising for MHP who consistently or only rarely work with BSL users, the people who expressed interest in participating are professionals in DMH who have experience in that specific domain ranging from at least two years to more than 10, which renders them as deaf specialists. This could be due to recruiting only through specialist services, as the BPS and BACP did not respond. The sample, therefore, consists of targeted population of clinicians with expressed interest in DMH, and who were possibly drawn to a particular aspect of the study, for instance, the opportunity to narrate about their professional experiences, or to make recommendations on training and service provision. Additionally, half of the participants reported working within NDCAMHS, which further specifies the context of their experiences and their accounts’ interpretation. Finally, participants come from the disciplines of clinical psychology, counselling, and psychotherapy, whereas, interestingly, no professionals from other applied psychology domains such as counselling and forensic expressed interest. This might mean that either practitioner psychologists other than clinical psychologists are underrepresented in the services I contacted and therefore, they were not reached, or that they were not interested in the research. Interestingly, Wright et al. (2012) in introducing NDCAMHS, represented staffing by profession across NDCAMHS and outreach centres, with clinical psychologists being the core MHP as opposed to “other therapists”, leaving unclear if counselling psychologists are in the picture. The particular circumstances of participants (significant experience in DMH, strong presence of NDCAMHS, and qualification) should be acknowledged when interpreting this study’s claims.

6.4.2. Difficult-to-reach population and anonymity
Related to sampling implications, since DMH professionals constitute a small speciality, some information about their interest in deafness, particular sources of learning, their employment history, the particular geographical area of practice, or specificities of their working settings have been omitted. This was either after a participant’s request, or initiated by me to ensure anonymity and adhere to the ethical research guidelines. This, as a result, has led to some information not being used to explain particular ideas or experiences. Furthermore, owing to this being a small speciality, it has already been argued that DMH research appears to be at its infancy (Glickman & Harvey, 2008) and hence, there was a lack of prior research to serve as a foundation for understanding the findings. This renders the current study as exploratory rather than explanatory.

6.4.3. Study design, areas of interest, and terminology

This study aimed to explore three different areas of DMH, namely, i) professionals’ background and training, ii) professional experiences, and iii) provision for MHS and training recommendations. It was observed that participants were inclined to discuss more extensively either their experiences, or service provision, whereas questions about training and competency were sometimes either overlooked by me depending on the participants’ personal circumstances (such as being a CODA), which would act as a bias, or due to time constraints. This resulted in some gaps in information about training background and/or professionals’ educational needs.

Another consideration is that studying all three areas resulted in a big amount of data to be reported qualitatively which resulted in less material being included in the analysis. Emphasising exploration of training by questionnaire could be allow for interviews to be focused on the other two themes and facilitate an in-depth exploration of experiences and/or service provision.

Finally, despite utilising the term ‘BSL users’ in this study, participants would rarely refer to their clients using that term, and they would rather speak about them as d/Deaf. Even though the term ‘BSL users’ is inclusive of people who do not experience hearing loss but identify BSL as their primary language, at the same time, it might be limiting to service users who
prefer other means of communication such as Sign Supported English or interpreters, but still access MHS and work with professionals.

6.4.4. Specialist topic

A final aspect that might have influenced the focus of this study as well as the interpretation of the participants’ accounts is that DMH is a specialist topic for which I developed my knowledge through reading. Even though I do not consider the lack of prior knowledge as compromising my interest in the study, it has shaped, for instance, the interview guide and the initial focus on training recommendations. This was because I was not familiar with the political aspects of DMH and how deaf education, health, and social acceptance come together to influence not only deaf people, but clinicians’ experiences as well, as the participants narrated about. Having been familiar with those political dimensions, might have shaped the interview questions to more flexibly explore broader societal and political topics. Nevertheless, this has also allowed space for my participants to ‘educate’ me about some basic aspects of their work and deafness, providing rich accounts of multiple dimensions of DMH, also in context of their different professions. Being novice in DMH has also influenced how I interpreted the accounts, as I was utilising research, but not personal experience to tailor my claims. However, this might have facilitated the narrative process of staying close to the participants’ accounts, and the QI’s value of acknowledging one’s biases.

6.5. Future research

Following from the methodological limitations, I here consider where future research on DMH health could focus to address some of those concerns, and some additional areas worth exploring. Firstly, considering sampling, future research on the training and experiences of hearing deaf specialists could aim for recruiting participants through national bodies in addition to specialist services, to reach a more diverse sample in terms of titles, experience, and working settings. In terms of the study’s design, it is highly recommended for researchers wishing to explore DMH professionals’ training and sources of knowledge, to utilise a flexible enough questionnaire allowing participants to clearly state if they have received formal training, identify their additional sources of training, whether they have additional education needs and
make specific recommendations on training being developed. Such a questionnaire, is expected to facilitate the flow of a follow-up interview, be more focused on areas that call for attention, and eliminate the amount of verbal data, allowing for more of it to be presented in a study’s writing. Another recommendation is for future research to utilise the term d/Deaf when advertising for, and writing the study, especially if reaching to national bodies and professionals across the board, to enhance the applicability of the study to the UK-based hearing professionals, and deaf people. Moreover, researchers that are specialists in DMH, or have some background knowledge, are expected to contribute significantly to structuring a specialist study such as this, considering aspects or examples of their work that are possibly unique. Finally, I cannot highlight enough the gap in DMH research and the need for more research to further explore DMH professionals’ struggles, how they address them, and what needs they have. It would be interesting for researchers to explore which intervention and assessment tools MHP administer, as well as how they adapt them, and with which population, in an attempt to map assessments and intervention techniques for d/Deaf service users, and provide some preliminary evidence for effective practice, that goes beyond generalised guidelines that tend to focus on communication and multicultural competencies.

6.6. Contribution to knowledge for counselling psychology and beyond

This study is one of a few exploring hearing MHP’s experiences, training, and views on DMH in the UK. It contributes to the limited literature on DMH by exploring particular challenges those clinicians face as related to working with d/Deaf clients, colleagues/services they liaise with, as well as societal practices. It discusses what appears to strongly characterise DMH practice, which is clinicians’ acknowledgment of diversity and their response, the involvement of additional professionals in sessions (such as relay interpreters and deaf colleagues), the lack of MHS or accessibility to them which results in deterioration of difficulties, how poor deaf education pushes clinicians to adapt their practice, the difficulty of utilising psychological outcome measures appropriate to d/Deaf clients, the difficulty of conducting and assessing relevant research, how cultural differences influence therapeutic boundaries and choice of interventions, how societal oppression towards d/Deaf people impacts on therapeutic dynamics, and finally, how lack of Deaf awareness (and possibly oppression) leads clinicians to educate others, and advocate with, or on behalf of, their clients. The study also recommends best practices for clinicians based on participants’ accounts, changes for MHS, and changes in
the wider context; for citizens, and services who support d/Deaf people, claiming that changes on all those levels need to come together for improvements in mental health practice (and therefore, mental health of d/Deaf people) to be achieved.

Utilising CR allowed me to claim the centrality of the participants’ reported experiences as perceptions of reality, that of DMH bringing particular experiences and challenges, and therefore, to use in that sense the concept of SJ, to locate those perceptions in context of psychology and allied professions, and to make a case for recommendations based on the participants’ accounts. Moreover, utilising NA has contributed to staying close to the participants’ accounts, valuing each one as a unique set of statements, and identifying the particular experiences of each participant as mentioned, rather than merely identifying common themes amongst the accounts. This has helped to attend to richness in the data that only narrative analyses would allow for. At the same time, the particular use of DNA has further added value, by not only giving status to the story itself (considering it as perceptions of reality), but also through seeing how stories come together to create the social. The meaning of a story, as well as the shape of the ‘social’ through story/stories is very powerful, especially when aiming for social change, and I have already claimed for the need for wider social actions to address DMH.

Finally, writing from a counselling psychology’s perspective offers additional lenses in the meaning of the present study, due to the rich theoretical background that holistically supports the discourse on d/Deafness, and the exploration of power and subjectivity. The concepts of SJ, intersectionality theory, multicultural competency, and the value of diversity contributed in interpreting and locating the participants’ accounts in contemporary discussions that not only render d/Deafness relevant to every counselling psychologist, but also, to the wider public, regardless professional status. This is of particular importance as lack of Deaf awareness in professionals and citizens has been claimed in this study, supporting the existing literature on both clinicians’ (Thomas et al., 2006; Bartlett, 2017) and clients’ (BDA, 2012) experiences of mainstream mental health support to deaf people.

As DMH is relevant to all, the study has wider implications for all MHP, MHS, and public bodies including regulatory and statutory bodies, who could consider the study’s claims to critically reflect on how to make things fairer and more acceptable for d/Deaf people. Starting
with ourselves individually, we could all think about our Deaf awareness, and personal stance and practices toward our d/Deaf fellow citizens.
Chapter 7: Conclusion

The current study was concerned with DMH in the UK, reflecting an identified gap in the literature. It particularly explored: i) the experiences of hearing professionals-deaf specialists in working with BSL users, ii) their perspectives of mental health and public service provision for BSL users, and briefly iii) whether they received specialist training. The RQ to be answered were:

i. How do hearing therapists who work therapeutically with BSL users speak about their experiences, training and competence in this area?

ii. How do hearing therapists who work therapeutically with BSL users speak about the current mental health services provided, therapists’ training in working with BSL users, and the future of deaf mental health?

Eight participants, two men and six women were interviewed. All of them position themselves as hearing (which was an eligibility criterion for the study). Five participants identified as clinical psychologists, with the rest being counsellors or psychotherapists. Half of the participants reported working with NDCAMHS, three of them reported working with adults, whereas one reported having worked with both populations. A QI design was employed, informed by the methodological paradigm of CR, claiming that the participants’ experiences are as real as events, and their accounts of their experiences are their perspectives of reality. Semi-structured interviews were utilised, and participants’ accounts were analysed using DNA, hence, a particular interest was on how stories, as realities, can, and do, shape social actions.

The study approached DMH through the theoretical bases of multicultural and diverse practice, intersectionality, and SJ.

Based on participants’ reports about their training, informal opportunities to be educated about DMH were identified, and it is, hence, suggested, that specialist training in working within DMH is necessary, but should be flexible and contextual to meet the particular needs and circumstances of professionals. The findings highlight that deaf specialists of this study face obstacles in how they provide for d/Deaf clients due to some particularities of DMH, such as including additional colleagues in sessions (deaf specialists, different types of interpreters), and difficulty in conducting research and using suitable outcome measures, but also, to aspects of working across cultures and languages, for example, cultural norms and boundaries. They
further referred to obstacles deriving from political and societal practices, such as lack of mental health services accessible to d/Deaf people, poor deaf education, oppression, and lack of Deaf awareness which leads to educating others and advocating with or on behalf of their clients.

The study has claimed that social change, which is of fundamental importance within counselling psychology, is feasible and essential, on three interconnecting levels; the personal one - including clinicians of mainstream and specialist services, that of MHS, and, importantly, that of public bodies and the wider system as citizens of a nation of which d/Deaf people are part.
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Appendices

Appendix 1. American Counseling Association – ACA Advocacy competencies
Appendix 2. Audit Trail
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Appendix 8. Consent Form
Appendix 9. Reflexive Questions (Patnaik, 2013)
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Client/Student Empowerment Counselor Competencies and Strategies

In direct interventions, the counselor is able to:

- Identify strengths and resources of clients and students.
- Identify the social, political, economic, and cultural factors that affect the client/student.
- Recognize the significance of counselor’s own cultural background and sociopolitical position in relation to power, privilege and oppression and in relation to the client or client communities.
- Recognize signs indicating that an individual’s behaviors and concerns reflect responses to systemic or internalized oppression.
- At an appropriate developmental level and cultural perspective, help the individual identify the external barriers that affect his, her or their development.
- Share resources and tools that are appropriate for the client/student’s developmental level and issue.
- Train students and clients in self-advocacy skills.
- Help students and clients develop self-advocacy action plans.
- Assist students and clients in carrying out action plans.
Client/Student Advocacy Counselor Competencies and Strategies

In environmental interventions on behalf of clients and students, the counselor is able to:

- Identify barriers to the well-being of clients and students with attention to issues facing vulnerable groups.

- Recognize the significance of counselor’s own cultural background and sociopolitical position in relation to power, privilege and oppression and in relation to the client or client communities.

- Identify potential allies for confronting the barriers including those within the organization as well as those who have cultural expertise relevant to the client’s issue.

- Develop an initial plan of action for confronting these barriers in consultation with client and ensuring plan is consistent with client’s goals.

- Communicate plan with client including rationale, and possible outcomes of advocacy.

- Negotiate relevant services and education systems on behalf of clients and students.

- Help clients and students gain access and create a plan to sustain needed resources and supports.

- Carry out the plan of action and reflect/evaluate effectiveness of advocacy efforts.
Community Collaboration Counselor Competencies and Strategies

In collaborating with the community, organization or school community to address systemic barriers or problems facing clients and client groups, counselors are able to:

- Identify environmental factors that impinge upon students’ and clients’ development.
- Alert community or school groups with common concerns related to the issue.
- Develop alliances with groups working for change and explore what has already been done to address the issue. Understand counselor’s sociocultural position in relation to the issue, the client group, and allies.
- Use effective listening skills to gain understanding of the group’s goals and help facilitate examination of causes and possible avenues for advocacy.
- Facilitate understanding of group dynamics, cultural and sociopolitical variations in group members, and how that may affect group decisions as well as variable repercussions for different group members.
- Identify the strengths and resources that the group members bring to the process of systemic change and communicate recognition of and respect for these strengths and resources.
- Identify and offer the skills that the counselor can bring to the collaboration as well as any ethical limitations they might have as a professional.
- Facilitate the group in considering possible outcomes of action, both favorable and unfavorable, and support them in preparing for possible resistance or other challenges.

ACA Advocacy Competencies (Updated 2018)

- Integrate considerations of the ecological and political context in which the advocacy actions will be taking place.
- Assess the effectiveness of counselor’s collaborative efforts with the community.
Systems Advocacy Counselor Competencies and Strategies

In exerting systems-change leadership at the school, organization or community level, the advocacy-oriented counselor is able to:

- Identify environmental factors impinging on students’ or clients’ development.
- Understand the cultural, political, developmental and environmental contexts of the clients or client groups.
- Understand the counselor’s own cultural identity in relation to the group and the target of advocacy including privilege, oppression, communication, values, and intentions.
- Investigate the issue, population and possible allies and stakeholders.
- Provide and interpret data as well as share research and expertise to show the urgency for change.

ACA Advocacy Competencies (Updated 2018)

- In collaboration with other stakeholders, develop a vision to guide change.
- Analyze the sources of political power and social influence within the system.
- Develop a step-by-step plan for implementing the change process, attending to possible ethical issues.
- Develop a plan for dealing with probable responses to change.
- Recognize and deal with resistance.
- Assess the effect of counselor’s advocacy efforts on the system and constituents.
Collective Action Counselor Competencies and Strategies

In partnering with client groups and community members to address environmental and systemic issues, and inform the public as well as policy makers about the role of environmental factors in human development, the advocacy-oriented counselor is able to:

- Recognize the impact of oppression, other barriers, and environmental factors that interfere with healthy development.
- Identify factors that are protective of healthy development as well as various avenues for enhancing these protective factors through the public arena.
- Share research and professional expertise with partner client groups and community members in developmentally and culturally appropriate ways.

ACA Advocacy Competencies (Updated 2018)

- Determine appropriate role within community initiative such as facilitator, researcher, negotiator, etc. aligned with professional and personal skill set.
- Understand counselor’s own cultural identity including positionality related to power, privilege, and oppression and how that influences the ways they work with the community and the targets of advocacy (e.g., decision makers).
- Participate with and/or facilitate community partners in identifying the source of problems, setting goals, developing an action plan, considering possible outcomes, and implementing the action plan.
- Prepare written and multimedia materials that provide clear explanations of the role of specific environmental factors in human development in consultation with engaged community or client groups.
- Communicate information in ways that are ethical and appropriate for the target population.
- Disseminate information through a variety of media appropriate for the target audience.
- Collaboratively prepare and present materials and information to influence decision makers, legislators, and policy makers, ensuring that the community’s voice is central.
- Facilitate the community group in assessing the influence of their public information and advocacy strategies.
Social/Political Advocacy Counselor Competencies and Strategies

In influencing public awareness, legislation and policy in a large, public arena on behalf of client groups or communities, the advocacy-oriented counselor is able to:

- Identify the communities affected by this issue including who makes up the community and whether the community is engaged in advocacy around the issue.

- Consult with communities affected by the issue to understand their views and experiences, with attention to economic, social and cultural perspectives.

- Distinguish those problems that can best be resolved through using the counselor’s expertise and where the community may have limited access.

- Identify ways the community may have input into the advocacy process.

- Identify and collaborate with other professionals as well as other allies who are involved in disseminating public information and may be interested in or already engaging in policy advocacy.

- Identify appropriate mechanisms and avenues for addressing these problems and distinguish the role of public awareness, legislative, policy and judicial action.

- Understand counselor’s own cultural identity including positionality related to power, privilege, and oppression and how that influences the ways they work with the community and the targets of advocacy (e.g., decision makers).

- Support existing alliances for change through providing information, support, and expertise.

- With allies, prepare convincing data and rationales for public awareness campaigns or to lobby legislators and other policy makers.

- Maintain open dialogue with communities and clients to ensure that the social/political advocacy is consistent with the initial goals.
First example:

R: have you experienced a BSL session? How is it for you? I understand it’s not just you and the client, for various reasons. It’s the interpreters there, and the parents possibly. So how do you feel in those sessions?

P: In the sessions I’m doing therapeutic work in BSL?

R: yeah. Umm, interestingly now, I don’t think about it so much because it’s more common for me to work with an interpreter than without, often. I think umm, it’s a different dynamic and when you, and you have to acknowledge the interpreter as part of that dynamic [questioning tone]. Umm, so, when I’m first working with a young person, often they might not have much experience in working with interpreters, but when I’m first working with a young people I will always, always, always talk about communication, and what they, you know, what they prefer. Umm, I’m working very closely with our interpreters, I know them well as well. So, I’ll talk with the interpreter before the session and after the session, before we talk about what the purpose of the session is umm after we may talk about any communication issues that came up or the interpreter might want to clarify things. Umm, you have to trust the interpreter that you’re working with. I always ask an interpreter should work this way but you know it’s often good to clarify that if there’s anything that the interpreter misses, that they’re not sure about just to tell me in the room, you know. So, an interpreter might say ‘I didn’t quite
get what he said there or he's signing this but I'm not sure what it means. Umm, I think is a different, (brief pause) there's a couple of different dynamics, depending on your fluency in BSL. So I do, I'm level 6 at BSL, so either I work with an interpreter and the dynamic in the room might be suddenly different, and if you don't know any BSL, so I can access what that young person is saying to me, but the interpreter will always voice over. Umm, so I can get some of the nuances from what that person's saying cause I'm level 6. Umm, so I think that helps but I've not always been level 6 BSL so I think then you have to trust the interpreter. But the main thing for me is how you set communication at the start of the therapeutic intervention; it's not a barrier if you set it up well and if you have a good interpreter cause that's the other thing you know, it's really important to have a good interpreter. In fact, it's far, it's the opposite to being a barrier, it's like, a barrier would be if you couldn't communicate well with that person so I think interpretation opens doors. There's something interesting about working cross-linguially, if that makes sense. Because, you don't often get the subtle nuances, but I think what it makes you appreciate in the therapeutic situation, is how important the non-verbal is as well [questioning tone], it's not always about language, there's so much non-verbal communication that happens regardless of whether you're using the same language in therapy or a different language to your client. And I think that [indistinct] more on the non-verbal. And it forces you to really focus on what that person's communicating, because you have to. But I don't find it a barrier anymore. Umm I think the only barrier that I found at the beginning, was that I just wasn't used to it, the third person in the room. But it feels much natural now.
Second example:

P: yes, so that's part of it. But how I think about it, is you know, cause most deaf children [indistinct] hearing parents, so from the very outset there's discrepancy between language and communication and attunement and understanding. So that in itself, it's really tricky. So at the very first stages where that baby is born, with a hearing parent that might more than likely never come across a deaf person in their life, that's at least the stories that we hear they have never met a deaf person before, so they [indistinct – need?] this deaf child that they have, this deaf baby, so they go through all sorts of processes, grieving process, loss, mourning the child that they didn't expect to have and then they're sucked into this medical model of hearing loss and impairment rather than ideas around positivity around being deaf. So, there's no deaf person that would be introduced to the family, not as far as I'm aware in that moment when a doctor is giving a diagnosis to a baby. So, there's so many factors involved in being a deaf child umm that creates, in my eyes, a vulnerability and problems later on. So it starts with that very early moment of being told that they're deaf, the baby, and the parents, what kind of support they have, how to communicate, so I always hope that now people have moved away from saying 'well, if you're gonna have cochlear implants then you can't sign cause you need to talk' but actually, the people we see, kids 10, 11, 12, still talk to us about being told by professionals that is best not to sign because it disrupts on their language, spoken language development. So this is the kind of advice that hearing parents are getting, with their brand new baby, child, toddler, that it's sort of setting up this whole idea about language and
communication that actually it's better to speak because otherwise they're not gonna develop properly, and they're not gonna fit in with the world and society. And nowhere in that moment, unless they're encouraged to seek out other alternatives, umm, are they introduced to a deaf person who actually says 'oh do you know what? It's okay. Like, I sign, I do this, I do that, your world is not only that' that sort of thing. So, that's right at the very beginning, and then as the parents continue, if, I mean the parents that we see, tend not to be, or have difficulties in attunement to their child, so, they find it difficult to really understand what their deaf child's needs are. And so, obviously we don't see the parents that are really engage and attune with their child, so we see the one who have difficulties obviously, cause that's how they end up being here with us. So, the parents that I see, something's happened to them in their lives, or something is umm, they're needing more support in being able to understand what is like to be deaf, and that's the bit that they miss earlier on. So, the communication is so important to them be able to develop everything else; language, emotional understanding, concept development, social development umm being engaged in the world, communication drives all that. And even if you don't, if you're not, it's not about being fluent in BSL, it's about understanding and being attuned to that relationship, which then forms attachment and all of that. So that's the sort of vehicle that fits. So, (brief pause) we often work with parents here that have had some disruption to that early process, so there's been other traumas, like you know, illness and hospital stays, family, normal, you know, family traumas.
Appendix 3. Interview Guide

Exploring therapists’ interest, commitment and competency in working with British Sign Language Users: Training recommendations

Interview Guide

Areas of Interests

A. Competency: skills and professional training undertaken

Question 1: What route have you followed to be qualified as a therapist?

Question 2: What training have you received in working with BSL users and/or interpreters?

Prompt: How relevant is your practice to your specific training (How useful was the training)?

Question 3: Do you follow any specific guidelines (e.g. BPS – working with interpreters)?

Question 4: How do you feel about your competency in working with BSL users and/or interpreters?

B. Experiences of providing counselling services to BSL users

Question 4: How do you experience your role in a BSL session?

Prompt: Is it challenging, fulfilling, not different from working with other client groups?

Prompt: From where does your interest in working with BSL users derive?

Question 5: How do you experience the interpreter's role in a BSL session? (where applicable)

Question 6: From your perspective, how clients experience an interpreter in the session? (where applicable)

Question 7: What difficulties, if any, do you face in working with BSL users and/or BSL Interpreters?

Prompt: How easy is finding a suitable supervisor?

C. Views on current training and services provided

Question 8: What do you think of the current counselling services provided to BSL users?

Question 9: What do you think of current therapists’ preparation in providing services to BSL users?
Question 10: What is your opinion on the guidelines provided by the British Psychological Society on working with BSL interpreters?

Question 11: Would you say that you are interested in social justice?
   
   Prompt: What social justice in psychology means to you?
   
   Prompt: Would you consider counselling BSL users as social justice’s practice?

Question 12: What do you think is your Society’s role on counselling BSL users?
   
   Prompt: What can be improved?
Appendix 4. Study Advertisement

Dear all,

I am looking for participants for my doctoral research of which the topic is: **Working with British Sign Language (BSL) users in psychotherapy.** I am interested in your experiences of working with those clients, and of your relevant training journey.

I am looking for participants who are

- either qualified as, or in training as, therapists
- therapists of any discipline (e.g. counsellors, psychotherapists, practitioner psychologists, PWPs)
- therapists of any therapeutic approach(es)
- both past or current experience of working with BSL clients
- hearing
- both practicing by directly using BSL or via BSL interpreters

The study is based around a conversational interview, which I imagine will run for about 45-90 minutes, based on your experiences and stories.

This interview could take place face to face at a convenient location for you, or via skype.

With your permission, the interviews will be audio recorded. I will then transcribe and analyse it using Grounded Theory. You will be given the interview transcript if you wish to, and you will have the opportunity to omit any part of it you are uncomfortable being included as part of the material for analysis.

The recordings and transcripts will be anonymised and only seen by myself, as the researcher, although I would of course hope to present and discuss the results of the study as a whole at relevant practice and academic arenas.

This doctoral study takes place under the supervision of Erica Burman, Professor at the Manchester Institute of Education, The University of Manchester, and she can be contacted in the following e-mail address: erica.burman@manchester.ac.uk

Just to be clear, I am writing from the position of a hearing individual, and I am currently a Counselling Psychology student. The study has received ethical approval by the University of Manchester.

If you are interested in discussing about your experiences in working with BSL clients, or if you have any questions about this study, or would be interested in hearing further information, please contact me here: aliki.vasiliadou@postgrad.manchester.ac.uk
I am aiming to conduct the interviews in the period April-November 2019, so would really look forward to hearing from you and fixing a time to meet (face to face or virtually). Within this period, I am flexible and can travel to you, by mutual arrangement

Many thanks in advance!
Appendix 5. Analysis Questions

1. *How* incidents are storied? Why is the *succession of events* configured that way?
2. *Why* incidents are storied? *For what purpose* was this story constructed?
3. *For whom* was this story constructed? Who tells which stories to whom/ who would immediately understand that story and who wouldn’t?
4. What storehouse of *plots* does it call up?
5. What does the story *accomplish* (what are the *effects* on the reader or listener)?
6. Are there *gaps and inconsistencies* that might suggest preferred alternative or counternarratives?
7. What *cannot be spoken*?
8. What resources shape how the story is being told?
9. What resources shape how listeners comprehend the story?
10. Are there some people whom you wouldn’t tell that story to and why not?
11. Who does the story render external or other to that group? Who is excluded from the ‘we’ who share the story?
12. How does the story teach people who they are and how do people tell stories to explore whom they might become?
13. How is the storyteller holding their own in the act of telling that particular story in that way? How do the stories that some people have available convince them of what they have to do and to be in order to hold their own? Also, whom the story renders vulnerable; who has an increased problem of holding their own, once the story has been told?
14. What particular words/tones are used?
15. What influences (historical, political, economical, cultural) are evident?
16. How gender and sexuality influence what is said?
17. What pronouns are used? (human agency)
18. In what voice are the verbs used; passive, active, agentless passive? (human agency)
19. What key phrases are used to communicate how the narrators understand the link of self to normative social models, making a micro to macro link that intrinsically involves the narrator’s agency?
20. How is imagery used?
21. What figures of speech are used (metaphors, catchphrases and proverbs)?
### Appendix 6. Accounts’ synthesis process

<table>
<thead>
<tr>
<th>Topics</th>
<th>Number of participants</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving training in working with BSL users:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Deaf awareness training</td>
<td>8/8</td>
<td>i. Informal</td>
</tr>
<tr>
<td>ii. Working with interpreters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. BSL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv. Other training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaf awareness: sources</td>
<td>8/8</td>
<td>P1: teaching others; years of doing this job</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P2: personal encounters; specialised courses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P3: through interpreters</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P4: personal encounters; Deaf clubs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P5: personal encounters; Deaf clubs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P6: accessing and conducting research</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P7: CODA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P8: reading about Deaf culture; blogs etc</td>
</tr>
</tbody>
</table>
Typically working with interpreters: 3/8
- P1
- P3
- P8
Occasionally work: P4, P7
Never: P2, P5, P6

| Challenges in their work with BSL users: | 8/8 | / |
| Challenges specifically related to the service users (but not because of them): | 7/8 | P1: age – power imbalance  
P2: boundaries – cultural differences  
P3: age – inadequate education – adaptation of intervention; Perception of her as a hearing therapist  
P4: deaf education e.g. genetics – adaptation of intervention  
P5: boundaries – cultural differences  
P7: age – inadequate education – adaptation of intervention  
P8: – adaptation of intervention |
| Challenges related to other professionals-colleagues & settings: | 5/8 | P1: interpreters (especially trainees)  
P2: GP staff (boundaries); Therapists who work as interpreters (boundaries); Practicalities – consideration of the therapeutic environment  
P3: Interpreting services – no consistency  
P4: psychologists – not in their competency  
P8: deaf colleagues – attunement in communication; Interpreters – in the past |
Challenges related to social practices (service structure and delivery, social understanding of deafness):

- P2: medical model is incompatible, oppression
- P3: schools – inappropriate referrals
- P4: oppression – hearing people tell them what to do
- P6: accessibility barriers due to communication – severity of mental health difficulties; Research is irrelevant or inaccessible
- P7: not enough services – severity of mental health difficulties
- P8: schools and families not enough support

Opinions about working with interpreters:

- P1: means to communication; dynamics and confidentiality are issues. But considers BSL interpreters’ training as more robust than language interpreters’ one and did not experience breach of confidentiality from BSL interpreters.
- P2: trust and confidentiality are issues. Better than nothing. Deaf people have the right to have therapy in their first language.
- P3: positive experience; like a co-therapist
- P4: trust and confidentiality are issues. Also, clients do not look at you at all. Better than nothing. Deaf people have the right to have therapy in their first language.
- P5: better in BSL but clients sometimes want face to face (probably means directly); clients do not look at you at all.
- P6: clients do not look at you at all. Costs on the dynamics and transference. Deaf clients are used to interpreters. Interpreters are decent, ethical, registered,
badge carrying. Deaf clients to decide the means of communication.
P7: not asked/not expressed
P8: it changes dynamics but that also depends on your BSL fluency. However, it opens doors and it is not a barrier.

<table>
<thead>
<tr>
<th>Perceptions on training of mental health practitioners:</th>
<th>5/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1: Speaks of systemic training that she delivers as including working with interpreters, plus with BSL interpreters which she initiated.</td>
<td></td>
</tr>
<tr>
<td>P2: not asked/not expressed</td>
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<tr>
<td>P3: gap in clinical psychology training about working with deaf people; training only when clinicians meet a deaf person and realise they don't know how to work with them; not a priority, not on anyone’s agenda; are not set up to offer training for things you’ll be dealing with everyday.</td>
<td></td>
</tr>
<tr>
<td>P4: not a standardised training for therapists and that’s definitely a lack; need for more training in working with interpreters.</td>
<td></td>
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<tr>
<td>P5: lack of training for working mainly with deaf CYP not only through institutions, but registration bodies too.</td>
<td></td>
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<tr>
<td>No other aspects mentioned.</td>
<td></td>
</tr>
<tr>
<td>P6: not asked/not expressed</td>
<td></td>
</tr>
<tr>
<td>P7: not asked/not expressed</td>
<td></td>
</tr>
</tbody>
</table>
| P8: there is not enough working with interpreters and cultural minorities training. Believes that clinical psychology is not diverse enough (middle-class, female,
white) and training on those matters will not suffice, we need more psychologists with the lived experience. Having to have a good academic degree is limiting for both clinical and counselling psychology.

| Perceptions on mental health services: (schools, and engagement with research) | 8/8 |
| P1: asked but misunderstood questions and I didn’t clarify because of lack of time. Speaks only of adult mental health services appearing to have a good number of practitioners who can sign. |
| P2: not enough deaf people in high up positions but rather hearing people who are driven only by money |
| P3: misunderstanding about working with deaf people e.g. learning disability/ deaf and dumb; mainstream services do not realise deaf people might identify themselves as culturally different than hearing – medical problem, a disability. Preventative work is lacking. Deaf community is lucky for NDCAMHS cause it is good – fast paced. Adult deaf services are lacking. |
| P4: not many services to respond to the different levels of presentation and risk severity; depends where you live; signhealth offers better services than hearing people get in their services because there is a psychologist to assess the deaf in the first point of contact; its growing since she started; services are mixed up they are not specialised and clinicians are expected to know how to work with every presentation. |
| P5: lack of access - we are not able to address the needs of all deaf people – doesn’t expand on that; deaf people |
seem to choose hearing people to work with (who can sign fluently).

P6: considers services for deaf CYP better because they have access to both CAMHS and NDCAMHS. Specialised services are brilliant and better than hearing services for deaf people because they have the knowledge background. However, the services for adults reduce significantly – “so thin on the ground”. Hearing personnel rest on their laurels a bit – not taking into consideration their competency in working with deaf people specifically. Specialist services are isolated – not common standards because no research to show evidence of what works for deaf people so every service is doing it their way. Research is difficult to be conducted and to be accessed because of being written in English and because of diversity of deaf population.

P7: not enough support for clinicians to write research papers (very isolated as professionals maybe?); We are not supporting deaf kids since we are mainstreaming them and also not being able to notice their MH difficulties because they are quiet, until they get severe e.g. self-harming. Preventative work – tier 2 is lacking. More services on all tiers plus charities. But at least we have NDCAMHS in different locations - not everywhere, but parents can drive to them. Joint up services is what is needed: all services for deaf kids to work together.

P8: not enough people with the lived experience.
Considered working with deaf people as a social justice matter:

In different understandings

- P1: unfair treatment
- P2: staff with the lived experience - deaf people in deaf MHS – political decisions (more socially)
- P3: accessibility
- P4: accessibility
- P5: accessibility
- P6: no
- P7: oppression and discrimination (more socially)
- P8: staff with the lived experience

Recommended best practices for practitioners:

- P1: be transparent; work with qualified interpreters; check about confidentiality with the client in the room; do speak with the interpreter in front of the client so we don’t disempower them (and possibly to express that therapists lead the session).
- P2: have a personal interest; BSL level 6, socialise with Deaf culture so you understand the history of oppression; adopt a culturally affirmative approach; therapy in BSL.
- P4: receive appropriate training (e.g. BSL) and supervision; therapy in BSL.
- P5: BSL level 6 (doesn’t directly suggesting working in BSL).
- P6: deliver therapy in BSL if you can; engage deaf clients – learn from them what they need (that is the specialist training); have at least one deaf peer to discuss and reflect.
P7: knowing your limitations in BSL, learn BSL, have Deaf awareness training; ask for language support if necessary.
P8: learn BSL from a deaf person; educate yourself about Deaf culture.

<table>
<thead>
<tr>
<th>Changes on mental health services:</th>
<th>8/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services need to come together to achieve those changes</td>
<td>P1: to work with qualified interpreters</td>
</tr>
<tr>
<td></td>
<td>P2: to engage more deaf people in deaf MHS in high up positions – trust and logic; scrap the medical model &amp; adopt a linguistic cultural minority model</td>
</tr>
<tr>
<td></td>
<td>P3: to do preventative work; more MHS for deaf adults</td>
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<tr>
<td></td>
<td>P4: more mental health services to respond to the different severity of presentations</td>
</tr>
<tr>
<td></td>
<td>P5: to provide training on working with deaf CYP and adults; getting it right for everybody</td>
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<tr>
<td></td>
<td>P6: deaf MHS to communicate – to maintain the same professional standards</td>
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<tr>
<td></td>
<td>P7: more MHS to respond to risk earlier on.</td>
</tr>
<tr>
<td></td>
<td>P8: to engage more deaf people in deaf MHS - equity and lived experience</td>
</tr>
</tbody>
</table>

| Solutions outside the discipline of mental health: | 5/8 |
| Changes need to happen on a societal level | P2: social understandings of deafness – need to stop being oppressors. |
|                                            | P3: deaf education and local authorities; interpreting services need to be consistent; social understandings of deafness to change – “deaf and dumb” |
|                                            | P6: to make research more accessible (but does not identify how) |
|                                            | P7: deaf services to be working together (not only MHS) |
preventative work; national strategy - package of care for deaf kids and their families; educate other services like those who diagnose deafness.

P8: to increase Deaf awareness people don’t know much about deafness and coming from a minority group.
Appendix 7. Participant Information Sheet

Exploring therapists’ interest, commitment and competency in working with British Sign Language Users: Training recommendations

Participant Information Sheet (PIS)

This PIS should be read in conjunction with The University privacy notice

You are being invited to take part in a research study for the purpose of a dissertation as part of my doctorate in counselling psychology qualification. The aim of the study is to explore therapists’ training in working therapeutically with BSL users, and training-related issues, such as experiences of the counselling process, perceived competency, and perspectives on current services provided. The ultimate goal of the study is to provide relevant recommendations, derived from the participants’ accounts, regarding training therapists in effectively working with BSL users. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

Who will conduct the research?

The research will be conducted by me; Aliki Vasiliadou, as a counselling psychologist trainee based at the Institute of Education, the School of Environment, Education and Development, The University of Manchester, Oxford Road, Manchester M13 9PL.

What is the purpose of the research?

The aim of the study is to explore therapists’ training in working therapeutically with BSL users, and training-related issues, such as experiences of the counselling process, perceived competency, and perspectives on current services provided. The ultimate goal of the study is to provide relevant recommendations, derived from the participants’ accounts, regarding training therapists in effectively working with BSL users.

Why have I been chosen?
You have been chosen to take part in this study because you are a qualified therapist or a therapist in professional training working or having worked with BSL users.

**What would I be asked to do if I took part?**

You will be asked to participate in an interview with me, as the researcher, which will be based on your experiences of working with BSL users, your training route and your views on current issues of the topic. The interview will be in a semi-structured form and therefore, relevant themes are expected to emerge throughout the interview. The transcript of the interview will be given to you, as the participant, in case you feel the need to add, amend or exclude any information.

**What happens to the data collected?**

In order to undertake the research project, we will need to collect the following personal information/data about you:

- Name
- Age
- Position
- Work place
- Ethnicity
- Contact Information

The process of the interview will be audio-recorded using a recorder and a verbatim transcript will be produced using the audio.

We are collecting and storing this personal information in accordance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018 which legislate to protect your personal information. The legal basis upon which we are using your personal information is “public interest task” and “for research purposes” if sensitive information is collected. For more information about the way we process your personal information and comply with data protection law please see our [Privacy Notice for Research Participants](#). The University of Manchester, as Data Controller for this project, takes responsibility for the protection of the personal information that this study is collecting about you. In order to
comply with the legal obligations to protect your personal data the University has safeguards in place such as policies and procedures. All researchers are appropriately trained, and your data will be looked after in the following way:

Data will be used for the purpose of the dissertation only. Data will be anonymised by using a code as soon as collected. However, your consent form, contact details, audio and transcript will be retained for 1 year. The audio and its transcript will be stored in the University of Manchester's Research Data Storage. Only the researcher will have access to this information.

You have a number of rights under data protection law regarding your personal information. For example, you can request a copy of the information we hold about you, including audio recordings. This is known as a Subject Access Request. If you would like to know more about your different rights, please consult our privacy notice for research and if you wish to contact us about your data protection rights, please email dataprotection@manchester.ac.uk or write to The Information Governance Office, Christie Building, University of Manchester, Oxford Road, M13 9PL at the University and we will guide you through the process of exercising your rights.

You also have a right to complain to the Information Commissioner's Office, Tel 0303 123 1113

**How is confidentiality maintained?**

The audio recording will be used to produce a transcript. The transcribing will be performed by me as the researcher. Personal information will be removed from the final transcript, and a code will be used instead of names. The audio and its transcript will be stored in the University of Manchester's Research Data Storage. Only the researcher has the right to access both the audio and transcript. Your consent form, contact details, audio and transcript will be retained for 1 year. The audio will be deleted and the consent form, contact details and transcript will be shredded.

There may be the following circumstances which may lead to disclosure of personal information:

- in the event that there are concerns about your safety or the safety of others I may need to contact your GP/care team/family member
- where there is a professional obligation to report misconduct/poor practice I may need to inform your employer/professional body

- reporting of current/future illegal activities to the authorities

**What happens if I do not want to take part or if I change my mind?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason and without detriment to yourself. However, it will not be possible to remove your data from the project once it has been anonymised and forms part of the dataset as we will not be able to identify your specific data. This does not affect your data protection rights.

Declining the recording is not possible as it will be used to produce the transcript. However, you have the right to stop the recording at any time in case you feel uncomfortable.

**Will my data be used for future research?**

When you agree to take part in a research study, the information about your health and care may be provided to researchers running other research studies in this organisation. The future research should not be incompatible with this research project and will concern psychology. These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the [UK Policy Framework for Health and Social Care Research](https://www.hesrc.org.uk/policy-framework/).

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research and cannot be used to contact you regarding any other matter or to affect your care. It will not be used to make decisions about future services available to you.

**Will I be paid for participating in the research?**

Participation is voluntary. There is no payment.

**What is the duration of the research?**
The interview will last no more than one hour and a half.

**Where will the research be conducted?**

The interviews will take place at a convenient for you place, which will be quiet, or via telephone/skype.

**Will the outcomes of the research be published?**

Research findings might be used as anonymous data as part of a published paper.

**Who has reviewed the research project?**

The current research study has been reviewed and approved by the school of Environment, Education and Development of the University of Manchester.

**What if I want to make a complaint?**

**Minor complaints**

If you have a minor complain after the completion of the interview, you may contact my research supervisor Dr Erica Burman at erica.burman@manchester.ac.uk

**Formal Complaints**

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact

The Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674.

**What Do I Do Now?**

If you have any queries about the study or if you are interested in taking part then please contact the researcher at aliki.vasiliadou@postgrad.manchester.ac.uk

This project has been approved by the School of Environment, Education and Development of the University of Manchester
Appendix 8. Consent Form

Exploring therapists’ interest, commitment and competency in working with British Sign Language Users: Training recommendations

Consent Form
If you are happy to participate please complete and sign the consent form below.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I confirm that I have read the attached information sheet for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.</td>
<td></td>
</tr>
<tr>
<td>2 I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set.</td>
<td></td>
</tr>
<tr>
<td>I agree to take part on this basis</td>
<td></td>
</tr>
<tr>
<td>3 I agree to the interviews being audio recorded.</td>
<td></td>
</tr>
<tr>
<td>4 I agree that any data collected may be published in anonymous form in academic books, reports or journals</td>
<td></td>
</tr>
<tr>
<td>5 I agree that the researchers may contact me in future about other research projects.</td>
<td></td>
</tr>
<tr>
<td>6 I agree that the researchers may retain my contact details in order to provide me with a summary of the findings for this study.</td>
<td></td>
</tr>
<tr>
<td>7 I understand that there may be instances where during the course of the interview information is revealed which means that the researchers will be obliged to break confidentiality and this has been explained in more detail in the information sheet.</td>
<td></td>
</tr>
<tr>
<td>8 I agree to take part in this study</td>
<td></td>
</tr>
</tbody>
</table>

Data Protection
The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the Privacy Notice for Research Participants.

Name of Participant __________________________ Signature ______________________ Date __________________________
<table>
<thead>
<tr>
<th>Name of the person taking consent</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

One copy of this signed consent form will be kept by the researcher and one by the participant.

This project has been approved by the School of Environment, Education and Development of the University of Manchester.
Appendix 9. Reflexive Questions (Patnaik, 2013)

- How has my personal history influenced the choice of topic?

- What are my personal value systems that may influence the process of research?

- How do my gender, culture and professional background influence my positioning in this topic and my relation with the participants?

- What are the alternate roles I might be called upon to play while interacting with the participant, apart from my primary role as researcher?

- What are the possible advantages that I have in terms of personal history and professional competence?

- What might be the barriers that my personal history and professional competence can create during data collection?

- How are the emerging data assimilating with my prior knowledge; making me revisit an earlier stance?
Appendix 10. Supporting Quotes

**Extract 1:**
I once was umm at a presentation by a guy called [information omitted] who works at the [information omitted] and he said something that always stuck with me, a couple of things. And it was about when he was working in a secure unit, among other things he said, here’s one ‘on my first day when stuff get there, if they had no idea of deaf culture, you have to tell them that the patients, are gonna grab them, they’re gonna tap them and that you don’t have to like panic, and pin them to the floor, it’s just that that’s just their way of getting your attention’. And the other was when he’d be talking to a patient who had schizophrenia, and this patient was saying to him and the other stuff ‘you know the government are talking to me through my cochlear implant’ and he said to a couple of the deaf stuff ‘oh yeah he is saying that the government are controlling him for his cochlear implant’. And these two deaf stuff just went ‘yeah?, well yeah, the government is making us all have cochlear implants to try and wipe out deafness and blah blah’. And the psychiatrist had to go like ‘no, no, no. that’s not what he means. He means he is hearing voices through his cochlear implant. He doesn’t mean that the government are controlling us by trying to get people to have cochlear implants’. And it’s that cultural nuance that if you don’t have that, can create all sorts of misdiagnoses or sorts of problems. Because without that, lens to interpret and understand the behaviour through, you would see it as pathological behaviour. (54-71)

**Extract 2:**
and in particular one of the things you have to swallow is to sit there with deaf clients and they’re moaning about hearing people, and they’re moaning about hearing culture, they’re telling you how shitty it is, how awful hearing people are. And you are sat there as the hearing person thinking ‘yes, we are awful, we do oppress you’. You know and it’s hard to swallow, and sometimes I’ve had to be like ‘you do realise that I’m hearing right?’ ‘yes’ ‘oh okay, just checking, just checking’. But, but, it’s, the really is that we are part of the oppressors, the reality is that you know, there is something to answer for, and I suppose in my mind, it’s akin to the civil rights movement in the 60s, perhaps a bit less energetic, but it’s almost akin to it in the respect that I think there’s an apology that deserves to come from institutions within the hearing world for their previous treatment of deaf people. Because they have tried to lock them out and done seriously horrible things. And I don’t think it’s ever even been acknowledged by the majority of the hearing population. It’s you know, I don’t think it’s been acknowledged in a lot
of ways. And I think because of that there’s still a huge amount of hatred, resentment and fear amongst deaf people, of hearing people. And you know, it causes huge boundaries. (766-781)

**Extract 3:**
Because I think so many deaf people are institutionalised, and by that I mean ‘doctor knows best’, ‘hearing knows best’. You know, they will just take it as given, and they always would position themselves as less than, as less than hearing people. And a huge part of my work with I would say a majority of my deaf clients is looking at their identity and their deaf identity, and there’s a sign in sign language that is this [signs] and it basically means like being assertive, like kicking back against the oppressor. And that’s a huge thing for me is to build their confidence and work in a way that affirms that there’s nothing wrong with being deaf. (608-615)

**Extract 4:**
I think probably you know, I’m employed by the NHS, in my service I don’t think that was seen as a necessity for me, because I’ve done all the training that I’ve done in mental health. So, I think there was sort of an assumption that I can pick that up within the team and with asking people in the team and working with my supervisor and reading and stuff. I don’t really, they don’t need to pay for me to go and do a you know one day a week course or something, I think it ends up being, it’s not a masters but it’s like a stand-alone course you know umm. So yeah it’s one of those things that I’d like to do a lot more but it’s finding the time really, cause I work full-time so it’s you know you’ve got to really have buying in from your manager to let you have that time to do those courses and you know, it’s very difficult in the NHS (soft laughter). (214-223)

**Extract 5:**
so, in a hearing group you could take certain things for granted, about how you know, you inherit, you have the genetic make-up of your parents, that you inherit a vulnerability genetically which may or may not be expressed depending on a number of mental conditions. So you can give a few examples might take 20 minutes in a group, so in the deaf group, we quickly came up against the idea that they have no idea about genetics or inheritance. So we spend time talking about inheriting characteristics from your parents, so it might be hair colour, or eye colour, then we had a massive digression because they were all interested in inheriting deafness or not, and then the following week we started talking about the idea that you may or
may not inherit something, so, if your parents have diabetes for example, you are more vulnerable, you might get it but might not get it, depending on what happens with you da, da, da. Three weeks down the line, we’re back to where we started going like now let’s talk about schizophrenia. And that again, that’s a very typical thing. (429-441)

Extract 6:
Cause one of the issues around working in deafness is you’re expected to know about everything. So again, this is another umm issue of inequality. If you’re a hearing person, with an eating disorder for example, you go to an eating disorder service, or you’ve got problems with substance misuses, you to a substance misuse service. If you’re a deaf person, you go to a deaf service, which is supposed to deal with your eating disorder, your substance misuse, your schizophrenia, you know, you kind of juggle all traits and that’s very much what it is in the beginning. Over the years, that’s changed a bit in that there’re now specialist forensic services for deaf people which is good, cause that didn’t use to happen, umm, and there’re other people who developed interests, but it’s a little, it’s still quite like that, which isn’t right, because we don’t all know everything about everything. (256-266)

Extract 7:
R: do you think they [BPS] have a role there? (279)

P: (softly laughs) umm, I did do some work [omitted] through the BPS. That was again because I (indistinct) my noise in because I found that the BPS had asked someone to do it... (281-4)

Extract 8:
P: well I think in any organisation you could you bottom-up or top-down can’t you? In my experience, I think you need buying from the top (questioning tone), you know, and I just don’t think it’s a priority you know. Although I’m, umm I’m an advocate of change regarding deafness in all kinds of things, I’m not a committee person (laughs). So maybe if there was someone from the BPS that was passionate about deafness, then maybe the BPS would have a role, I’m just a bit cynical about them. (294-9)

Extract 9:
P: But I think what’s more tricky is the more Tier 2 typed work. So, a lot of the preventative type of work is lacking, umm a lot of the knowledge and expertise in working with deaf kids
would be lacking in the more generic sense, so that’s tricky. Whereas hearing children, that’s much more available to them, of course. (42-5)

(…)

R: what changes would you recommend for tier 2 then? What do you think it should be necessary? (60-1)

P: I think, thinking about it, joint up services would be better. So, practically, it’s about how we as deaf CAMHS link in with all the other services that are out there that work with deaf children such as the charity and the voluntary sectors and all of that. I’m thinking about a cohesive way of working together with these kids cause the charities do a lot of work, the NDCS for example, they’re doing lots of work with families and deaf kids, but they’re not mental health professionals. So, they’ve got a limit into what they can offer umm and so, there isn’t a tier 2 service, at all, for deaf kids. So where would you start with that is such a [indistinct] project, isn’t it? You need lots more money, which we haven’t got, to be able to provide that sort of service, cause that would be nationally, and that would be across the country, it’s just about more Deaf CAMHS and tier 3, let alone tier 2. (64-74)

**Extract 10:**
R: do you think the BPS has a role there? Either in terms of guidelines or funding? (381)

P: I don’t know what the BPS would do. I don’t think they do much at all, do they? (…) I don’t know, I don’t know what the BPS does really, to support any psychologist to be honest. (383-5)

**Extract 11:**
Umm I think the problem in our profession, in clinical psychology is that umm it is notoriously White middle-class female (indistinct). And there’s been a lot of work in the past 10 years to try and move away from that and increase diversity in the profession. But I think the very nature, and I think that’s probably true for counselling psychology maybe not to the same extent, but in order to get into this profession, you have to have a good academic degree. And you have to have, you know, good knowledge base and understanding umm etc, etc. and I think that, that limits, that’s limiting…and there’s a constant threat that that’s going to be revoked,
that will no longer be NHS funded placements. Which is incredibly worrying for the profession because it will streamline even more this white middle class emphasis, not emphasis, bias. Because you’ll have to be able to afford the fund yourself for 3 years of postgraduate education with no salary. Umm but also paying for it. And the truth of the matter is that is you know, the more people that are going to afford that are going to be white middle-class people.

(320-336)

Extract 12:
And I think (sighs), I hesitate with the BPS because, BPS feels like (brief pause) much less of a robust organisation than it used to be, there’s lots of cracks in the BPS now for various reasons. Partly because umm you know it’s not our regulatory body, the HCPC regulates our profession. There’s no longer a requirement for psychologists to be part of the BPS because of that. There’re a lot of political issues with the BPS so I think maybe that’s a different discussion, but to answer your question, yes I think every, every professional body has a responsibility to ensure that they, people that it is governing, are (pause) educated to a certain level in working with interpreters and different languages and different cultures. (280-8)