# Lost in translation? Therapy in a Deaf world.

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**Abstract**

Deaf communities worldwide have varying experiences of counselling and psychotherapy. The impact and significance of Deaf culture and language on the relationship dynamics between therapist and client are explored. Early childhood experiences, psychological factors, barriers and challenges faced by members of the Deaf community when seeking to engage the services of a therapist have been examined in this thesis. These barriers primarily pertain to the lack of availability of therapists who are proficient in sign language and who are culturally competent vis à vis Deaf culture. Furthermore, this paper discusses reasons why members of Deaf communities engage with therapy; motivations which are specific to their social and cultural contexts. These include Deaf people's experience of cultural dissonance from hearing family members during childhood, its impact on identity formation, including feelings of isolation and navigating the complex dynamics of belonging. Also observed in this thesis are perspectives of invested stakeholders; particularly therapists and interpreters. This is a secondary piece of research and outcomes of same are discussed in the conclusion section. These findings consider interventions that are both effective and challenging, which include recommendations for best practice frameworks in the therapeutic arena; to prevent Deaf people's personal narratives from getting lost in translation.

*Keywords: Deaf communities, counselling and psychotherapy, sign language, interpreters, culture.*

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**Lost in translation? Therapy in a Deaf world.**

This thesis is concerned with exploring the trajectory of Deaf people's therapy journey, from pre-counselling to post counselling experiences. It seeks to understand Deaf people's experiences of therapy as well as highlighting the impact and significance of Deaf culture and language on the relationship dynamics between therapist and client. Throughout this work, *deaf* will be presented with a capital D as it is common practice to do so when identifying as culturally Deaf and a member of the Deaf community (Whyte et al., 2013).

The first chapter, *Before the Chair*, will focus on the period leading up to a Deaf person's engagement with a therapist. It will start by examining early childhood experiences, psychological factors, barriers and challenges faced by members of the Deaf community when seeking to engage the services of a therapist. These barriers primarily pertain to the lack of availability of therapists who are proficient in sign language and who are culturally competent vis à vis Deaf culture.

Chapter Two, *In the Chair* will explore the experiences of sitting in a therapeutic environment, from both a client and therapist perspective. This chapter will also consider some of the main reasons why members of Deaf communities engage with therapy, reasons which are specific to their social and cultural context, their sense of self. These include Deaf people's experience of cultural dissonance from hearing family members during childhood, its impact on identity formation, including feelings of isolation and navigating the complex dynamics of belonging; which may change over the life course as relationships between Deaf individuals, their families and Deaf communities are discovered.

Finally, Chapter Three, *Beyond the Chair,* will discuss what current practice frameworks are effective, identifying challenges; and going forward how the therapeutic field can evolve in a way where Deaf people can equally enjoy a world of holistic therapy.

Figure 1. Susan Dupor, *Family Dog.* 1991.

## Chapter One – Before the Chair

### Deaf People and Early Childhood Experiences

We know from research that Deaf children are more likely to be isolated, bullied or abused (Wolters et al, 2011; Kvam, 2004), which can impact upon mental health. There is a large body of literature on prejudice towards Deaf children and their families and experiences of feeling stigmatised.

The above painting, *Family Dog*, by Susan Dupor, (Figure 1) captures the emotions and experiences of being a Deaf child in a world of hearing families that do not use sign language. The faces are blurred, which equates lipreading to the experience of listening to a

TV programme disrupted by static. The Deaf child, who wears hearing aids, is likened to a family pet that is patted on the head while being told 'Good girl, good girl.' Dupor, (1991) notes how Deaf children of hearing families can feel very lost and alone if there is a lack of strong and positive communication methods taking place within the family. In the painting, the child is isolated and kept distant from the family by a gate, expressing the isolation felt by being ignored and emotionally neglected.

Furthermore, Whyte et al (2013) mention how a great number of Deaf people share a common experience called the ‘dinner table syndrome’, a term informally coined by counsellors working with Deaf college students. It describes how hearing family members speak about their day around the dinner table and, all the while, the Deaf person is missing out on these exchanges. Access to information is further reduced because radio, television, movie soundtracks, overheard conversations, public address announcements, and other auditory sources of information are inaccessible to Deaf people (O’Hearn & Pollard, 2008).

However, these feelings of isolation are not restricted to private life, they are also experienced in public life. In the Irish context, institutional abuses would have had a considerable impact among the generation of people in their sixties and seventies. Two chapters in the Ryan Report (2009) are dedicated to the deaf schools in Cabra, Dublin (St. Mary's and St. Joseph's) where children were segregated on the basis of their ability to hear/speak and many were actively discouraged from signing (by tying hands behind their backs) as it was believed they would become lazy and not make a proper effort to learn to speak. This was not only culturally damaging, but psychologically too as cited under Nature of Allegations (Ryan Report p. 555, Section 15.26 / p. 577, Section 13.136 & p. 559 Section 13.31).

**Psychological Factors leading to Deaf People Seeking Therapy**

Deaf people often experience additional difficulties, including sight, neurological and learning disabilities; particularly among those with non-genetic causes of deafness. Deaf children, particularly those born to hearing families, often experience difficulties in age appropriate language development, in addition to social, psychological, emotional and educational development. Over 90% of Deaf people with early profound deafness are born to hearing parents; which can generate questions around one's identity and sense of belonging in hearing and deaf worlds (DeafHear, 2015).

Leigh (2009) discusses cultural marginality being born into this environment and having no Deaf peers; and how this social marginality can lead to psychological marginality regarding identity confusion, for example a poor sense of self. Moreover, this cultural marginality can also occur for Deaf people who develop linguistic competence in English and sign language, as they are caught between two worlds; deaf and hearing, and struggle with a sense of not belonging to either. Furthermore, those who have an acquired deafness struggle with the loss of their hearing identity, all the while navigating a new one (Leigh, 2009).

A recent study found how psycho-social difficulties are four times greater among Deaf children than in a group of hearing children (Fellinger et al., 2012). This is echoed by DeafHear, (2015) who note how Deaf children overall are more likely to experience emotional, physical and sexual abuse than hearing children. Approximately 25% of hearing women in the United States experience rape in their lifetime, whereas 69% of Deaf women have been found to experience increased rates of assault consistent with other marginalized populations, with 56% experiencing multiple types of assault (Smith & Pick, 2015).

There is emerging data regarding suicide risk within the Deaf community. Research suggests that Deaf people have higher rates of suicide ideation and/or suicide attempts than their hearing counterparts (Turner et al., 2007). Also relevant to suicide risk is evidence that

Deaf individuals have a higher incidence of being abused. It is estimated that Deaf children are twice as likely to be neglected or emotionally abused, and four times as likely to be physically abused as their hearing counterparts (O'Hearn & Pollard, 2008).

Delays in access to services and difficulties in diagnosis, including misdiagnosis, often lead to prolonged duration of mental health difficulties. In certain cases, severe mental health problems such as schizophrenia and psychosis may go untreated for several years, adding to the already vast array of barriers to therapy (DeafHear, 2015).

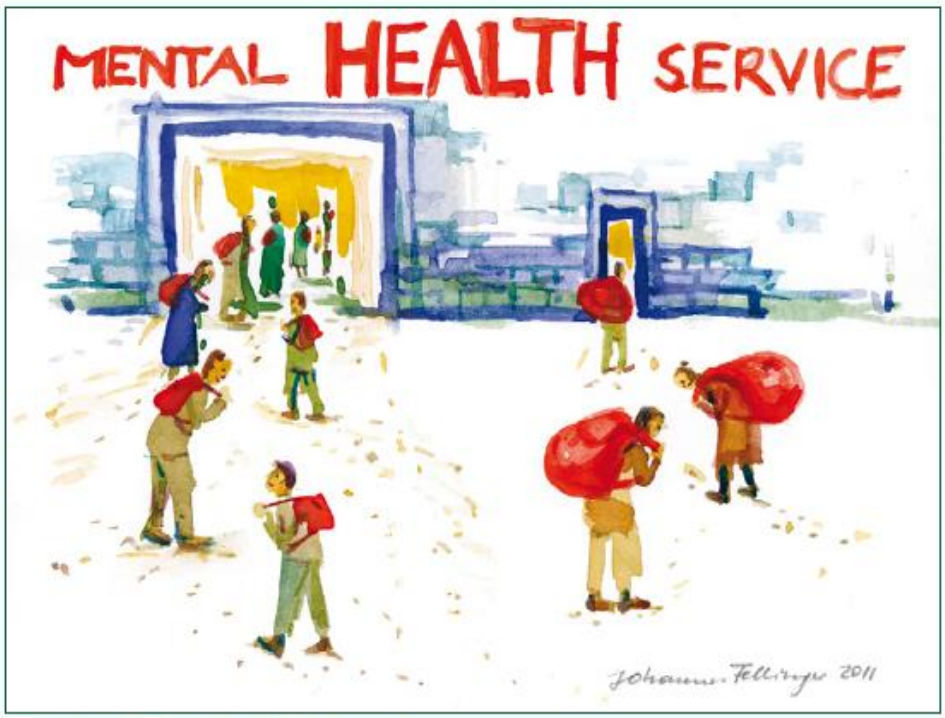


***Figure:*** **Burden of mental health problems on deaf people**
The burden of mental health problems is symbolised by rucksacks, which everyone carries and from which they seek relief. The rucksacks of deaf people are bigger but the entrance to services is smaller, because accessibility is poor.

Figure 2. Burden of mental health problems on Deaf people. Johannes Fellinger 2011.

**Barriers to Therapy**

Are mental health services balanced or do they indiscriminately discriminate? What are the main obstacles faced by Deaf people that the hearing community do not have to navigate? In the image above, Fellinger, 2011 (Figure 2), gives a visual representation depicting Deaf people's experience of access to therapy; which he argues are characterised

by low levels of access relative to the prevalence of mental health problems among Deaf communities. Anderson & Wilkins (2019) speak of the many hurdles in a Deaf person's path to therapy, including language barriers, health literacy and cultural considerations.

A Deaf person's primary language is sign language, however there are a limited number of sign language fluent therapists. As written English is acquired as a second language, many Deaf individuals have also been impacted by early language deprivation. Additionally, according to the Irish Deaf Society, Ireland is unique due to having gendered sign language. Irish Deaf men and women can display variances in their vocabulary due to being segregated on the basis of gender in their education; this mainly applies to older Deaf adults.

Having established that only 10% of Deaf children are born into Deaf families; if a hearing majority family does not learn sign language, or recognise the need for greater communication, a Deaf child may not access language until school age. This can result in an array of language, cognitive and socioeconomic delays. Additionally, many adults Deaf since birth or early childhood do not know their own family medical history, having never overheard their hearing parents discussing this with their doctor, or themselves (Anderson & Wilkins, 2019).

The Deaf community sees itself as a linguistic and cultural minority group as opposed to being disabled and needing to be 'fixed' by the majority. It is living in a non-signing world that can be disabling, not the experience of being Deaf. Deaf people share a collective name, language, culture, history, values and feelings of community among others. Being Deaf is a biological characteristic, it is not a condition, it is a way of being (Whyte et al., 2013).

A historic year for the Irish Deaf Community was 2017 as the Dáil passed legislation that gave official recognition to Irish Sign Language for the first time. While this is ground-breaking in ensuring the provision of an interpreter is upheld in the public sector, a prevalent

barrier is the scepticism and fear among Deaf people associated with the prospect of communicating through a sign language interpreter for a therapy session, which will be explored in the next chapter.

## Chapter Two – In the Chair

### Understanding Deafness and a Sense of Self

One of the many functions of language acquisition is the child's understanding of him or her as the *self*, as well as parents, siblings et cetera being the *other*. In many cases, the "development of and exposure to language appears to be delayed for Deaf children of hearing parents" (Du Feu & Chovaz, 2014, p. 39).

The family environment is often where "oppression first shows itself" (Corker, 1996, p. 38). Corker observes how Kleinian theory placed the roots of the self very firmly in the mother-infant relationship, even to the point where the wider world was regarded as being "insignificant in the development of the self, which precedes the development of identity and it does not preclude environmental and social factors from influencing the development of identity" (Corker, 1996, p. 34).

Additionally, for "psychosocial development, a child's first task is to resolve the conflict between trust and mistrust and the success with which this can be done will depend on whether they form secure attachments with their parents" (Corker, 1996, p. 34). Corker further observes how some Deaf clients "internalise hatred and ambivalence" and experience alienation from the self and others (Corker, 1996, p. 47). For a person who is oppressed, one of the key tasks of identity formation then involves coming out as different and integrating a sense of that difference into a healthy self-concept, which may itself be stigmatised by the majority society (Croker,1996).

Deafhood, as coined by Paddy Ladd, represents a process by which each Deaf child, Deaf adult and Deaf family explains to themselves, and each other, their own existence in the world, "specifically by treating Deaf people as Deaf people rather than treating them as hearing people who cannot hear" (Ladd, 2003, p. 3).

Furthermore, not only are Deaf people deaf within their own community, they are part of a wider society in which they have no identity. Ladd continues by noting how many Deaf people, who grow up in hearing households, will talk about finding the Deaf community in their twenties and finally achieving a sense of belonging that they never had at home.

Studies show there can be some grief over a lost youth and also blame and anger towards parents who took decisions to opt for cochlear implant or mainstream education, rather than engaging with the Deaf Community (Alexander et al., 2012). In contrast, Ladd notes how sign language users are those who were born Deaf or became so at an early age, and for them, the issue of loss has no meaningful reality (Ladd, 2003).

According to Padden & Humphries, "culture offers the possibility of making Deaf people whole" (Padden & Humphries, 2005, p. 161), as opposed to Ladd who observed how "Deaf people already see themselves as being whole". The fact of not being able to hear is rendered secondary to the positive experiences created by their "social, cultural and artistic lives together" (Ladd, 2003, p. 164). Culture also provides a way for Deaf people to reimagine themselves and form a sense of self. It allows them to think of themselves not as unfinished hearing people but as cultural and linguistic beings in a collective world with one another (Padden & Humphries, 2005).

**In the Chair - from the Client's Perspective**

As discussed above, throughout history Deaf individuals have been chastised for using sign language, for instance in their schools. Corker observes how Deaf clients,

especially older clients, are likely to have conflicts about their language usage and cultural identity within the therapeutic relationship.

Often significant others in a Deaf person's life have not learned sign language. Without effective language interactions, Deaf individuals may have limited ability to express themselves with others and may also struggle to label their own experiences, thoughts, and feelings (Corker, 1996).

Padden & Humphries note that most available therapists are hearing and therefore represent the majority oppressor group. Additionally, they observe how "Deaf people struggle with the problem of voice and how to make themselves heard over a powerful other voice of hearing people who define them and their needs differently" (Padden & Humphries, 2005, p. 101). Furthermore, Deaf people have had to contend with hearing people being positioned as expert in relation to their wellbeing, which has fostered resentment and mistrust (Ladd, 2003).

Research into Deaf experiences has shown that counsellors who are unaware of their disablist attitudes may further oppress their disabled clients within the counselling room (Corker, 1996). Examples of oppression experienced by Deaf individuals in therapy include assumptions by the counsellor that relationship problems are the result of impairment or disbelief that a disabled client would consider refusing surgical intervention to be normalised (Reeve, 2002).

Deaf clients' experiences are, that if a history of oppression is not addressed in the therapeutic process, it can lead to increased mistrust and fear along with a decrease in engagement, efficacy and value (Whyte et al., 2013). Encouraging a Deaf client to become more hearing for instance, by suggesting that the client should speak or consider getting a cochlear implant, resulted in the client feeling less than human.

To combat this, Deaf clients expressed how several important issues need to be considered, including cultural competence, client empowerment and working with sign language interpreters, in an effort to ensure effective therapy (Whyte et al., 2013).

In the case of interpreted interactions, “Deaf clients can harbour fears and misgivings about the confidentiality of proceedings and the impact on their privacy; one such fear is that the interpreter will be known to them” (Anderson, 2017, p. 119). Studies show how this fear is heightened by the fact that many CODAs, Children of Deaf Adults, go on to work as interpreters and therefore the Deaf person's private information is perceived as being at risk of exposure across the Deaf community (Anderson, 2017).

Anderson continues to note when Deaf individuals are able to access behavioural health services, they often express confidentiality concerns similar to other persons living in small communities. These concerns include the high probability that interpreters belong to the same social circles as the client, as well as the possibility that the client’s private information will travel through the “Deaf grapevine” to community members that may judge or even harm them (Anderson, 2017, p. 119).

Sign language interpreters are not only interpreting what is said between the Deaf and hearing persons, they are also mediating between cultures (Whyte et al., 2013). The presence of an interpreter also “alters the dyadic relation” between therapist and the Deaf client (Lane et al., 1996, p. 352). However, introducing a person who signs into the therapeutic relationship does not instantly solve communication problems. For example, when a Deaf person is nodding, it means he or she is listening and sees what is being said. It does not necessarily mean that person is in agreement with what is being said. It is therefore important that an interpreter, or therapist who signs, has a level of proficiency which enables them to fully understand the client’s expression, which involves signs *and* non-manual features including body and head movements, and facial expressions (Herrmann, 2013).

Additionally, experiences have shown the paramount importance of being mindful that while the sign may be used for emotional words of varying intensity may be the same, much meaning around the intensity of emotions is conveyed through other indicators such as facial expression. For example, when a client signs that she or he is mad with an enraged facial expression for instance, there is no telling what terminology the interpreter will choose to describe the client's anger (Ladd, 2003).

Language difficulties may persist despite the presence of an interpreter and many relationship factors are changed with the addition of a third person (Williams & Abeles, 2004). For example, the addition of a third person changes transference dynamics and alliance development. A Deaf client may either see the interpreter as an intruder or as the true helping professional, with the hearing therapist becoming the outsider. Furthermore, an interpreter will likely experience countertransference-like reactions to the client much as the therapist will (Williams & Abeles, 2004).

### In the Chair - from the Therapist's Perspective

The Irish Association of Counselling and Psychotherapy's Code of Ethics allow for therapists having respect for the rights and dignity of the client, and to give due regard to their moral and cultural values (IACP, 2018). Within counselling, the core conditions offered by the counsellor are considered to be the essential minimum for a working alliance between the therapist and client. A healthy counselling relationship occurs when the counsellor-client relationship is one of partnership and equality (Corker, 1996). As discussed above, the main imbalance of this equality can be due to hearing privileges. However, a therapist will begin with the assumption that each client has his/her own personal language. The task is uncovering and understanding what the meaning of that language is for that individual (Boyd, 2007).

While contemporary data on both sign language interpreters and hearing therapist research is limited, Jeni Boyd's experience reflects a range of collective encounters felt amongst hearing therapists. Boyd's experience led her to feel that there is a climate of underlying negative assumptions about deafness generally with a focus on the disability rather than the person, resulting in feelings of inferiority and shame. Ladd supports this argument by noting how one assumption is that each born Deaf person is a helpless, isolated hearing-impaired individual, with no intrinsic relationship with any other Deaf person, past or present, no group allegiances or history. Another is that Deaf individuals can be "restored to society by the use of technology in conjunction with Oralism", especially if they are denied access to Deaf adults and, sign language and, where possible, other Deaf children (Ladd, 2003, p. 163).

In Boyd's experience, both the client and therapist come to the room with their own individual assumptions. Given a hearing privilege, Boyd experienced a power imbalance. While Corker (1996) suggests that this power inequality can inhibit the counsellor's use of transference and counter-transference, Boyd found that "this in fact enhanced the therapeutic alliance" (Boyd, 2007, p. 94).

Therapists are not immune to cultural biases and misconceptions about Deaf people. These assumptions need to be confronted so that they do not hinder the therapeutic process. The fact that nonverbal messages are a central component of sign language (Corker, 1996), combined with the fact that Deaf individuals are traditionally less powerful in their relationships with members of the mainstream hearing culture and therefore may be more attuned to nonverbal cues, suggests that they will be quick to perceive therapists' anxiety or discomfort (Williams & Abeles, 2004).

As Boyd became aware of her own feelings of disempowerment, she was able to appreciate more fully how a Deaf person can become the victim who is persecuted by hearing

people; and “straight away found herself embroiled in her own rescue fantasy” (Boyd, 2007, p. 94). In this particular case study, Boyd observes how therapists cannot cure a medical condition, “a client’s deafness is permanent and any trace of pity was eliminated by the lack of self-pity the client had in herself” (Boyd, 2007, p. 94).

Ladd supports this point as traditionally, one assumption is that Deaf individuals have been seen as needing a language helper; however, the reality is that most Deaf individuals have ample experience in communicating in less-than-ideal circumstances (Ladd, 2003). It is also worth noting that interpretation is not only a requirement of a Deaf person; it facilitates communication in both directions. These strengths, along with challenges, will be explored in the next chapter.

## Chapter Three – Beyond the Chair

### Current Strengths - What is Working?

Historically, most evidence based therapies that combine traditional talk therapy with client worksheets, fail to meet Deaf clients’ unique linguistic and cultural needs (Anderson & Wilkins, 2019). However, incorporating contemporary approaches has enriched the therapeutic experience for the Deaf community. Translating worksheets into sign language, along with using visual, pictorial and video aids have made significant improvements.

Anderson & Wiklins (2019) also note how the use of technology through apps, mood trackers and sign language videos promote effective communication between the client and therapist. Hoggard (2006) observed how art and the use of images are paramount when accessing the silent world. This is supported by Hindley & Kitson (2000), who mention how imagery has proven successful while practicing systemic theory in a family therapy setting.

Furthermore, mindfulness practices involving internal directives such as watching one’s thoughts or feelings quietly, are particularly challenging for Deaf people. This may be

due to the extreme isolation and lack of interaction growing up in hearing families where communication was often severely limited. Therefore, focusing on what can be "seen, touched and smelled in the room for two minutes has proven to be less traumatic" (O'Hearn and Pollard, 2008, p. 410).

Narrative therapy is another constructionist approach that has been suggested as a "linguistically appropriate style of therapy for use with Deaf clients" (Munro, 2008, p. 310). This is echoed by Freedman (2019), who observes how the use of storytelling, life-lines, genograms and externalisation of the issue for example have been extensively successful when working with Deaf clients.

Additionally, the influences of constructivism can be seen in several different modalities; including humanistic, person-centered, cognitive behavioural, dialectical, psychodynamic and existential approaches to therapy. Research has shown how adapting best practices in cognitive behaviour therapy for Deaf clients has been successful; especially when the treatment is oriented around the development of psychosocial skills (Glickman, 2009). Cognitive behaviour therapy can lend itself to adaptation to various client groups, including Deaf people, "as its strength is its ability to produce individualised treatment plans" (Hindley & Kitson, 2000, p. 388).

CBT bespoke treatment plans have been successfully used to change negative thought patterns. Having established that Deaf people have an elevated risk of suicidal behaviour, incorporating scale questions into this intervention has been helpful when communicating feelings. Understanding that certain words discussed earlier have the same sign, for example *angry, furious* et cetera; and acknowledging that the intensity of the sign and facial expressions may change; has proven crucial in therapeutic interactions.

Likewise, given the word suicide in English has several specific signs, such as *slash wrist, take pills* or *hang self,* the use of straightforward questioning, for example '*do you*

*want to kill yourself?*' has proven to be successful in communicating clearly (Whyte et al., 2013).

Furthermore, while application of the humanistic core conditions of empathy, congruence and unconditional positive regard is the foundation of a strong therapeutic alliance, learning basic sign language and finger-spelling, alongside working with qualified and accredited interpreters, may aid in building rapport and demonstrate an interest in the client's language (Whyte et al., 2013).

### Current Challenges - What is Not Working?

While having established that holding a basic knowledge of sign language has benefited the therapeutic relationship; some communication challenges are still prevalent. Siegrist (2012) notes how several Deaf people never learned a natural sign language; relying only on distinctive sign systems developed within their family of origin as their primary means of contact.

Moreover, assuming Deaf people can use English and practice lip-reading is a "common oversight by therapists who are unfamiliar with Deaf culture and sign language". This assumption can lead to fear within the client of not being able to communicate adequately; and concern as to how this may impact their treatment. Further aspects of Deaf culture, including the valued sense of community, deaf communication tactics and the intrinsic resistance of the 'deaf-as-deficit' view, could cause "ruptures within this therapeutic relationship if they are not understood" (Gill & Fox, 2012, pp. 644, 648). Therefore, Deaf individuals feel more comfortable communicating with sign-proficient therapists, as there is a belief that they would have greater awareness about Deaf culture (Steinberg et al., 1998).

As all modalities of psychotherapy rely on clients being active participants throughout the process, a lack of understanding of what the therapist is communicating is likely to result in ineffective therapy or disengagement. Additionally, therapists experience increased emotional responses, due to the fact that sign language is visual (Gill & Fox, 2012). Similarly, interpreters experience vicarious trauma while in therapeutic sessions. Research indicates how multiple interpreters feel physically immersed within the content of a therapeutic session, and experience the same emotions as the client (O'Connell, 2020).

Nevertheless, the provision of an interpreter can create an "illusion of inclusion" (O'Hearn and Pollard, 2008, p. 404). Steinberg et al. (1998) notes how therapists must not assume that the presence of an interpreter ensures adequate communication and observe how some sign language users have no alternative but to involve their family or friends in the therapeutic process as their interpreter; which can affect both the therapeutic and personal relationships.

While the strive towards appropriate, inclusive and accessible therapy is ongoing, providing Deaf clients with only those services where communication is less demanding is as "irrational as the man who is looking for his lost keys under the lamppost, because the light is better there, instead of in the dark location where he really thinks he lost them" (Pollard, 1994, p. 157).

Alongside communication barriers, Whyte et al. (2013) speak of the medical model of deafness, whereby members of the Deaf community may possess an identity that was imposed on them. This has the potential to consciously or unconsciously interfere with the client's life, relationships and perspectives of Deaf people; which can present itself in therapy.

Further evidence in support of this is provided by Ladd (2003) who offers a cultural-linguistic model of Deafness. This essentially focuses on the collective nature of the Deaf experience rather than what is wrong with the person. “Engaging with services which are designed, operated and controlled by hearing people who enact a medical model of deafness, makes engagement with services difficult for Deaf people” (Ladd, 2003, p. 164).

**Going Forward - Where to Next?**

There has been a recent move away from the medical model of describing a person’s deafness towards this cultural-linguistic model, where “deafness is not framed as a tragedy but as a difference that can be supported and nurtured” (Du Feu & Chovaz, 2014, p. 28).

Furthermore, it has been repeatedly emphasised that Deaf people can benefit from the full range of individual psychotherapy approaches; once the therapist is “sensitive to client dynamics, sociocultural aspects of deafness, and communication issues as relevant to each approach” (Leigh et al., 2003, p. 209).

Ladd (2003) believes that if lay people learned to sign, especially as a compulsory part of their education, that both Deaf and hearing communities would be enhanced. The need for more specialist mental health services for Deaf people was observed by Fellinger et al. (2012) in a survey of Deaf adults who showed an overwhelming preference to seek mental health services from sign-proficient therapists.

According to the Irish Deaf Society (2022), there are circa five thousand Deaf sign language users in Ireland, for whom Irish Sign Language is their language of choice. Recognising the need for Deaf specific supports at national level, a specialist Deaf mental health programme was launched in 2006. This policy, *A Vision for Change*, sets out the direction for Mental Health Services in Ireland. It describes a framework to ensure accessibility, inclusion, cultural awareness and the knowledge required to meet the needs of

the Deaf community. More specifically, it recommends that effective interpretation services should be made available to ensure that people who are Deaf can access mental health services.

Another positive step forward has been the constitutional recognition of Irish Sign Language; but much hinges on the implementation of that legislation. The Irish Sign Language Act (2017) outlines the obligations of public sector bodies which include those pertaining to provision of and payment for sign language interpretation. This extends to the Health Service Executive (HSE), where Deaf individuals accessing counselling through CIPC (Counselling in Primary Care) are supported.

Although the Irish Deaf Society, Chime (formally DeafHear) and the HSE provide a collaborative range of supports for the Irish Deaf community; the lack of Deaf-led and Deaf-friendly therapy centres is evident. Much inspiration can be taken from Deaf4Deaf, who reach an estimated three hundred clients per year. This UK and Northern Ireland based service delivers low-cost and affordable Deaf-focused counselling and psychotherapy, through a team of therapists that provide evidence-based psychological therapies to people with anxiety disorders and depression.

Leeson (2020) observed a marked rise in the demand for mental health services due to the COVID-19 pandemic. The Council of Irish Sign Language Interpreters, the Irish Deaf Society and the Centre for Deaf Studies, Trinity College worked collaboratively to develop new vocabulary and explanations of COVID-19 terminology; for example ‘lockdown’, ‘social distancing’, ‘herd immunity’ and ‘contact tracing’. This supported the Deaf community, interpreters and improved awareness among Deaf individuals.

While the pandemic created a national collaborative response to improve communication and understanding, there are no specific studies of mental health in the Irish Deaf community. Furthermore, there are no specialist services serving this community.

Given the lack of Deaf-specific supports, Leeson (2020) notes how ‘this is worrying at the best of times, but with the increased demand for mental health services arising from COVID-19, access to culturally and linguistically appropriate responses is a necessity that requires investment’.

## Conclusion

### Summary

This research explored the three stages of a Deaf person’s therapeutic journey; and the impact that cultural and linguistic themes have on various stakeholders. *Before the chair* examined early childhood experiences, psychological factors, barriers and challenges faced by members of the Deaf community when seeking to engage in therapeutic services.

*In the chair* included both the client's and the therapist's perspectives on sitting in a therapeutic atmosphere. It also looked at some of the key reasons why Deaf people seek therapy; reasons that are unique to their social and cultural contexts.

The importance of effective communication in the therapeutic process was a common theme throughout this research. *Beyond the chair* examined what current interventions are effective, together with identifying various cultural and linguistic challenges; and highlighted recommendations on how the therapeutic field can evolve in a way where Deaf people can enjoy a world of inclusive therapy.

### Limitations

This body of work was a secondary piece of research, with no qualitative or quantitative data.

### Recommendations

There is much evidence in this research paper to support the need for Deaf friendly and Deaf led therapeutic services, together with additional sign proficient therapists. This is heavily supported by Steinberg et al., (1998), Fellinger et al., (2012), and Whyte et al., (2013)

who observed an overwhelming preference from Deaf communities to seek mental health services from sign-proficient therapists.

It would be worthwhile to explore Ladd's (2003) viewpoint of compulsorily learning sign language in schools. Furthermore, including sign language in counselling and psychotherapy degree programmes, along with cultural awareness training through continued professional development workshops, would allow for effective communication; especially as Irish Sign Language has legislative footing.

The author identifies the strong need for further research. Contemporary data on both sign language interpreters and hearing therapist research is limited. Furthermore, there are no specific studies of mental health in the Irish Deaf community and this study has inspired the author to research these gap themes further.

To conclude, this paper demonstrates the ways in which the author's body of work opens up a suite of possibilities for future research within this particular arena. Researching invested stakeholders, together with fostering effective communication, will inform future practice frameworks. This would enhance the therapeutic world where Deaf people's experiences, concerns and personal struggles are not lost in translation.

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# Appendices

Figure 1. *Family Dog.* Susan Dupor, 1991.

Figure 2. *Burden of mental health problems on Deaf people*. Johannes Fellinger, 2011.