

**A PHENOMENOLOGICAL STUDY INTO
BRITISH SIGN LANGUAGE USERS'
EXPERIENCES OF PSYCHOLOGICAL THERAPIES**

by

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the degree of Master of Science by Research at the
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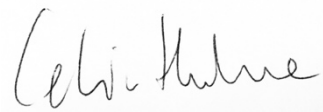
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Abstract

The provision of mental health services for Deaf people in the United Kingdom is mostly from secondary and tertiary health care that caters for the moderate to severe spectrum of mental health issues with little provision from primary care such as psychological therapies. Improving Access to Psychological Therapies (IAPT) was launched in 2008 and found not to be accessible for Deaf people; this resulted in a new BSL IAPT service being set up in 2011. Deaf people were not able to access the BSL IAPT service because of how each Clinical Commissioning Group (CCG) commission services for their local population. Commissioners do not have evidence to show the impact on Deaf people who access therapy with an interpreter versus with a Deaf therapist, and the literature on Deaf people's experiences in psychological therapies is very limited.

The aim of this study was to investigate the BSL users' relationships with their therapists by exploring their experiences of therapy alliance in Deaf/Deaf therapy and Hearing/Deaf/Interpreter therapy and to identify best practice for BSL users' who require psychological therapy.

This qualitative study uses Smith, Flowers and Larkin's Interpretative Phenomenology Analysis (IPA) approach. Data were collected from 8 participants (7 females and 1 male), who formed two groups: Group 1 had experienced therapy with a Deaf therapist and Group 2 had experienced therapy with a hearing therapist via an interpreter. Semi-structured interviews were conducted with all participants to explore their experiences of psychological therapies. Data were analysed from transcripts and these were coded using NVIVO where themes emerged.

The findings identified 6 broad themes along with 12 overarching sub-themes such as translation problems, the lack of cultural competency, holding back information, issues with there being three people in the room, and feeling safe/unsafe in therapy situations. Some participants reported they use SSE instead of BSL due to the interpreter not capturing the essence of their disclosure. It seems that the client-interpreter-therapist triad and the therapist's lack of cultural competency causes complications such as therapeutic rupture and making clients feel insecure, frustrated and vulnerable. The benefits of having a Deaf therapist were also apparent, their ability to share their similar experiences, making clients feel validated and less isolated. Combining cultural competency with the sharing of experiences appears to promote a strong therapeutic alliance.

Some of the findings suggest that Deaf people receiving therapy from a hearing therapist via an interpreter encounter negative experiences that are minimised or eliminated in the context of receiving therapy directly from a Deaf therapist. These findings are of importance as they contribute to the evidence around issues that can arise from the triad and the benefits of direct therapy for Deaf people.

The study identified four recommendations for further research. (1) perspectives of Deaf people regarding Deaf therapists, (2) to investigate if the interpreters process of strategic omission removes the essence of the Deaf client, (3) look at the cause and effect on having a third person in the room and (4) explore the views of Deaf people who have experienced both hearing and Deaf therapists using the same approach as this study.

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Abbreviations

AOHL	Action on Hearing Loss
ASL	American Sign Language
ASLI	Association of Sign Language Interpreters
BSL	British Sign Language
BSLHM	BSL Healthy Minds
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
DH	Department of Health
GAD-7	Generalised Anxiety Disorder
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Analysis
KTP	Knowledge Transfer Partnership
PIS	Participant Information Sheet
PHQ-9	Patient Health Questionnaire
RNID	Royal National Institute for the Deaf
UK	United Kingdom
VLP	Visual Language Professionals
WSAS	Work and Social Adjustment Scale

CHAPTER 1 INTRODUCTION

1.1. Background

Deaf people compared to hearing people experience a higher incidence of problems with mental well-being (Fellinger et al., 2012). The provision of mental health services for Deaf people in the United Kingdom is mostly within secondary and tertiary health care, which caters for the moderate to severe spectrum of mental health issues. For Deaf people who have low to moderate mental well-being problems, there is little provision for them at primary care level. Furthermore, the psychological therapy provision in primary care for Deaf people is very ad hoc; there is no national structure that Deaf people can follow.

Nevertheless, in 2008, Improving Access to Psychological Therapies (IAPT), a new primary care service, was launched. It originated from *The Depression Report* (2006), commonly known as the 'Lord Layard Report', which provides NICE-approved psychological therapies mainly in anxiety and depression. Consequently, this was found not to be fully accessible for Deaf people, and therefore a British Sign Language (BSL) IAPT was set up to address this issue in 2011. It would appear that even with this service provision, Deaf people were still not receiving the same access as their hearing counterparts because of the new commissioning landscape in primary care health provision.

Mental Health Commissioners from Clinical Commissioning Groups (CCGs) are not providing equity of access to psychological therapies for their local Deaf populations (Hulme, 2015). Additionally, in England there are 211 CCGs of which only two provide full access to their Deaf population by offering access to BSL IAPT; however, the other 209 CCGs all provide a different service. For instance, a Deaf person may be asked to use a hearing therapist from mainstream IAPT with an interpreter; a Deaf person may get access to BSL IAPT but have to wait months before receiving therapy because individual funding has to be approved; a Deaf person may be told that there are no

interpreters and they can bring a friend or family member to sign or simply be refused access to any service. It is a very different experience from that of the hearing population who are able to access their local services without any external factors such as GP approval or waiting for funding.

There is dissonance amongst Deaf people about this lack of parity and the fact that their requests for a Deaf therapist are being ignored. Moreover, it is hard to argue with Commissioners about the need for Deaf people to have a Deaf therapist without supporting evidence. There is very little literature available that shows the lived experiences of Deaf people in psychological therapies. As a consequence, this is where my research study comes in.

1.2. Positioning myself within the thesis

I am a profoundly Deaf sign language user and I have been Deaf since birth. I consider myself to be a culturally¹ Deaf person who is bilingual in both English and British Sign Language (BSL). I was brought up by hearing parents and I have 3 older siblings, one of whom is Deaf. I attended Deaf boarding schools from the age of 3 until school leaving age, and throughout this period I was using the aural² method with very little sign language. Since leaving school, I started to attend Deaf clubs and Deaf social events; this is where I started to learn BSL and become a proficient user.

As a Deaf person who is a strong member of the Deaf community with the same lived experiences as other Deaf people, I can empathise with, and have an insight into, the problems Deaf people face such as communication struggles that impact on mental well-being, especially when accessing services that are not specialist.

¹ In other words, I have a strong affinity with the Deaf community.

² This means communicating through listening and speaking.

I am aware of the impact of my position within this study as a Deaf person, and I believe that my knowledge can address ontological and epistemological issues. Therefore, the reflexive value of my personal experience led me to the choice of phenomenology as my research method.

1.3. *Motivations for the study*

The motivation for this study began in my post as a Knowledge Transfer Partnership³ (KTP) Associate working with University of Central Lancashire and the BSL Healthy Minds team from SignHealth. BSL Healthy Minds provides low level intensity psychological therapies to the signing population. My task was to evaluate the service; review the training programme, business plans, and marketing; and make recommendations on how to improve service provision.

There was a budget put aside to do a higher degree within the post. It was an opportunity that could not be missed and the area of study could be anything I wanted to do as long as it was linked to my personal development. However, through my KTP work, I had to look for evidence to back up statements linked to Deaf people's experiences of psychological therapies, and this proved to be difficult. It became very obvious what I needed to do; I had to contribute to the research evidence pool, especially with the perspective of a Deaf person which is not commonly seen in the field of health care research with Deaf people.

My personal and professional experiences of being Deaf and working in the Deaf community has motivated me to carry out this study.

³ This scheme is overseen by Innovate UK who facilitate the partnership working between the University and the 'project'.

1.4. Rationale

The initial literature review into Deaf people's experiences in therapies highlighted the lack of perspectives from a Deaf person in relation to psychological therapies.

Moreover, with this knowledge, a study into the experiences of Deaf people using psychological therapies was developed.

The aim of the study is:

To investigate in-depth BSL users' relationships with their therapist, specifically looking at alliances, dynamics, engagement, understanding and shared decision making

The objectives of the study are:

1. To explore the experiences of therapy alliance in Deaf/Deaf therapy and Hearing/Deaf/Interpreter therapy
2. To identify best practice for BSL users who require psychological therapy

Interpretative Phenomenological Analysis (IPA) is the chosen approach for this study as it provides an appropriate methodology to explore the Deaf participants' personal experiences of psychological therapies in detail. The IPA's three main underpinnings – phenomenology, hermeneutics and idiography are used to explore, from an insider's perspective how each participant makes sense of their experience. Parallel to the participants, my role as a researcher and interpretation of the data is acknowledged in the study.

1.5. Chapter Guide

To give an overview of the thesis structure, the remaining chapters of this work, chapters two through six, are briefly outlined here.

Chapter **Two** is in two parts. The first part presents the background to the study and pulls together key information about the Deaf population, including how Deaf people are viewed and exist in society. Three models of deafness are identified, and Deaf culture and Deaf identity are discussed further. An overview of the current situation of mental health services for Deaf people is outlined with a specific focus on psychological therapies. The second part is a more focused review of the literature on Deaf people's experiences in therapy. This section includes the search strategy where 10 papers were identified as the most relevant to the study, and this is explored and discussed. A summary is provided to explain why my study was required.

Chapter Three is the methodology where the study design and methods are described in detail. The chapter starts by looking at the ontology and epistemology of Deaf people, as this influences how the researcher approaches the study. It then shows how the Interpretative Phenomenological Approach (IPA) was implemented. This chapter also looks at practical issues related to researching in the Deaf community such as ethical implications, informed consent and translation concerns. I also discuss the rigor of the study as well as recruitment, interviews, translation and data analysis.

Chapter Four reports on the findings from the study, headlined by the main themes. In this chapter, eight participants are introduced individually to give the reader background knowledge to lead them through the rest of the thesis.

Chapter Five is where the findings are discussed in more detail and evaluated. The strengths and limitations of the study are presented and the chapter concludes with my personal reflection on the research process.

Chapter Six brings together the whole thesis. An overview on each chapter concludes the study.

The following chapter centres on the theoretical frameworks of the Deaf population and discusses the literature review.

Chapter 2 Background

2.1. Introduction

This background chapter is structured in two main parts. The first part presents theoretical frameworks to familiarise the reader with the Deaf population. Topics such as language, culture, access, barriers, mental health and psychological therapies for Deaf people are covered, along with some historical information about how services have been provided to the Deaf population over the years.

The second part of this chapter comprises the results of a structured search for literature and studies directly relevant to this paper, focussing on Deaf experiences in psychological therapies. Ten relevant papers are identified and explored.

2.1.1. Deafness

Deafness can be described in different ways. Thomas (2014: 8) states that it can *'be identified and quantified by a person's ability or inability to physically hear a certain decibel range, discussed as a disability or be defined on a cultural identity'*.

There are three main models linked to deafness, which are (i) medical, (ii) social/disability and (iii) cultural-lingual. Each model has its own way of describing what it is like to be deaf and how Deaf people are perceived, as well as its own epistemological issues.

The "medical model" of deafness is one of the oldest and other models evolved from

this over time as many Deaf people felt that they did not fit comfortably into this model (Ladd, 2003). The medical model often looks into the problems of hearing and 'fixing' that problem through assistive technology; hence it takes a negative position initially. Ladd (2003: 163) describes the medical model as having 2 constructs. The first is the characterisation of an *'isolated hearing-impaired individual, with no intrinsic relationship with any other Deaf person, past or present, [and] no group allegiances or history'*. Ladd goes on to say that the second construct is the notion that *'that these individuals can be 'restored to society' by the use of technology'*, such as hearing aids and cochlear implants.

The "social/disability" model emerged from the medical model in the early 1990s. Shakespeare and Watson (2002: 4) describe its key element as the conception of disability as an oppressed group. They claim that *'disabled people are an oppressed social group. [The social model] distinguishes between the impairments that people have, and the oppression which they experience. And most importantly, it defines 'disability' as the social oppression, not the form of impairment'*. This was mirrored in the field of deafness by Ladd (2003) and he interpreted that this model focuses more on Deaf people's physical access to services.

It appears that for many Deaf people the social model did not fit in with their needs, and there was a need for another model. The "cultural model" focuses on being deaf as a human experience. It is generally aimed at Deaf people who use sign language, those who embrace being Deaf and have a strong Deaf identity. It looks at the language, values and traditions of a culture (Ladd 2003).

2.1.2. Deaf population

The Deaf community is heterogeneous with many diverse backgrounds. This heterogeneity starts from being diagnosed as deaf and continues through language choice/use, identity, education and life experiences. Temple and Young (2004: 83) say

that *'heterogeneity among d/Deaf populations, however, is not just about issues of identity and representation that cluster around what we might mean by deaf and/or Deaf. Like all people, d/Deaf people are diverse for multiple reasons, including sexuality, gender, ethnicity, and disability.'* It is therefore important to take into account the Deaf person's life journey and be knowledgeable about their heterogeneity when carrying out research in the Deaf community.

Deafness with a capital 'D' refers to a group of people with a strong identity who are typically sign language users. Those referred to with a little 'd' are usually deaf people who do not use sign language or have a Deaf identity (Young and Hunt, 2011). As the primary focus of this research is British Sign Language (BSL) users, I will be using the capital 'D' throughout this paper. There is one exception to using the capital D, which is when I refer to deaf children, as they will have not yet fully developed their Deaf identity.

British Sign Language is a complete language in its own right and has a structure and grammar totally different to English (Sutton-Spence and Woll, 1999). It was officially recognised as a language in 2003 by the British Government. But this does not afford Deaf people much reduction in stress, as they still face barriers in all areas of their lives ranging from education to employment and health (Ferguson-Coleman, Keady and Young, 2014). There are no accurate records of how many Deaf BSL users there are in the United Kingdom; although some official figures have been produced, they do not correlate. For example, the 2013 Census (Office of National Statistics [ONS], 2013) documented 22,000 and the 2009-2009 GP Survey estimated 125,000 for England (IPSOS GP Patient Survey 2009-2010), while Young, Ferguson-Coleman and Keady (2016) conservatively estimate that there are between 50,000 to 100,000 BSL users. It is apparent that there is no clear data recording system to officially note how many Deaf BSL users there are in this country. However, based on my Deaf community experience and working in the Deaf community for over twenty years, it is likely to be over 100,000.

How Deaf people exist in the world very much depends on how they are brought up and educated. It is estimated that around 90% of deaf children are born to hearing parents (Mitchell and Karchmer, 2004). Many parents want 'normalcy' for their deaf child; a study by Steinberg et al. (2003) looked at the communication modalities parents chose for their pre-lingual deaf children. A high proportion opted for the aural method, i.e. listening and using speech, over sign language because they want their child to fit into a society that mainly uses speech to communicate.

On the other hand, for those deaf children whose parents choose sign language as their main source of communication, it does not mean that they are in a better starting position than their deaf peers using the aural method, as each modality has its own set of problems. For children who use sign language in education, their literacy skills could be affected by poor access to education, including a lack of the right provision, and teachers with poor signing skills, which the children are unable to compensate for as their language understanding has not fully developed (Mayer, 2007).

A study by Conrad (1979) found that deaf pupils left school with median reading ages of nine. The results were reported in terms of median scores, where half of the children score higher and the other half score lower, which came to a median of 9.0 years. Poor literacy and educational attainment has a knock on effect that continually impacts their everyday lives. An illustration of this would be employment; unemployment and underemployment of Deaf people is proportionally very high. AOHL (2011: 11) states that *'Deaf people are four times more likely to be unemployed than the general population, even when there are low levels of unemployment'*. This can lead to social exclusion and isolation, which could in turn cause low self-esteem and a lack of confidence and social skills that contributes to poor mental well-being.

Deaf people experience inequality in their everyday lives. The health sector is no exception. The studies and reports of Deaf people's access to healthcare all show communication, health knowledge and access to information as problematic (Kvam,

Loeb and Tambs, 2007; Alexander, Ladd, and Powell, 2012; Fellingner, Holzinger and Pollard, 2012; Levine, 2014; Emond et al., 2015; Keunburg, Fellingner and Fellingner, 2016). Communication problems range from poor Deaf awareness among professionals to a dearth of interpreter provision. There is very little health information available in sign language which means that Deaf people have fewer opportunities to learn preventative measures. Emond et al. (2015: 6) point out that *'lack of awareness, underdiagnosis and undertreatment of chronic conditions may be putting them at risk of preventable ill-health and potentially reduced life expectancy.'* Such occurrences are common across health and social care provision, and as a whole, Deaf people experience poorer health compared to their hearing peers (Keunburg et al., 2016).

2.1.3. Mental Health and Deafness

As previously mentioned, Deaf people experience inequality in education and employment, as well as social exclusion, which potentially develops into poor mental health (Emond et al., 2015)? They experience the same proportion of serious mental health difficulties as the general population, but have higher rates of common mental health problems (Fellinger et al., 2012). Kvam, Loeb and Tambs (2007) compared mental distress in the deaf versus hearing population. The results showed that Deaf people experience higher incidences of depression and anxiety than the hearing sample. The possible reasons behind this according to Kvam, Loeb and Tambs (2007: 6) *'may stem from childhood, or, for example, from different etiologies of deafness, socioeconomic issues, or different experiences related to stigma and discrimination.'*

The care pathway for Deaf mental health services is very fragmented and Flynn (2011: 10) states the Deaf community are often referred *'inappropriately to specialist tertiary services without an assessment at primary care as part of a stepped care approach.'* Culturally appropriate mental health services for Deaf people are very limited; there are just three national Deaf mental health centres in the UK that focus on secondary

and tertiary services (London, Birmingham and Leeds/York). There is far less provision in primary care settings and *'specialist knowledge and access to care is likely to remain isolated in pockets and insufficient for the majority of deaf people in the country'* (Levine, 2014: 462).

Not all Deaf people access specialist mental health services. They may access their local mental health services using lip-reading, pen and paper, or sign language interpreters (Alexander et al., 2012). Using services that are not culturally appropriate often leads to further problems for the Deaf person, thus they are disadvantaged by this. There may be misdiagnosis due to a failure to give culturally competent assessments, and insufficient cultural awareness of their Deaf patient. Most of the mainstream⁴ mental health services have a range of self-reporting tools such as the Patient Health Questionnaire (PHQ-9), the General Anxiety Disorder (GAD-7) questionnaire, and the Work and Social Adjustment Scale (WSAS), which are available in English. As explained above, Deaf people in general have poor literacy skills which means they are often unable to fill in the reporting tools accurately, and this possibly could lead to misdiagnosis and inappropriate treatment (Glickman and Gulati, 2003; Rogers et al., 2013). It would appear that many mainstream services are not aware that such issues exist for Deaf people. Importantly, the issue with self-reporting tools being in English was taken on by Rogers et al. (2013) who translated the PHQ-9, GAD-7 and WSAS into BSL and the translations were then validated and approved for assessments with Deaf BSL users. These translations are used with BSL fluent practitioners (Flynn, 2011) however; there is no evidence to show that mainstream practitioners are using these adjustments.

One common misconception that many mental health mainstream practitioners have in working with Deaf people is that providing an interpreter creates adequate access to their service. This is not always the case as it is confounded by a range of problems, such as the lack of qualified interpreters trained to work in mental health settings, and

⁴ Mainstream is referred to as services that Deaf people access the same as the hearing population and are non-Deaf specific

the fact that most practitioners do not know how to effectively work with interpreters (Steinberg et al., 1998; DeVinney and Murphy, 2002; Steinberg et al., 2002; Lezzoni et al., 2004; Munro et al., 2008; Leigh, 2010; Gill and Fox, 2012; Horton et al., 2012; Konig, 2012; Cabral et al., 2013).

2.1.4. Psychological Therapies

Psychological therapies are a range of talking therapies treatment which involves talking to a trained therapist in order to help someone overcome their difficulties. Examples of such treatment are Cognitive Behavioural Therapy (CBT) and counselling.

Historically, counselling provision for Deaf people according to Corker (1994: 4) was *'best described as ad hoc, piecemeal, lacking in clear philosophy and relevant structure and often dependent on a chance encounter in the institutional corridor'*. This was the case for many Deaf people until the British Deaf Association delivered a counselling service in the late 1990's by providing counsellors who were able to work using sign language. This service was reassigned to SignHealth⁵ in 2010 who then expanded it such that it has become, to date, probably the UK's largest provider of psychological therapies who employ and train culturally appropriate Psychological Wellbeing Practitioners, Counsellors and Therapists (Flynn, 2012). They also maintain a list of freelance therapists/counsellors. It must be noted that there are other services that provide therapy direct to the Deaf community in the North East, Cumbria, and areas surrounding Bristol.

The Department of Health (DH) commissioned a report *'A Sign of the Times'* (DH, 2002), to review mental health services for Deaf people. This very timely, important report highlighted the dissatisfaction with poor mental health provision for Deaf

⁵ SignHealth is a charity dedicated to making sure Deaf people get the same sort of access as hearing people to healthcare and health information.

service users, and issues arising from this were addressed in a follow on report, *'Mental and Deafness – Towards Equity and Access'* (DH, 2005). The DH outlined 26 recommendations, some specifically focussing on primary care provision. It is from these reports that access to psychological therapies for Deaf people started to improve.

Traditionally, psychological therapies for Deaf people in the UK have been very limited. They were usually reserved for those who met Step 4/5 criteria, which are at crisis and inpatient level, based on the Stepped Care Model.⁶ Many Deaf people whose problems could have been dealt with at primary care level were being referred unnecessarily to those higher levels because of little or no access to primary care services (Flynn, 2011).

In 2008, Improving Access to Psychological Therapies (IAPT), a new primary care service, was launched. It originated from *The Depression Report* (2006), which provides NICE-approved psychological therapies mainly in anxiety and depression. This was found not to be accessible for Deaf people as highlighted by Flynn (2012); therefore, a Deaf specific IAPT service was developed in 2011 to meet the linguistic and cultural needs of BSL users by providing culturally competent therapists and outcome measures, and assessment tools (the GAD7, PHQ9 and WSAS) that had been translated into sign language (Rogers et al., 2013).

This service is available to be commissioned through Clinical Commissioning Groups (CCG). However, it has been highlighted by Hulme (2015: 453) that CCG's are not meeting the needs of their local Deaf communities. She states that CCG's *'are starting to refer Deaf people who need therapy to mainstream mental health services with a BSL interpreter and not commissioning BSLHM.'* She goes on to say *'this is suitable for Deaf people who are able to cope using a BSL interpreter and a hearing therapist but what of those who are not? Choice or parity of esteem is not offered.'*

⁶ **Stepped Care** is a system of delivering and monitoring treatments, so that the most effective, yet least resource intensive, treatment is delivered to patients first, with '**stepping** up' to intensive/specialist services only taking place as clinically required.

Arguably, such a vital service should in theory reduce the mental health burdens that Deaf people have and not increase them. The illustration (Table 1) paints a visual picture of how mental health services differ for Deaf and hearing people. The large doorway has many people walking through with small bags (smaller burdens), while the smaller doors way is being squeezed into by fewer Deaf people with big bags (bigger burdens). This is a powerful comparison that conveys what mental health services are like for Deaf people.

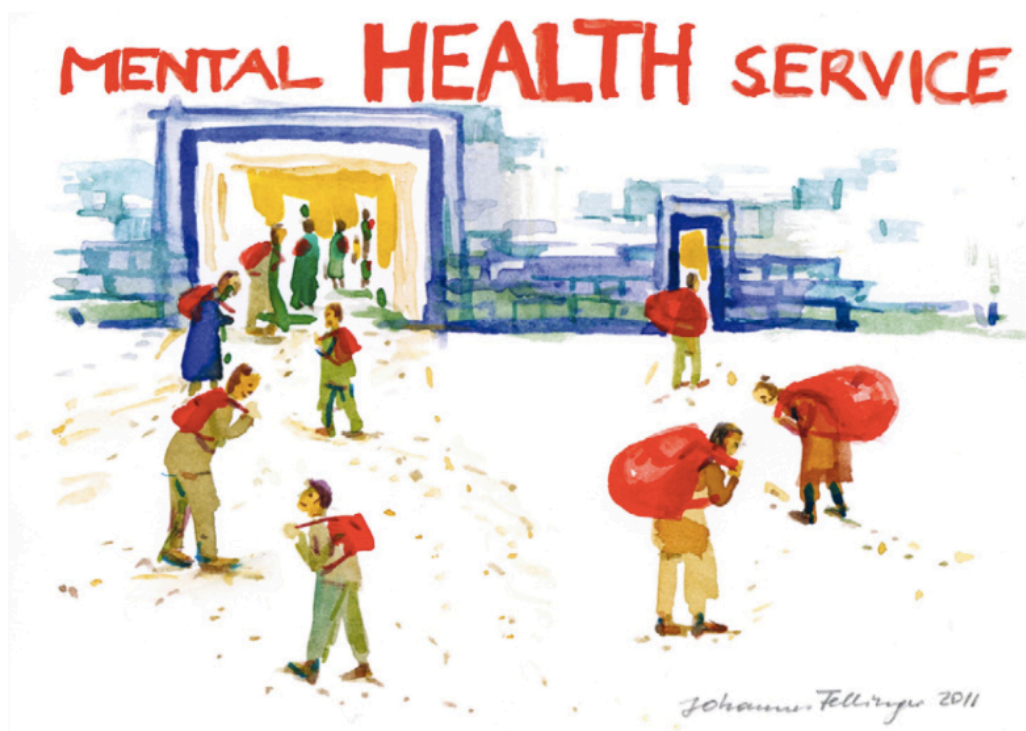


Figure 1: *Figurative illustration of burden of mental health problems on deaf people* (Fellinger, Holzinger and Pollard, 2012)

2.2. Literature Review

This section reviews the literature available on the topic of Deaf people's experiences of psychological therapies. A literature review according to Daren (2015: 1) '*is essentially a survey of scholarly articles, books, dissertations, conference proceedings, and/or other published material*' and also '*provides a summary, description, and critical evaluation of a topic, issue, or area of research*'.

A comprehensive and systematic search strategy was implemented for this review. I accessed databases that might contain sources associated with deafness and mental health, such as PsychINFO; PsychArticles, Psychiatry Online, Wiley Online, British Library Electronic Thesis Online (EThOS), Taylor and Francis, Google Scholar, Project Muse, ResearchGate, SAGE Journals Online, NICE Evidence Search and EBSCO Host.

Searches were also conducted in journals such as the *Journal of Deaf Studies and Deaf Education*, the *International Journal on Mental Health and Deafness*, *British Medical Journal*, *Sign Language Studies* and *American Annals of the Deaf*.

"Deaf and psychological therapies" was my initial search term combination, but this did not result in very specific literature; what it presented was studies on mental health and deafness. Therefore, I broadened my search words and combinations "mental health and deafness", "deaf mental health", "deaf + mental health", "Deaf depression", "BSL therapy", "Deaf therapy", "deaf counselling", "mental health deaf", "Deaf + anxiety", "therapeutic alliance", and "Deaf and primary care + Deaf".

I would like to comment that EBSCO Host was the most used database as it covered most of the suitable literature and offered a direct reference link to RefWorks. With a combination of search words inputted using PsychINFO via EBSCO Host, the following

literature was found: Mental health + Deafness (412), Deaf therapy (80), Deaf counselling (8) and Deaf depression (83). Many of the hits were not relevant; therefore, the filtering facility, using inclusion and exclusion criteria, was put into place to reduce the number of results (Table 1).

Inclusion Criteria	Exclusion Criteria
Studies with ethical approval	Discussion papers
Deaf user perspectives/views	Deaf Children
Qualitative studies	Quantitative studies
Mental health and Deafness	Professional views only (does not include
Therapist/Counsellor + Deaf	Deaf users)
Interpreters + Deaf	Medical view of deafness
Studies reported in English	

Table 1: Inclusion and Exclusion Criteria

In total, 27 papers were identified as having a direct link to Deaf perspectives on and experiences of mental health services which encompassed therapy. However, some of those included quantitative methods (6), children (1), professional views (4), meta-analyses of literature (2), no ethical approval (1), and non-mental health foci (3), so these were removed from the search.

Overall, 10 academic papers were identified to take forward for a final literature review on Deaf people's experiences in psychological therapy. A detailed meta-summary outline of each paper highlighting each study's methodology, country, perspective, participant demographics, results and limitations were put into a table format and this can be found in the Appendix 1. The majority of the studies are American (7), with 2 from Australia and 1 from the United Kingdom (Scotland).

Using the meta-summary, I was able to review each paper to discover common themes by considering what each study noted in their findings (Aveyard, 2007). The themes I found in common amongst most of the studies are referred to here as: (a) barriers to accessing mental health services, (b) deaf/hearing therapist, (c) interpreters, and (d) cultural competency. Each theme will now be discussed in more detail using authors from the 10 selected papers, starting with the theme relating to the pre-therapy period, followed by themes linked to experiences whilst in therapy.

2.2.1. Barriers

One of the first problems that Deaf people face before a therapeutic relationship ensues is accessing the service itself. Prior to accessing a service, there needs to be an awareness of such a service. According to the study by Horton et al. (2012), Deaf people's low level of awareness about mental health services meant that some are completely unaware of what is available to them, and hence they do not access such services. In addition to the lack of awareness, another barrier for Deaf people was actually understanding letters they receive from mental health services (RNID, 2009; Cabral et al., 2013). Difficulty in understanding letters is related to the low literacy levels of Deaf people as explained earlier in this chapter.

Contacting mental health services is also considered a barrier, and is described by DeVinney and Murphy (2002). DeVinney explained that her first problem accessing a mental health service was actually getting in contact with the services via a TTY⁷ phone call. The person at the other end did not know how to use it and they disconnected the call at least three times. This shows a lack of cultural knowledge that a service needs to possess when dealing with Deaf people.

It is interesting to note that all of the studies selected for this literature review

⁷ TTY is a qwerty keyboard telephone that Deaf people can use to make phone calls. The other party must also have one of these to take a direct call. In the UK this is referred to as a minicom.

mentioned interpreter issues ranging from access to actually being in the therapy session itself. For this section, interpreters as access issues are the focus and interpreters in the therapeutic alliance are discussed in more depth later on in this chapter. Most of the participants in RNID's (2009) study commented that they had low expectations when it came to interpreter access which led to them being frustrated and isolated. The study also highlighted additional obstacles such as the need for advance booking. A participant said '*they'd been told that they had to wait maybe two weeks*' for an interpreter to be available for an appointment (RNID, 2009: 23). In contrast, Deaf people from Cabral et al.'s (2013) study found booking interpreters a challenge as they were either told that there was no funding or were completely refused one. Problems securing qualified interpreters acted as a barrier to access highlighted by Horton et al. (2012) and DeVinney and Murphy (2002), in particular when it comes to hiring interpreters, as services tend to go for the lower end pricing *which mostly likely means...[working with] under-qualified individuals*' (Horton et al., 2002: 243).

2.2.2. Deaf/Hearing Therapist

Communication with clinicians/therapists was emphasised in most of the articles describing positive and negative experiences with Deaf and hearing therapists. However, six articles go into more detail about Deaf people's preference for which modality they would like to use in therapy. It was recognised within these articles that Deaf people were more comfortable with a practitioner who is able to sign, and even more so if they are Deaf (Steinberg et al., 1998; Cohen, 2003; Steinberg et al., 2006; Cabral, 2013).

Cohen (2003) looked into the perspectives of Deaf people in psychotherapy and her participants had a great deal to say about their experiences of working with Deaf and hearing therapists. Jackie, a Deaf participant who uses ASL, had a hearing therapist who could not sign. She commented, '*it was awful because when I'm talking about*

something emotional, I can't control my voice, [and] this means I have to suppress my emotions to speak clearly' (Cohen, 2003: 32-33). It seems that she could not express herself fully due to not being able to communicate with her therapist. Another of Cohen's participants experienced something similar but with an interpreter. He said, *'I felt I needed to work extra hard to show them who I am...what my feelings are...to share my feelings through English, I had to work harder...making sure the interpreter knows what I mean'* (Cohen, 2003: 33-34).

Cabral et al.'s (2013) participants interestingly gave a mixture of reviews of using Deaf or hearing therapists. Several participants said that they would prefer a Deaf therapist but perceive a hearing therapist would know more *'because they get a lot more incidental learning than deaf people...a deaf person's perspective isn't wide enough'*, and Cabral said a reason for this could be *'internalized stigma'*⁸ as one of her participants said that *'Deaf people prefer to work with hearing clinicians [rather] than Deaf people because they know more'* (Cabral et al., 2013: 652-653). A lack of awareness of mental health issues could create stigma within the Deaf community which could lead to Deaf people not being open about their emotions and histories.

Furthermore, as a consequence of the Deaf community being small, confidentiality is seen to be an issue when working with Deaf therapists and interpreters (Munro et al., 2008; Sheppard and Badger, 2010; Cabral et al., 2013).

Sheppard and Badger's (2010) study looked at the lived experience of depression amongst Deaf adults. Out of nine participants they interviewed for their study, eight of them *'expressed that an interpreter would be unwelcome when seeking mental health'* (Sheppard and Badger, 2010: 786). Two of the participants explained that this was the

⁸ *Internalized stigma is defined as a 'subjective process, embedded within a socio-cultural context, which may be characterized by negative feelings (about the self), maladaptive behavior, identity transformation or stereotype endorsement resulting from an individual's experiences, perceptions, or anticipation of negative social reaction on the basis of their health condition'* (Livingston & Boyd, 2010).

case because they did not want the interpreters to know their problems due to stigma and confidentiality. One major criticism of this study, in fact, is that the authors did not explore further the participants' preferences when they said they did not want to use an interpreter.

2.2.3. Use of interpreters

The use of interpreters in therapeutic encounters seems to have considerable impact on the relationship that the therapist develops with the Deaf person, in a largely negative way (Steinberg et al., 1998; DeVinney and Murphy, 2002; Cohen, 2003; Munro et al., 2008; RNID, 2009; Sheppard and Badger, 2010; Horton et al., 2012; Cabral et al., 2013). Nevertheless, there were some participants who did have positive experiences using interpreters in therapy (Cohen, 2003; Munro et al., 2008; RNID, 2009; Horton et al., 2012). An example of this can be seen in Horton et al.'s (2012) study where it is reported that a Deaf mental health user was comfortable using an interpreter in therapy and perceived this as supportive. The use of interpreters in therapy is recognised and valued (RNID, 2009); however, mental health providers must not assume *'that a presence of an interpreter ensures adequate information'* (Steinberg et al., 1998: 984). This is further supported by Horton et al. (2012: 456/457) who makes reference to the court case *'Tugg v Towey (1994) stating that services provided through a sign language interpreter are not equivalent to the services hearing people receive.'*

The factors that contribute to negative experiences of using interpreters in therapy are fourfold. Firstly, as alluded to previously, there are issues linked to confidentiality due to the smallness of the Deaf community (Steinberg et al., 1998, RNID, 2009; Sheppard and Badger, 2010). Secondly, there were several references about unqualified interpreters and interpreters who lack mental health knowledge and experience, in particular the ability to pick up on subtle nuances, which is a vital part of mental health interpreting (Steinberg et al., 1998; DeVinney and Murphy, 2002; Horton et al., 2012).

Thirdly, a participant reported that she had three different interpreters across various sessions and highlighted that she would prefer to have the same one throughout as it would be less confusing and more comfortable (Munro et al., 2008). Finally, participants raised negative feelings about having another person in the room. For instance, Horton et al. (2012: 246) found that some of her participants would prefer someone who can communicate directly, as having *'a third person in the room changes the dynamic'*. Cabral et al. (2013: 653) reported that some of her respondents were uncomfortable with another individual being present and *'had a fear of things being misinterpreted'* and one participant said *'it took longer to feel comfortable in the therapy session because of the presence of two individuals'* (Cohen, 2003: 34).

2.2.4. Cultural awareness/competency

It is clear from the literature that the therapist's cultural awareness of Deaf issues is important to this group of clients and that a shortage of cultural competency leads to negative emotions (Cohen, 2003; Munro et al., 2008; RNID, 2009; Davidson et al. 2012; Horton et al., 2012; Cabral et al., 2013). Cohen's (2003) participants, referred to as Al, Selma, Marti and Belinda, each went through negative experiences with their therapist due to this lack of cultural awareness. For instance, Al's therapist gave him additional anxiety and self-doubt, and Selma did not feel validated by her therapist. Furthermore, one therapist gave her Deaf client hand-outs to read which were full of jargon, leading to the client feeling frustrated (Munro, 2008). If the therapist had cultural competency, they would know about the typical literacy skills of Deaf people and be able to meet their needs.

Cohen (2003: 37) talks about the importance of the therapist sharing oneself in the process as it *'instils a sense of hope and normalizing the experience'*. This is illustrated by Robin and Dana respectively, who state that *'the fact that he was Deaf had an impact on my therapy because I looked at him as a role model'* and *'the fact that he shared his experience, helped me feel that I could get over it'* (Cohen, 2003: 37).

It would seem that an insufficient cultural awareness takes time away from focusing on the client's real problems, as a participant from Cabral et al.'s study (2013: 246) observed: *'having direct communication, there would be more time spent addressing real issues'*. The general consensus seems to be that Deaf therapists who possess high cultural knowledge were the most desired as they can *'more easily understand who I am'* and *'they would understand me better. They can help me feel better. They have the same life experiences I have. They know what it is like'* (Cabral et al.: 652).

Out of the 10 papers, only one study (Cohen, 2003) explores the therapeutic relationship in detail. Other papers tend to provide a more superficial appreciation of the issue, eliciting only brief anecdotal comments from participants, even though they are intended to be qualitative studies. However, the limitations to Cohen's (2003) study is that it is American, such as the life experiences of American and British Deaf people are different in terms of education, country, lifestyle, culture and environmental factors. Cohen's work does not fully explore the therapeutic alliance in detail. For example, the bonding with the therapist and the difference between Deaf and hearing therapists is not considered sufficiently. Furthermore, there are no comparative studies examining two groups of Deaf people to explore and contrast their therapy experiences.

2.3. Summary

This chapter provided a background for understanding on deafness, the Deaf population, their mental health needs, and psychological therapies. A literature review highlighted ten studies that were investigated in more detail, and from which four common themes were identified. This review found that just one paper (Cohen, 2003) explores the therapeutic alliance in detail but it does not address the participants' bond with the therapist in detail. The lack of minimal literature shows the important need for this study.

The following chapter focuses on the methodological approach to the study.

Chapter 3 Methodology

3.1. Introduction

This chapter discusses the methodology that is used in this study. The first section discusses Deaf epistemologies that potentially influence the choice of methodologies explained in the next section. The second part of this chapter looks at the cultural appropriateness of research within a Deaf population; how the researcher positions themselves within a community and addresses translation issues. The third and subsequent parts describe the parameters of the research such as the research design, interviewing, storage and data analysis.

For the purpose of this study design, I am focusing on Deaf people who use sign language and fit into the cultural model of deafness, (as described below), and the methodological approach is to take into account that generally Deaf people do not have a good standard of English and see the world in a visual format.

3.2. Deaf epistemologies

Before the study design can be determined, it is important to look into the ontology and epistemology of Deaf people as these influences the choice of methodologies and the shaping of the research design. Young and Temple (2014) identified the importance of combining epistemology and methodology as it does matter where a researcher begins their study.

Epistemology addresses how we know what we know and ontology looks at the being of a person and how they exist in the world. In terms of this study, this means that we effectively need to look at epistemology and ontology to get a rich understanding of

how Deaf people see and experience the world. The concept of epistemology has evolved over time and has different schools of thought but when it comes to Deaf epistemology; it is still an emerging field with new concepts from different contributors. Ladd (2003), Holcomb (2010), Hauser et al (2010), De Clerck (2010), and Young and Temple (2014) each bring their individual views as to what Deaf epistemology is and the consensus is on whether there is a place for 'Deaf epistemology'. Ladd (2003) thinks that Deaf people experience the world based on their views and Sutton-Spence and West (2011) say that Deaf people are what they are because of how society places people. Temple and Young (2014) found that with different authors having different views, there is more than one explanation of Deaf epistemology, hence it is now referred to in the plural sense as 'Deaf epistemologies'.

Hauser et al. (2010: 486) describe very clearly what Deaf epistemology is, and they point out that epistemology *'constitutes the nature and extent of the knowledge that deaf individuals acquire growing up in a society that relies primarily on audition to navigate life.'* They go on to say that *'Deafness creates beings who are more visually orientated compared to their auditorily oriented peers. How hearing individuals interact with deaf individuals shapes how deaf individuals acquire knowledge and how they learn.'* In other words, Deaf people see things differently because they cannot hear and how they grow up in society very much impact on their learnt knowledge. Being a visual person means that you are more observational and learn more from your surroundings; therefore, it is likely you become what you are through your environmental factors. This ties in well with the social learning theory by Bandura (1977) who claims that most human behaviour is learned observationally and hence is affected by the behaviours of others.

With regard to Deaf epistemologies, the question to address next is how do Deaf people see and experience the world? Bahan (2008: 83) describes deaf people as those who *'inhabit a highly visual world. They use a visual language to communicate and have developed a visual system of adaptation to orient them in the world that defines their way of being.'* Temple and Young (2014) provide evidence to support the belief

that Deaf people see things differently. They mention a 1994 novel by Maitland, *'Home Truths'* where it tells a story of a Deaf child breaking a bowl. The child looks at the shapes of the broken glass in awe and cannot understand why the hearing people did not look at it the same way as she did. Those who heard the sound were brought to the room based on the noise of the smash, thus revealing a visual and auditory comparison of a same situation. It would appear that a Deaf and a hearing person would see and experience things differently.

3.3. Qualitative research

Qualitative research incorporates a diverse range of approaches such as phenomenology, grounded theory, discourse analysis, ethnography, and interpretative phenomenological analysis (IPA).

According to Elliott et al. (1999:216), what all qualitative research has in common is *'that their central purpose is to contribute to a process of revision and enrichment of understanding, rather than to verify earlier conclusions or theory'*. One of the benefits of qualitative research suggested by Farrell (2013: 93) is that it is *'especially effective in obtaining culturally specific information about the values, opinions, behaviours, and social contexts of particular populations'*. Each qualitative method has its own theoretical and methodological approaches. For example, phenomenology explores and tries to understand the experiences of the participants' life world, whereas discourse analysis looks at the language in context and is *'concerned with how participants construct themselves and others through their discourse and how these selves may be undermined'* (Bloor and Wood, 2006: 54).

When choosing a qualitative method, it is necessary to think about a variety of issues. What is it that you want to find out about a particular phenomenon? What data collection method do you wish to use? The researcher must think carefully about the population they are studying and what they would like to research.

3.3.1. Phenomenology

Phenomenology has been selected as the methodological approach for my research as it is a method that looks at human experience through analysing the person's description of an event. It is derived from a philosophical movement that was established by Husserl and Heidegger with other contributors such as Merleau-Ponty and Sartre (Smith, Flowers and Larkin, 2009).

Husserl's (1859-1938) concept of phenomenology *'involves stepping outside of our everyday experiences, our natural attitude, as he called it, in order to be able to examine that everyday experience'* (Smith et al., 2009: 12). Stepping outside of our experiences is commonly known as 'bracketing' or 'psychological reduction'. This can be described as where you remove all your prejudices, your predetermined ideas being noted and put to one side, to create pure phenomenological exploration of the experiences (Carpenter, 2007). However, it is argued that bracketing is very difficult to do in phenomenology in particular when doing hermeneutic research (LeVasseur, 2003)

Heidegger was a student of Husserl who took on all his teachings but differed from Husserl in his phenomenology concept. Cammell (2015: 238) describes Heidegger's view of being in the world is *'we who are close to ourselves, we interrogate ourselves about the meaning of Being'*, and that was when the hermeneutic concept was born. Heidegger was also of the opinion that we should be looking at the individuals. Another equally important development of Heidegger's theory is existence. Smith et al. (2009: 17) state that Heidegger is *'more concerned with the ontological question of existence itself, and with the practical activities and relationships which we are caught up in, and through which the world appears to us and is made meaningful'*.

Hermeneutic⁹ phenomenology derived from Heidegger and described as *'an attempt to unveil the world as experience by the subject through their life world stories'* (Kafle, 2011, p. 186). Kafle also states that *'interpretations are all we have and description itself is an interpretive process.'*

Merleau-Ponty echoes the views of Husserl and Heidegger but felt that they did not address how humans embody themselves into the world. Smith et al. (2009: 19) supports Merleau-Ponty's view of how the fact that *'the body shapes the fundamental character of our knowing about the world is critical to how we research'*. Sartre focused on our existence in the world rather than just the world (Macann, 1993). His view on existentialism contributed to a large part of the phenomenology methodologies.

Sartre wrote a vignette mentioned in (Smith et al., 2009: 20) that grasps the meaning of how we exist, fit in and experience the world: *'I myself expected to see Pierre and my expectation has caused the absence of Pierre to happen as a real event concerning this café'* Sartre goes on to say that *'It is an objective fact at present that I have discovered this absence, and it presents itself as a synthetic relation between Pierre and the setting in which I am looking for him. Pierre absent haunts this café and is the condition of its self-nihilating organization as ground.'* Smith et al. (2009: 20) said that if Pierre was there *'the rest of the café would fit into place around him, and give texture to him. Instead, Pierre not being there, his nothingness, fixes the meaning of the café for Sartre at this point in time.'* It would appear that this changes your concept of being and perception of the world around you. Arguably, this questions how people perceive and place themselves in the world and this is the heart of phenomenology.

In conclusion, phenomenology is a philosophical umbrella pulling together different methods and views as outlined by the phenomenologists mentioned above. The

⁹ Hermeneutics is the study of methodological principles of interpretation

mentions of lived experiences, being, existing and viewing all tie in agreeably with hermeneutics.

3.3.2. Interpretative Phenomenological Analysis (IPA)

Smith et al.'s (2009) Interpretative Phenomenological Analysis (IPA) has three main underpinnings – phenomenology, hermeneutics and idiography. Idiography focuses on the particular, meaning the individual. It is a branch of nomothetic¹⁰ inquiry which is used considerably in psychology. Smith et al. (2009: 30) argues that nomothetic inquiry is not suitable for IPA as it '*prevents the retrieval or analysis of the individuals who provided the data in the first place*'. In IPA, it is important to study the individual, who is unique and has his or her own distinctive life history.

Based on the methodology literature, it was decided that the best method to adopt for this study was the Interpretative Phenomenology Analysis, as it offers detailed examination of the human lived experience. It reflects on personal experience, offers hermeneutic experience and focuses on the particular. Smith et al.'s IPA approach will be discussed in more detail throughout the rest of this chapter.

3.4. Culturally appropriate research within the Deaf community

There is much literature focusing on the primary hearing researcher within Deaf research (for example, Pollard 1992, Harris et al., 2009; Graybill et al., 2010; Stone and West, 2012; Young and Hunt, 2011; Young and Temple, 2014 and Singleton et al., 2015) with many discussions, suggestions and recommendations on how best to work with the Deaf community. For this section, I will focus on issues that are relevant to me as a primary Deaf researcher.

¹⁰ Nomothetic describes the study of classes or cohorts of individuals

Researchers who have Deaf participants in their studies are no different from other researchers. They still have to follow ethical practices and guidelines (Singleton et al., 2014). However, when doing research with the Deaf community there are wide ranging issues that need to be considered. Such examples are ethics, communication, accessibility and translation.

The first step is to ensure an appropriate research study title and aim as it is important to carry out research that benefits the community. Pollard (1992: 90) draws our attention to the fact that *'the research must benefit the host community in ways that are recognized and valued by that community, not just by the researchers'*. It is also equally important for the researchers to take into account the epistemological and ontological positioning of Deaf people (Harris et al., 2010; Young and Temple, 2014) when thinking about research design and methodologies.

The next step is to ensure that data collection with Deaf participants is fully accessible. The usual practice of recruitment is to put out a call for participants and this is usually in the written format such as adverts and posters; upon expressing interest, participants are sent an information sheet with in-depth details of the research; filling in a consent form and other paperwork relating to the study. In all research studies with sign language users, where there are written formats, there must be BSL equivalents made available (Hauser et al., 2010; Graybill et al., 2010; Young and Hunt, 2011; Singleton et al., 2015).

Informed consent is one of the most crucial parts of the study. It is where a participant signs a consent form to show that they understand the research and agree to be a part of it. Singleton et al. (2015) did a study looking at the views of Deaf participants linking to informed consent. They found some poor practices of informed consents such as participants signing consent forms without being fully informed (i.e. with information not having been provided in sign language); in a study about Deaf genes, some were unsure what their blood tests were being used for. This makes it all the more

important for researchers to be *'ethically accountable for fully debriefing the Deaf participants'* (Singleton et al., 2015: 10). To ensure that Deaf participants are fully informed, all information must be available in BSL and the researcher should personally discuss the study with the participant to confirm that they know what they are signing up to.

Young and Hunt (2011) talk about insider/outsider status when doing research in the Deaf field. They describe insider/outsider status as *'something that is constructed. Political ideologies, social forces, historical practices and ethical frameworks can all serve to construct some as outsiders, not just because they are "other", but in how that "otherness" is portrayed'* (Young and Hunt, 2011: 11). Obasi (2014) brings up interesting points in her article about this. She is a hearing Black female who is a qualified sign language interpreter, and she interviewed a group of hearing black women and a group of Deaf women. She had different experiences with both groups, describing her experience with the black women as *'one that is underpinned and strengthened by experience, knowledge and connectivity'* and with the Deaf women as *'an interpretation that can only be seen as limited, partial and boundaried'* (Obasi, 2014: 75). A person would interpret the data differently depending on whether they are inside or outside the Deaf community (Ladd, 2003; Young and Hunt, 2011; Obasi, 2014).

I perceive myself to be an 'insider' as I am a strong cultural member of the Deaf community. There are pros and cons to being an insider. The pros are knowledge, access, interaction and knowledge of the community you are working in. One's subjectivity can thus be a strength, as it enables insights born out of immersion in and affinity for a particular culture (insights that may be precluded to researchers not similarly situated). Alternately, the subjectivity of the researcher can be associated with risks of bias, for example blinding to aspects of the data that disconfirm or contradict strongly held beliefs. Nevertheless, Greene (2014) argues that *'the same warning may be made to outsider researchers, in that they may inadvertently hold preconceived and perhaps even incorrect perceptions of the social group under the*

study.' However, this can be overcome by exploring the trustworthiness of the study in a detailed way, declaring your position in the study and offering reflexivity (Greene, 2014). Such a reflexive positioning can ensure that care is taken to attend to disconfirming data and scrupulously reflect upon analytic decisions for possibilities of bias. I have ensured that this has been acknowledged in the work.

Young and Temple's (2004) research into qualitative methods and translation dilemmas throws up plenty of interesting debates. They discuss whether it should be declared who did the translation as traditionally research in the Deaf field is usually done by hearing people who are not fluent in BSL. Many of the authors who write about research in the Deaf community put a large emphasis on how the data is translated.

It is argued by Temple and Young (2004) that whether we should declare who did the act of translation, and if it matters who does the translation, are important questions to consider. The researcher themselves could do the translation, but within the Deaf field it is not common to find a Deaf researcher who is able to translate their own work (Ladd, 2003; Temple and Young, 2004; Stone and West 2012). On the other hand, an external translator could be brought in and this offers objectivity which gives an extra dimension to the trustworthiness of the study (Temple and Young, 2004). There are some negative aspects to using translators as they could lose the meaning of the interview by filtering out information or not being able to recognise cultural nuances that an insider researcher would pick up on (Young and Ackerman, 2001; Harris et al., 2009; Graybill et al., 2010; Singleton et al., 2015).

Taking everything into account, Temple and Young (2004: 170) conclude that *'it does not mean that a Deaf researcher necessarily produces better research than a hearing researcher, just different research'*. It is important for this study to take into account accessible data collection; informed consent; detail the position of the researcher within the study and how data is translated.

3.5. Research Design

3.5.1. Study title

'A phenomenological study into British Sign Language users' experiences of psychological therapies'.

3.5.2. Aim and objectives of the study

The study will investigate in-depth the BSL user's relationships with their therapist, specifically looking at alliances, dynamics, engagement, understanding and shared decision making.

The objectives of the study are:

1. To explore the experiences of therapy alliance in Deaf/Deaf therapy and Hearing/Deaf/Interpreter therapy
2. To identify best practice for BSL users who require psychological therapy

3.5.3. Rigour/Trustworthiness

In qualitative research the methods used to establish trustworthiness include credibility, transferability, dependability and confirmability (Guba and Lincoln, 1994), whereas determining trustworthiness in quantitative research involves looking at internal validity, external validity, reliability and objectivity (Malakoff, 2012). An example of comparison between qualitative and quantitative trustworthiness is

transferability and external validity. Malkaoff (2012: 1) states that in qualitative research '*transferability means applying research results to other contexts and settings in order to get at generalizability*'. And on the other hand, he goes on to say that in quantitative research '*external validity is used to generalize from the research sample to the larger population*'.

I will now consider individually the four aspects of trustworthiness outlined by Guba and Lincoln (1994).

3.5.3.1. Credibility

Shenton (2004) pulls together a comprehensive list of how credibility can be achieved in qualitative research. It can be showed by adopting well recognised research methods; random sampling; triangulation; ensuring honesty from participants; debriefing sessions between researchers and supervisors; peer scrutiny; the use of reflexive comments; and the positioning of the researcher in the study.

The data collection was in the form of semi-structured interviews. There was no fixed time for the interviews and questioning occurred until saturation took place. I often summarised and reinforced what the participants said back to them to ensure that I had their true account. The translated transcript from the interviews allowed me to revisit the data repeatedly to check emerging themes to ensure I remained true to participants' accounts of psychological therapies.

My reflexive comments that were noted after the interviews and when I was re-watching them offer an extra dimension. An example of my reflexive notes can be seen in Appendix 2. The comments I made were linked to my feelings at the time, why I asked a particular question, whether I was too influential, my ideas for further

research and what would need to be changed if I was to do the study again. This line of reflexivity is acknowledged by Biggerstaff (2012).

3.5.3.2. *Transferability*

Transferability looks at how this study can be applied to others. This can be realised through prolonged engagement and having thick, rich description of texts (Morse, 2015). The participants for my IPA study were recruited by purposive sampling where numbers are purposively small to ensure in-depth full data (Smith et al., 2009). It is difficult to generalise data in phenomenology (Giorgi, 2008); however, the main purpose of my study is to explore in-depth individual life experiences. Therefore, I am not aiming for generalisability but transferability.

The available literature relevant to this study is rather limited due to it being a very specific and new field. From what I had, I drew on how others addressed their research, theories and limitations. Such information would be *'the number of participants involved in the fieldwork; the data collection that was employed; the number and length of data collection methods and the time period over which the data was collected'* (Shenton, 2004:70). I used those outcomes to formulate my study.

3.5.3.3. *Dependability*

Shenton states that *'in order to address the dependability issue more directly, the processes within the study should be reported in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results'* (Shenton, 2004: 71). To ensure dependability, I have detailed the research design, approach, data gathering and limitations within this methodology chapter for readers to see how the research was done.

3.5.3.4. Confirmability

Confirmability means *'the qualitative investigator's comparable concern to objectivity' and the researcher must ensure that the findings are the experiences and ideas of the participants rather than the researcher'* (Shenton, 2004: 72).

This was done during the interviews where I sought clarification with the participants to ensure that I interpreted their account correctly. In addition, after each interview, I always ensured I put time aside to capture my feelings and note down anything that seemed important in my reflexive diary to use during the data analysis stage.

Equally important, emerging themes were discussed with my two supervisors who had phenomenological and counselling backgrounds, which allowed assumptions to be challenged.

3.5.4. Ethics

I gained ethical approval (Appendix 3) to proceed with the study from the University of Central Lancashire (UCLan) STEMH Ethics Committee.

Deaf people in general have poor literacy skills (Mayer, 2007) as mentioned in detail in the introductory chapter. Therefore, whatever information is given to the participant, there should be a BSL version available. This is to ensure that participants are fully briefed about the study they potentially may be involved in and are able to make informed choices and give informed consent (Young and Temple, 2014). During the interview stage, at the start of the interview, I convey through BSL the whole consent form (Appendix 4) to ensure that the participants fully understand the implications. This is further backed up by filming their nods of informed consent when I ask them before the interview if they know what they are agreeing to.

As BSL is mine and the participants' first language, in order to capture the interview, it had to be filmed. Many people would find being filmed quite obtrusive as opposed to a tape recorder that can be hidden out of sight. However, for the BSL community, being filmed is not an uncommon experience. For example, BSL users may have previously been research subjects; they may have been asked by BSL learners for help with assignments which needed to be filmed; school/university assignments done in BSL; and, most popularly, communicating via Skype/FaceTime which is a daily occurrence for many BSL users. With regard to storage of the film clips, I have followed the Data Protection procedure set out by UCLan.

3.5.5. Recruitment

Data collection took place between April 2015 and June 2015. I focused on a particular heterogeneous¹¹ group of Deaf people and included several factors to reduce the sample size (Smith et al., 2009). The first inclusion criterion was that they must be sign language users; the second factor was they must have experienced therapy between February 2013 and February 2015. The other essential criterion was that participants must not currently be receiving therapy. One of the main reasons for this was that I wanted the experiences to be fresh and up to date, and therapy 5 years ago, for example, would be very different to what is available now.

As I was comparing two groups' experiences, the sample size should be slightly bigger than a single study which is usually no more than five in each group as outlined by Smith et al. (2009). I looked at the population size and used my experience within the Deaf community to come up with a feasible number, whilst also taking into account recommendations for IPA. As a result, I opted to interview eight people from two discrete groups:

¹¹ Heterogeneous means diverse of character or of content

Group 1 (four people) who have been with a Deaf therapist and

Group 2 (four people) who have been with a hearing therapist via an interpreter.

A three minute BSL clip along with the written advert asking for participants to come forward (Appendix 5) was uploaded to Facebook, Twitter, and YouTube, and emailed to the Yahoo group Deaf UK Jobs (many Deaf people are subscribed to this group and it is used as a tool to pass on information) to maximise the outreach. This meant my recruitment strategy was all online. Facebook is one of the biggest online tools with which to reach people, as according to Ross (2014, p. 1), *'Facebook allows you to reach a well-defined target audience'*. There is a large number of Deaf people in Facebook who are in specific groups, for example, Deaf Opinions which has over 7000 members (Swinbourne, 2016). The initial video I put on Facebook via my personal page had 58 shares and 1200 views. Overnight I had the full quota of eight people. However, after initial screening, three of them were not suitable. I waited another two weeks for other participants to come forward. This did not happen, so the recruitment video was distributed again. The recruitment number was fulfilled the next day.

Participants were able to contact me via email, Facebook Messenger, mobile text and FaceTime. Those who were suitable and agreed in principle to be involved in the study were given another link to a video of a BSL version of the Participant Information Sheet (PIS) (Appendix 6). After watching this, they got back in touch with me to say that they would like to participate, and the interview dates, times and venues were booked.

The number of participants who came forward in total were 14. It was on a first come first served basis to ensure open and fair sampling practices. As stated, eight of these were recruited ultimately. Of the other six, two were suitable but they came after the places were filled; three were not suitable because they had received therapy in both modalities and the last one was currently receiving therapy.

Seven of the interviews were arranged at the participant's local GP surgeries. The reason for this is that the participants would more than likely have had their therapy sessions there, and they would feel familiar. Also, the GP rooms provide privacy and safety. The other interview took place in a counselling room in a university building.

3.5.6. Data collection: Interviewing

The interview was based on an IPA semi-structured interview style which is the most popular way of data collecting in phenomenology as it enables you to explore in-depth layers of the participant's experiences (Smith et al., 2009). Due to the nature of the study which is asking about people's experiences of a phenomena, for best results, it is paramount for the interviews to be open, allowing the participants to engage in a conversation style discussion. It is also important for the researcher to attune to the participant's method of communication to ensure full rapport which is especially relevant when interviewing Deaf people (Singleton et al., 2015).

The philosophy of the hermeneutic circle¹² by Heidegger and Gadamer was very evident during the interviews. Very often participants were asked to expand on a statement that matched my thematic topics so that I could reduce my pre-conceived ideas on the subject. The pre-understanding and understanding of the hermeneutic circle practice was very apparent during the interviews. The circle figure (refer to Figure 3 below) by Alvesson and Skoldberg (2009) encompassed my experiences of the hermeneutic circle. I frequently re-affirmed the participant's statement on a particular subject to ensure that I could communicate their experiences accurately.

¹² *'The part can only be understood from the whole and the whole from only the parts'* (Alvesson and Skoldberg, 2009)

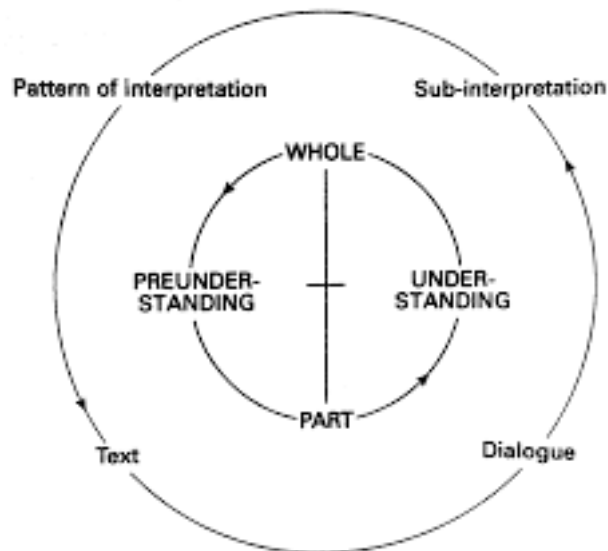


Figure 2: Figurative illustration of *the hermeneutic circle: basic version*

All the interviews consisted of just myself and the participant. Each interview began with an open ended question, ‘tell me about your therapy experiences’, and I referred to the interview schedule (Appendix 7) where there were a few main themes noted for discussion with the participant. Such themes were “accessing therapy service”; “Understanding/addressing of Deaf issues”; “Alliance/bond”; “Transference/Counter-transference”; and “personal preference for future therapy if needed”; and participants were asked at the end about their experience of the interview so that I could compare feedback from those in Group 1 and Group 2.

Each of the interviews was videotaped with a single camcorder and recorded onto a memory card. Approximately 10 minutes at the start of the interview were devoted to reinforcing the study aims, completing the participant information sheet and ensuring the participants understood what they were getting involved in. The interview length ranged from 45 minutes to 90 minutes with the average being 60 minutes.

During the interviews, a relationship inevitably developed with all the participants. They were very appreciative that I was looking into their experiences and that a Deaf person was doing the research and interviews.

Soon after the first interview, I translated the BSL video into written English and this transcription was shared with my supervisors to review my questioning and strategies. This is a very good practice, and highlighted that I asked too many questions all at once which meant some questions did not get the full attention. The lessons learnt from this review were implemented for the subsequent interviews.

3.5.7. Data storage

Crow and Wiles (2008: 3) state that *'anonymity and confidentiality of participants are central to ethical research'*. All the participants were informed of their rights from the start to the end of the study with a strong emphasis on confidentiality and anonymity via the PIS. The Deaf community is very small and without changing obvious names and locations, they are easily identifiable.

The study followed the requirements set out by the Data Protection Act (1998) in relation to data storage and confidentiality. It has been rigorously adhered to as anonymity and confidentiality is of paramount importance.

The raw data (videos) were uploaded to an encrypted file on the University's online filing system, as were the written translations. The only person who had access to this was me, the researcher.

The paper trail, including consent forms; personal details; and other paperwork was locked in a filing cabinet with each participant having a file under a pseudonym.

Identifiable information was kept separately from the data so that it could not be cross-referenced.

3.5.8. Data analysis

In order to analyse data from the filmed interviews, they had to be put into a written format to enable me to do further investigation of their experiences.

I translated all the videos myself. Young and Temple (2004: 168) say that the researcher as a translator offers '*significant opportunities for close attention to cross cultural meanings and interpretations and potentially brings the researcher up close to the problems of meaning equivalence within the research process*'. It is true that I was able to translate the majority of the film but there were two occasions where I could not find an English word for a particular sign as it was pure BSL that had no direct English equivalent. I contacted my research peers about these signs and asked how they would translate them. This practice seemed to work well.

I took into account Smith et al.'s (2009) recommendations on how to deal with data analysis. I started by immersing myself into the text, making notes and highlighting statement comments. As this process was very time-consuming, I looked for other ways of making it easier. I came across Amedeo Giorgi's data analysis procedure and I found similarities between my method and his. Even though Giorgi is a descriptive phenomenologist rather than an interpretative phenomenologist, I found his method for reviewing data excellent. Giorgi's (1985) method contains four essential aspects of data collection. The first is to gain the general sense of the whole by reading the whole texts; the second is to re-read the text with the aim of discriminating 'meaning units', i.e. highlighting statements; the third aspect is to go into detail with respect to the highlighted meaning units; and the final aspect is to put all the meaning units together and structure the experience.

I initially inputted the interview transcripts into the data analysis software NVIVO. However, I found it difficult to read full texts on a computer screen. I ended up doing the full text analysis manually and inputted my findings into NIVO, where thereafter I did further analysis using the software's various functions for data analysis.

I also took into account Braun and Clarke's (2006) very descriptive guide on how to do thematic analysis which they define as '*a method for identifying, analysing and reporting patterns (themes) within data, it minimally organises and describes your data set in (rich) detail.*' This was applied to my data analysis process to identify emergent themes.

NVIVO enabled me to detail each interview transcript by putting them into many coded themes, and over time it became clearer what the emerging themes were. Of these, six main themes were identified. An example of how themes were coded in NVIVO can be seen in Appendix 8.

3.6. Summary

This chapter looked at the methodologies used in this research. Justifications were given on why I chose to use the interpretative phenomenological analysis. Qualitative methods such as interviews were the main ways used to gather data to achieve the research objectives.

The following chapter discusses in detail the findings from the data collection.

Chapter 4 Findings

4.1. Introduction

The purpose of this chapter is to present findings of the study. Six themes emerged and each one has several supplementary sub-themes. A short introduction of each participant will be given to enable ease of reference and to contextualise their lived experience. Each theme, along with the sub-themes, will be represented in sub-sections where it will be described and supported with direct quotes from the participants' interviews.

4.2 Characteristics of the study sample

Eight participants were recruited from several geographical locations across the United Kingdom. These ranged from areas in the Northwest of England, the Midlands and South of England. The study participants consisted of six white women, one Asian woman and one white man aged between 23 and 55, with the mean age being 39. There are equal numbers of participants from each therapy modality; there were four participants who received therapy with a hearing therapist via an interpreter and four participants who received therapy directly from a Deaf therapist.

4.3 Introducing the participants

A short synopsis for each participant has been provided, in preparation for making reference to them throughout this chapter. Background details include their name, age, geographical location and therapy modality. Each participant was given a pseudonym to maintain confidentiality and this is extended to services or individuals

named by the participants. Furthermore, any other descriptors that could personally identify participants have been changed or removed.

4.3.1. *Natalie*

Natalie, a woman in her late 20s from the Midlands, received therapy from her university. Her therapy modality was with a hearing therapist via an interpreter where she later removed the interpreter from the equation. The new set up was having therapy with the hearing therapist via a laptop with both of them in the same room typing to each other. Natalie felt this option was the best on offer with the lack of alternatives, such as access to Deaf therapists.

4.3.2. *Isabella*

Isabella, a woman in her early 40s, comes from the North West and received therapy through her local Improving Access to Psychological Therapies (IAPT) service. Her therapy modality was with a hearing therapist via an interpreter. She did not want Deaf therapy because she used to work for an organisation where one of its services is to provide Deaf psychological therapies. She thought it was a bit too close for comfort to have a Deaf therapist from the same organisation she used to work at.

4.3.3. *Hugo*

Hugo is a male in his early 30s from the North West, and he received therapy from his local IAPT service. His therapy modality was with a hearing therapist via an interpreter. He did not complete his course of therapy as he had to stop due to having different interpreters at each therapy session which made him feel very uncomfortable.

4.3.4. Rose

Rose, a female in her early 50s, comes from the Midlands and has received psychological therapies through various services. Her therapy modality was with hearing therapists via interpreters. Rose expressed that she preferred to be with hearing therapists as she does not trust Deaf therapists because of the smallness of the Deaf community.

4.3.5. Sophie

Sophie is a female in her early 40s who comes from the South of England. Her therapy modality was with a Deaf therapist which she chose to have because of the ease of communication.

4.3.6. Hannah

Hannah, a female in her mid-50s who is from the South of England, initially received therapy through her local IAPT service using email with a hearing therapist; however, this was only for one session, and she did not feel it was working as she needed to see someone face to face. She then chose to have sessions with a Deaf therapist.

4.3.7. Samina

Samina is a woman in her early 20s from the Midlands, and her experiences of therapy came from her stay at a Deaf residential college. Her therapy modality was through sign language, where she had a hearing therapist who could sign and a Deaf therapist at separate times.

4.3.8. Charlotte

Charlotte is a woman who is in her early 40s and comes from the North West. She has experienced both therapy modalities but the sessions with her hearing therapist were very brief. For this study, her experience of Deaf therapy is the main focus.

4.4. Themes

The connection of themes and sub-themes were identified using Braun and Clarke's (2006) approach to data analysis. They recommended a six-step approach: Step 1 is to get familiar with the data; Step 2 is to do some initial coding; Step 3 is to search for themes; Step 4 is to review the themes to check if they work with others; Step 6 is to define and name the themes; and finally Step 6 is to start reporting the findings. I went through all the participant's transcripts and used the contextualisation approach where I looked at the connections to identify emergent themes. I found five themes through this approach, and I found one more theme when I searched the transcripts using NVIVO. With this new information, I reread all the narratives and identified safety and security as a new theme.

The main themes identified are as illustrated below and they all are equally represented and viewed in any order.

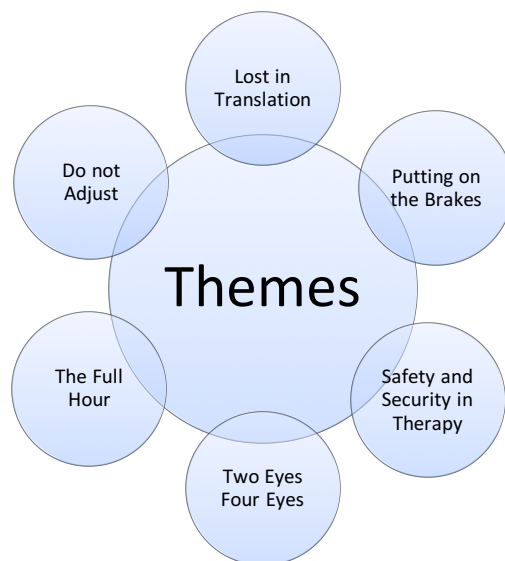


Figure 3: Figurative illustration of emergent themes from the study

The main themes were coded and statements from each transcript were allocated a code. From an in-depth analysis of each theme, sub-themes were identified and each was given its own code. Both the main themes and the sub-themes described in Table 2 overarch with one another and are not seen as singular separate categories. The table below highlights the sub-themes that emerged from the main themes.

Main Themes	Sub-Themes
Lost in Translation	1. Trust 2. Emotional state
Putting on the Brakes	1. Holding back information 2. Exposure
Do not adjust	1. They get me 2. They don't get me
Two Eyes Four Eyes	1. Third person in the room 2. How many know my secret?
The Full Hour	1. All about me 2. What do you mean?
Safety and Security in Therapy	1. Feeling safe 2. Not feeling safe

Table 2: Overview of emergent themes and sub-themes

The aim of the analysis was to ensure a fair reflection of each participant's experience. However, due to the large data set as opposed to individual case studies which is commonly used in IPA research, I had to emphasise the participants' shared commonalities to ensure that I kept within word count limitations. This approach is in line with IPA studies (Smith et al., 2009).

Symbol	Meaning
[...]	This indicates that some words have been removed from the quotation in order to enrich clarity for the reader
('non italic writing')	This shows words entered by me to clarify either the participant's feelings or the context of the quotation
Transcript 001, 10-12 (example)	This is in reference to the participants' transcript numbers and line numbers, to show where the extract is from.

Table 3: Symbols used within some of the quotations in section 4.4 below

I will now describe each theme in turn.

4.5. Lost in Translation

There are currently two modalities where psychological therapy is delivered to Deaf people, either (1) with a hearing therapist via an interpreter, or (2) directly with a Deaf therapist. The accounts of participants in this section focus on the first modality where issues range from a lack of trust of the interpreter to how the interpreter's accuracy or lack thereof impacts on the participant's emotional state.

4.5.1. Trust

Isabella wrote a diary about what happened to her for her counsellor to read.

"Before my first counselling session, I wrote down a diary of things that have happened to me to give to the counsellor. I know an interpreter was going to be there but I wanted to make sure that I got everything down and that the counsellor knows everything."

Isabella (Transcript 002, 118-120)

The question here is why did Isabella feel the need to write everything down? It could be that she felt that the interpreter was not able to translate everything she said in detail and it was important to her that the counsellor knew everything she had been through to get the full benefit of the therapy sessions to aid her recovery.

Therapy settings rely on positive relationship formation in the first instance. This can facilitate the therapeutic alliance and aid the client to achieve their goals for therapy.

"I do generally find it hard to trust interpreters. I have had to use SSE to explain my feelings and thoughts, not in BSL as I felt the interpreter would translate it wrongly or make things up."

[...] I compare the three-way communication with Chinese whispers, what I say to the counsellor is probably changed and what she says to me is changed. This causes miscommunication and misunderstanding.”

Hugo (Transcript 003, 274-276, 278- 281)

For Hugo, it appears that his distrust of interpreters hindered his chances of forming such an alliance.

Hugo wanted to use BSL in his therapy sessions to get his feelings and thoughts across to the therapist. However, he felt this was not possible because of his distrust of interpreters; he did not want the interpreter to ‘*translate it wrongly or make things up*’, so instead he had to use Signed Supported English¹³ (SSE) to ensure that the interpreter understood what he was talking about. Even if it was done in SSE, it would appear that this does not make any difference for Hugo as he sees the three-way process as making people lose sight of the original meaning due to ‘*Chinese whispers*’, which causes miscommunication and misunderstanding for him.

Like Hugo, Rose used SSE get her feelings across to the counsellor:

“I told the interpreter that she had to relay exactly what I say and not to twist anything. [...] You can’t change things in court; you have to say exactly what they say. For example, ‘Fuck you’, I would not expect the interpreter to say ‘she was swearing at you’. I would expect her to say ‘Fuck you’. This is the same with counselling, feelings are important to get across as this builds up the rapport with the counsellor. If it was said differently, I don’t think there would be much engagement from the counsellor. This is why it needs to be accurate.”

Rose (Transcript 004, 412-413, 444-449)

¹³ Signed Supported English (SSE) is where BSL signs are used in spoken English word order

She seems to have poor trust in the interpreter's ability to translate from BSL into English as she describes that they 'twist' things. It would appear that Rose felt that the interpreter would display poor lexical choices that she thinks would not represent what she is signing. If Rose did the sessions in BSL, she feels that she would not get as much engagement from the counsellor because the interpreter would not translate her feelings correctly. Engagement and rapport with the counsellor for Rose is more important than being able to converse in her first language.

It is quite interesting to note that individually, all the four participants who had a hearing therapist with an interpreter, Natalie, Isabella, Hugo and Rose had trust issues with their interpreters. Interpreters in the Deaf community come with mixed reviews. There are excellent interpreters who are trained in the area in which interpreting is required, for example mental health interpreting; however, the number of interpreters that fit in this category are very few. Lack of training in such areas appears to have an impact on the Deaf person which often leads to distrust of the interpreter. Other reasons for distrusting interpreters are that they are unqualified, or they might be qualified but do not follow good working practices, or their understanding of the Deaf person's signing is very poor and this is reflected in the voice over. The latter appears to be the most common contributing factor for distrust.

4.5.2. Emotional state

Natalie talks about how the interpreters' choice of signs can affect moods:

"Also you have to be careful how you phrase it in sign language. This is not about language access or understanding; it is about choosing the right signs to match how the Deaf person is thinking, and their current mood/emotions, as one wrong sign could make them flip. Interpreting from English to BSL can be a fast form of communication; not much time or thought is put into how it could be signed appropriately."

Natalie (Transcript 001, 134-141)

It would appear that the wrong signs have made Natalie *'flip,'* even though she does not talk about the situation directly. Natalie will probably have been in a therapy session where she is feeling emotional and sensitive, and the interpreter's seeming lack of thought in their choice of signs has impacted on her mood. This dearth of sensitivity could be due to the interpreter's insufficient experience in therapy sessions and lack of mental health training.

"I had an interpreter who struggled to keep up with me as I sign fast when I am upset; I have had the counsellor interrupting me mid-conversation. It is stressful being in a situation where both are interrupting and there is no flow in the session. Having a flow is very important to me."

Rose (Transcript 004, 475-479)

On the other hand, Rose experienced stress because of the interpreter's lack of ability to keep up with her and this resulted in the counsellor stopping the conversation for clarification.

It is a common occurrence in therapy sessions for someone to feel upset due to all the emotions coming to the surface, which affects voice, tone and speed. This happened for Rose; nevertheless, she was not able to accurately portray her upset feelings and get the benefit of therapeutic support from her counsellor because her interpreter struggled to keep up. Rose just wanted to be able to express her feelings whilst being upset without interruptions.

Therapy sessions are meant to aid recovery, not encumber it, but for Natalie and Rose their interpreter's lack of ability and choice of signs made them upset, stressed and frustrated.

4.6. Putting on the brakes

Through data analysis, holding back information seemed to be a common view either because of someone else in the room with the therapist or external factors such as knowing the person or working for the organisation that provides the therapy.

4.6.1. Holding back information

Clients should be able to express how they feel freely in therapeutic settings; however, this has not been the case for a number of participants.:

“I have been in many situations where I have been talking about something and the interpreter has reacted to what I was talking about, i.e. raising eyebrows or making a shocked face. I think, that’s enough; I can’t talk more about it. I could tell that the interpreter was not comfortable with what I was talking about.

[...] the interpreter started to become upset and cry. I thought it was their personal issues that made them like that. This really put me off as it made me think, interpreters do have feelings too; they are not just a third party robotic figure.”

Natalie (Transcript 001, 230-238, 39-41)

Natalie alluded that interpreters reacting to what she said made her hold back information. It appears that Natalie had to be conscious about what she says in order not to upset the interpreter whom she acknowledges is not a robot. She sees the interpreter as having feelings. A therapist would be trained how to deal with their emotions whereas an interpreter usually would not, and it would appear that this lack

of training has affected both of them, not just Natalie. Nevertheless, this should not be the case as the session is about her, not the interpreter.

“The three times I went, actually four times including the one where the interpreter never turned up, there was a different interpreter each time. Half an hour into the fourth session I told them I was feeling better, but actually I lied. I told them that I had achieved my goal. I did want it to stop anyway as it was not working due to the three-way communication and different interpreters each time. (I asked Hugo later on in the interview why he wanted to stop the sessions) [...] I did not want to talk about it in front of two people.”

Hugo (Transcript 003, 205-210, 442)

Hugo talks about how having different interpreters in each session impacted on talking about his feelings. He actually had to lie to finish the sessions because he did not want to talk in front of two people.

Hugo was not able to be truthful about why he wanted to finish therapy. Perhaps he did not feel comfortable enough in the therapeutic alliance to tell the truth or did not want to hurt the therapist’s or the interpreter’s feelings.

4.6.2. Exposure

Other factors contributing to ‘putting on the brakes’ are the familiarity within, and smallness of, the Deaf community and its limited specialist services:

“As I am a student, I regularly use and see the same interpreters, and this means the boundaries of separation can get overlapped as we see each

other regularly. I do know my interpreter personally and sometimes before we start a lecture, she asks how I am, linked to yesterday's counselling session. I sign (cut throat) to say don't ask me; please keep this separate. This is why I stopped having interpreters in my sessions."

Natalie (Transcript 001, 65-70)

The 'boundaries of separation' have resulted in Natalie deciding to stop using interpreters in therapy. They were becoming too over familiar by asking Natalie about her last therapy session. She clearly did not want to talk about this, and articulated it by signing 'cut throat' which is rather a severe way to get a point across. Natalie probably wanted to separate her counselling and university life, and having the same interpreter may have reminded her of her counselling sessions which sometimes she probably wants to put aside.

The Deaf community is small, and therefore the people and services provided in it are known to many, which Isabella had difficulty with.

"In DeafTalk, the Deaf counsellors know all Deaf people. I know they follow confidentiality and should not mention names. [...] If the Deaf counsellor was from a different company, I would have tried that. Because the Deaf person works for DeafTalk, I said no because it was a bit too close to home."

Isabella (Transcript 002, 252-253, 84-85)

Isabella used to work for the same organisation as DeafTalk but in a different service from therapy. DeafTalk is the main provider of therapy, and Isabella was offered one from there but said that she did not want to use one from there as it is a bit 'too close to home'. Working for the same organisation made Isabella 'put on the brakes' and go with a hearing therapist.

4.7. Do not Adjust

A good relationship between the client and the therapist is the main base for the therapeutic alliance and having the right relationship is perceived as one of the main therapeutic tools for achieving change.

4.7.1. They don't get me

The client's bond with the therapist is one of the main foundations of a working alliance; there are several reasons why a bond may not form. For many of the participants, the therapist's lack of cultural competency is the main reason for the lack of bonding.

"I don't know how or if counsellors are trained to pick up on body language such as emotions. I feel that hearing counsellors can't pick it up; sometimes I go into a session where I am in a mood and they don't pick it up. Interpreters do pick it up but they can't say to the counsellor 'her mood is a bit low today' as it is not their job to say so. Sometimes I see that the counsellor thinks all is fine when it is really not.

[...] a Deaf counsellor would pick up on body language clues . . . spot if you are faking it. A lot of Deaf people in mental health fake being OK, nodding with thumbs up when really they are not OK."

Natalie (Transcript 001, 219-223, 224,226-227)

Natalie's therapist's lack of Deaf awareness meant that she did not spot that Natalie was in a negative mood when she arrived in a therapy session.

Picking up on body language alone is important to Natalie; she just wanted someone to say 'Are you OK?' without having to say anything. The interpreter picked this up because in general, they are the epitome of cultural competency but they are not allowed to give their views which mean it does not get addressed. Natalie alluded that a Deaf counsellor would be able to notice her negative language straight away and immediately know if she was not telling the truth by identifying subtle nuances such as facial expressions and eye gaze. It would appear that Natalie has faked being OK and this has gone unnoticed.

The quotation below highlights one of the reasons for a lack of bonding:

"I feel I can't have a relationship with the counsellor because they don't sign and they don't get me.

[...] I feel more of a rapport with the interpreter because they understand your situation better than the counsellor does but they do not have the tools to help."

Natalie (Transcript 001, 295-299)

The bond seems to be with the person who can sign, which in Natalie's case is the interpreter. It is important to Natalie to have a therapist who can sign and who intuitively understands her.

"I felt vulnerable because I told her my problem and it immediately hit me that she did not understand it because she could not sign.

[...] She is hearing and I am Deaf; this means we don't understand each other's worlds. I have 0% experience of the hearing world and she has 0%

experience of the Deaf world - how are we supposed to match? There is neither bond nor engagement there.”

Hugo (Transcript 003, 266-267, 385-388)

The therapist’s lack of signing ability was an issue for Hugo too. Hugo declared his innermost feelings to his therapist only to realise that she could not sign and because she could not sign, he felt that she would not understand what he was talking about. This caused him to feel vulnerable which is not an ideal therapeutic alliance. For Hugo, a therapist who matches his experience of the Deaf world would enable him to engage.

“I think this was the first time he met a Deaf person. I don’t think he understood clearly about the ways of how a Deaf person exists and their culture. [...] I felt very frustrated because he kept asking me questions and I had to explain.”

Isabella (Transcript 002, 51-52, 140)

The therapist’s lack of cultural competency according to Isabella made her frustrated. It is the therapist’s responsibility to delve into the client’s world to get to know them better, but in this case it is likely that it caused a therapeutic rupture¹⁴ with Isabella because of the constant questioning about being Deaf.

¹⁴ Therapeutic ruptures are often described as deteriorations in the relationship between the client and therapist.

4.7.2. *They get me*

Being in a positive therapeutic relationship can be a rather powerful experience, especially when a therapist really *'gets you'*, for instance, intuitively understands your feelings.

"We talked a bit about Deaf schools. [...] With Jessica (Therapist), our personal experiences were very similar. However, with a hearing person, they perhaps would not understand what experiences I had through school."

Hannah (Transcript 006, 142-144, 162-163)

In Hannah's situation, the sharing of experiences made her bond with her Deaf therapist. For Hannah, it was important to her that her therapist had knowledge about Deaf schools. It is one of the epistemological characteristics of a Deaf person to question which school a new acquaintance went to as it reveals a lot about a person. It is apparent that if the therapist recognises the name of the school, this is highly beneficial as it gives them numerous instant pieces of background knowledge about the client's upbringing.

"She knows the A - Z in-depth details of the Deaf world. It was very important to me. This meant we could have a deep bond. If they did not know much about the Deaf world, it would make others things more difficult to link up. The Deaf counsellor knew how to connect the dots. It made my life a lot easier."

Samina (Transcript 197-202)

Samina received therapy from a Deaf therapist with whom she had a deep bond.

The key aspect for Samina is the therapist knowing the ins and out of the Deaf world and guiding her with relevant information from her world. It can be seen that knowing about the Deaf world has a positive impact on a person's life, which in Samina's case made her *'life a lot easier'*.

"They understand what it is like not being able to hear, they know the stressful life we live every day, and they know what we are going through as they are going through it themselves. A hearing counsellor, they are completely opposite, they can hear, they can do a lot of variety of things. I would feel put down if they said 'oh, you can do it'.

[...] They would not understand me or get me. Actually, they might understand me but they would not be able to get me."

Sophie (Transcript 005, 105-110, 168)

Sophie reiterated what Samina, Hannah and Charlotte feel about having a Deaf therapist, which is that they understand your life-world. It is apparent that Sophie would not appreciate receiving guidance from a hearing therapist, as she perceives a hearing therapist to have a superior life than she does. Sophie argues that a hearing counsellor might understand her but they would never *'get'* her.

"I was wowed at the fact that he was able to respond to every question/problem I had. I did ask someone else for advice on something; they took time to respond whereas with him it was immediate. It was wow.

[...] Deaf and hearing people are different; we have to adjust to meet each other's communication and understanding needs. With a Deaf person, there is no need to adjust."

(Charlotte 008, Transcript 356-358, 195-196)

Indeed, Charlotte's bonding and therapeutic working relationship with her Deaf therapist creates a powerful vision. It is clear that the impact of having a Deaf therapist for Charlotte is an immeasurable one. This is due to the therapist being able to communicate directly in her language and understand her life-world, in addition to the fact that she did not need to adjust her communication; she was able to be just herself.

4.8. *Two Eyes Four Eyes*

There was a sense amongst the participants that having a third person in the room created an extra dimension to the therapeutic relationship.

4.8.1. *Third person in the room*

"The counsellor was a girl who was perhaps a few years older than me and next to her was an interpreter, a man who was wearing an open shirt. They were both looking at me and I felt extremely uncomfortable. There were going to be two people looking at me when I am going to express my innermost feelings; I was not comfortable with this."

Hugo (Transcript 003, 124-128)

For Hugo, having a third person in the room made him extremely uncomfortable. The process for Hugo to get to the therapy room probably would have been a difficult period for him, for instance, recognising that he has a problem and that he needs to talk about it. Therefore, to talk about your innermost feelings to one person is difficult enough let alone two people. Hugo found this very challenging when he had two people looking at him.

“I have anxiety as well; I don’t want another person in the room. There are some Deaf people who are strong and some who are weak. I’m the weak one definitely.”

Sophie (Transcript 005 316-317)

Sophie’s view was that having another person in the room would increase her anxiety levels. Moreover, her mention of being the weak one is likely to be in reference to why she has anxiety.

“This reminds me of growing up with my family, the lack of communication we had and the feeling of being left out.”

Charlotte (Transcript 008, 376-379)

Charlotte and I were having a discussion about why she would not have a hearing therapist. She said that she would feel left out in the therapeutic alliance. She alluded that this was because it would remind her of the lack of communication she had growing up with her family.

“I did not have good family communication as I was growing up and the counselling with the hearing counsellor reminded me of that. I felt I could not be bothered with it.”

Samina (Transcript 007, 48-49)

It is interesting to note that Samina also mentioned familial communication as her reason for not having a hearing therapist.

“Imagine having two circles. Some people’s circles don’t meet, but ours overlapped perfectly and the shape in the middle was perfectly aligned. The interpreter fitted into the space in the middle of the two circles.”

Rose (Transcript 004, 656-658)

Despite the fact that most of the participants are not keen on having another person in the room, there was one participant, Rose, who stated that having a third person in the room worked perfectly for her.

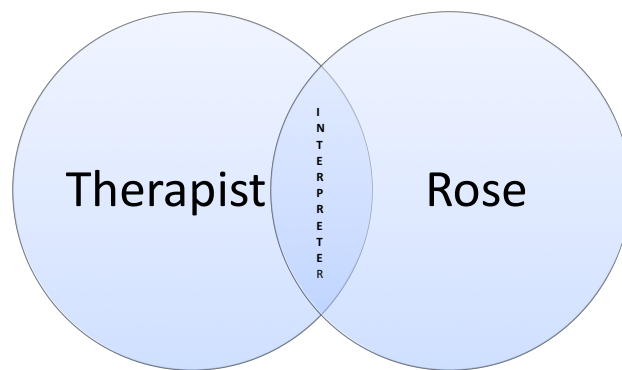


Figure 4: Rose’s concept of the therapeutic alliance

4.8.2. How many know my secret?

It can be seen that sharing your dark thoughts can cause deep emotional stress and especially with two people, it can be intimidating:

“I am looking at four eyes, not two eyes (counsellor and interpreter). I am offloading my dark thoughts to two people. That was a major problem for me. [...] It felt intimidating having two people in front of me when I am talking about my deepest innermost feelings.”

Hugo (Transcript 003, 245-250, 474-475)

Hugo's description of '*two eyes four eyes*' in the context of sharing his dark thoughts evokes a strong visualisation of what it is like for him. It is hard enough to maintain eye contact with one person when you are describing your feelings, let alone two people. For Hugo, when talking about his feelings, looking at four eyes instead of two makes him feel intimidated.

"I have spoken to the Deaf person but she is very reluctant to receive it. She did not want a Deaf service. [...] Her worry about people gossiping about her is still a very strong factor."

Hannah (Transcript 006, 505-506, 510)

Hannah was approached by her GP to persuade a Deaf person from the same practice to get Deaf therapy. The Deaf person did not want to receive it because she was worried that people would gossip about her. This kind of distrust on the part of Deaf people could be due to the fact that they are often let down many times when asking for support, and that with the Deaf community being so small, it is inevitable that someone will know someone through multiple work and social circles. This can make badmouthing and gossiping quite common occurrences. When this is applied in the context of Deaf therapists who come from the same community, it is natural that people feel anxious about using a Deaf service. It is up to the service and its users to educate and reassure people of its good working practices with a particular focus on professionalism and confidentiality.

4.9. The Full Hour

Therapy is usually allocated in 50-minute sessions, but with Deaf people this is often extended to an hour due to translation time lag and the need for further clarifications due to the client's lack of incidental learning.

4.9.1. What do you mean?

“Having a hearing counsellor was not perfect as we only had an hour per session; I spent half of it explaining deaf issues such as my Deaf background, Deaf culture, Deaf families and what it is like in the Deaf community. Then I was able to focus on my real issues. This meant that a lot of time was lost and wasted.”

Natalie (Transcript 001, 47-50)

Natalie's therapist kept asking questions about Deaf culture. The questioning about Natalie's Deaf background made her feel that the counsellor was not addressing her 'real' issues. The questioning appears to be for the benefit of the counsellor to learn about about Deaf culture. Natalie just wants the benefit of the full hour to focus on her issues.

“I felt very frustrated. He kept asking questions and I had to explain. There was no flow; it was stop start stop start due to explaining. The flow of the session kept getting stuck.”

Isabella (Transcript 002, 140-142)

The lack of flow in the session was very frustrating for Isabella. The therapist obviously did not understand where Isabella was coming from when explaining something about

her Deaf background; this happened too often, which affected the flow of the session, which in turn mean that Isabella did not get the full benefit of the session.

4.9.2. All about me

“Having a hearing therapist is more hard work due to lack of communication; there is limited time in the sessions focusing on my problems even though it is a full hour. [...] With a Deaf therapist, you get the benefit of the full hour as there are no barriers.”

Charlotte (Transcript 008, 289-292)

Charlotte alludes that hearing therapists are ‘*hard work*’ and would not benefit from the full hour. She goes on to say that with the Deaf therapist, she would have no barriers and thus get the benefit of the full hour. She sees the hearing therapist’s lack of cultural competency as a barrier to her recovery.

“If I had a hearing counsellor via an interpreter, I would have to explain my Deaf background, which school I went to, how I grew up, how I fought for access and explain many other issues. Once I’ve finished explaining, my session will have ended, and I would not be able to talk about my problems! With a Deaf counsellor, they would know all that straight away and more time would be focused on my problems.”

Hannah (Transcript 006, 656-660)

Hannah elucidates that having a hearing counsellor would mean having to explain her Deaf background in detail and that she would not even have her problems addressed. It is important to Hannah that a therapist is culturally competent so that they can immediately address her problems.

4.10. Safety and Security

When receiving therapy, you want to be able to be in a place where you feel free to be yourself, where any emotion is possible and where you feel listened to, wanted, valued and validated. A number of issues were identified in what made participants feel safe and unsafe, which are illustrated below.

4.10.1. Not feeling safe

“When you are in the Deaf world, they do know your business and can gossip. But with the (hearing) counsellor, they don’t know the Deaf community, and they don’t know my business. I find it easier to offload it to her without any judgments.”

Isabella (Transcript 002, 245-247)

“I know that I am safe with a hearing counsellor as opposed to in the Deaf world. I would be worried if they were talking about me or having slip talk.¹⁵ Hearing people are out of the Deaf world; I can function knowing that it won’t be talked about in the Deaf community.”

Rose (Transcript 004, 680-683)

The smallness of the Deaf community is a recurring theme throughout this study and it can cause the participants to feel unsafe as described by Isabella and Rose. Both Isabella and Rose talk about how Deaf gossip made them feel unsafe. They would prefer to go to a hearing counsellor because they do not know about the Deaf world

¹⁵ Slip talk is a word I translated from a sign that Rose used. I could not find an English word that matched the sign. It is referred to a conversation where a person accidentally slips out confidential information.

and therefore cannot make any judgments. Additionally, Rose feels more relaxed with a hearing counsellor because she knows that they are not part of the Deaf community.

"I felt vulnerable because I had told her my problem and it immediately hit me that she did not understand it because she could not sign.

[...] I thought I would feel safe, but I did not. I felt very raw after the first session which led me to drinking; I felt dazed and confused."

Hugo (Transcript 002, 266-267, 318-319)

Hugo's experience of not feeling safe had quite a serious impact on him. The therapist's lack of signing skills made Hugo realise that she did not know anything about the Deaf community. He had just offloaded his problems to her hoping to feel better, only to grasp that she did not understand. This doubled his vulnerability which led to him drinking. For Hugo to feel safe, he needs to have someone who understands his Deaf background.

"It took three months. I told them I really needed it. I could feel myself sinking deeper into depression."

Sophie (Transcript, 59-60)

Sophie talked about the time it took for her to get therapy. Her doctor had to apply for funding for her to get therapy with a Deaf therapist. It took 3 months before she could receive therapy and according to Sophie she was '*sinking deeper into depression*'. The waiting time to receive therapy led her to feel emotional and unsafe.

4.10.2. Feeling safe

To feel safe is one of the fundamentals in the therapy room, and this study found many factors contributing toward participants feeling safe in therapy.

“She had highlighted parts and showed me, to ask me more about them. Because of her interest in my story and effort she put in reading it, I felt bonded to her.”

Isabella (Transcript 002, 123-126)

Isabella wrote down her story linked to a specific incident and shared it with her therapist. For Isabella to feel safe, she needed her therapist to show an interest in her. Her therapist did this by referencing parts of her story and talking about it. This act of reaffirmation made Isabella bond with her therapist and feel safe.

“I started signing to her and she reconfirmed what I said, this showed that she fully understood me. She said things that I could not find the words for; I felt that she really understood me before I even walked into the room!”

Samina (Transcript 007, 183-185)

The act of reaffirmation is what made Samina feel safe. As well as reaffirmation, Samina felt safe because she perceived that her therapist really understood her. When Samina spoke of things that she could not find the words for, her therapist was able to fill in the gaps which gave her clarification.

“He knew how to respond to all my problems. He matched everything perfectly. I felt right and that is what made it powerful. He knew how to control me when I was getting agitated. He was really good.”

Charlotte (Transcript 008, 33-338)

For Charlotte, the fact that the therapist was Deaf made all the difference for her. Having a therapist who is able to guide the client through problems and explain in a clear manner is what is important to Charlotte. She found this a very powerful experience because she fully understood everything and he was able to calm her when she was feeling agitated. The fact that he was Deaf and perfectly matched made her feel safe.

“Having a person who can sign, who understands my language, would make me feel safe; it would be better if they were Deaf themselves.

[...] If I am talking about something where I think I am the only one who has experienced it, I would like them (the Deaf therapist) to say that they have been through the same or know of some others who have done so, to reassure me that others have gone through the same.”

Hugo (Transcript 003, 321-322,324-328)

Shared experiences with the therapist is what made Hugo feel safe. Hugo wants the therapist to normalise the experience for him by saying that they know of others going through it. This would lead to him feeling validated and less isolated.

“She was very emotional. She felt what I felt. I told her you’re crying and she said that it was because she could feel my pain. I thought she really cared about me.

I: Did you feel that you had an alliance/bond with her? (Interviewer)

Yes. At first I was unsure but when I saw her cry; I’m used to people not showing their emotions linked to work but I saw that she cared for me and felt how I felt; that’s when I felt the bond with her.”

Hannah (Transcript 006, 220-226)

For Hannah, she felt safe with her therapist because she showed that she cared. The therapist showed that she cared by crying; Hannah was unsure about this at first as she was not expecting the therapist to cry in sessions. Hannah believed that they hold back emotions; it is usually the client that cries, not the therapist. However, this has had a positive impact on Hannah who developed a strong bond with her therapist because of this incident.

4.11. Summary

This chapter introduced the participants in the study, and the findings were discussed in more detail with reference to the six main themes identified - (1) Lost in Translation; (2) Do not adjust; (3) Putting on the brakes; (4) Two Eyes Four Eyes; (5) The Full Hour; and (5) Safety and Security. Each theme had additional subthemes.

The findings raised very interesting issues such as distrust of interpreters (under the theme ‘safety and security’). Interpreters posed a problem for many of the participants ranging from their lack of signing ability and culture competency to feeling exposed and having someone else in the room. Furthermore, participants talked about their powerful experiences of when the therapeutic alliance works which is having a therapist who fully understands the issues and offers shared experiences and

validation, and having the benefit of the full hour without having their Deaf background questioned.

The following chapter discusses the discoveries from this chapter and brings together what is known, what has been found and how it can make changes for psychological therapies for Deaf people.

Chapter 5 DISCUSSION

In this chapter, the main findings from the accounts of Natalie, Isabella, Hugo, Rose, Hannah, Sophie, Samina and Charlotte in relation to their experiences of therapy are evaluated. In addition, general conclusions based on the findings of the studies are described. Furthermore, the strengths and limitations of this study are presented as well as recommendations for future research. The chapter concludes with a personal reflection on the research process.

5.1. Introduction

The aim of this study was to investigate in-depth the BSL user's relationship with their therapist, specifically looking at alliances, dynamics, engagement, understanding and shared decision-making. This was done by exploring their experiences of therapy alliance in Deaf/Deaf therapy and Hearing/Deaf/Interpreter therapy using Smith, Flowers and Larkin's (2009) interpretative phenomenological analysis methodological approach. In addition, my ontological perspective from a Deaf person is embedded in this study.

This thesis has looked at the lived experiences of the study participants through the phenomenological lens as well as the lens as a Deaf researcher. Accordingly, this is emphasised in the findings where their experiences are highlighted and explored in more detail. Some of these findings are consistent with the literature review where ten papers were reviewed; however, there were several findings in this study that are not mentioned in previous research, and this is likely to contribute to new knowledge.

The literature reviewed for this thesis found four common themes which are (1) barriers, (2) preference of Deaf or hearing therapist, (3) use of interpreters, and (4) cultural awareness/competency. The findings from this study are compatible with the

themes identified from the literature review, in particular the use of interpreters and cultural competency which is discussed in more detail.

Furthermore, I now reflect on what has been identified and learned during this study, which has produced a variety of interesting and important observations that merit further discussion.

5.2. *Distrust of interpreters*

This study found that the participants' levels of mistrust of interpreters were particularly elevated, and the distrusting of interpreters is highlighted by most of the previous literature which includes Steinberg et al. (1998), De Vinney and Murphy (2002), Cohen (2003) Munro et al. (2008), RNID, (2009), Sheppard and Badger (2010), Horton et al. (2012), Cabral et al. (2013). Examples from this previous literature of reasons for distrust of interpreters are: misinterpretation, not being qualified, and the awkwardness for the client of having a third person in the room.

All the participants in the study stated that they encountered difficulties with interpreters. Sophie, Hannah, Samina and Charlotte mentioned that their previous experiences with interpreters in other settings led them to opt for a Deaf therapist. On the other hand, Natalie, Isabella, Hugo and Rose who had therapy via an interpreter reported a deep distrust of interpreters.

The main reasons for this were said to be the interpreter's lexical choice of inaccurate or inappropriate signs, including for example those that caused Natalie to '*flip*' and created a stressful situation for Rose that affected her emotional state in a negative

way. This is important because therapy sessions are meant to aid recovery, not encumber them.

There were reports of abandoning BSL in order to ensure that their therapist really understood what they wanted to say. Isabella wrote down her story so that the counsellor got all the details that she felt the interpreter would possibly miss out. Natalie ended up having therapy via a laptop with the therapist in the same room because she felt that there was too much information getting lost in translation with the interpreter in the session. This had a deep impact on her recovery to the point where she decided to remove the interpreter from the situation and have therapy in written English, through which she felt that she could get more benefit from her therapist. Both Hugo and Rose resorted to using SSE to get their feelings across because they felt that the interpreters would '*translate it wrongly or make things up*' and '*twist*' things. It is obvious that none of them trusted the interpreter to accurately communicate their feelings (Tribe and Morrissey, 2004), and this mistrust could in turn damage the cognitive therapy process.

There are several possible explanations for distrust. Each participant portrayed different experiences, and the question is why there is such a problem with interpreters? There are several possible justifications for this which are (1) poor judgement in choice of lexical signs; (2) lack of interpreter training in the mental health field; (3) the interpreter may be unqualified; and finally, (4) omissions in the translation process. These explanations are indicated in the data, which have come from the participants themselves, alongside my interpretation of their accounts.

It is part of the interpreter's role to omit or reduce what is being said from one language to another during translation to ensure clarity (Harvey, 1986; Kaufert 1990; Raval, 2003; Napier and Major, 2012). In her useful study of accuracy in interpreting, Napier (2004: 137) found that '*every interpretation has an omission potential*' and it

would appear that omission has caused issues for four of the participants. Nevertheless, interpreters are allowed to make omissions based on cultural and linguistic knowledge to decide what is relevant and what is redundant (Napier, 2004). The act of omission can be contrasted with Husserl's theory of bracketing where a *'sequence of reductions is intended to lead the inquirer away from the distraction and misdirection of their own assumptions and preconceptions, and back towards the essence of their experience of a given phenomenon'* (Smith et al., 2009: 14). Husserl's use of reduction does not mean omission; it is just merely setting things aside to aid the interpretation. This can be seen as a positive act. On the other hand, the omission/reduction the interpreters make appears to have a negative impact on the participants. More importantly, this raises the question that needs to be asked - are interpreters omitting the right parts? Are they actually comprehending the essence of their Deaf client? The Deaf client's interpretation of their essence (the emotional message they want to get across) could be different from the interpreter's view of what the essence is. Further research should be done to investigate a comparison of what the essence is according to the Deaf client versus according to the interpreter.

5.3. When the therapeutic alliance does not work

Therapy settings rely on positive relationship formation in the first instance. Bugental (1987: 49) describes the therapeutic alliance as a *'powerful joining of forces which energises and supports the long, difficult and frequently painful work of life-changing psychotherapy'*. Bordin (1979) contributes an extra dimension where he differentiated goals, bonds and tasks of the working alliance, with these three aspects all being required for any form of therapy to be successful.

It would appear that for the alliance to be successful, there needs to be a bond that underpins all effective work. With regards to the literature review in Chapter 2, the findings from the reviews identified problems with the therapy but does not go into

detail about the alliance and what causes it to rupture. More importantly, the findings from this study reveal numerous reasons why the therapeutic alliance has not formed or worked.

It is interesting to note that the lack of therapeutic alliance in this study affected all four participants who received therapy with a hearing therapist via an interpreter. In contrast, the four participants who received therapy with a Deaf therapist all reported positive working alliances.

The main reasons for lack of alliance are distrust (which has been described in 5.2); lack of cultural competency, where the therapist does not know enough about Deaf issues (this will be explored further in 5.4); and having a third person in the room. Additionally, the other reasons are to do with exposure, for example, for Hugo one of the main reasons for the lack of alliance is that he had different interpreters for each session.

As mentioned earlier, to have a strong alliance you need to form a bond which is usually with two people; however, when you add a third person to the alliance, this raises the question of who the bond is with, if there is any bond. In this context, the third person is the interpreter and the *'presence of an interpreter raises ethical and practical matters which are challenging'* (Trivasse, 2010: 1) to all in the therapy room. Some of the participants see both the interpreter and therapist as barriers to them forming an alliance (Corker, 1994; Steinberg, 1998; Glickman and Gulati, 2003; Horton et al., 2012; Cabral et al., 2013). Several participants said that they formed more of a bond with the interpreter because they communicate in their language and the eye gaze is with them, not the therapist (Steinberg, 1991; Green et al., 2001). On the contrary, in reference to interpreters, Natalie said that *'things got lost in translation'* and Hugo described the three-way process as being like *'Chinese whispers'*, which contributed to the scarcity of alliance. This has specifically caused Natalie and Hugo to

'put on the brakes' and withhold information because they were not comfortable disclosing information that was getting lost in translation.

Exposure in this context is the feeling of discomfort based on who the feelings are being revealed to and shared with. For Isabella and Rose, sharing their feelings with a Deaf therapist or an interpreter made them feel exposed due to the smallness of the Deaf community. It is foreseeable that someone will know someone through work and social circles, and the Deaf therapists and interpreters are part of this small Deaf community, which these participants felt could result in 'slip talk' and gossiping (Munro et al., 2008; Sheppard and Badger, 2010; Cabral et al., 2013). Therefore, fear of exposure is a barrier to effective therapeutic alliance.

Finally, having different interpreters in each therapy session is a significant barrier to forming an alliance (Westermeyer, 1990; Turner et al., 2000, Williams and Abeles, 2004). This made Hugo develop a distrust of the situation that made him feel vulnerable because he was having to disclose his innermost feelings each time; the knowledge that more than one person knows his secrets did not make him feel safe. Hugo had 3 interpreters before he stopped the sessions. He had several reasons for stopping therapy, and the number of interpreters was one of them.

Moreover, the act self-disclosure is a difficult undertaking for anyone. It makes people feel vulnerable, and for Hugo, having more people in the room increased his vulnerability. Fundamentally, when there is an act of disclosure, the therapist immediately flags this in their thinking and considers ways of how to protect themselves in order to deal effectively with this disclosure, because this kind of sharing of experiences could lead to a profound disclosure. However, for Hugo the profound disclosure with his therapist was not there because of several reasons, such as his distrust of interpreters which could have blocked his alliance with the therapist; the

therapists lack of cultural competency; and/or just simply having a third person in the room. It is likely to be the case that it is all of the above.

5.4. *The importance of cultural competency*

Findings from the study correspond with previous literature in relation to the need for therapists to have cultural competency (Cohen, 2003; Munro et al, 2008; RNID, 2009; Davidson et al, 2012; Horton et al, 2012; Cabral et al, 2013).

Cultural competency involves, as described by Whyte et al (2013: 3), '*understanding one's own worldviews as well as the client's*' and '*integration of cultural attitudes, beliefs and practices into the building of rapport, diagnosis and treatment, education and training.*' It is important for the therapist to have background knowledge on the client's language, values, beliefs, customs, ethnicity, behaviour norms, community and social structures (Glickman and Gulati, 2003; Guthmann et al., 2004; Willcox, 2006; Glickman, 2009; Whyte et al., 2013; Wright and Reese, 2015). This is reinforced by Lago (2011) who wrote about transcultural counselling and identified seven domains that a therapist must have when counselling a client who is from a different culture than themselves. These are (1) acceptance, (2) humility, (3) humanity, (4) compassion, (5) encounter capacity¹⁶, (6) relational capacity¹⁷ and (7) empathy and motivation.

Natalie would have appreciated a culturally competent therapist when she turned up at one of her sessions in a negative mood. She said that her hearing therapist failed to pick it up and she alluded that a Deaf therapist would pick it up straight away. Furthermore, she said it would be hard to fake it with a Deaf therapist. The 'faking it' and saying that you are fine when you are really not, is a fairly common occurrence

¹⁶ To be able to deal with self and others

¹⁷ This means the level of trust between the therapist and the client

amongst Deaf people. This is supported by Glickman and Gulati (2003: 10) who say that *'hearing people, uncomfortable with the communication problems, are usually all too willing to accept the deaf person's "empty nod" at face value'*. Corker (1994) recognises the importance of picking up non-verbal communication in therapy and Williams and Abeles (2004: 644) reinforce Corker's view on non-verbal communication when they state *'these unspoken conversations are vital to establishing and maintaining a therapeutic relationship with a client'*. The evidence shows that it is important for the therapist to pick up on the body language nuances of a Deaf person to enable them to feel that they are understood.

Several of the participants divulged that their therapist's lack of cultural competency was a barrier to recovery and made them frustrated because the therapist kept asking questions about deaf culture and asking them to clarify what they meant, and that resulted in not getting their real issues addressed.

An illustration of this is described by Natalie (4.6.1. Pg 68) who stated that she had to talk about her Deaf background more than her real problems. On the other hand, Hannah (4.6.2. Pg 71), who had a Deaf therapist, said that if she had a hearing therapist she would have no time to talk about her issues whereas with a Deaf therapist there would be no such basic cultural questions asked. For instance, Hanna spoke about Deaf schools and her Deaf therapist immediately understood without any further probing. Clearly, it is important for the therapist to have knowledge of Deaf culture, norms, values, and beliefs, and a current awareness of what is happening in the Deaf community (Cabral et al., 2013; Whyte et al., 2013).

Sophie, Hannah, Samina and Charlotte all referred to receiving the full hour of therapy and feeling that their problems were the sole focus, mainly because there were no cultural barriers. They felt their therapist showed cultural competency by sharing experiences, which is echoed by Cabral et al's (2013) participants. Hannah spoke about

the importance of the therapist knowing about Deaf schools, as she obviously had issues with it and the therapist was able to share her experiences which made Hannah feel validated. Furthermore, it must be pointed out that it is one of the epistemological characteristics of the Deaf community to ask which school an individual went to, as it reveals a lot about a person. Therefore, it would be beneficial for the therapist to have this kind of knowledge, as they get instant background knowledge about their client.

Samina referred to her Deaf therapist as being the source of all Deaf knowledge. She described this as *'she knows the A-Z in-depth details of the Deaf world'*, and knowing this made her feel safe and allowed her to develop a deep bond which is a sign of an effective therapeutic alliance which leads to positive recovery.

The word *'get'* as in *'gets me'* was a common occurrence across the study and this is summed up well by Sophie who said that a hearing therapist could possibly understand her but would not be able to *'get'* her. Obviously, to *'get'* a person, one needs to have cultural competency that includes shared experiences, the knowledge to be able to signpost to accessible and relevant services for Deaf people, and an understanding of their life-world. This *'getting'* also contributes to trust and alliance issues for both the therapist and client. This is in relation to the *'knowing me knowing you'*¹⁸ that is a part of the alliance process; the concern here is how to build trust with someone who you do not really know or *'get'*.

¹⁸ A common therapist/counsellor parlance

5.5. Two Eyes Four Eyes

I have called this theme Two Eyes Four Eyes because in Hugo's narrative, he evokes the very signing deployed in BSL for this notion. As such it is a strong visualisation of how it looks and feels like that there are more than three people in the therapy room with the reference to four eyes. In this context it represents how many eyes the Deaf person is looking at in the therapy room. Moreover, this seems to have created an extra dimension to the therapeutic alliance.

It is more than just about having a third person in the room; it is about the effect that this has on the client, particularly Hugo who felt '*extremely uncomfortable*' and '*intimated*' because he is '*looking at four eyes, not two eyes*'. This contributes to distrust and the holding back of information, and affects the flow of communication, for instance, the client would have to consider who their eye gaze is on thus disrupting their thought processes, and additionally the shifting in eye gaze makes the communication jarring. Based on Hugo and Rose's experiences (as mentioned in 5.2), the eye gaze is on the interpreter because they want to see how the interpreter translates them. Ideally, the eye gaze should be on the therapist as they are the ones that the client needs to bond and form an alliance with (Steinberg, 1991; Green et al, 2001).

There are a lot of elements to ensuring that the therapeutic room is a place where someone can feel safe to share their emotions and feelings. Examples of factors that need to be taken into consideration are the alliance, environment, trust, feeling safe, and understanding (Hazler and Barwick, 2001). However, it would appear that having another person in the therapy room increases anxiety. Sophie, who already suffers from anxiety, felt that she was not strong enough to be able to deal with another person in the room; it is an extra person that she needs to think or worry about.

For some of the participants, having someone else in the room evoked strong negative memories about feeling excluded and they did not want this replicated in the therapy room. This is reinforced by Glickman and Harvey (1996), who mention environmental triggers from childhood having an impact on the client's emotions of 'feeling left out'.

In contrast, having a third person in the room did not seem to bother Rose. She said that it worked perfectly for her, which she described using two interlinking circles with the interpreter 'perfectly aligned' between the two circles. However, it must be noted that Rose did have problems with her interpreters such as translation issues but these were far outweighed by her reasons for not going with a Deaf therapist. She had trust and confidentiality issues with the Deaf community and going with a hearing therapist according to Whyte and Smith (2010) '*results in few problems with confidentiality within the small Deaf community*'. For Rose, going with a hearing therapist meant peace of mind knowing that the chance of members of the Deaf community knowing about her problems is non-existent.

5.6. *The need to feel safe and secure*

The therapeutic environment should be a place where the client feels free to be themselves, to be listened to, to not feel judged and not be blamed. Furthermore, a good therapist will listen with empathy, acceptance, and understanding, and will be able to communicate with the client effectively.

Several of the study participants, in particular Isabella, Rose, Hugo and Sophie, experienced not feeling safe and this caused a therapeutic rupture for some of them. The reasons for this are a lack of cultural competency (see 5.4), not being able to sign, simply being Deaf, and the waiting time to receive therapy.

It is important to state here that the therapist could be well meaning and have the right attitude to the alliance, but a lack of cultural competency of Deaf issues and an inability to sign could render the therapist ineffective, as happened for Hugo. Consequently, it led to Hugo feeling very unsafe, vulnerable, dazed, and confused, and it caused him to drink heavily which he does not normally do. It would appear for Hugo to feel safe, he would benefit from a therapist who can sign and understand his background.

The waiting time for receiving therapy made Sophie feel unsafe. She had gone through the process of recognising that she had a problem, debated whether or not she should receive therapy, and then she decided to go for therapy only to be told that to get a Deaf therapist, funding would have to be applied for and that the process could take a while. As Sophie already suffered from anxiety, the waiting time to hear whether funding would be approved triggered feelings that made her feel unsafe about her emotions. Unfortunately, the waiting time to get funding to receive therapy from a Deaf therapist is an all-too-common experience for many Deaf people in England (Hulme, 2015).

Nevertheless, for Rose and Isabella, a therapist who is Deaf would make them feel unsafe because of the smallness of the Deaf community. They both alluded that they would have the fear of the possibility that the Deaf therapist may talk about or gossip about them (see 5.5). Like with any small community, 'grapevine' talk and backstabbing is a common occurrence, and this is no different in the Deaf community (Munro et al, 2008; Leigh, 2010; Sheppard and Badger 2010; Cabral et al, 2013; Whyte et al, 2013). It would appear that this has happened to Rose and Isabella, which caused them not to trust Deaf therapists, not because of any fault from the therapists themselves, but because of the nature of the Deaf community prompting them to apply the same brush to the Deaf therapists. Accordingly, the Deaf community need to be educated on how therapists work in regards to confidentiality and informed of the complaints process in the event that confidentiality is ever breached.

Isabella, Samina, Charlotte, Hugo and Hannah all shared their experiences of feeling safe. Collectively, what made them feel safe was validation, including the therapist showing that they care and where they both (client and therapist) shared their lived experiences.

Validation *'is the recognition of acceptance of another person's thoughts, feelings, sensations and behaviours as understandable'* (Hall, 2012: 1). In particular, for Samina, the act of validation was a very prevailing experience for her. Samina's therapist was able to internalise Samina's meanings and respond in a culturally appropriate, contextual way (Leigh and Lewis, 2010), which in turn made Samina feel validated. Moreover, validation is a good sign of cultural competence.

Isabella and Hannah both mentioned that the therapist's act of caring was a factor making them feel safe and able to form a bond with their therapist. For Isabella, her therapist showed that she cared by reading her storybook and highlighting parts to discuss in therapy sessions. Accordingly, the act of reaffirmation and effort that the therapist took in reading it made Isabella feel safe. In addition, for Hannah, her therapist's emotions made her feel safe which was emphasised by the therapist crying. This made Hannah realise that her therapist understood and cared for her. It is clear to see that the act of caring can make someone feel safe, and any therapist can offer this regardless of whether they are Deaf or hearing.

Sharing one's experience was another factor of feeling safe in therapy, as it gave Hugo and Hannah the opportunity to feel less isolated and more validated, and more importantly, to know that someone else has experienced the same. This sentiment is similar to that of participants from Cohen's (2003) study who say sharing experiences helps them process their difficulties; it gives them a sense of hope and enables them to normalise the experience.

Yalom, in his conversation with Wyatt (2006), discusses how the therapist should be able to share a little about themselves if they think it is relevant and helpful to the alliance, but states that they must always bring the conversation back to the client's original point. It is usual practice amongst most therapists to not do much disclosure; however, with Deaf therapists, it is a unique characteristic to share experiences on a regular basis. Moreover, it is important that the therapist does not elaborate their experiences further; in other words, the therapist should not share their feelings, but instead merely mention an experience in terms of it being a fact that something relevant to the client has also happened to them. Examples are being brought up orally as a child, encountering a lack of communication in the family setting, and being isolated in room full of hearing people.

5.7. *Strengths and limitations of the study*

The two sub-sections below explore some of the strengths and constraints affecting this research.

5.7.1. *Strengths*

One of the benefits of doing qualitative research is that the data are rich in detail which enables the researcher to look deeper into complex issues. The methodological approaches (see 3.4) have attempted to be rigorous in covering credibility, confirmability, trustworthiness and dependability.

I believe that my being Deaf is a strength to this study as it offers insight from an 'insider' perspective, and my deafness also had a positive impact on those who I

interviewed. All of the participants appreciated the reasons behind this study, which were to collect experiences and try to advise on changes in how therapy is offered.

My supervision sessions were interpreted, as my supervisors are hearing. Consequently, the set-up had positive influences on the supervisory discussions as it gave us both somewhat of an insight on how a Deaf person might feel accessing a hearing therapist via an interpreter. It also highlighted the importance of the interpreter knowing academic signs to ensure smooth translation. Subsequently, this meant that we all were able to experience what it is like if the wrong signs are used or if we are translated inaccurately, and compares this to how a Deaf person may feel in therapy with an interpreter.

5.7.2. Limitations

This study was designed to find out about individual experiences of Deaf BSL users in psychological therapy. Therefore, the participants in my study are not representative of the entire UK population due to the sample size being small and not generalisable. Nevertheless, phenomenology does not attempt to provide generalisable findings to the whole Deaf community, and there are still aspects of the study that could provide insight. The number of participants in this study is eight, which is considered a reasonable sample size for phenomenology since it seeks to discover the in-depth lived experiences of a small number of people.

The next limitation is the gender of the participants. They were almost all females, with only one male. However, it was not a research design criterion to have an equal number of males and females. With regards to being mostly women, this could have occurred because women possibly seek therapy more than men. It is unknown

whether having equal numbers of each gender would have caused the study reach a different outcome.

Being a Deaf researcher can be seen as a limitation. The participants could assume that the researcher knows about a particular issue therefore they do not go into as much detail in what they are talking about. In addition, the Deaf researcher could also subconsciously not ask for elaboration as it could be assumed to be a shared experience.

The final limitation is that the Group 1 participants (with a Deaf therapist) all received their services from the same provider. There are a few services that provide a Deaf therapist to the Deaf community; however, most of the Deaf therapists come from a large provider and this is where all the Group 1 received their services from.

5.8. Recommendations for further research

The following recommendations for future research are proposed:

1. Further study is warranted to look into the perspectives of Deaf people regarding Deaf therapists. The reason for this is that there were many negative references to using a Deaf therapist such as the beliefs that they will breach confidentiality and they are not qualified enough.
2. It is important to investigate the topic of 'essence' and whether interpreters' really do get the essence of what the Deaf person is talking about in therapy. Does the interpreter's process of strategic omission/reduction unconsciously remove the essence of the Deaf person? How does the interpreter decide what to include and not include in the translation?

3. It is recommended to examine the impact of 'looking at four eyes' in the therapeutic alliance. What does it mean to have a third person in the room for a Deaf person? What is the cause and effect with respect to their emotions?

4. This study focused on two particular groups, Group 1 - Deaf Therapist, and Group 2 - hearing therapist with an interpreter. When I was doing the recruitment process, there were a considerable number of people who came forward that were not suitable for the study because they had experienced both therapy modalities. It would be interesting to see if the same study could be carried out with Deaf people who have experienced both hearing and Deaf therapists.

5.9. *My personal journey throughout this process*

In this section, I focus on my journey of learning and understanding the research process throughout this study. Engward and Davis (2015: 1532) describe reflexivity as *'developing transparency in decision making in the research process at multiple levels; personal, methodological, theoretical, epistemological, ethical and political'* and that it is important to question our assumptions. I also discuss the use of myself as a researcher, covering both academic and personal views.

I had one main assumption at the start of the research process because of my involvement in a Deaf therapy service. I was a Knowledge Transfer Partnership (KTP) Associate and my role was to work with a Deaf therapy service where I had to evaluate the service as a whole, identifying areas of improvement, the issues that Deaf clients faced and the training of Deaf therapists to name a few. I had insider knowledge on

what it was like for a Deaf person to receive therapy, especially the length of time it took them to get therapy. I knew from experience that some Deaf people were told to go to mainstream therapy using an interpreter when really they wanted a Deaf therapist. But there was not much supporting evidence to use in my arguments about such issues when discussing them with potential commissioners.

Because of what I knew, I wanted to be able to contribute to the evidence pool and prove that 'receiving therapy is better with a Deaf therapist', which was the first assumption I made before the research process started.

As I started to build the study, my researcher role started to overtake the personal assumption I initially had. It would appear that it was the process of learning about ethics, rigour and in particular credibility that has enabled me to look at the research from a different angle. Thereafter, I wanted to be able to produce a study with credibility and trustworthiness that readers could refer to. This meant that I had to produce a fair study where readers could clearly see the experiences and make up their own mind.

As with any research, there are always concerns about whether participants would come forward during the recruitment stage. I was pleasantly surprised with how quickly they came forward which meant I was able to start the study very swiftly. I particularly enjoyed the interviewing stage, as I got to meet Natalie, Isabella, Hugo, Rose, Samina, Hannah, Sophie and Charlotte, who each moved me in different ways.

The first few interviews I found especially challenging because of my lack of experience in research interviews. I was conscious about what questions to ask, when to probe and how to deal with emotions from the participants, as it is in my personal nature to lightly touch people such as putting my hand on their shoulder or knee to show my

support, and I was not able to do this in the interviews. I had to think of different ways of demonstrating caring, without touch.

I believe that my being Deaf enabled me to elicit more information from the participants, which was also assisted by the interview style being quite informal and not too intrusive. All the participants mentioned that they enjoyed the interview, which made me feel validated as a researcher. They appreciated the professionalism behind it, especially Hannah, who previously had experienced issues with Deaf people not being professional.

The length of the interviews for Group 1 and Group 2 were slightly different. There was more time spent on interviews with those who had a hearing therapist via an interpreter (Group 2). I wrote in my reflexive journal about this, and questioned whether it was a result of my bias; however, after a few more interviews and translation, this matter was resolved. I came to the conclusion that the interviews were longer because there were three people in the process, which is one more extra person than in the Group 1 (Deaf therapist) scenarios, and this added more time.

Soon after each interview, I translated all the videos and really enjoyed this process as I was very excited with all the material that was emerging. The translation process for each interview took approximately 8 hours, and in total 64 hours was spent translating, which made it very time consuming; nevertheless, it was worth the effort.

Every stage of the research process has necessitated absorbing knowledge about new concepts such as phenomenology, which has been taken on board positively because of my love of learning. My biggest challenge has been the academic writing as it is not something I use on a daily basis. Quite often there have been times where I am on the ball with great writing but there have also been times when I have really struggled; it is not something that comes naturally to me, but it improves with experience and regular use.

I have learnt that to produce a quality research study it is crucial to be organised, dedicated, committed and adherent to deadlines. This has proved quite difficult with the life balance of work, social obligations and study, especially with birthday milestone celebrations amongst friends and family in the last year. It is also important to have a pool of people that to rely on for support both academically and personally to keep motivation high, which I was lucky to have. Overall, undertaking this study has been a positive personal experience and it has developed my academic thinking and approaches. More importantly, it has given me confidence to possibly do a Doctorate.

5.10. Summary

This chapter pulled together findings which were discussed and interpreted. The discussion was presented under five headings which were (1) Distrust of interpreters, (2) When the alliance does not work, (3) The importance of cultural competency, (4) Two Eyes Four Eyes - how looking at more than one pair of eyes affects a person in therapy, and (5) The need to feel safe and secure in therapy. The strengths and limitations of the study have also been commented on and recommendations on future research have been given. I have also looked back on my personal journey through the research process, exploring what I have learnt as a consequence.

It is clear to see that the triad (therapist, interpreter, client) and the therapist's lack of cultural competency causes complications, such as the interpreter choosing the wrong lexical signs, the omission of what the Deaf person is saying and the hearing therapists' questions about the Deaf background that reduces the therapy time, which leads to a lack of self-disclosure and therapeutic rupture. Fundamentally, this makes Deaf people feel unsafe, insecure, frustrated, angry, fearful, distrusting, confused and vulnerable. The consequences of this can derail the therapeutic alliance process, thus sabotaging the purpose of therapy.

Notwithstanding this, it is also equally clear to see the positive benefits of having a Deaf therapist. For instance, a Deaf therapist is culturally competent; thus the Deaf client gets the full advantage of the therapy session because there is no questioning about their Deaf background, and the only questions that are asked are linked to their need for therapy. Sharing one's experiences and knowledge of what other Deaf people have been through is seen to be a factor contributing toward a constructive therapeutic alliance, as it makes the Deaf client feel normalised, less isolated, more validated and safer. Therefore, combining the cultural competency and sharing of experiences makes for a strong therapeutic alliance.

The next chapter concludes the whole study.

CHAPTER 6 CONCLUSION

This thesis set out to explore BSL users' experiences of psychological therapies, which has resulted in significant amounts of rich qualitative data that have been discussed and interpreted in previous chapters. This concluding chapter briefly highlights the approach, emerging themes and points of interest from the discussion chapter followed by recommendations for research and practice.

The study used Smith, Flowers and Larkin's (2009) interpretative phenomenological analysis as its methodological approach, and the lifeworlds of the participants were explored using a phenomenological lens. This approach enabled me to interview 8 Deaf participants where each gave a very rich personal account thus allowing me to extract and interpret the data using NVIVO as a tool for the administration of the emerging themes.

Six broad themes emerged through the study's data analysis as well as 12 sub-themes. This is illustrated in the table below which has been extracted from the Findings chapter (4.4) pg. 59:

Main Themes	Sub-Themes
Lost in Translation	<ol style="list-style-type: none">1. Trust2. Emotional state
Putting on the Brakes	<ol style="list-style-type: none">1. Holding back information2. Exposure
Do Not Adjust	<ol style="list-style-type: none">1. They get me2. They don't get me
Two Eyes Four Eyes	<ol style="list-style-type: none">1. Third person in the room2. How many know my secret?
The Full Hour	<ol style="list-style-type: none">1. All about me2. What do you mean?
Safety and Security in Therapy	<ol style="list-style-type: none">1. Feeling safe2. Not feeling safe

Table 2: Overview of emergent themes and sub-themes

The literature review on Deaf perspectives in therapy identified 10 papers using a comprehensive and systematic search strategy where databases and journals were accessed. The common themes across this review were: (a) barriers to accessing mental health services, (b) deaf/hearing therapist, (c) interpreters, and (d) cultural competency. The findings from my study concur with most of these themes, in particular interpreters and cultural competency. However, there are several of my findings that are not mentioned in previous literature, such as the impact interpreter omissions have on the therapeutic alliance.

In previous literature there were discussions about the need for therapists to be culturally competent but very little detail about why they need to be, and I believe that my study provides an in-depth outline of the reasons why cultural competence is important when dealing with Deaf clients. For instance, lack of cultural competence generates negative feelings for Deaf clients such as feeling vulnerable and unsafe; additionally, Deaf clients do not get the benefit of the full therapeutic hour. All the findings are equally important; however, what stood out for me was the need to have a culturally appropriate therapist and the benefits this has for Deaf clients. The other salient finding was the impact it has on a person's emotions to have a third person in the room, which is a factor beyond translation issues.

The discussion chapter highlighted five key issues from the findings which are briefly summarised in 6.1 to 6.5 below.

6.1. *Distrust of interpreters*

This finding was that all the participants who had a hearing therapist via an interpreter had distrust issues with their interpreter, which in turn impacted their therapy in a negative way. There are several possible justifications for this distrust of interpreters which are: (1) the interpreter's poor judgement in choice of lexical signs (2) a lack of

interpreter training in the mental health field (3) the interpreter may be unqualified, and finally, (4) interpreter omissions from the translation process, where the omissions could contain the 'essence' of what the Deaf person is saying. The distrust of interpreters led two of the participants' to use SSE instead of BSL, and two more participants' resorted to written English to get the essence of what they wanted to say across to their therapists. Each of the justifications are important; however, number four (omissions) is the most significant part because in therapy, to deal with emotions, the client needs to get across the essence of how they are feeling. It would be seen as a barrier to recovery if the therapist does not capture this because of the interpreter's omissions.

6.2. *When the therapeutic alliance does not work*

Therapy settings rely on a positive relationship formation in the first instance. Previous literature identified problems with the alliance but it does not go into detail about what causes the alliance to rupture. Furthermore, this study found reasons for potential rupture of the alliance which are: (1) lack of cultural competency, where the therapist does not know about Deaf issues, (2) having a third person in the room, (3) having different interpreters for each session, and (4) exposure, where self-disclosure to an interpreter or a Deaf therapist makes the client feel exposed because of the smallness of the Deaf community. It has been shown that where the alliance does not form, it leads to the Deaf person feeling exposed, fearful, vulnerable, and unable to disclose.

6.3. *The importance of cultural competency*

Findings from this study correspond with previous literature in relation to cultural competency. It is important for the therapist to have background knowledge on the

language, values, beliefs, customs, behaviour, norms, community and social structures of the Deaf community, because all of these combined means a person has cultural competence. Moreover, the findings identified problems where the therapist lacks cultural competency such as failing to pick up on body language, and the therapeutic 'hour' being taken up by questioning clients on their Deaf background, which meant their problems did not get addressed. As a result, the lack of competency is seen as a barrier to recovery. This is in contrast to the participants who had a Deaf therapist; they reported that their therapist's cultural competence made them feel understood and validated because of shared experiences, and that their therapist 'gets' them, hence makes them feel safe.

6.4. *Two Eyes Four Eyes*

The client feeling that there are more than three people in the room is another aspect to the therapeutic alliance that has not really been addressed in previous literature. The effect of looking at four eyes makes the Deaf person feel uncomfortable, intimidated, distrusting, not being able to disclose, the flow of communication is affected because who the eye gaze is on. Some participants stated that their eye gaze is on the interpreter because they want to see how the interpreter translates them. However, other participants indicated that having an interpreter in the therapy room is not an issue for them, even though they sometimes have problems with the interpreters in terms of translation; it is their preferred mode of therapy due to trust and confidentiality issues with Deaf therapists and the smallness of the Deaf community.

6.5. *The need to feel safe and secure*

A good therapeutic environment and alliance leads a person to feel safe and secure. Half of the participants reported feeling unsafe because of the therapist's lack of cultural competence, the therapist not being able to sign, the smallness of the Deaf community and the waiting time to receiving therapy. For example, one participant's unsafe feelings about this disclosure caused him to drink. On the other hand, several participants said to feel safe they need validation, for the therapist to show that they care and to be able to share experiences.

6.6. *Strengths of the study*

This study contributes to existing literature where it reinforces that Deaf people do have issues with interpreters and the therapists' lack of cultural competency. However, it also contributes to new knowledge such as whether the interpreters' acts of omission affect the working relationship, and this study also has captured how Deaf people feel in the therapeutic alliance in a way that is perhaps more detailed than in previous literature.

6.7. *Limitations*

Several limitations of my study have been identified. Phenomenological studies tend to be small in sample size, which typically means that the findings cannot be generalised; however, such generalisation was not the intention of my study. Rather, the findings can be used to give a restricted but valuable insight into what therapy experiences could be like for a range of clients from the UK Deaf population. Furthermore, most of the participants were women; it is unknown whether having equal numbers of gender would cause a different outcome. Additionally, being a Deaf

researcher with insider status can be seen as a limitation due to subjectivity and bias. The final limitation was that all Group 1 (Deaf therapist) participants received therapy from one service provider. It could be that if they had experiences with Deaf therapists from different service providers, this would have provided different outcomes due to how therapy is accessed and processed.

6.8. Recommendations for research

Four potential areas for further research have been identified from this study. Firstly, it is important to look at the perspectives of Deaf people on Deaf therapists such as their views of using Deaf therapists, because it was clear from the study that some of the participants had issues with trust, confidentiality and level of qualifications of the Deaf therapists. Secondly, future studies should examine whether the interpreter's process of strategic omission/reduction unconsciously removes the 'essence' of the Deaf person. Thirdly, it will be worthwhile to research the impact of looking at 'four eyes' in the therapeutic alliance with a specific focus on the Deaf person's emotions; and finally, further work could investigate the views of Deaf people who have received therapy in both modalities, including on the strength of their therapeutic bond (with a hearing therapist via an interpreter versus with a Deaf therapist).

If I was asked to pick a study to carry out next, I would choose the perspectives of Deaf people on Deaf therapists because the findings and implications could be far reaching. Such a study would hopefully identify their views and reasons, which in turn could be used to educate Deaf people about therapy more effectively. This could increase in their mental well-being; for example, if they learn more about the relevance of a therapist's cultural competency, they may be likely to consider working with Deaf therapists. This study would address a gap in the literature as I believe there is no study that solely looks at the views of Deaf people on Deaf therapists.

6.9. Recommendations for practice

There are a number of recommendations based on the findings and interpretations in this study that I would like to put forward to improve working practices in regard to BSL users receiving psychological therapies.

6.9.1. Recommendation 1

It is recommended that the therapist must be culturally competent to deliver therapy to a British Sign Language user. The impact it has on the BSL user if the therapist cannot sign or is not knowledgeable about their Deaf background is serious and negatively affects their emotional well-being. To develop this competence, it would not be enough to read from books or attend a basic sign language or Deaf awareness course. Realistically, to be culturally competent, a person would need to understand sign language and take frequent opportunities to immerse themselves into the Deaf community to learn about its behaviour and norms.

6.9.2. Recommendation 2

It is recommended that those with specialist expertise in this area should educate hearing therapists about taking on a Deaf client, with a focus on how the alliance can go wrong and how problems can be resolved. I can contribute to educating hearing therapists by publishing articles linked to this study.

6.9.3. Recommendation 3

It is recommended for British Sign Language/English interpreters to receive training in mental health and how to interpret in therapy situations before taking on a therapy

assignment. This would give them background knowledge on how to deal with emotions in therapy settings and an awareness of appropriate lexical signs for the context of the session. There are training courses for interpreting in mental health settings available in the UK which can be accessed through sign language interpreting bodies such as ALSI, VLP, BSL courses providers and interpreter agencies.

6.9.4. Recommendation 4

It is recommended for Deaf therapists/counsellors, either freelance or from a service provider, to raise their profile among Deaf people with a particular focus on confidentiality and trust. The aim of this is to educate and reassure the Deaf community that therapists/counsellors are professional and adhere to the strictest protocol of confidentiality. This can be done by giving presentations at Deaf events, and creating leaflets and video clips to share via social media.

6.9.5. Recommendation 5

It is recommended that the same interpreter is used throughout the therapy sessions to avoid generating feelings of being unsafe, therapeutic rupture and dropping out. The service provider that the Deaf client is under must take responsibility of ensuring that the same interpreter is booked throughout the whole therapy session block. In the event the interpreter is not available on a particular day, it is recommended that the client, therapist and interpreter discuss a new date that is suitable for them all.

6.9.6. Recommendation 6

The study has highlighted many issues with having a third person in the room such as implications on the dynamics of the alliance because of who the eye gaze is with, and not being able to use BSL because of not trusting the interpreters' translations. The

positives of having direct contact with a Deaf therapist who can sign included many benefits such as feeling safe, understood, and able to share experiences. It is therefore recommended for the Deaf client to receive therapy with a direct therapist who is culturally competent and fluent in sign language. If CCG's start to commission a Deaf therapy service for their local Deaf population, there will be a need to increase the number of Deaf therapists across the country because there are not enough.

6.10. Conclusion

The aim of this study was to look at the experiences of, and identify best practice for, BSL users in psychological therapy, and this has been done through capturing the rich experiences of Natalie, Isabella, Hugo, Rose, Samina, Hannah, Sophie and Charlotte. Furthermore, their contributions have been used to add to the mental health and deafness knowledge base, to influence changes in practice and contribute to further research.

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Appendix 1: Literature review meta-summary

	Author	Title	Country	Perspective	Methodology	Participants	Result	Limitations	Critical Appraisal
1	Steinberg, A., Sullivan, V., Loew, R. 1998	Cultural and Linguistic Barriers to Mental Health Service Access: The Deaf Consumers Perspective	America	Deaf clients	Qualitative – cross sectional survey	54 Deaf 31 women 23 men	High % mistrust of providers; communication difficulties as primary cause of MH problems; deep concern about communication in therapy	Results in a quantitative format; no in depth views; 89 questions is a lot to ask – affects quality of responses	Results presented in quantitative format with little opportunity to question participant's experiences. 89 questions asked meant diluted quality of responses.
2	DeVinney, J., Murphy, S. 2002	Mental Health Experiences and Deafness: Personal and Legal Perspectives	America	Deaf client perspective	Qualitative – single case study	40 year old Deaf female	Identified barriers with staff knowledge of deafness; using qualified interpreters; patient participation	1 person experience; in-patient experience;	Case study highlights outcomes similar to other papers however it is very factual, based on one person and does not offer in-depth analysis of her experiences.
3	Cohen, C. 2003	Psychotherapy with Deaf and Hard of Hearing Individuals	America	Deaf people	Qualitative Semi-structured interview	10 Deaf	Highlights the importance of cultural sensitivity; understanding of family pressures; differing of communication styles; interpreter in the therapy room	Did not include those with CI; deafened; limited number of participants; researcher became deaf later in life; participants were college students	Does not really explore the participant's experiences of therapy such as their relationship with the therapists.
4	Steinberg, A., Barnett, S., Meador, H., Wiggins, E., Zazove, P. 2005	Health Care System Accessibility: Experiences and Perceptions of Deaf People	America	Deaf people who use ASL	Qualitative Focus group	91 Deaf participants	Communication difficulties; mistrust; fear; frustration. Positive experiences with interpreters; practitioners with sign language skills	Did not ask if prefer hearing or deaf professionals; Not representative of entire deaf US population; participants highly educated, not generalised	There were few questions asked about accessing mental health services; responses were generalised i.e. most of participants preferred practitioners with sign language skills. There was no discussion as to why the participants preferred this option.

5	Munro, L., Knox, M., Lowe, R 2008	Exploring the potential of Constructionist Therapy: Deaf Clients, Hearing Therapists and a Reflecting Team	Australia	Therapist Team Deaf clients Research done by: Hearing person	Qualitative Semi-structured interview Constructionist research	2 female use Auslan 1 counsellor 3 on Reflecting Team	Deaf culture is different from hearing Recommends to use same interpreter throughout sessions	Three-way, (small sample, all female. No professional Deaf input other than clients views	There were no Deaf perspectives from a professional point of view other than the participants. The participant's views were about the delivery/layout of the therapy rather than what the therapy is about.
6	RNID 2009	Scottish Mental Health Services: the experience of deaf and deafblind people	Scotland	Mental Health Services Deaf service users Research done by hearing person	Mixed methods approach – postal survey & qualitative case studies – constructivist approach	Deaf- 39 Deafblind – 6	Identified gaps and recommendations offered to address gaps i.e. lack of communication, access & cultural awareness	In-patient experience focus, no mention of therapy or counselling	There was no mention of therapy or counselling and the main focus was on in-patient experiences.
7	Sheppard, K., Badger, T. 2010	The lived experience of depression among culturally Deaf adults	America	Deaf view	Hermeneutic phenomenology approach	9 Deaf 2 male 7 Female	Deaf experience of why feel depressed showed that: family communication lack of understanding; communication barriers in health services;	why use interpreters not Deaf people for credibility voiced translation – what was voiced over Researcher hearing	Study identified why Deaf people get depressed but it does not focus on therapy experiences.
8	Davidson, F., Cave, M., Reedman, R., Briffa, D., Dark, F. 2012	Dialectical behavioural therapy informed treatment with Deaf mental health consumers: An Australian pilot program	Australia	Deaf	Qualitative 23 group sessions	4 Deaf	High level of Deaf cultural awareness needed to do DBT with Deaf people; include group activities' role plays i.e. how to be assertive with hearing people; more intensive approach to clinical training & Deaf therapists be beneficial	Benefits to professionals to improve DBT approach	Study highlighted the need for more role-play; how to be assertive; and that a high level of Deaf awareness is needed to do DBT with Deaf people, however, it does not look at the views of Deaf people receiving therapy.
9	Horton, H., Kim, H., Mills, M. 2012	Mental Health Services for the Deaf: A focus group study in New York's Capital Region	America	Deaf users Mental health stakeholders	Focus group	5 Deaf 4 hearing 3 Social Services 4 interpreters 3 MH consumers	Identified barriers to effective MH; the need for culturally competent MH professionals	Not clear who said what; generalisation;	Mixed focus group study – it is not clear who said what in the study, i.e. was it from a Deaf or hearing perspective.

10	Cabral, L., Muhr, K., Savageau, J. 2013	Perspectives of People Who are Deaf and Hard of Hearing on Mental Health, Recovery, and Peer Support	America	Focus group Semi-structured Interviews	Qualitative	8 Deaf individuals 4 Deaf in focus group	Main themes: stigma; barriers; understanding & experiencing recovery & peer support. Some reference to which communication modality	Participants all from one service provider; limited number interviewed; Limits generalisability	The findings from this study was very much about the views of mental health in the Deaf community such as stigma and peer support. There was some mention about which communication modality they would like to have therapy in, however, the study did not go into detail about the Deaf person's experiences.
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Appendix 2: Reflective Journal

Example of reflective notes:

Today is the day of the first interview. The video camera made me nervous - a lot of thoughts were running through my head, what if it does record, what if it goes off half way and what implications this would have on the interview.

I told Natalie that I would need to see the video is recording and that it has not stopped during our interview. I felt grateful that she understood about this as the camera could be seen as interference. As it happens, I visited the camera twice during the first part of the interview when we went through consent forms. I decided that I had to trust the camera and deal with the consequences if it did not record the full interview.

The first thing I did when I got back home was to look at the video, phew, it recorded the whole interview. I look forward to translating the video so that I can start analysing.

My heart sank when Hannah told me that she had a hearing therapist before she saw a Deaf therapist. I travelled a long way to interview her. There were negative thoughts running through my head such as 'what if this is a waste of time?' I decide to carry on with the interview as I am there anyway. Hannah told me that she never really had a hearing therapist as it was done through email. I could see the cloud lifting from my head by this news; it meant she

did not really receive the full benefit to be able to make comparisons with a Deaf therapist. I can use her for my research.

I felt that Hannah and I bonded really well. There were times where I over shared my experiences but I could see that Hannah was thirsty for this kind of interaction. For instance, Hannah spoke about Deaf counsellors and their lack of qualifications. She had assumed that Deaf therapists received basic counselling training. I knew this was not true. Do I leave it and let Hannah think this or do I tell her that this is not true? Do I take off my researcher hat or leave it on? I decided it was through the greater good to tell her that Deaf therapists do go to university and study to get qualifications now.

I found myself thinking who she is talking about when Rose was talking about a Deaf therapist she did not get on well with. Why did I feel the need to want to know this information as it is not beneficial to the research? I decided it was more to do with my curiosity and let it go.

Hugo was telling me about his bad experiences with his hearing therapist and that he had different interpreters for each therapy session. I felt angry that he had to go through that especially when it all could have been avoided by seeing a direct therapist.

Appendix 3: Ethical Approval



2nd March 2015

Michael Mckeown/Celia Hulme
School of Health
University of Central Lancashire

Dear Michael/Celia,

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 293

The STEMH ethics committee has granted approval of your proposal application 'Experiences of Deaf British Sign Language (BSL) users in psychological therapies'. Approval is granted up to the end of project date* or for 5 years from the date of this letter, whichever is the longer.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use [e-Ethics Closure Report Proforma](#)).

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'G Thomson', is written over a light blue circular stamp.

Gill Thomson
Vice Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

Appendix 4: Consent Form

CONSENT FORM



Participant Identification Number:

British Sign Language (BSL) user's experiences of psychological therapies

Please Initial box

1. I confirm that I have read and understand the Participant Information Sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.
3. I understand that I am free to not answer all of the questions and may end the interview at any time and without giving a reason.
4. I understand that if I would like to remove my data from the study, then I should contact the research team within one month of the interview taking place.
5. I agree to take part in the above study.
6. I agree to the interview being video recorded.
7. I agree to the use of my anonymised data in peer reviewed academic journals; presentations; local seminars and thesis.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

This study has been approved by the University of Central Lancashire Ethics Committee – STEMH 293

Want to share your experience?



British Sign Language (BSL) user's experiences of psychological therapies

- Are you a British Sign Language user? Yes
- Did you finish psychological therapy between February 2013 – February 2015 either in Group 1 or Group 2?
- Would you like to share your experiences?

Group 1 – BSL user with a BSL therapist

Group 2 – BSL user with a hearing therapist via a BSL Interpreter

If all, I would like to meet with you!

What is the research about?

My name is Celia Hulme and I am a part-time student at the University of Central Lancashire (UCLan) doing a Masters by Research under the School of Health. I am looking into the experiences of BSL users' in psychological therapies (for example, CBT and Counselling). I would like to hear more about your experiences of therapy in particular your access to the service; your relationship with the therapist; and how you felt about their understanding of your issues.

If you would like more information about this research or are interested in sharing your experiences, please contact Celia Hulme on any of the following:

Email: chulme@uclan.ac.uk

Text: 07974 365 664

Skype: chulme-sign

This study has been approved by the University of Central Lancashire Ethics Committee – STEM 293)

PARTICIPANT INFORMATION SHEET



British Sign Language (BSL) user's experiences of psychological therapies

What is the research about?

My name is Celia Hulme and I am a part-time student at the University of Central Lancashire (UCLan). I am looking into the experiences of BSL users' in psychological therapies (for example, CBT and Counselling).

Many Deaf BSL users' who require psychological therapy access mainstream psychological therapy using a hearing therapist with an interpreter. Some BSL users' argue that they prefer to have a BSL therapist as they understand them better. There is not enough evidence to back up either therapy communication (Deaf BSL /Deaf BSL or Hearing/Deaf BSL /BSL Interpreter).

There is some research that looks in the experiences of a therapist using an interpreter and the interpreter's experience in therapy. But there is not much about the BSL users' experiences in psychological therapy. I am interested in looking at your experiences, in particular these two groups: -

Group 1 – BSL user with a BSL Therapist

Group 2 – BSL user with a hearing therapist via a BSL Interpreter.

I am looking for Deaf BSL users who fit in with Group 1 **OR** Group 2. You need to have finished therapy between February 2013 and February 2015. If you have received therapy from Group 1 **and** Group 2, I am sorry you cannot be part of this research.

Your participation in this research may contribute to improving access to psychological therapies for sign language users.

What do I need to do if I agree to take part?

If you decide to take part, we will discuss your experiences of psychological therapy. I would like to find out more about your access to therapy; your relationship with the therapist; your engagement with the therapist and understanding of the therapy. It will be in an interview setting, where there are some topics to be discussed and it will free flow most of the time. This will probably take about an hour but may be a bit longer or shorter depending on how much there is to talk about. A letter will be sent to your GP explaining your involvement in the research.

We will meet at your GP surgery or at a health centre near you. When we meet I will film the interview so that I can watch it again to transcribe it into English. You will also be asked to sign a consent form. This will be available in BSL at the interview.

There are no direct risks in taking part in this research though it is possible that you might find the interview emotional, there will be a debrief sheet explaining what you can do if you are feeling upset.

How will information about me be used – is it kept confidential?

Yes. All your personal information used in this research will be handled confidentially in accordance with the Data Protection Act 1998. The only people who will be allowed to have access to the consent forms, recordings and full data transcripts are myself, and my research supervisors (Mick McKeown and Karen Wright). Under no circumstances your details will be identifiable in the research. The research will be available in one or more of the following sources; articles in peer reviewed academic journals; presentations at a regional conference; local seminars and thesis. Your details will be kept for 5 years in a secure filing cabinet that will be removed and destroyed at the end of December 2020.

Can I withdraw from this research?

You can withdraw at any time during the research. Your data will not be used and will be removed straight away. During the interview you do not have to answer all of the questions, and you may end the interview at any time, without giving a reason. If you decide after the interview that you do not wish your data to be included in the study, please contact a member of the research team within one month after the interview has taken place, and request that all your data be removed.

I am interested in being involved, what happens next?

Please get in touch with me (details at the end of sheet) to say that you are interested in taking part. I will then send you a Participant Details Form that will collect your personal details along with an SAE. You must return the form within 7 days. After I have received the form back, I will then arrange an interview date with you and travel to your GP surgery or your nearest health centre.

Study Results

I expect to have this study completed by approximately December 2015. If you would like a brief summary of the results, a Study results form will be provided to you during the interview.

Who has reviewed this study?

All research through University of Central Lancashire is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the STEMH Research Ethics Committee. If you wish to query more about this, please contact the administrators Stuart Holmes or Alison Naylor at roffice@uclan.ac.uk

If I have complaint, what do I do?

If you have any complaints about this research, you can contact the University Officer for Ethics at OfficerForEthics@uclan.ac.uk

Research Team:

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INTERVIEW SCHEDULE



British Sign Language (BSL) user's experiences of psychological therapies

Prompt Sheet

The interview style is loosely based on a semi-structured interview approach. This is a prompt sheet where there are a few main themes for discussion with the participant. It should be noted that the 'interview schedule' is merely the basis for a conversation. It is not aimed to be prescriptive and the participant is to take the lead during the conversation.

- **Welcome, introduction & consent**
- **Accessing therapy service**
 - How did you know about the service?
 - Deaf/Hearing therapist
 - Appointment process
- **Understanding/addressing of Deaf issues**
 - Therapist understand your Deaf issues?
 - Talk about it
 - Address it
 - Understand it
- **Alliance/bond**
 - Therapists bond with participant
 - Consensus of techniques/methods used with the rapist/participant
 - Consensus of goals
- **Transference/Counter-transference**
 - Relationship with therapist
 - Difficult to engage/just right/too involved
 - Therapist behaviour/views/lack of understanding affect participant?
- **Personal preference for future therapy if needed?**
 - Why choose that modality?

This study has been approved by the University of Central Lancashire Ethics Committee – STEMH 293

Appendix 8: NVIVO coding example

The screenshot displays the NVivo software interface. On the left, there is a navigation pane with categories: SOURCES (Internals, Externals, Memos), NODES (Nodes, Node Matrices), CLASSIFICATIONS, COLLECTIONS (Sets, Memo Links, Annotations), and QUERIES. The main window shows a list of nodes with columns for Name, Sources, Referenced, Created On, Modified On, and Modified By. The 'Nodes' category is selected, showing a list of nodes such as 'Dynamics of safety and...', 'Trust in interpreters', 'Lost in Translation', 'No need to adjust or the...', 'Bad Fit', 'Don't get me', 'get me', 'Good Fit', 'Putting on the brakes', 'The full hour', and 'Two eyes - Four eyes'. Below the list, a 'Reference' window is open, showing a text snippet: 'Even in an emergency situation, the police can stop you for speeding. In my view, I felt that the counsellor disagreed with what I said. My view and his view are different. This means our wavelength is not the same.' To the right of the text, there are two reference statistics: 'Reference 1: 0.73% coverage' and 'Reference 1: 0.95% coverage'. Below these, there are two more statistics: 'Internals\IP003 Hugo' and '2 references coded, 1.58% coverage'. At the bottom, there is a 'Bad Fit' window showing a list of nodes: 'Bad Fit', 'Two eyes - Four eyes', 'Trust in interpreters', 'Dynamics of safety and security in th...', and 'The full hour'.

Name	Sources	Referenced	Created On	Modified On	Modified By
Dynamics of safety and...	19	9 Aug 2015 14:36	CH	11 Aug 2015 17:12	CH
Trust in interpreters	0	11 Aug 2015 11:30	CH	11 Aug 2015 11:30	CH
Lost in Translation	3	9 Aug 2015 14:19	CH	11 Aug 2015 17:11	CH
No need to adjust or the...	0	9 Aug 2015 14:22	CH	11 Aug 2015 10:51	CH
Bad Fit	2	11 Aug 2015 11:29	CH	11 Aug 2015 16:15	CH
Don't get me	3	9 Aug 2015 11:40	CH	11 Aug 2015 16:50	CH
get me	2	3 Aug 2015 11:40	CH	11 Aug 2015 17:14	CH
Good Fit	2	11 Aug 2015 11:29	CH	11 Aug 2015 15:22	CH
Putting on the brakes	2	5 Aug 2015 14:20	CH	11 Aug 2015 16:04	CH
The full hour	3	5 Aug 2015 14:20	CH	11 Aug 2015 17:14	CH
Two eyes - Four eyes	3	11 Aug 2015 10:28	CH	11 Aug 2015 17:11	CH

Reference 1: 0.73% coverage
 Even in an emergency situation, the police can stop you for speeding. In my view, I felt that the counsellor disagreed with what I said. My view and his view are different. This means our wavelength is not the same.

Reference 1: 0.95% coverage
 I remember feeling vulnerable. That is the word I was looking for not valid. She listened to what I was saying and I was talking a lot. I did not feel any kind of link with her like I do with my friends. The interpreter was just there, I felt awkward. The three people in a room did not feel right; I tell the interpreter and the interpreter tells the counsellor and vice versa.

Internals\IP003 Hugo
2 references coded, 1.58% coverage

Reference 1: 0.95% coverage
 I remember feeling vulnerable. That is the word I was looking for not valid. She listened to what I was saying and I was talking a lot. I did not feel any kind of link with her like I do with my friends. The interpreter was just there, I felt awkward. The three people in a room did not feel right; I tell the interpreter and the interpreter tells the counsellor and vice versa.

Bad Fit
 Two eyes - Four eyes
 Trust in interpreters
 Dynamics of safety and security in th...
 The full hour