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# A qualitative synthesis of literature on mental health therapies for Deaf and hard-of-hearing people from multiple perspectives: the Deaf client, the mental health practitioner and the sign language interpreter

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## ABSTRACT

Understanding the experience of mental health therapies including counselling, psychology or psychotherapy for culturally Deaf, and hard-of-hearing individuals, is an important area of research, because of the many unique challenges faced by Deaf people. This qualitative synthesis aimed to discover the experiences of the therapeutic triad from the perspective of the Deaf client, mental health practitioner and sign language interpreter. The aim was to expose a range of experiences, as well as potential solutions to inform best practice. A search strategy was conducted using PRISMA guidelines. The data was analysed using thematic synthesis. Themes were categorised under the three therapeutic perspectives. Three main themes were generated for the Deaf client, including access issues, lack of mental health knowledge, Deaf community and identity. Three main themes were generated for the mental health practitioner, Deaf awareness, difficulties with adapting therapeutic practice and difficulties with diagnosis. One main theme was generated for the sign language interpreter, vicarious trauma. In order to strengthen the triangle of care, multiple solutions were identified. Clinical implications include improving access to mental health services for Deaf clients, offering clinical supervision for sign language interpreters and providing training for mental health professionals and sign language interpreters to meet the cultural and linguistic needs of the Deaf.

## ARTICLE HISTORY

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## KEYWORDS

Counselling; mental health therapies; Deaf and hard-of-hearing; Deaf client; mental health practitioner; sign language interpreter

## Introduction

### *Historical context and background*

Historically, Deafness was perceived as a physical impairment which needed fixing (Branson & Miller, 2002; Mousley & Chaudoir, 2018). Prior to the 1970's many countries worldwide adopted the oralist method in Deaf education which profoundly impacted Deaf people's language acquisition and cultural identity (Anglin-Jaffe, 2013). The oralist method was an educational approach to communication where

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lip reading, speaking and writing were enforced. Accordingly, Deaf children were told to sit on their hands and sign language was prohibited with the idea of supporting societal integration through assimilation (Anglin-Jaffe, 2013; Branson & Miller, 2002; Bridgman et al., 2021; Lawyer, 2018). Recently, there has been a growing international trend away from the medical-model perspective. Global attitudes are generally moving towards a more supportive approach to Deafness, advocating for equitable access, celebrating Deaf culture and acknowledging its rich heritage and proud identity (Jones, 2002; McIlroy & Storbeck, 2011; United Nations, 2015).

A person who is Deaf, written with a capital D, communicates that a Deaf person affiliates with Deaf culture. In contrast, using a lowercase d for “Deaf” refers to the condition of Deafness (Padden & Humphries, 2006) or to those who predominantly socialise with hearing people (Aotearoa, Deaf, 2025). Padden and Humphries (2006) use the term “Deaf culture” to describe and offer insights into Deaf people and their realities. Padden and Humphries (2006) explain that those who identify as belonging to Deaf culture often have a shared history, share experiences, practices, beliefs and language. Deaf culture encompasses unique expressions, through sign language, facial and body movement. Deaf culture normalises Deafness, further supported through common experiences such as Deaf education, Deaf clubs, sports teams and organisations. These shared experiences provide a sense of belonging and shared Deaf identity (Leigh & O’Brien, 2020). Additionally, this group reacts to the world visually and customs include a variety of artistic experiences such as visual arts, story-telling and signed poetry (Aotearoa, Deaf, 2025). Ladd (2003) discusses the modern term “Deaf community” as it implies a pluralistic view of a group of people consisting of many communities, such as various cultural backgrounds. This is attitudinal Deafness, where a Deaf person adopts the identity of being culturally Deaf (Ladd, 2003). Contrastingly, not every Deaf person connects with Deaf culture and may not have the opportunity or want to be involved with the Deaf community. For example, those who lose hearing in old age or those who lack access to Deaf communities for reasons such as living rurally may not connect with Deaf culture. Additionally, as nine out of ten D/Deaf people have hearing parents, this may have an impact on their exposure to Deaf culture (Bone, 2019). It is important to recognise the diversity of being Deaf, including differing verbal communication, levels of sign language proficiency or multiple cultural identifications. Moreover, the use of auditory technologies varies between Deaf people, including those with cochlear implants, hearing aids or those using no technology. Therefore, it is important to note that the term Deaf encompasses unique and individual experiences (Aotearoa, Deaf, 2025).

### ***Deaf mental health context***

United Nations 2030 Sustainable Development Goal 3 aims towards good health and well-being for all (United Nations, n.d.). This recognises that all people need equitable access to health care (United Nations, 2015). For the Deaf population, challenges with mental health and wellbeing can be similar to those who are hearing and, at times, specific to being Deaf (Levinger, 2020). Moreover, mental health problems rate higher for Deaf people than the hearing population (Fellinger

et al., 2012). However, current mental health services are arguably aligned with western models of therapy for the hearing population. These systemic issues emphasise the need for increased funding and resourcing to meet a wider range of people who have diverse needs, and specifically, Deaf people (N. S. Glickman, 2013; T. James, 2016; Leigh & O'Brien, 2020; Wright & Reese, 2015). Recent scholarly literature emphasises the need for mental health practitioners to acquire skills and develop awareness to support their clients cultural frame of reference. This expects mental health practitioners to offer an environment which welcomes multiple cultural expressions (Diller, 2016; T. James, 2016). When reflecting on harmful narratives which may impact Deaf identity, it is equally important to understand how assumptions and unconscious bias can contribute to misunderstandings, which may damage the therapeutic relationship (Arthur, 2018; Giegerich et al., 2020; T. James, 2016; Kopua et al., 2020).

### ***Therapeutic triad***

As mental health practitioners are typically not proficient in sign language, mental health therapies with culturally Deaf people often consists of a three-person alliance involving the mental health practitioners, sign language interpreters and the Deaf client. This unique coalition in talking therapy has an alternative system of communication, whereby translation occurs through sign language. This dynamic creates a different rhythm of conversing that is typically slower than direct communication. For sign language interpreters their role is to embody, at times, highly emotional and traumatic content with considerations made toward negotiating the subtle differences of Deaf culture, likened to a cultural broker (Chatzidamianos et al., 2019). Therefore, it is important for research to be conducted to assist policy makers, mental health practitioners and sign language interpreters to understand how to best serve Deaf clients.

### ***The goal of the study***

It is a human right for the Deaf to receive equitable health services (United Nations, 2022). Provisions need to be in place to achieve this given that mental health problems rate higher for Deaf people than the hearing population (Fellinger et al., 2012). Therefore, this qualitative synthesis examined recent and relevant literature to explore the experience of Deaf mental health therapies from the perspectives of the triad: the Deaf client, mental health practitioners and sign language interpreters. Understanding the therapeutic triad from all perspectives will ensure relevant information is accessible for all and will inform best practice (Fellinger et al., 2012). Due to the gap in relevant, contemporary literature pertaining to Deaf mental health therapies and Deaf marginalisation, the rationale to conduct a qualitative synthesis in this area was justified. This is both morally right and an imperative which aims towards equitable health outcomes for all (United Nations, n.d.).

The role of a qualitative synthesis is “to aggregate findings and identify patterns across primary studies” (Levitt, 2018, p. 367). As this study aimed to understand the therapeutic

triad, comprehensively assess the available literature and catalogue the findings, it was valid to conduct a qualitative synthesis using qualitative meta-analytic methods (Levitt, 2018).

## Methods

### *Positionality statement*

Reflexivity is an important component of qualitative research (Creswell & Creswell, 2018) which includes acknowledging one's ontological perspectives; how one's interpretation is shaped by experience, including culture, history, gender and socio-economic background. Additionally, identifying epistemological assumptions are necessary in research (Holmes, 2020). This qualitative synthesis is underpinned by the philosophical standpoint of the constructivist paradigm and thus assumes that researchers construct their own understanding of the world, in conjunction with the participants in the included research articles (Creswell & Creswell, 2018; Punch & Oancea, 2014). One of the researchers is a CODA (Child of Deaf Adults), living between two worlds growing up, the Deaf world and the hearing world. Her experience consisted of providing a "bridge" of connection for her parents, as challenges with communication caused a myriad of barriers. These experiences led to an interest in the phenomena of the therapeutic triad and raised questions regarding the standard and efficacy of mental health service delivery. Whilst there are pros and cons of being an insider/outsider, Beals et al. (2020) suggests that this positionality can help expand the boundaries of each "world" thereby raising the profile of marginalised communities. Furthermore, it is important to understand this research in the context of Aotearoa-New Zealand and acknowledge the researchers' backgrounds as New Zealand/European women may have influenced this research.

### *Procedures*

Massey University approved a low-risk application for this research on the 15 April 2023, approval number 4,000,027,319. Massey University's ethical principles include the avoidance of harm (University, 2017). Similarly, Berger and Lorenz (2015) advocate for social and cultural models of disability to enhance the power of the disabled community in qualitative research. Therefore, this review was enacted with care and inclusivity, being mindful of accurately and positively portraying the Deaf community. Furthermore, it is essential to view this study from a wider socio-political context. As the researchers are based in Aotearoa-New Zealand, this included honouring Aotearoa-New Zealand's founding document, The Treaty of Waitangi, in order to uphold cultural and social responsibilities.

When identifying studies for a qualitative synthesis, Levitt (2018) suggests that researchers consider "the fit of the primary study to the meta-analytic study question" (p. 371). A search strategy allows the researcher to develop a methodology to identify articles which will answer their research questions, thereby enabling the researcher to manage the vast number of journal articles available through reputable databases (Boland et al., 2017). Through identifying the population/problem, interest and context (PICO) (Murdoch University, 2023), the researcher can find relevant terms

regarding their area of research. During the scoping process, duplicates can be eliminated and feasibility of articles can be checked (Petticrew & Roberts, 2006). To examine the experiences of mental health therapies for the Deaf, appropriate search terms were selected with the purpose of getting an even spread of articles over the triad of perspectives. Search terms used were:

deaf\* OR "deaf people" OR "hearing impair\*" OR "hard of hearing" AND psycholog\* OR counselling OR counseling OR therap\* OR psychotherap\* OR "mental health" OR counsel\* OR practition\* AND perspective\* OR attitude\* OR experience\* OR perception\* AND interpret\* OR "sign language" OR translat\*

The search strategy used the Massey University's database EBSCO host and Scopus. Selected databases were Medline, APA PsycINFO, academic search premier, complementary index, education source, education research complete, CINAHL Complete, ERIC, Directory of Open Access Journals, Health source: Nursing/Academic Edition, Social sciences citation index.

Inclusion and exclusion criteria were specified and [Table 1](#) outlines these criteria.

The qualitative synthesis focused on current, relevant and available literature and excluded literature published before 2000. This was due to the extensive changes which have occurred over this time regarding how D/Deafness is understood. Furthermore, in numerous countries, sign language become a national language in the 2000's. Chain/hand searching was used to find studies which met the inclusion/exclusion criteria (Boland et al., 2017). Chain searching allows the researcher to search for further data by considering the bibliographies of relevant articles (Boland et al., 2017). Hand searching refers to searching through "electronic tables of contents of key journals . . . to identify potential articles of interest" (Boland et al., 2017, p. 71). The final search was conducted on the 28 May 2023.

Once the search strategy was developed and applied to the database search engines, inclusion and exclusion criteria were applied and duplicates removed. Thereafter, three quality articles were hand-selected from the Deaf and mental health practitioners' perspective. Titles and abstracts of 1337 articles were assessed, leaving

**Table 1.** Inclusion and exclusion criteria.

Criterion for evaluation	Inclusion	Exclusion
Methodology	Qualitative studies Qualitative aspects of mixed methods research	Quantitative studies Case studies
Population	Culturally Deaf or hard of hearing people Any age, gender, cultural associations	Cochlear implants Sensory disorders
Phenomenon	Talking therapies including not limited to: Counselling, psychotherapy and psychology	Genetic counselling Audiology
Publication dates	Articles published 2000–2023	Published before 2000
Triangle of care	Perspectives of Deaf client, Mental Health Professionals and Sign Language Interpreters involved in therapy	Perspectives other than that of the Deaf client, Mental Health Professionals and Sign Language Interpreters involved in therapy
Language	English articles	Non-English articles
Ethical considerations	Research within the bounds of Massey Universities code of Ethical conduct (University, 2017)	Research outside the bounds of Massey Universities code of Ethical conduct (University, 2017)

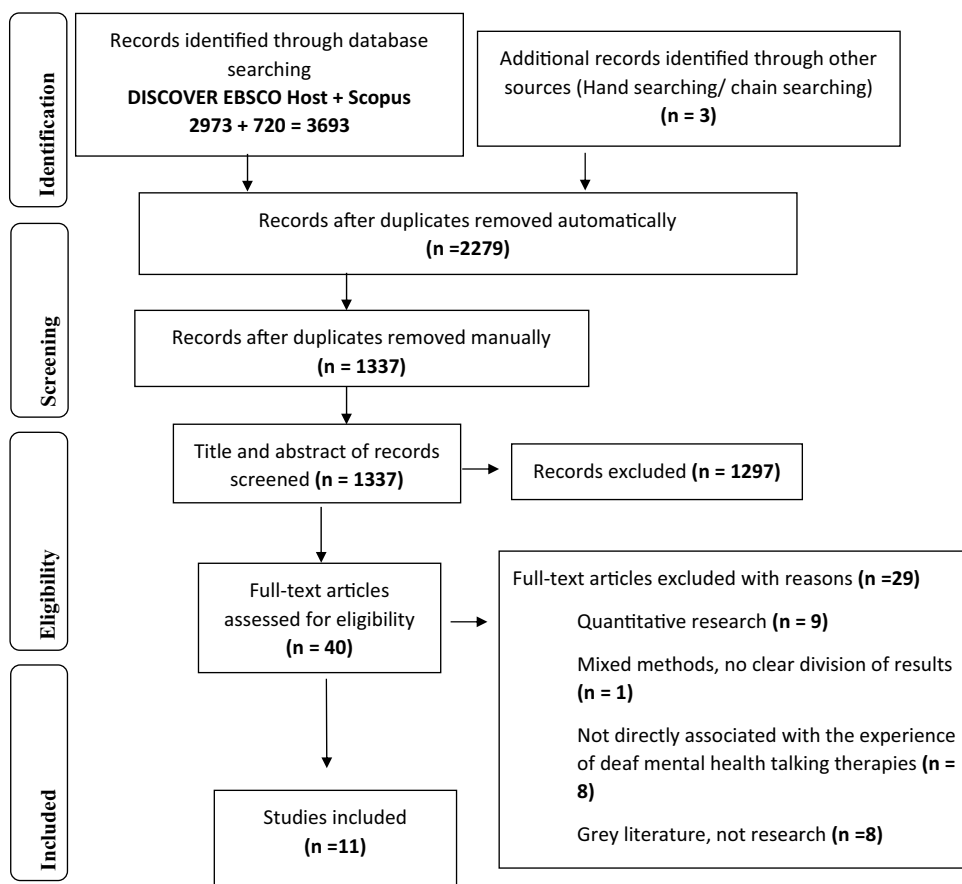


Figure 1. Flow diagram of study selection process.

40 remaining with clear reasoning for exclusion. Figure 1 offers a detailed outline of the study selection process.

A qualitative synthesis considers the quality of the studies (Levitt, 2018). To evaluate the quality of the studies, the modified Critical Appraisal Skills Program [CASP] (Long et al., 2020) was utilised. The CASP provides a detailed assessment for qualitative studies. By answering questions posed in the CASP, the researcher can be transparent by critically analysing the studies. The 11 questions posed in the CASP allowed the researchers to identify the strengths and weaknesses of each article ensuring a rigorous, transparent and valid approach (Long et al., 2020).

All 11 studies reported on showed high relevance to the research questions and provided all three perspectives involved in Deaf mental health therapies. To review the quality of the studies, a sensitivity analysis was deemed appropriate, which assessed each CASP question based on relevancy to the research questions, not just on a hierarchy of evidence (Long et al., 2020; J. Thomas & Harden, 2008). The CASP questions which were seen as most important included clear research statements, appropriate methodology, data analysis rigour, clarity of findings and overall relevancy. As answers to these specific questions were mostly “yes,” with a few

reporting “somewhat,” all articles were included as they were considered moderate to high quality. Considering the triad, it was decided no article would be weighted stronger than the other. Instead, evidence of each theme arising in multiple studies would strengthen the consensus of each theme. Two of the articles, Bridgman et al. (2021) and Cawthon et al. (2017), lacked explicit reporting of specific processes such as ethics, however, as there was the potential that these were sufficient, the choice of “can’t tell” on the CASP was selected. Despite this, these two articles had other inherent strengths for example answering “yes” to question 11 of the modified CASP checklist, “How valuable is the research?” (Long et al., 2020, p. 35) thus giving reason to include them in this qualitative synthesis.

Table 2 lists the articles included offering a summary of the study characteristics. Focusing on the perspectives of the triad, four articles were included from the Deaf perspective, four from the mental health practitioner’s perspective and three from the sign language interpreters’ perspective. Most studies conducted one-on-one interviews (10 out of 11) to capture the participants’ thoughts, lived experiences and subjective meanings, while C. Thomas et al. (2006) conducted focus group interviews. Each study had less than 20 participants, predominantly females took part, and most articles were from the USA and the UK, with one from Aotearoa-New Zealand and one from Brazil. The 11 articles reported on were extremely relevant to the research questions and explored the experience of mental health therapies for the Deaf to inform best practice.

J. Thomas and Harden (2008) method of thematic synthesis was used to synthesise the qualitative data. Thematic synthesis differs from conventional thematic analysis whereby thematic synthesis is more explicit. While both methods formally identify and develop themes, thematic synthesis goes a step further, “the reviewers ‘go beyond’ the primary studies and generate new interpretive constructs, explanations or hypotheses” (J. Thomas & Harden, 2008). This methodology was appropriate to use in this qualitative synthesis as it stays close to the results of the original studies, whilst providing a method of interpretation. Thematic synthesis has three phases. First, the reviewer codes the primary studies using “line-by-line” coding. Secondly, these codes are organised into categories and “descriptive themes” are developed. Lastly, the reviewer generates “analytical themes” (J. Thomas & Harden, 2008). Focusing primarily on the results and recommendations sections of the articles, the researchers carried out the line-by-line coding using NVIVO software. Descriptive codes were consolidated into themes with the strongest relevancy to the research questions. Codes and themes were informed by the literature from all three viewpoints. During the coding process researchers made an effort to ensure inductive coding was open to unknown, emergent themes. The researchers checked carefully whether themes from each viewpoint were able to be transferred to other perspectives in the therapeutic triad. If themes were relevant to other perspectives, that specific data was included in that perspective. For example, if the Deaf client text discussed sign language interpreters, this text was included in the sign language interpreter’s category. In the last stage of thematic synthesis, researchers are invited to extend the original content to develop additional concepts, knowledge or hypotheses (J. Thomas & Harden, 2008). While generating these analytical themes the researchers carefully assessed the strength of themes across the articles and it became apparent that each perspective within the therapeutic triad were



Table 2. Articles included and summary of study characteristics.

Included studies	Title	Participant number	Country	Qualitative methodological approach strategy/design/par-adigm	Findings/Themes
<b>Deaf client perspective</b>					
Bridgman et al. (2021)	Mental health experiences of deaf in New Zealand: Interviews with twelve Deaf with mental illness	12	NZ	<ul style="list-style-type: none"> <li>Paradigm not specified</li> <li>Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>Deaf identity</li> <li>The family system</li> <li>Education</li> <li>Interpreting</li> <li>Assessment &amp; Diagnosis</li> <li>Treatment &amp; recovery</li> <li>Cultural knowledge and sensitivity</li> <li>Importance of communication processes</li> <li>The use of the social work/therapeutic relationship</li> <li>Culturally syntonik interventions</li> <li>Meaning of "mental health"</li> <li>Role of interpreters in mental health care</li> <li>Role of doctors</li> <li>Role of the Deaf community</li> <li>Nature of treatment and help</li> <li>What Deaf people need</li> </ul>
Cohen, (2003)	Psychotherapy with Deaf and hard of hearing individuals: perceptions of the consumer	10	USA	<ul style="list-style-type: none"> <li>Grounded theory, inductive data analysis</li> <li>Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>Early emotional chaos</li> <li>Feeling depressed</li> <li>Reaching out</li> <li>Deaf belonging</li> </ul>
Reader et al., (2017)	Investigating barriers to mental health care experienced by the Deaf community in North Wales	5	UK	<ul style="list-style-type: none"> <li>Exploratory study, narrative approach to data collection and emergent themes (inductive approach)</li> <li>Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>Deaf belonging</li> </ul>
Sheppard & Badger, 2010	The lived experience of depression among culturally Deaf adults	9	USA	<ul style="list-style-type: none"> <li>Exploratory study that used a hermeneutic phenomenological methodology</li> <li>Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>Deaf belonging</li> </ul>

**Mental health practitioner perspective**

(Continued)

Table 2. (Continued).

Included studies	Title	Participant number	Country	Qualitative methodological approach strategy/design/paradigm	Findings/Themes
Cawthon et al., (2017)	Trauma and the use of formal and informal resources in the deaf population: perspectives from mental health service providers	19	USA	<ul style="list-style-type: none"> <li>● Grounded theory</li> <li>● Interviews</li> </ul>	<ul style="list-style-type: none"> <li>● Accessibility</li> <li>● Formal supports</li> <li>● Informal networks</li> <li>● General awareness/stigma/attitudes</li> <li>● Gaps in resources</li> <li>● Other themes: External resources</li> <li>● Concerns with privacy and confidentiality</li> </ul>
Downtin & Day, (2019)	Signs and barriers: Play therapy training experiences of Deaf and hearing clinicians	5	USA	<ul style="list-style-type: none"> <li>● Phenomenological research design, horizontalization (inductive analysis), transformative approach</li> <li>● Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>● Access to play therapy training and supervision training</li> <li>● Kinaesthetic practice</li> <li>● Processing feelings</li> <li>● Intensive workshops</li> <li>● Preparation and Initial Difficulties</li> <li>● Contextualization and Subjectivity of Deaf Patients</li> </ul>
Neves et al., (2020)	Psychoanalytic psychotherapy with deaf patients: A qualitative study of characteristics and technical adaptations in clinical practice	6	Brazil	<ul style="list-style-type: none"> <li>● Exploratory research design</li> <li>● Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>● Characteristics and Technical Adaptations of Clinical Practice</li> </ul>
C. Thomas et al., (2006)	Community mental health teams' perspectives on providing care for Deaf people with severe mental illness	8 focus groups	UK	<ul style="list-style-type: none"> <li>● Paradigm not specified</li> <li>● Inductive analysis, ATLAS-ti software was utilised.</li> <li>● Focus groups in two stages</li> </ul>	<ul style="list-style-type: none"> <li>● CMHT lack of skills/knowledge/resources</li> <li>● Communication difficulties</li> <li>● Distance of specialist Deaf services</li> <li>● Joint working between CMHT and specialist Deaf services</li> <li>● Issues specific to Deaf patients with severe mental illness</li> </ul>

(Continued)



Table 2. (Continued).

Included studies	Title	Participant number	Country	Qualitative methodological approach strategy/design/paradigm	Findings/Themes
<b>Sign language interpreter perspective</b> Chatzidamianos et al., (2019)	Clinical communication and the "triangle of care" in mental health and deafness: Sign language interpreters' perspectives	7	UK	<ul style="list-style-type: none"> <li>• Interpretative Analysis. Emergent themes (inductive approach)</li> <li>• Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>• Nurturing the triangle of care</li> <li>• Communication, trust and the balance of power</li> <li>• Willingness to collaborate</li> <li>• Importance of continuity and quality</li> <li>• Interpreters need support</li> <li>• Shared vision and knowledge</li> <li>• Interpreter seen as co-facilitator and part of the team</li> <li>• Lack of Deaf awareness</li> </ul>

(Continued)

Table 2. (Continued).

Included studies	Title	Participant number	Country	Qualitative methodological approach strategy/design/par-adigm	Findings/Themes
Darroch, (2018)	An illusion of inclusion? – Can counselling psychology do more to ensure equality and access to psychological therapies for Deaf people, through their work with interpreters?	6	UK	<ul style="list-style-type: none"> <li>• Interpretative phenomenological analysis. Contextual constructivist perspective. Emergent themes (inductive approach)</li> <li>• Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge and understanding</li> <li>• Knowledge not shared</li> <li>• Lack of understanding</li> <li>• Knowledge shared</li> <li>• Building a relationship with clients</li> <li>• Interpreters' experiencing</li> <li>• Emotional and psychological impact</li> <li>• Need for debrief</li> <li>• Forbidden: How confidentiality limits access to emotional support</li> <li>• Coping strategies</li> <li>• Development</li> <li>• Positive change</li> <li>• Inconsistency of treatment</li> <li>• Suggestions for improvement</li> <li>• Emotional challenges of the job</li> <li>• Ruminating on patient's emotions and experiences</li> <li>• Consequences of interpreting dilemmas</li> <li>• Becoming used to interpreting emotional sessions</li> <li>• Benefits of obtaining support.</li> </ul>
Zafirah et al., (2020)	The impact of compassion fatigue on mental health sign language interpreters working with children: A thematic analysis		UK	<ul style="list-style-type: none"> <li>• Inductive qualitative approach from a critical realist perspective</li> <li>• Semi-structured interviews</li> </ul>	<ul style="list-style-type: none"> <li>• Coping strategies</li> <li>• Development</li> <li>• Positive change</li> <li>• Inconsistency of treatment</li> <li>• Suggestions for improvement</li> <li>• Emotional challenges of the job</li> <li>• Ruminating on patient's emotions and experiences</li> <li>• Consequences of interpreting dilemmas</li> <li>• Becoming used to interpreting emotional sessions</li> <li>• Benefits of obtaining support.</li> </ul>



inextricably linked through a symbiotic relationship. This relationship was categorised as the “Triangle of care”. The triangle of care includes the Deaf client, mental health practitioners and sign language interpreters.

While the main author is a CODA and has lived experience of the topic, it was appropriate that the main author took the lead and identified initial themes. The process was overseen by the co-author who reviewed the coding of the primary researcher in a supervisory role. Furthermore, throughout the coding process, the author and co-author discussed the findings and made decisions together on what codes to include based on the research questions.

## Results

During the thematic synthesis process, it became clear that each perspective within the therapeutic triad of the Deaf client, mental health practitioners and sign language interpreters, were intricately, inseparably linked. This link was defined as a “Triangle of care”. Additionally, themes were found to be transferable between perspectives of the Deaf client, mental health practitioner and sign language interpreter. With this in mind, themes have been categorised into the three perspectives; the Deaf client, the mental health practitioner and the sign language interpreter.

Three main themes relating to the Deaf perspective were generated. The first main theme is *access issues*, with two sub-themes of *interpreter access* and *funding*. The second main theme is *lack of mental health knowledge*. The third main theme is *Deaf community and identity* and three sub-themes include *each Deaf person is unique*, *audism/prejudice*, *Deaf community and confidentiality*. Three main themes relating to the mental health practitioners’ perspective were generated. The first main theme is *Deaf awareness*, the second is *difficulties with adapting therapeutic practices* and the third is *difficulties with diagnosis*. One main theme relating to sign language interpreters was generated, that of *vicarious trauma and support*. Each main theme and sub-theme are defined and discussed below. [Table 3](#) specifies themes generated from each article.

### **Deaf client**

#### **Access issues**

The ability to engage with mental health services. Access to adequate mental health support was identified as one of the most prominent themes regarding the challenges faced by Deaf individuals. Notably, 10 of the 11 articles highlighted barriers to access, including difficulty with interpreter and mental health services. When experiencing mental health challenges, Deaf individuals do not always know how to access the help they need due to systemic barriers. Solutions to improve access include specialist Deaf agencies providing pathways for support, advocacy by mental health practitioners for the implementation of communication support, active engagement with the Deaf community and funding that promotes equity.

**Interpreter access.** The ability to confidently employ the services of an interpreter. A range of experiences were communicated through the various articles, detailing how

interpreter access was a frequent challenge. Commonly, interpreter services were difficult to organise, funding was a challenge, and individuals with a range of hearing and speaking abilities were often assumed to be okay without interpreters. One Deaf participant shared that it is a common misconception that an interpreter is not required, “I don’t look Deaf, I don’t sound Deaf, but I should be accepted as Deaf, coz I am Deaf” (Bridgman et al., 2021, p. 55). At times, substitutes such as pen and paper or family members interpreting provided an alternative means of communication. Additionally, when it comes to interpreters being involved in the therapeutic process, there can be resistance to seeking treatment as interpreters are often involved in multiple contexts. From a Deaf perspective, whilst there was a desire for support, reaching out to services was articulated as “embarrassing and frustrating” (Sheppard & Badger, 2010, p. 786). One Deaf client expressed that “You cannot trust an interpreter” (Bridgman et al., 2021, p. 56) as only 13 interpreters were available in their region. This highlights a resistance to include a third person in therapy and raises further questions regarding accurate translation, as well as ethical issues regarding confidentiality. A team of mental health practitioners highlighted “the limited availability ... of interpreters ... makes a crisis especially difficult to manage; and reliance upon family members to interpret may not yield a comprehensive and unbiased impression, and confidentiality would be compromised” (C. Thomas et al., 2006, p. 306). Solutions were identified in articles across all three perspectives that long-term sign language interpreters trained in mental health were ideal for Deaf clients. This would address confidentiality and trust issues and would improve consistency and the quality of mental health services.

**Funding.** The ability to fund mental health services. Financial constraints and funding were identified as barriers for Deaf clients accessing mental health therapies. Bridgman et al. (2021) argues for resourcing in line with the elevated need of the Deaf community. Neves et al. (2020) highlights the difficulties Deaf people have regarding access to health services due to financial barriers. Solutions to improve access include equitable funding options.

#### ***Lack of mental health knowledge***

The ability to understand mental health services. For some Deaf individuals, mental health terminology can be difficult to comprehend. As a result, Deaf people may not understand their own symptoms and/or diagnosis, and consequently not know how to manage their mental health. Markedly, three out of the four articles from the Deaf perspective raised this critical issue, and one from a mental health practitioners’ article. The following quote articulates this challenge, “borderline personality disorder, she had no idea what her label meant, and what the medication was supposed to do. Her clinicians’ never took the time to actually talk to me ... ” (Bridgman et al., 2021, pp. 61–62). This statement highlights the challenges with comprehension of terminology and the importance of taking time for understanding to be achieved. Solutions from three articles include improving health promotion, creating a strategy on mental health literacy and educating on conditions such as depression. Additionally, it is suggested that mental health practitioners ask specifically about each symptom.

### ***Deaf community and identity***

How the Deaf client sees themselves in relation to the practices, values and world views of other Deaf people. Having a positive Deaf identity encompasses being proud of Deaf culture and language. In contrast, having a negative Deaf identity may include perceiving Deafness as a deficit which may be a result of historical, societal narratives. Nine of the 11 research articles discuss Deaf culture and identity and their inherent complexities. This identity is not exempt from the therapeutic space.

***Each Deaf person is unique.*** Respecting the uniqueness of the individual. Whilst Deaf culture and identity was widely discussed, two of the four Deaf perspective articles highlighted the importance of seeing each Deaf person as unique. Being Deaf covers a wide range of hearing and communication abilities: using cochlear implants, hearing aids, sign language with or without voice, and lip reading or not. Cohen (2003) shares, “although participants had diverse styles of communication, from oral speech reading and ... American Sign Language, all participants noted the importance of communication processes” (p. 32). Furthermore, multiple identities are not always taken into consideration when working with a Deaf person. Hence, for marginalised communities or cultures, there can be a double impact. Bridgman et al. (2021) shares one participant’s experience in Aotearoa-New Zealand, “some of her children have been uplifted ... or transferred in custody arrangements, demonstrating how the twin oppressions of audism for the Deaf and colonisation/racism, come together for Deaf people of Māori and Pasifika cultures” (p. 65). Audism can be defined as an ideology which takes the view that hearing people are superior to those who are D/Deaf or hard of hearing and considers inequities in systems which do not acknowledge differences in people’s hearing (Mairson & Howe, 2024). Therefore, for mental health practitioners and sign language interpreters it is important not to assume what it means to be Deaf, but instead to find out the preferred modalities of communication, cultural norms and values unique to the Deaf client.

***Audism/prejudice.*** An ideology which takes the view that hearing people are superior to those who are D/Deaf. Six out of the 11 articles highlighted audism as a problem. The experiences of audism can make a Deaf person feel invalidated and misunderstood, especially when seeking mental health support. A Deaf participant explained her feelings of invalidation as her therapist assumed her issues were related to puberty, highlighted in this quote, “I had specific problems with my deafness because my mother viewed my deafness as a medical issue ... that there was something wrong with me and it needed to be fixed (Cohen, 2003, p. 32). Deaf identity can be difficult for Deaf people to assert when faced with prejudice. Responses to this includes empowerment strategies, Deaf advocates, professionals and role models to provide education on stigma reduction for Deaf communities and hearing service providers. Furthermore, Deaf awareness training is suggested and for mental health practitioners to explore perceptions and bias regarding Deaf culture.

***Deaf community and confidentiality.*** Sharing the worldviews of Deaf people and trusting others in the triangle of care. An important factor in acquiring a positive Deaf identity is connection with the Deaf community. Seven of the 11 articles mentioned the importance of the Deaf community and the inherent challenges. In a positive light, Deaf

culture and sign language are normalised, encouraging social relationships which provide a sense of belonging. Conversely, small community gossip can be prevalent therefore Deaf people are not always willing to share with Deaf friends or community members. This may exacerbate feelings of isolation often felt by Deaf individuals. Additionally, confidentiality has been identified as a concern due to interpreters being involved in various Deaf contexts including social circles, resulting in most of the articles highlighting a lack of trust when it comes to confidentiality. The following recommendations are suggested, robust confidentiality processes and assurances, as well as specialised mental health trained interpreters.

## ***Mental health professionals***

### ***Deaf awareness***

Practitioners understanding of Deafness. Nine out of the 11 research articles discussed mental health practitioners lack of Deaf awareness and the benefits of having a Deaf aware therapist. Part of Deaf awareness is understanding the role of the interpreter. Three articles highlighted misunderstandings which can occur, leading to further inaccuracies and challenges between the triangle of care. One mental health practitioner shared their thoughts on Deaf awareness, “the moment when a deaf person goes into therapy and finds someone who can understand him, for him it is fantastic” (Neves et al., 2020, p. 450). Likewise, from the Deaf client perspective this comment resonates, confirming that small efforts go a long way, for example, learning basic sign language and developing a curiosity towards Deaf cultural tenants. A Deaf client explains their experience with their mental health practitioner, “I like her. She went to Deaf mental illness professional development because she wanted to learn, which is good, that’s nice. She got to understand Deaf culture, little by bit over time and is doing well” (Bridgman et al., 2021, pp. 74–75). This experience supports the need for Deaf awareness training, endorsed by four articles to inform mental health practitioners on the cultural and linguistic needs of Deaf people.

### ***Difficulties adapting therapeutic practice***

Accommodations for Deaf clients. Highly relevant to the issue of lack of Deaf awareness, six of the 11 research articles highlighted the challenges when it comes to mental health practitioners adapting to the Deaf client’s needs. There was mixed opinion amongst mental health practitioners as to how to adapt therapeutic practices. Neves et al. (2020) suggested there is no need for new therapeutic approaches for this population. However, most articles from both the mental health practitioners and Deaf client perspective suggested Deaf specific resources and approaches. Suggestions of therapeutic approaches from all three perspectives include learning basic sign language and engaging directly with the Deaf client at times to develop a therapeutic relationship. Examples include, active listening, expressive modalities, aiming to utilise hand and facial expression, the use of visual aids, externalising negative introjects related to Deafness and empowerment strategies. Additionally, if suitable, non-verbal approaches such as art therapy to support emotional processing is suggested. Notably, transference and countertransference were referred to in three of the 11 articles. Communication challenges are a core trigger for Deaf individuals hence misunderstandings can easily cause transference in

the therapeutic space towards the sign language interpreters and mental health practitioners. Also, both professionals need to be prepared for countertransference. For the sign language interpreter, this highlights the need for emotional support, such as clinical supervision.

### ***Difficulties with diagnosis***

Understanding medical terms and definitions. Two notable perspectives were raised when discussing challenges with diagnoses. Firstly, from the perspective of the Deaf client, there were often misunderstandings related to diagnostic language such as depression and anxiety. One Deaf client shared, “They didn’t explain it to me at all. Anxiety was never explained to me ... for example, if I have an anxiety attack, what’s that ... how do I know that’s happening?” (Bridgman et al., 2021, p. 59). This raises the critical issue of assumed comprehension which is often overlooked. Some Deaf people may not have come across specific terms or may not have had these words explained to them in-depth. Moreover, Deaf people’s experiences of misdiagnosis and/or incorrect prescription of medication was highlighted. Solutions to this critical issue include taking time to clarify mental health terms and definitions and asking about each symptom and clarify understanding. Furthermore, suggestions include developing mental health literacy strategies for the Deaf and encouraging mental health practitioners to constantly seek clarification of understanding to ensure accurate diagnosis and health promotion.

### ***Sign language interpreters***

#### ***Vicarious trauma and support***

Sign language interpreters may experience trauma through the emotions of others which requires support. All three articles focusing on the sign language interpreter’s perspective encompassed strong themes around vicarious trauma and the need for emotional support. Mental health interpreting requires an embodiment of emotional and, at times, traumatic content, thus impacting the mental health of sign language interpreters. One sign language interpreter shares, “ ... we are privy to some disturbing disclosures ... There’s nowhere to put that when you get it” (Chatzidamianos et al., 2019, 2012). This highlights that sign language interpreters are bound to confidentiality making it difficult to process emotional content. Also, translation is not always literal, so at times sign language interpreters feel responsible for outcomes based on translation choices. Thus, all three research articles from the sign language interpreter perspective suggested clinical supervision, peer support, briefing and debriefing with mental health practitioners.

## **Discussion**

This qualitative synthesis aimed to discover the experience of mental health therapies for Deaf and hard-of-hearing people from the perspective of the Deaf client, mental health practitioners and sign language interpreters. In addition, the researchers aimed to explore the lived experiences of each member of this therapeutic triad. Furthermore, the researchers sought to offer guidelines to inform best practices for

mental health practitioners and sign language interpreters when working with Deaf clients. Providing equitable mental health services is not only important to Deaf people, but is supported by national and international legislation, explicitly, the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2022).

The themes generated in this synthesis were consistent with the limited contemporary literature available on mental health services for the Deaf. Of particular importance, the Deaf clients perspective highlighted the following themes: access issues, lack of mental health knowledge, Deaf community and identity. The experiences of mental health practitioners highlights the need for increased Deaf cultural awareness training and adaptations of therapeutic practice in order to decrease miscommunication, misdiagnosis and incorrect treatment (T. G. James et al., 2022; Sage Crowe, 2017). Sign language interpreters' theme is vicarious trauma, highlighting the challenges with translating emotional content and the need for emotional support. These identified challenges impact mental health services and the wellbeing of Deaf people. This is particularly concerning as Deaf mental health needs are more common than in the hearing population (Fellinger et al., 2012; Johnson et al., 2018). Causes of mental health distress include prevalence of trauma, child maltreatment, sexual abuse and other forms of abuse, therefore in order to ensure adequate and equitable mental health services for all, change is required (Bridgman et al., 2021; Cawthon et al., 2017; Johnson et al., 2018; Sheppard & Badger, 2010; Zafirah et al., 2020).

Several factors impact Deaf people's ability to access mental health support. Different countries around the globe have different systems which provide care, such as Deaf specific agencies, hospitals, community facilities or private practices or mainstream providers. D/Deaf specific services can have resourcing and funding challenges, evidenced through agency closures in both Aotearoa-New Zealand and the USA (May, 2021; McDonnall et al., 2017). This raises critical issues regarding ongoing costs required for services and professionals to meet the needs of Deaf people (C. Thomas et al., 2006).

### ***Clinical implications***

Findings from this qualitative synthesis have the following clinical implications. Mental health services are encouraged to engage directly with the Deaf community (Reader et al., 2017) and increased advocacy is needed for Deaf clients to access mental health services (Cohen, 2003). Deaf services are encouraged to offer a consultative role in supporting local service providers (C. Thomas et al., 2006). Furthermore, it may be helpful to increase support options such as specialised Deaf awareness community support or online services may be helpful as Bridgman et al. (2021) argues that services can be highly dependent on geography and population. Further findings in this qualitative synthesis identified barriers to access include lack of trust towards services and sign language interpreters. Sign language interpreters working in multiple contexts can create discomfort and may lead to Deaf clients questioning confidentiality. Hence, sign language interpreters and mental health practitioners need to discuss confidentiality, providing assurance of trust and professionalism (Boness, 2016).

Witko et al. (2017) findings discuss the importance of communication and organisation. Pre-appointment contact can be difficult with Deaf people and may require alternative modes of communication, for example, texting could be offered as a good alternative. Additionally, pre-appointment bookings of interpreters require front loading of client information and in the case of a mental health crises, immediate interpreter access could be compromised. C. Thomas et al. (2006) suggests improved interagency collaboration and encourages detailed documentation and information made available on client care. Witko et al. (2017) points out that there is a risk of assuming a Deaf person's communication ability and likewise, Sheppard and Badger (2010) suggest asking the Deaf person how they prefer to communicate. This is in line with literature in Aotearoa-New Zealand, where a paradigm shift is occurring where people with disabilities are progressively being placed at the centre of decision-making (Sepuloni, 2022). By reducing barriers, streamlining systemic processes between government funding, providers and clients, and collaborating with the Deaf client, equitable mental health services are increasingly achievable.

Effective, meaningful and comprehensible communication in Deaf mental health care is vital. The importance of understanding mental health terminology pertaining to personal health and wellbeing can aggravate outcomes due to lack of understanding of symptoms, diagnosis and medication (Giegerich et al., 2020; N. Glickman & Hall, 2016). The responsibility lies on both the sign language interpreter's ability to translate concepts in a culturally responsive way and mental health practitioners to clearly understand the Deaf client. Studies in this qualitative synthesis suggest the triangle of care requires clear roles, systems, rhythms of communication and mental health training for sign language interpreters. Moreover, Platform (2020) comments on how Deaf people are visual, therefore facing the Deaf person, communicating slowly, having good lighting and double-checking for understanding are important. Furthermore, Anglemeyer and Crespi (2018) argue that diagnosis hinges on a mental health practitioners' level of Deaf awareness, as emotions such as anger can come across as more visually intense which may lead to altered perceptions. Hence, T. G. James et al. (2022) strongly advises how it is essential to seek clarity of communication in order to avoid further harm.

Likewise, cultural competency enhances communication between the mental health practitioners and the Deaf client and has been increasingly documented in the literature as an expectation for mental health practitioners (Corey, 2021; Hook et al., 2017). To meet this competency, Deaf awareness training for mental health practitioners has been recommended by studies in this qualitative synthesis. These recommendations include mental health practitioners learning basic sign language, increased use of facial and body expression, mental health practitioners increased efforts to understand the Deaf world, considerations of multiple identities, audio-logical and unique linguistic ability. These actions align with ethical best practices to support clients within their worldview as an integral part of professional practice (New Zealand Association of Counsellors, 2020). It is essential for mental health practitioners to understand the importance of supporting Deaf identity, being aware of the complexity of multiple oppressed identities, such as indigenous Deaf people, as well as acknowledging that audism and the stigma of being D/Deaf is still prevalent in society (Bridgman et al., 2021). Furthermore, this highlights the necessity

for mental health practitioners to holistically welcome the person in front of them, limiting their own assumptions and bias where possible (Corey, 2021).

Regarding therapeutic treatment, seven articles suggested that adaptations, specific resources and approaches for this population would be beneficial. These approaches would assist with understanding specific terminology and would support the therapeutic processes to work towards healing. Anderson et al. (2021) advises providing visual handouts in both English and sign language, and if not available, the suggestion is to use sign language interpreters' skills to convey essential information pertaining to Deaf client's mental health. Additionally, resources and supports need to be further developed to support Deaf clients. Apart from a few resources of psychoeducational content a limited number of appropriate resources for Deaf people was noted (Anderson et al., 2021; N. Glickman, 2016).

While therapeutic knowledge and support is acknowledged for the mental health practitioners, the needs of sign language interpreters appear to be overlooked. Sign language interpreters embody traumatic content, and if not addressed, could lead to prolonged emotional stress, compassion fatigue, feelings of sadness, overwhelm, anger, distress and hopelessness (Daly & Chovaz, 2020; Darroch & Dempsey, 2016). Therefore, like mental health practitioners, it is suggested that all sign language interpreters receive clinical supervision along with briefing and debriefing to prevent further harm (Chatzidamianos et al., 2019; Darroch, 2018; Zafrah et al., 2020). Additionally, the awareness of transference and countertransference for both mental health practitioners and sign language interpreters is acknowledged and requires clinical supervision, as dysfunctional relational beliefs can play out during therapeutic sessions. Therefore, provisions are required to increase emotional safety (Anderson et al., 2021; Bravo & Garcia, 2015; Prasko et al., 2022).

### ***Limitations and recommendations for future research***

There are several limitations within this qualitative synthesis. First, the reported articles date range was from 2000 to 2023 and thus the results do not necessarily reflect present-day experiences of mental health therapies for the Deaf as participants shared past experiences with no specified dates. Therefore, there is a need for current research to be carried out. Second, female participants featured more prominently in most of the reported studies, with cultural diversity not always explicitly shared. Therefore, the results may not provide experiences from a range of cultures and identities. This confirms the importance for future research to encompass adequate representation, including a range of perspectives. Third, while the data from the 11 articles was comprehensive, themes such as causes of mental health distress, could have been focused on. Lastly, cultural and social considerations within mental health therapies for the Deaf requires further research. Therefore, there is, an opportunity for Deaf mental health to be researched more deeply.

### ***Summary of implications for practice***

This qualitative synthesis identifies specific implications for practice as access for Deaf people requires systemic solutions including:

- advocating for equitable mental health services for Deaf clients, including funding for communication support and sign language interpreters,
- increased funding for specialist Deaf mental health consultative services for support, resourcing and education,
- supporting mental health literacy for Deaf clients,
- promoting positive Deaf identity.

For mental health practitioners to:

- undertake Deaf awareness training,
- inquire about clients preferred communication,
- ask specifically about individual symptom,
- actively engage with the Deaf community,
- offer early assurances that confidentiality will be upheld,
- regularly brief and debrief with sign language interpreters.

For sign language interpreters to:

- receive specific mental health training,
- receive emotional support including clinical supervision and peer support.

## Conclusion

The experiences of mental health therapies for the Deaf have the potential to be culturally and linguistically supportive, enabling Deaf people to benefit from the services provided. This qualitative synthesis raised some important issues and solutions to the challenges that are inherent in each perspective of the therapeutic triad. There is a need for attention and action at all levels, from government systems to mental health services, to professionals working directly with Deaf clients. The triangle of care highlights the interconnected reality of this therapeutic phenomenon and suggests that each connection within this triad needs to be effective and strong, as a weak link may impact therapeutic success. Communication, expectations, clear roles, access to professional support and effective delivery of therapeutic interventions are necessary to ensure professionals are supported to carry out their role and the Deaf client feels comfortable and supported. Furthermore, recognising the importance of a positive Deaf identity is paramount as prejudice continues to impact Deaf people today. A secure Deaf identity results when services provide adequate cultural and linguistic support to create ease and normalcy for the Deaf person. Therefore, to provide equitable mental health services for the Deaf requires change and solutions at multiple levels providing hope for improvements which the sector clearly needs.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

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