An exploratory study into the skills necessary to provide counselling services to the d/Deaf: A mixed methods study in a South African context

By

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Abstract

This study aimed to determine the skills necessary to provide therapeutic services to the d/Deaf in the South African context. A triangulation mixed methods design was used which included both quantitative and qualitative data in the form of surveys and interviews. The quantitative data investigated the skills and training existing practitioners working in the field of Deaf Therapy have that aid them in their work, whereas the qualitative data looked at the challenges faced by these professionals and the skill demands that are being placed on them. This data was then triangulated and combined to form a list of recommendations for those within the field or wanting to enter the field of mental healthcare delivery to the d/Deaf community in South Africa. It was evident from the data that professionals working in the field of Deaf Therapy are faced with many challenges, some of which require specialised training so as to provide adequate and effective services to the d/Deaf community. The primary recommendations made by participants were that professionals should be trained in Sign Language and Deaf Culture so that they are more able to communicate with the d/Deaf, be aware of and sensitive to the communication and interactional needs of the d/Deaf, and to understand some of the unique differences in culture between the hearing and d/Deaf communities. Participants identified a possible lack of available and appropriate services to the d/Deaf in the field of mental health, as well as a lack of training available to professionals providing services to them. In order for professionals to be sufficiently equipped with the skills and training that have been recommended, their training needs will need to be addressed. It would seem that research in the field of mental health focusing on the d/Deaf population is underrepresented in the South African context, and that further research needs to be undertaken so that a better picture of the state of mental healthcare to the d/Deaf can be gained and necessary advancements can be made.

Key Words

Deaf, deaf, hearing impaired, mental health, critical realism, mixed methods, South Africa

Ode to a Deaf Child...

One day I saw a little child as lovely as a flower,
She danced and ran, she jumped and turned ...
I watched her for an hour.

This child of God was all the things I'd want my own to be,
Magnificent of heart and limb a curiosity.

But when God made this little one he didn't give her sound,
He left her in silent world where quiet is profound.

A deep abyss, a lonely world, away from all who hear,
To never know the voice of man in happiness or fear.

And as I watched her hands make pictures in the air,
A silent unknown rhythm that I could never share.

For in this world of silence the hearing rarely go,
Because they lack the picture words it never can be so.

This causes me to wonder about the world of sound,
What is it that we're missing where the silence is profound?

And then I knew the answer, it suddenly was there-
To live and love together means people have to share.

Thus in the world of picture words where pretty symbols flow,
The meanings of I LOVE YOU is there for all who know.

And so I guess the world of sound will stay a world apart,
Until it learns the picture words, it cannot share the same heart.

Philip A. Bellefleur, Ph.D.

("Deaf Poetry," 1999)

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1. Introduction

This study aimed at addressing the question of what skills are necessary to provide therapeutic services to d/Deaf (see section 1.1) persons in the South African context. It focused on how therapy is currently being conducted by professionals working with the d/Deaf, and set out to determine what recommended skills or training needs to be adopted by those interested in providing mental healthcare services to the d/Deaf and/or hard of hearing.

As can be seen by the poem above, d/Deaf and hearing individuals are frequently seen to be living in separate worlds with one often feeling like an outside observer to the other. As a child the researcher was exposed to the world of the d/Deaf for a brief period and became fascinated by the possible difference in experience the presence or absence of sound could make. Going on to study psychology and always having this fascination, lead the researcher to ask questions about how the therapeutic experience and interaction may differ when working with those with varying degrees of hearing loss. So began their enquiry into the field of Deaf Therapy, where they were met with a complex array of considerations and challenges one would be faced with and have to keep in mind when working with a hard of hearing client. It is from this point that this research study took flight and has transformed into the research that is presented below.

1.1 Defining Deafness

There are numerous terms used with reference to those with varying forms of deafness and hearing loss, many with their own specific cultural and linguistic nuances, making the decision over how to collectively refer to individuals who identify with each of the terms difficult (Roberts & Hindley, 1999). The upper-case Deaf refers to the view of hearing impaired individuals, of their unique deaf culture with its own traditions, who primarily communicate using Sign Language, and who see themselves as a cultural and language minority group (Middleton et al., 2010; "National Institute for the Deaf," 2011; Roberts & Hindley, 1999; Steinberg, Barnett, Meador, Wiggins, & Zazove, 2006; Vernon, 2007). Although the term 'hearing impaired' is apparently neutral, it brings about strong feelings in many deaf adults and older deaf children who dislike the notion that they have an impairment (Roberts & Hindley, 1999). The lower case 'deaf' and 'deafness' are terms

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used to refer to those with any level of hearing loss, moderate or profound, who cannot hear verbal language (without aid) well enough to comprehend its meaning (Haskins, 2004; Middleton et al., 2010; Steinberg et al., 2006). As in the article by Middleton et al. (2010), this study will utilise the term 'd/Deaf' to refer to all individuals who are deaf, Deaf, hard of hearing, deafened and hearing impaired, as the researcher wishes to have the entire population who fall within those categories form part of the study's scope. The term 'Deaf Therapy' is used by the researcher to refer to therapeutic and mental health services provided to the d/Deaf.

1.2 Background to the Research

According to the 2001 Census, it is estimated that 20% of all disabled South Africans are d/Deaf or hearing impaired (Lehohla, 2005; Moola, 2010). Other sources state that approximately 4 million South Africans (Moola, 2010; Van Rooyen, 2009) or as many as one in every ten new born babies in South Africa suffer from some form of hearing impairment (Jordaan, 2009). Statistics gathered from the most recent South African National Census (2011) indicate that 3.6% of South Africans who took part in the census have some degree of difficulty hearing; this was indicated through email communication with Statistics South Africa as well as was published in the "Profile of persons with disabilities in South Africa" report (Lehohla, 2014). In a 2012 report, Fellinger, Holzinger and Pollard stated that 15-26% of the world's population suffers from some form of hearing impairment, with the highest concentration being in third world countries. It is, however, difficult to determine the true extent of d/Deaf individuals in South Africa due to the ambiguities surrounding definitions of deafness (Middleton et al., 2010; Moola, 2010).

From the above statistics, it can be reasoned that there is a large deaf community in South Africa, and as will be demonstrated further on in this paper (see section 2.3), hearing impairment puts an individual at an increased risk of mental illness, making some of these individuals reliant on or in need of mental health services at some point in their lives (COI, 2005; Cornes & Wiltshire, 1999; Fellinger et al., 2005, 2012; Remvig, 1969). Due to this, the researcher wanted to identify what skills are necessary to provide such mental health services by surveying and interviewing a number of professionals who are currently involved in service provision of this nature. Furthermore, the researcher wanted to identify whether skills such as, knowledge of Deaf Culture, training in

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South African Sign Language, knowledge of the degrees of hearing loss and their causes, as well as the resulting developmental differences that may be present due to hearing loss are necessary requirements to work with the deaf or hearing impaired, and/or what other skills and training may be required.

A triangulation mixed methods design was chosen, in which different but complimentary data was collected in the form of both surveys and interviews. The quantitative data set out to determine what skills are believed to be necessary to work with this population, by those who currently provide such services. Whilst the qualitative data explored what challenges are faced by these service providers, and what skill demands are being placed on them in order to effectively cater to the d/Deaf. The reason for collecting both qualitative and quantitative data was to bring together the strengths of both forms of research to validate and compare the results, as well as provide comprehensive information regarding the current and preferred practice of Deaf Therapy.

1.3 Aim and Objectives

This study's aim was to do an exploration into the skills necessary to provide counselling services to the d/Deaf in South Africa, by surveying a sample of service providers nation-wide. Furthermore, the researcher aimed to conduct face-to-face interviews with a group of mental health service providers in Gauteng, to establish the skill demands that are currently being placed on them in order to work effectively with the d/Deaf. However due to lack of response, the researcher went on to conduct email interviews with those service providers national-wide who took part in the survey and were willing to take part in the interview as well. In doing so the researcher hopes that anyone who wishes to enter or who is currently working in the field of Deaf Therapy may be provided with information that will aid them in determining what skills they currently have that benefit them in their pursuit, or what further skills or training may be required. As such the information obtained from the sample of professionals, was used to develop a guideline or list of recommendations for those who wish to become practitioners in the field of Deaf Therapy.

Furthermore, the researcher hopes that the information gathered in this study can be utilised by academic and training institutions to improve and expand upon current professional

training courses and aid the development of relevant Continuing Professional Development (CPD) programmes which allow professionals training opportunities in the field of Deaf Therapy. As a registered student in a Masters Degree programme in Counselling Psychology, the researcher feels that their own training programme lacked in skill development with regards to service provision to the disabled. Current training, specifically in the field of Psychology, would seem to be focused on service provision to mainstream individuals. This implies that for a trained Psychologist to be able to work with particular marginalised groups, such as the d/Deaf, they would require additional training outside of their professional programmes in order to do so. This not only further marginalises these groups, but limits the number of professionals available to provide services to them.

2. Literature Review

2.1 Research into the Field of Mental Health and Deafness

Research concerning the exploration and development of mental health services for the d/Deaf seems to be a somewhat novel field, only sparking interest about 50 years ago, and one which has not received extensive attention overall (Marschark & Clark, 1993; Vernon, 2007). The early 2000's began to see this topic becoming more of a focus in research once again, which is promising, but as is echoed by those who have done research into the field of deafness and mental health, much work still needs to be done and there are numerous areas of improvement for service provision worldwide (COI, 2005; Fellinger et al., 2005, 2012; Haskins, 2004; Middleton et al., 2010; Vernon, 2007; Williams & Abeles, 2004).

As a result of research that is done into the field of Deaf Therapy occurring sporadically and not continuously being built upon, past studies are often outdated and therefore possibly irrelevant. The paucity in research and service delivery has led to the conclusion by some researchers that the d/Deaf are an underserviced and neglected population (Hoyt, Siegelman, & Schlesinger, 1981; Landsberger & Diaz, 2010; Thomas, Cromwell, & Miller, 2006; Wilson & Schild, 2014). From this it can be argued that increased and on-going attention to research in this field is vitally important if we are to address the needs of the d/Deaf.

Due to his work in the 1960's and the subsequent interest of researchers into this field, John D. Rainer can be seen as a pioneer in bringing attention to the needs of the d/Deaf with regards to the field of psychology (Shapiro & Harris, 1976). Rainer and colleagues headed up a 3 year pilot project in order to reveal the importance and viability of providing widespread mental health services to the d/Deaf in New York (Altshuler & Rainer, 1966). Yet, due to the shortage of continued research over the last 50 years there seems to be a lack of mental health services available to this group, as well as psychologists who are proficient in Sign Language and other appropriate forms of communication (Cornes & Wiltshire, 1999; Munro, Knox, & Lowe, 2008; Shapiro & Harris, 1976; Steinberg, Sullivan, & Loew, 1998; Wilson & Schild, 2014).

When looking at past research that has been conducted, d/Deaf children, particularly those from hearing families, are the focus of a large amount of the literature (Ahlert & Greeff, 2012; Cornes & Wiltshire, 1999; Elliot, Glass, & Evans, 1987; Harvey, 1984; Jackson & Turnbull, 2004; Marschark & Clark, 1993; Morton, 2000; Roberts & Hindley, 1999; Schlesinger & Meadow-Orlans, 1972; Shapiro & Harris, 1976; Shinn, 2013), further indicating the narrowed and unrepresentative approach research has taken up to this point. Research has primarily dealt with the administration of mental health services to d/Deaf children as well as how to overcome obstacles regarding the implementation of therapy with them and their families (Harvey, 1984; Roberts & Hindley, 1999; Shapiro & Harris, 1976; Shinn, 2013). Rather, a wider demographic focus needs to be undertaken for example, to include hearing impaired adults and children, from both hearing and d/Deaf families.

A review of the literature identifies that there is also an evident lack of research in South Africa pertaining to the state and nature of mental health service delivery to the d/Deaf, which promptly requires addressing so as to ensure that the needs of this population are being met. Currently, a substantial amount of research pertaining to deafness in the South African context focuses on the medical aspects and implications of deafness, as well as educational implications of deafness. However, the area of deafness and mental health appears to be neglected in the South African context.

2.2 Healthcare and Mental Healthcare Services for the d/Deaf

Deafness can be classified as an 'invisible' disability as it displays no visible symptoms other than an individual's difficulty in communication; and only becomes obvious when an individual displays such a difficulty or through their use of Sign Language (Harvey, 1984; Marschark & Clark, 1993). As will be discussed below (see section 2.2.1), society, including mental health professionals, often holds a negative view of the d/Deaf, which has led to the d/Deaf community feeling isolated and segregated from the wider community (Altshuler & Rainer, 1966; Cooper, Rose, & Mason, 2003). It has been argued that the perception and negative attitudes of mental health professionals with regards to the d/Deaf and their ability to benefit from

psychotherapy, has led to psychology as a field being slow to enter the realm of d/Deaf psychotherapy (Leigh, 1999).

2.2.1 Perceptions healthcare professionals have of the d/Deaf.

There are two notions of deafness that are believed to be held, brought to light by Freeman, Carbin and Boese (1981, p. 1) in their chapter "Deafness can either be a difference to be accepted or a deficit to be corrected". Many individuals view the d/Deaf as helpless, useless, unsocialized and unintelligent (Marschark & Clark, 1993), therefore as having a 'deficit to be corrected' (Freeman et al., 1981). However, the essential difference between the hearing and d/Deaf is that they communicate differently and experience a somewhat different world from that of the other (Freeman et al., 1981; Marschark & Clark, 1993), thus rather highlighting deafness as a 'difference to be accepted' (Freeman et al., 1981).

Research done by Cooper et al. (2003) on mental health professionals' attitudes towards d/Deaf patients showed that professionals display better attitudes towards d/Deaf patients when they have had contact with d/Deaf individuals who are of equal or higher status. This may stem from the common perception, as echoed above, that the d/Deaf are disabled, helpless, immature, irresponsible, paranoid and incompetent (Harvey, 1984; Marschark & Clark, 1993). Thus, mental health professionals being exposed to d/Deaf individuals of equal or higher status, with whom they can identify or regard in terms of status, makes it easier for them to be more accepting of other d/Deaf individuals and challenge the negative stereotypes seen above.

Cooper et al. (2003) also demonstrate that hiring more d/Deaf individuals into the field of mental health, or by increasing the training of professionals working with the d/Deaf, that this may result in hearing professionals having better opinions of and attitudes towards the d/Deaf. Freeman et al. (1981) suggest that goals for professionals with regards to working with the d/Deaf include the acceptance of the d/Deaf as equals, focusing on their strengths rather than their limitations and having compassion for these individuals. However looking at research conducted on the topic, it would appear that this is rarely the case.

The d/Deaf participants of the Steinberg et al. (2006) study, 'Health care system accessibility', articulated that they had strong feelings regarding their experiences of interactions with healthcare services, with many stating that they experienced fear and stress. This fear was with regards to sharing with the practitioners their misunderstandings or feelings of inadequate communication, as well as fears over the potential consequence of not establishing an effective means of communication with their practitioners. "Participants also felt that some health care workers disliked working with the deaf" (Steinberg et al., 2006, p. 263), and that the healthcare system treats the d/Deaf differently to the hearing. Ultimately this leads to feelings of mistrust of healthcare practitioners and the possible decline in the use of healthcare services by the d/Deaf. This was supported by a similar study carried out in the South African context by Kritzinger, Schneider, Swartz and Braathen (2014), where they also found that d/Deaf individuals hold the view that healthcare providers fear the d/Deaf and find it easier to ignore them.

2.2.2 Perceptions d/Deaf individuals have of healthcare professionals

In the same way mental health professionals hold negative perceptions of the d/Deaf, d/Deaf individuals have negative attitudes of mental health professionals and services. They often view them as "authoritarian, restrictive and prejudiced" (Steinberg et al., 1998, p. 983), and the hearing community as a whole as "privileged and hostile" (Fellinger et al., 2005, p. 738). In research by Steinberg et al. (1998), d/Deaf participants referred to or signed mental hospital by using 'prison', a 'straight jacket' or a 'crazy house'. One of the participants had the following to say "From a deaf person's point of view, they [jail and mental hospital] are the same" (Steinberg et al., 1998, p. 983).

These negative perceptions are understandable when one considers that specialized services, where a d/Deaf individual can feel cared for, understood and valued, are rare (COI, 2005; Fellinger et al., 2012; Haskins, 2004; Middleton et al., 2010; Vernon, 2007). The continued lack of service provision and research appears to widen the gap and segregation between the hearing and d/Deaf which, in a post 1994 South African context, stands in opposition to the objective of fair and equal treatment of all ("The Bill of Rights of the Constitution of the Republic of South Africa," 1996).

According to Steinberg et al. (2006), the d/Deaf tend to have poorer health than the hearing, however, they tend to use healthcare services less than the hearing. Steinberg et al. (2006) indicate that a common problem with d/Deaf individuals' interactions with healthcare services, is that they often struggle to understand the instructions and information given to them by their practitioners. This can be a concern for the field of mental healthcare with regards to pharmacotherapy, as with any medical complaint, the correct use of medication is vital to successful treatment.

It would be reasonable to assume that the d/Deaf may be weary of seeking treatment from mental health professionals, fearing that they may be mistreated, misunderstood or possibly misused for financial gain (Kritzinger et al., 2014). However, poor opinions of healthcare and mental healthcare providers held by the d/Deaf, may result in further obstructed access to mental healthcare services.

2.3 Deafness and Mental Health

Research has shown that deafness places individuals at a higher risk of mental illness as well as other challenges which might have an impact on d/Deaf individuals' social and emotional functioning (COI, 2005; Cornes & Wiltshire, 1999; Fellinger et al., 2012; Remvig, 1969). Fellinger et al. (2005) report that when compared to hearing individuals, d/Deaf people indicate having a poorer quality of life and greater mental distress. They state that "absence of early auditory stimulation and delay in acquiring language seems to affect neurocognitive processing domains, such as auditory and visual working memory, attention, and inhibition" (Fellinger et al., 2012, p. 1038). Furthermore, they indicate that d/Deaf individuals tend to be more vulnerable to becoming victims of abuse, particularly sexual abuse, and tend to be more frequently physically disciplined as children than hearing children (Fellinger et al., 2012). Such adversities are shown to increase susceptibility to mental health problems (Fellinger et al., 2012). Tambs (2004) suggests that hearing loss leads to possible social isolation due to difficulties in communication and stigmatization, which also increases vulnerability to mental health problems such as increased anxiety, depression and self-esteem problems.

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Schlesinger and Meadow-Orlans (1972, p. 1) state that "Profound childhood deafness is more than a medical diagnosis: it is a cultural phenomenon in which social, emotional, linguistic, and intellectual patterns and problems are inextricably bound together". Hence demonstrating how complex a disability like deafness can be and how it can be a causal factor in the development of psychological disorders. It furthermore demonstrates how hearing impairments may increase susceptibility to the development of emotional and behavioural disorders.

This is echoed by Remvig (1969), who states that there is a high incidence of mental illness in the d/Deaf community, which reveals the difficulties faced by this group as well as the lack of service provision supplied to them (Cooper et al., 2003). Fellinger et al. (2012) state that the causes of deafness related to disease and illness (e.g. rubella or meningitis) acquired before birth, often lead to other disabilities and increases in mental health issues. The aforementioned may account for the apparent increase in mental health problems within the d/Deaf community, particularly for those who were born with hearing difficulties.

2.3.1 The role of communication difficulties in Deaf Therapy

There are a number of reasons suggested by the literature for an increased risk in mental illness, one of which has to do with slower development of vocabulary and reading ability of d/Deaf individuals and the subsequent lack of early childhood communication and interaction (Fellinger et al., 2005, 2012; Haskins, 2004). It is suggested by Fellinger et al. (2012, p. 1039), that early communication development and socialisation shows an increase in quality of life and the development of "rich psychological resources" which may aid in warding off later psychological distress. Haskins (2004) and Williams and Abeles (2004) point out that communication problems may give rise to feelings of isolation, and might interfere with the development of conceptual and abstract thinking.

Most children who are born d/Deaf are born into hearing families where it is often difficult for them to effectively communicate with the family, as many d/Deaf individual's families do not know or become fluent in Sign Language (Harvey, 1982). This isolation is also a risk factor for mental illness (Fellinger et al., 2005). In adulthood, communication barriers are frequently not

improved upon, as can be seen by Fellinger et al.'s (2005) report that 75% of a d/Deaf adult inpatient sample they interviewed were not fluent in signed or spoken language. Furthermore, Haskins (2004) stated that the average d/Deaf adult reads at a grade 4 level. In South Africa, the typical d/Deaf school leaver is said to read at the level of an average 8 year old hearing child (Van Rooyen, 2009).

The Deaf community is one with its own unique culture and it is said to be very small and cohesive, in that most members spend their time and choose partners from within it (Fellinger et al., 2005; Williams & Abeles, 2004). The Deaf view themselves as part of a distinct community with its own language and culture, and thus do not view Sign Language as a lesser form of communication (COI, 2005). Language development and communication is shown to improve the psychosocial wellbeing of d/Deaf individuals and decrease their susceptibility to mental health difficulties (Fellinger et al., 2012). From the aforementioned it could be concluded that exposing children diagnosed with hearing difficulties to opportunities to develop language, be it Sign Language or oral communication, as well as increasing their opportunities to socialise within the family context and with other d/Deaf individuals, may decrease their vulnerability to developing mental health issues.

An argument brought to light by Hoyt et al. (1981) and Remvig (1969) which needs consideration, involves the difference in syntactical constructions between many forms of Sign Language and that of spoken English. Thus when differentiating language skills from distorted or unusual thinking which may be present as part of a psychopathology, one must take heed (Hoyt et al., 1981; Remvig, 1969). Landsberger and Diaz (2010) point out the importance of being aware of necessary assessment and interview differences when working with the d/Deaf, particularly when conveying hearing-based constructs e.g. auditory hallucinations, to a d/Deaf patient. They recommend that one must be certain of the d/Deaf patient's understanding to avoid them misinterpreting and possibly feigning comprehension so as to avoid the stress of appearing ignorant (Landsberger & Diaz, 2010).

A study by Landsburger and Diaz (2010) looked at a d/Deaf psychiatric inpatient sample and found that 11-13% of d/Deaf inpatients are diagnosed with psychotic disorders, a number which has decreased since the 1960's. Previous higher rates of diagnosis are attributed to practitioners' lack of knowledge of deafness and the linguistic differences present, which is suspected to have resulted in many practitioners using the diagnosis of psychotic disorders as a fail-safe and umbrella diagnosis when they were in doubt or unable to carry out accurate assessments (Landsberger & Diaz, 2010). With inadequate knowledge of language and culture differences one might, for example, be inclined to diagnose a patient with a thought disorder (Landsberger & Diaz, 2010).

It is important for mental health services and service providers to acquire greater knowledge and awareness of deafness and the cultural and linguistic differences in the treatment of the d/Deaf, as a lack of awareness could lead to serious implications for d/Deaf patients in terms of assessment, diagnosis and treatment. In therapy, difficulties in communication can lead to misdiagnosis and impact the development of the therapeutic relationship, further reinforcing patterns of isolation, misunderstanding and oppression experienced by many d/Deaf persons (Williams & Abeles, 2004). This, coupled with cultural differences that could be experienced between the therapist and patient (in terms of d/Deaf and hearing culture), may pose a further problem to the course of therapy (Cooper et al., 2003; Roberts & Hindley, 1999).

Hoyt et al. (1981) point out that a therapist must be cognisant of the fact that d/Deaf patients are much like other non-hearing impaired patients, and that their deafness is merely a limitation in typical communication, which may not in fact be part of the issue at hand. In some instances it may be the case that their psychological difficulties stem from their disability; however therapists need to be aware of this distinction and be careful of making these assumptions too soon.

2.3.2 Limitations to social development for the d/Deaf

Shapiro and Harris (1976) suggest that another reason for d/Deaf individuals being more prone to developing psychological or emotional complaints may be that their difficulties in audition,

speech and symbolic language impede their social development. Their deafness causes them to experience a unique reality unlike that of hearing children, which will naturally impact their social and psychological development very differently (Marschark & Clark, 1993).

2.3.3 Primary mental health concerns of the d/Deaf

Williams and Abeles (2004) state that d/Deaf people are likely to seek mental health services for the same reasons as hearing individuals, but that there does seem to be a higher prevalence of substance abuse and issues resulting from having experienced oppression, unemployment, isolation and mistrust of society. Fellinger et al. (2012) state that d/Deaf individuals are at a higher risk of becoming victims of abuse which further increases their risk of mental health problems. Furthermore, Fellinger et al. (2005) indicate that the d/Deaf tend to be seen for behavioural problems, psychosocial difficulties, substance abuse, impulse control disorders, learning disabilities, pervasive developmental disorders, stress-related problems and somatoform disorders. Cornes and Wiltshire (1999) state that children with hearing impairments more frequently develop behavioural problems than children without hearing impairments (six times more often).

According to research done by Landsberger and Diaz (2010) where they compared the diagnostic information of 30 inpatient d/Deaf individuals with that of 60 inpatient hearing individuals, they did not find higher rates of psychotic, mood, anxiety, eating, learning, language or cognitive disorders in their d/Deaf patient population compared to that of the hearing inpatient population; however, they did notice higher rates of impulse control disorders and pervasive developmental disorders, and lower rates of substance use disorders. The presence of higher rates of impulse control disorders has been suggested to potentially be due to the fact that many individual's are diagnosed as d/Deaf late into childhood which impedes their language development, socialization, development of problem solving skills and emotion regulation (Landsberger & Diaz, 2010). Landsberger and Diaz (2010) also found a higher rate of personality disorders in the d/Deaf and furthermore determined that the length of a d/Deaf patient's hospital stay was longer than that of a hearing patient with a similar diagnosis (Landsberger & Diaz, 2010). This may suggest that treatment modalities for the d/Deaf are not as developed as that for the

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hearing, or that treatment of the d/Deaf population brings with it significant challenges that lengthen duration of treatment.

It is important to become aware of the primary reasons for d/Deaf individuals' contact with mental health services so that intervention and treatment can be adapted and focused towards meeting the differing needs of the d/Deaf. In this research study, the researcher set out to determine the most frequently treated mental health concerns by practitioners in South Africa who form part of the research sample so as to gain better insight into the mental health needs of d/Deaf South Africans. This knowledge will hopefully aid practitioners in the field or those who intend to enter the field of Deaf Therapy in determining where they should focus and develop their primary modes of treatment.

2.4 Past and Present Service Provision

2.4.1 Treatment modalities

Cooper et al. (2003) revealed that d/Deaf individuals value the ability to communicate in their preferred language or communication style with individuals who understand and are sensitive to the cultural differences that are present between hearing and d/Deaf individuals. "Ideally, the deaf patient should be seen by a therapist fluent in sign language" (Hoyt et al., 1981, p. 808), and who has extensive experience with, and understanding of, Deaf Culture (Elliot et al., 1987; Harvey, 1984). Whilst this appears to be the recommendation of many researchers (see section 2.5), what treatment modalities are used and preferred in the field of Deaf Therapy?

A large number of participants (72%) in Steinberg et al.'s (1998) study, stated that they would in fact prefer a d/Deaf therapist, as they understand what it means to be d/Deaf, as well as understand Deaf Culture; whereas other participants assumed that all mental health professionals would in fact be hearing and did not consider the possibility of being able to be treated by a d/Deaf therapist.

Here the researcher attempts to provide a glimpse into the possible available methods of treatment when working with the d/Deaf, in order to acquire a better understanding of the current

nature of Deaf Therapy on an international basis. Little research has been conducted into such treatment modalities in the South African context, hence the researcher's current study.

2.4.1.1 Interpreted therapy

Hoyt (1981) believes that interpreters can be of great benefit to the therapeutic interaction, and may even display an attitude of acceptance, on the part of the therapist, of the shared difficulty in communication that may be experienced by the therapist and patient. It is also said to indicate a desire by the therapist to be fully understood as well as to fully understand the client, demonstrating a respect and concern for the client as well as the therapeutic relationship (Hoyt et al., 1981).

As mentioned above, in the research conducted by Steinberg et al. (1998), it was found through interviews with d/Deaf individuals, that many preferred interpreted therapy. A reason for this may be that many d/Deaf people do not have sufficient skill in the English language, including written English, to be able to facilitate suitable communication (Freeman et al., 1981; Hoyt et al., 1981; Remvig, 1969; Steinberg et al., 1998). These findings are echoed in more recent research (Fellinger et al., 2012; Haskins, 2004; Middleton et al., 2010; Van Rooyen, 2009).

Despite this preference, many d/Deaf individuals appeared to raise concerns over the use of an interpreter or even a d/Deaf practitioner due to confidentiality issues, thus displaying a preference to be seen by practitioners from the hearing community and not the d/Deaf community (Middleton et al., 2010; Steinberg et al., 1998). Concern over confidentiality issues may arise from the small and close-knit nature of the d/Deaf community (Williams & Abeles, 2004).

Confidentiality is of particular concern when the interpreter is not a professional interpreter but rather a family member or friend that is translating (Freeman et al., 1981; Hoyt et al., 1981). Therapists and professional interpreters may be bound by codes of ethics which ensure confidentiality, however non-professional interpreters, family members or friends of d/Deaf patients, are not governed by such ethics. The anxiety over confidentiality is an important consideration in a therapeutic setting where sensitive information is being shared. It becomes problematic using family members as interpreters when a patient's troubles may centre on the

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family. A related issue, brought to light by Roberts and Hindley (1999), is that a therapist should inform the patient of who will be interpreting ahead of the time, even in the case of professional interpreters, as some interpreters may be known personally to the patient and therefore will not be able to take part in the therapy due to matters of confidentiality.

The participants of Steinberg et al.'s (2006) study which comprised of d/Deaf adults, stated that interpreters with medical knowledge are preferable but are not often available to aid with communication between d/Deaf patients and their practitioners. These participants expressed dissatisfaction with alternative measures to the use of interpreters, e.g. 'speechreading' otherwise known as lip reading, written communication, or telephone communication (Steinberg et al., 2006). With regards to 'speechreading', participants felt that it was considered inadequate as an alternate means of communication due to unavoidable or unintentional physical barriers that may impede communication, such as the practitioner's facial features or the use of surgical masks (Steinberg et al., 2006). Whilst surgical masks are not typically used in the therapeutic setting, there are bound to be physical barriers at times that may make lip reading an inadequate means of communication in the therapeutic setting, for example the therapist may have facial hair or smaller lips. This can be seen in the quote by one of the participants of Steinberg et al.'s (2006, p. 261) study, "...his lips are very small. Even when he looks at me, it's hard for me to understand...." With lip reading the authors of the study stated that "only 30-40% of spoken English is visible on the lips" (Steinberg et al., 2006, p. 264). Written communication and telephone communication, which will take the form of written communication with transcription and text relay services, were also seen as inadequate due to difficulties experienced with the differences in syntax and vocabulary between Sign Language and spoken English (Steinberg et al., 2006).

Interestingly, one of the concerns raised by Steinberg et al.'s (2006) participants with regards to the use of Sign Language interpreters was the perception on the part of the hearing that the interpreter was for the d/Deaf individual, as opposed to being a means of facilitating communication between all parties.

Another issue with the use of an interpreter, is that it may disrupt the typical proceedings of the therapeutic relationship (De Bruin & Brugmans, 2006; Hoyt et al., 1981). Due to the fact that both the patient and therapist will have to look to the interpreter for translation, the interpreter may come to be viewed as the one who truly understands the patient and who has control over the interaction that is taking place (Hoyt et al., 1981), thereby potentially impeding the development of the therapeutic relationship between the therapist and patient. This fear may lead mental health practitioners to overvaluing direct contact with clients and undervaluing the use of interpreters (De Bruin & Brugmans, 2006).

2.4.1.2 Family therapy

Looking at older literature pertinent to the study, there is a strong focus on family therapy as a mode of therapy in working with d/Deaf patients (Harvey, 1982, 1984; Shapiro & Harris, 1976). Shapiro and Harris (1976), are of the belief that traditional psychotherapy is not effective with d/Deaf patients who also have psychological difficulties, as they have developmental limitations due to their disorders and disability, and thus they recommend the use of family therapy. They feel that hearing impaired psychiatric patients will not benefit from traditional individual psychotherapy as the treatment methods are based on symbolic interchange between therapist and patient during the course of mutually demanding interaction, and such symbolic exchange may be challenging when faced with communicative limitations (Shapiro & Harris, 1976).

2.4.1.3 Family therapy using an interpreter

Harvey (1982, 1984, 2003) is of the opinion that family therapy, when conducted with the use of an interpreter, can be very effective in treating d/Deaf individuals seeking therapeutic intervention. His reasoning for this is that the interpreter can be used as a therapeutic tool to modify family rules, challenge possible imbalances of power and encourage the use of projection and transference (Harvey, 1982, 1984, 2003). Similar arguments are made by Elliot, Glass, and Evans (1987), and Marschark and Clark (1993).

Harvey (1984, 2003) furthermore believes that, even though a therapist may be proficient in Sign Language and may be certified as an interpreter, they should not act as such in the family

therapy context whilst also providing therapy. He is of the opinion that it is not feasible to do both; to interpret for all members of the family and still provide therapy. Rather, that they should make use of the services of an interpreter, or another therapist who is proficient in Sign Language.

The use of a family member as an interpreter, is seen as potentially problematic and is commonly resented by d/Deaf individuals; whilst it might be more affordable than hiring a professional, it raises questions of confidentiality, as has been discussed (see section 2.4.1.1) (Freeman et al., 1981; Hoyt et al., 1981). Furthermore, using family members as interpreters was not seen as appropriate by participants in Steinberg et al.'s (2006) study due to feelings of exclusion in the interactions, as it was reported that family members often had the habit of speaking on behalf of and in place of the d/Deaf individual. This was echoed by the participants of Kritzinger et al.'s (2014) study where it was found that d/Deaf individuals often fail to develop the know-how or skills necessary to communicate with healthcare professionals as their parents take on the primary responsibility of communicating on their behalf. However, important information is not relayed on to the d/Deaf individual as these parents have not always developed effective communication with their d/Deaf children (Kritzinger et al., 2014). The result of this is that the d/Deaf do not learn to enquire or question new information and rather accept and go along with procedures, for example, without understanding why or for what they are being treated (Kritzinger et al., 2014). This becomes a disempowering experience for the d/Deaf and may lead to reduced confidence in healthcare settings, as well as increased feelings of mistrust and frustration (Kritzinger et al., 2014).

Harvey (1984) discusses how the presence of Freud's ego defence mechanisms in individual therapy with hearing impaired patients, can be useful in family therapy conducted with an interpreter. The role of these mechanisms are also discussed by Elliot et al. (1987) and Marschark and Clark (1993). According to Harvey (1984, 2003), an interpreter is a necessary third party to aid communication and group process in family therapy.

> The presence of an interpreter helps the therapist to modify family rules that deny the implications of deafness and prohibit the use of Sign Language, to modify the balance of power in the family, and to

encourage participants to exhibit the ego defense mechanisms of projection and transference (Harvey, 1984, p. 205).

These mechanisms come in to play in the form of speculating about what the interpreter may be thinking or feeling with regards to the interaction taking place (Harvey, 1984). The primary role of the interpreter is only to facilitate communication between all parties, not to give their opinions or advice (Harvey, 1984). Thus, the family and the therapist can only imagine and assume what it is that the interpreter thinks with regards to what is going on (Harvey, 1984). Harvey (1984), states that the family members are believed to transfer their feelings about the deaf child onto the interpreter; and conversely the d/Deaf child transfers their feelings relating to the parents, onto the interpreter. These small and subtle cues are essential and it is important that the therapist is aware of such phenomena.

Shapiro and Harris (1976) highlight the importance of an interpreter in the family therapy process through a case study example whereby they, as therapists, insisted on the presence of an interpreter during therapy so as to ensure absolute understanding and clear communication between all parties. The family did not see the point and were offended by the request, as they believed they did not need an interpreter to understand their child. However, to the parents' surprise, through the course of the interactions and the interpreter's skill, as well as the therapist's enquiries, they came to realise that they in fact misunderstood most of what the d/Deaf family member was trying to express. In the same manner, the d/Deaf patient themselves was made aware of their own misunderstandings of the family. A similar example was presented by Freeman et al. (1981) and illustrates, not that the use of an interpreter is the only way to successfully carry out therapy, but rather that a proper understanding of Deaf Culture as well as superior knowledge of d/Deaf means of communication are necessary to ensure full understanding and maximum benefit in a therapeutic context.

From the above it can be seen that there are different opinions regarding the appropriateness of using interpreters, either professional or family members, in therapy with d/Deaf patients. It would appear that there are many considerations that therapists would need to make in determining whether they choose to make use of interpreters, most important of which needs to be

the patient's comfort with using an interpreter, as well as whether preferable alternatives are available.

2.4.1.4 Group therapy

In an article by Roberts and Hindley (1999) it is proposed that therapy with d/Deaf children can take place in the context of a team, called 'The Deaf Child and Family team', made up of both d/Deaf and hearing specialists. Group psychotherapy has been suggested when working with d/Deaf children as "the common experience of deafness can give a cohesion to the group", however possible problems can arise relating to differences in the degree of deafness, system of communication and communicative ability between the children (Roberts & Hindley, 1999, p. 161).

In Altshuler and Ranier's (1966) report on their pilot clinic, they state that communication is a very important tool to alleviate the anguished mind of the d/Deaf mentally-ill. In an attempt to counter the isolation experienced by many of the d/Deaf patients, the clinic was set up in such a way as to encourage communication and develop a therapeutic community context where patients and staff can interact (Altshuler & Rainer, 1966). The basic idea behind such a design was that much behaviour is shaped in a group or social context, and that such a context may provide a relaxing environment for patients who often feel tense and anxious at not being understood and not being able to communicate normally (Altshuler & Rainer, 1966).

2.4.1.5 Individual therapy

It would appear that very little attention has been paid to the use of individual therapy with d/Deaf individuals by a psychologist trained in the evaluation, supervision and treatment of psychiatric patients with hearing impairments, as well as the effectiveness of such an approach. One possible reason for this may be that there are possibly very few Sign Language and Deaf Culture trained professionals who are able to conduct individual therapy. This is evident in the fact that most literature mentions or recommends that more mental health professionals need to be trained in dealing with d/Deaf patients, or similarly that more d/Deaf individuals need to be trained in therapy and the provision of other psychological services (Cooper et al., 2003; Cornes & Wiltshire, 1999; Shapiro & Harris, 1976; Steinberg et al., 1998).

2.4.2 Access to specialised services

When looking at more recent literature regarding service delivery it is clearly evident that there are limited services available to the d/Deaf, and of those that are available, access is restricted or problematic for the majority of the d/Deaf population (COI, 2005; Fellinger et al., 2005, 2012; Haskins, 2004; Middleton et al., 2010; Vernon, 2007; Williams & Abeles, 2004). This problem has been portrayed in an illustration by J. Fellinger whereby the burden of mental health is shown as rucksacks on the backs of people, the d/Deaf however are depicted as having larger rucksacks and a smaller door through which to access mental health services (Fellinger et al., 2012). Promisingly however, the United States and the United Kingdom have both begun to pay attention to this fact and are slowly starting to put measures in place to rectify it (COI, 2005; Haskins, 2004), which will hopefully influence such a trend in the rest of the world.

2.5 Skills Requirements and Recommendations

Much of the recent research makes reference to the skills that are considered ideal to have when working with the d/Deaf, or the manner in which services should be provided. Haskins (2004) and Middleton et al. (2010) believe that the provision of therapy in Sign Language to those fluent in sign, by therapists who are also trained in d/Deaf awareness or Deaf Culture, is most beneficial. Such a therapeutic setting allows the client to be more self-expressive and allows for more complete therapy with a lesser likelihood of misunderstanding and misdiagnosis (Haskins, 2004; Middleton et al., 2010).

Williams and Abeles (2004) believe that hearing therapists who work in the field of Deaf Therapy must be sure of their own competency, cultural assumptions they might hold, and their ability to work confidently with this population. They found that 85% of practitioners working with the d/Deaf did not have any specialised training in this area, leading them to ask the question of: what is the minimum requirement to carry out such work? (Williams & Abeles, 2004). Similarly, Vernon (2007) states that even fewer practitioners providing services to the d/Deaf had what were considered the proper credentials to carry out such work, further begging the question of what the proper credentials might be? Therapy conducted by a hearing therapist who has grown up in a hearing culture "becomes a cross-cultural and bilingual phenomenon" (Harvey, 1984, p. 207).

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Thus, it would appear that the consensus in the international community is that therapists must be sensitive to Deaf Culture as well as the psychosocial effects of deafness in order to be deemed capable of carrying out such work (Elliot et al., 1987; Harvey, 1984).

Suggestions made within the literature regarding the improvement of future d/Deaf service provision include:

- The development of dedicated psychiatric units staffed by experts in manual communication (Sign Language), Deaf Culture and relevant psychological training.

- The enforcement of existing laws, e.g. ensuring language and culture appropriate services are available to clients.

- The provision of continued education workshops by government institutions that provide d/Deaf education and Sign Language training to practitioners.

- The training of more d/Deaf individuals in professional positions within the field of mental health.

- The training of interpreters in the area of mental health services (i.e. terminology and phenomenology).

- The use of certified interpreters.

- The increased use of technology such as videophones, which allow real-time communication using a visual medium for clients that communicate via manual means, or Video Relay Services which make use of interpreters as intermediaries.

  (Cooper et al., 2003; Cornes & Wiltshire, 1999; Haskins, 2004; *Health Professions Act No. 56 of 1974*, 2006; Middleton et al., 2010; Shapiro & Harris, 1976; Steinberg et al., 2006, 1998; Vernon, 2007)

2.6 Conclusion

As indicated above, the literature review has shown that hearing impaired individuals are more likely to suffer from mental health problems than hearing individuals, and that this raises the question of why so few health professionals are adequately prepared and trained to work with the

d/Deaf (Cooper et al., 2003). This further illustrates the importance of research in such a field, so as to raise awareness of this issue, in not only research but also in training, and thus hopefully motivate the rectification of the problem. Development of specialised services for the hearing impaired is necessary to protect the rights of these individuals, as well as to encourage the development of good mental health in this population (Cornes & Wiltshire, 1999; Freeman et al., 1981).

As has been stated above (see section 2.1), research in the South African context is limited, the review of the relevant literature that has been provided may or may not be similar in the South African context, but it is the researcher's hope that through this study, a clearer picture of the nature of service provision of South African Deaf Therapy can be obtained.

3. Theoretical Point of Departure

In this chapter the theoretical framework from which the research is viewed and was carried out will be discussed. A discussion of both ontology and epistemology is put forward. Ontology refers to the nature of reality i.e. how or what is, whereas epistemology refers to how we go about acquiring knowledge of and coming to know this reality (Morrow, 2007; Willig, 2008).

3.1 Theoretical Framework

Three questions will be answered in looking at Critical Realism as a theoretical approach to the research that was undertaken:

1) What kind of knowledge does the research aim to produce?

2) What kinds of assumptions does the methodology make about the world?

3) How does the methodology conceptualise the role of the researcher in the research process?

(Willig, 2008).

The theoretical framework from which the researcher will be working is Critical Realism, a theory brought forward by Roy Bhaskar in the 1970's (Maree, 2009). As the researcher has chosen a Mixed Methods design to conduct this study, Critical Realism has been chosen as it is heralded as being a clever way in which to deal with the "paradigm wars" that often erupt between qualitative and quantitative research (Tashakkori & Teddlie, 2010, p. 146). Thus far there has been very little research conducted using mixed methods from a Critical Realist perspective (Tashakkori & Teddlie, 2010), which indicates a gap in research and further justifies the use of this paradigm. It is widely accepted that the ideal paradigm for qualitative research is that of constructivism, and for quantitative research 'post-positivist empiricism', which would imply mixed methods research being somewhat of an oxymoron (Tashakkori & Teddlie, 2010). Critical Realism, however, allows for the joining of these two seemingly opposite methods into one due to its acceptance of both methodological assumptions (Tashakkori & Teddlie, 2010).

When looking at ontology, Critical Realism rejects the notion of there being one objective reality, but rather sees reality being made up of three levels:

- *Real objects and mechanisms* (also known as the *Causal level*), which are independent of our human existence and refer to that which science has set out to discover, the "generative mechanisms of nature" (Bhaskar, 2008, p. 3)
- *Actual events*, which refers to reality as affected by those real objects and mechanisms discussed above, but which exists regardless of our interaction with it

- *Empirical experiences*, which refers to that which we live through and can experience by way of our senses, i.e. our experience of the interaction of real objects and mechanisms, and actual events

(Coghlan & Brydon-Miller, 2014; Lewis-Beck, Bryman, & Liao, 2004; Maree, 2009; Modell, 2009).

From this it can be seen that Critical Realism accepts the existence of a stable reality independent of human existence, however it rejects that this reality can be objectively or absolutely known, rather it is known subjectively and knowledge about reality is always fallible and corrigible (Modell, 2009).

When considering Critical Realist epistemology, the world is divided into *transitive* and *intransitive* domains (Coghlan & Brydon-Miller, 2014). The *transitive* domain refers to that which is constructed and given meaning through human experience and interpretation, whilst the *intransitive* refers to the world as it really is (Coghlan & Brydon-Miller, 2014; Lewis-Beck et al., 2004). Critical Realism aims to uncover causal mechanisms within the realm of the natural and social, i.e. the real objects and mechanisms which led to the production of the actual event under investigation (Coghlan & Brydon-Miller, 2014). Coghlan and Brydon-Miller (2014) state that the methodological process by which Critical Realist research in social science takes place is termed *retroduction*. In the physical and natural sciences experimentation uncovers causal mechanisms. This is possible because in the physical and natural sciences one works with closed systems or systems that can in principle be closed and controlled. However, social systems are in principle open, making experimentation difficult and sometimes impossible (Bhaskar, 1979). Thus, other approaches need to be discovered (like retroduction).

From an ethical standpoint, Bhaskar proposed that there is a connection between knowledge production and emancipation; as theory and knowledge build and adapt over time, the divide between transitive and intransitive narrows, revealing the actual reality as it may exist. (Coghlan & Brydon-Miller, 2014). Critical Realism proposes that "it is not enough to understand the social world: We must also act to change it, to further human well-being" (Coghlan & Brydon-Miller, 2014, p. 9).

Critical Realism places primary importance on understanding reality (Given, 2008). "Explanations should be rich and deep, invoking both agency and structural factors in a complex way to account for patterns in data" (Given, 2008, p. 7). When using multiple methods, each type of data can be used to provide evidence of what is happening in the world.

3.1.1 Critical Realism in this study

With regards to the proposed study, a Critical Realist approach would suggest that in trying to determine what skills might be necessary to work in a therapeutic setting with the d/Deaf, one would need to focus not only on what current service providers believe are the necessary skills, but also on what their perceptions are of working in such a field have been thus far, i.e. what challenges are they presented with in their line of work, which might suggest other skills necessary for effective therapeutic work to take place.

Humans shape society which shapes human activity i.e. the actual is caused by real mechanisms, therefore the way in which people carry out therapy is moulded by mechanisms influencing the way in which therapy can be conducted, and therefore influences future therapeutic models or practices (Coghlan & Brydon-Miller, 2014). It is these mechanisms that the researcher wishes to uncover and thus deduce what skills are necessary to provide therapy to the d/Deaf given light of these mechanisms.

In this study two types of data were collected and triangulated, with both types being based on what participants' perceptions are in each of their respective fields and sociocultural backgrounds, and uses them to ascertain an even more accurate representation of what might be determined as necessary skills to be gained in order to work therapeutically with the d/Deaf. These multiple perspectives will not only give light to the *empirical experiences* of these professionals, but also the *causal mechanisms* influencing their work.

4. Methodology

In the chapter to follow, a description of the research process is provided. An outline of the research design, description of the sample and development and implementation of the research instruments are described. Furthermore, this chapter will also include sections on the data collection process and data analysis, as well as a discussion on the ethics involved in the research study.

4.1 Research Design

The proposed study will, working from a Critical Realist perspective, be a concurrent triangulation mixed methods design. Mixed methods research is based on the assumption that combining both qualitative and quantitative approaches allows one to gain a better appreciation of the research problem at hand than with either method alone (Hanson, Creswell, Clark, Petska, & Creswell, 2005; Modell, 2009). The researcher is able to collect different forms of data at different stages either together or following one another and then interpret the results by bringing together the data from each (Hanson et al., 2005). It is argued that mixed methods approaches to research offer strengths to research designs that rectify the weaknesses of qualitative and quantitative procedures (Jick, 1979). By using both qualitative and quantitative, one method can help to elaborate on the other form of data and thus be used to complement each other (Hanson et al., 2005).

Qualitative research designs in the social sciences typically entail the detailed observation and/or questioning of research participants to gain in-depth subjective accounts which are then analysed and interpreted by the researcher (Seymour, 2001). Quantitative research, measures variables in order to obtain numerical scores which are analysed using statistical procedures (Gravetter & Forzano, 2006).

Quantitative research is criticised for not providing information about the context of the research problem, or directly paying attention to the voices and opinions of the people involved; whereas qualitative research is criticised for capturing the biases of the researcher as well as for its lack of generalisability. An argument for the use of a mixed methods design is that one type of data (qualitative or quantitative) is not able to give a complete picture of a phenomenon, so by using both one is able to obtain a more complete picture of the phenomenon under investigation (Jick, 1979). Given that the current research study aims to gain insight into a scarcely researched topic, the researcher felt that by applying a mixed methods design, allowing for more detailed and complementary data to be collected, that this will result in richer data being gathered on the topic at hand and facilitate understanding of the research problem.

In conducting mixed methods research Hanson et al. (2005) point out a number of key steps in determining the design of the research. They have identified six possible mixed methods

research designs that a researcher can utilise, each with differing purpose. In order to determine which of these is best suited to the particular research being undertaken they recommend that a researcher consider a number of factors. Aside from determining what the purpose of the study is and the research questions, they identify three additional key steps which will aid in determining which of the designs will be adopted. Firstly, they recommend that a researcher identify the theoretical framework from which the research will be conducted as this will impact the methodology and methods used. Secondly, they suggest that the researcher needs to decide how and in what order the data will be collected, and the priority given to the different forms of data. When looking at the order of data collection, Hanson et al. (2005) point out that data collection of the qualitative and quantitative data can happen either concurrently, meaning that they are collected at the same time during the same phase of the research; or sequentially, meaning that they are collected one after the other e.g. collection of qualitative data is done following the completion of the collection of quantitative data or vice versa. Priority of the data refers to whether one form or type (qualitative or quantitative) will be given more weight during the interpretation of the data or whether they will be given equal importance. Lastly, the researcher must decide at what stage of the research the data analysis and integration will occur. Will each type of data be analysed separately and then brought together in the discussion and interpretation of the research, or will one form be transformed into another e.g. will qualitative data be quantified before analysis and interpretation?

4.1.1 Triangulation mixed methods design

As discussed above (see section 3.1), the researcher decided on a Critical Realist approach as the theoretical framework from which this research was conducted, and a concurrent triangulation mixed methods design was chosen for this specific research study. A concurrent triangulation mixed methods design is seen as a validation technique or a method by which quantitative results, for example, can be enhanced by qualitative results (Hanson et al., 2005), as will be done in this study by collecting survey data which will be complemented by interviews. In this way, the triangulation of results enhances the validity of the study (Modell, 2009). Jick (1979, p. 604) states that triangulation helps "to enrich our understanding by allowing for new or deeper dimensions to emerge". Triangulation further enhances the strengths of both qualitative and quantitative designs and offsets the limitations of each (Jick, 1979).

The triangulation design used in this study, using the convergence model, consisted of two research phases that took place simultaneously, whereby quantitative data by means of a survey, and qualitative data by means of semi-structured interviews were collected (Creswell & Plano Clark, 2007). The two methods were given unequal weighting in the study with the quantitative data being of major focus and the qualitative data being supplemental to that (Creswell, Plano Clark, Gutmann, & Hanson, 2003). The results of both were merged in the interpretation phase of the study (Creswell et al., 2003).

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Quantitative data was given more weighting as it is here the researcher could determine what skills current practitioners working within the field of Deaf Therapy have. This will hopefully aid others who currently work or wish to work in the field, in determining what skills they currently have that will help them in this endeavour and which skills and training they may still require. The qualitative data which looked at the challenges faced by professionals in the field of Deaf Therapy and what skill demands are being placed on them, is used to enhance the quantitative data and provide recommendations for professionals as to what other skills may be necessary, skills which they may not necessarily have themselves as yet but feel would be beneficial.

The research design can be seen in Figure 1 below. In the figure, the capitalised 'QUAN' refers to the quantitative data collection, the data which is given priority. The lower case 'qual' refers to the qualitative data collection, the data which is given less weight and is supplemental to the quantitative data. These two forms of data are collected at the same time, are analysed separately and brought together in the interpretation phase of the research.
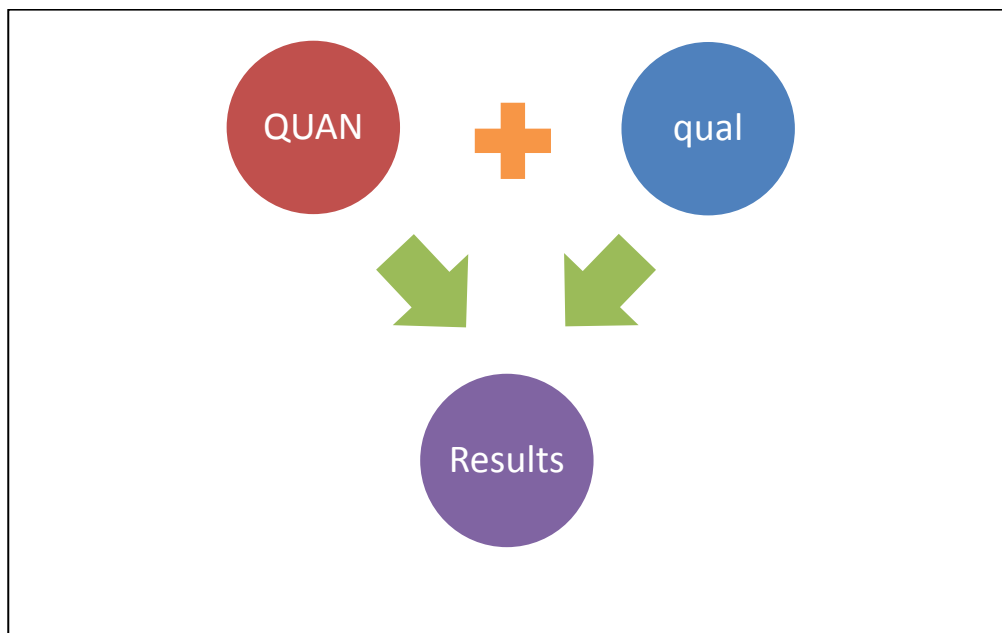
Figure 1 Concurrent triangulation mixed methods design

4.2 Sampling Strategy

This study made use of nonprobability sampling and used the method of respondent-assisted sampling. Nonprobability sampling was chosen as the total population of the sample is not known to the researcher and therefore, the probability of a particular member of the studied population being selected for the sample could not be known (Feild, Pruchno, Bewley, Lemay, & Levinsky, 2006). Furthermore, due to the population size being unknown the estimated sample size for both the survey and interviews could not be suggested either.

Respondent-assisted sampling, which is seen as an extension of nonprobability sampling, is utilised when the researcher gains assistance from those who would form part of the identified

population, to gain access to individuals in order to make up the research sample (Daniel, 2012). This method is used in circumstances such as that of this study, whereby the population under investigation is rare and difficult to locate and penetrate (Daniel, 2012). As has been discussed in the literature review (see section 2.2.2)(see section 2.4.1.1), the d/Deaf community, including service providers to the d/Deaf, is a small and closed community making it particularly difficult to enter by a hearing individual, such as the researcher, due to negative perceptions held about non-group members (Fellinger et al., 2005; Steinberg et al., 1998; Williams & Abeles, 2004).

4.3 Description of Participants

The relevant target population can be identified as any professional in the South African context providing on-going or frequent therapeutic services to any member of the d/Deaf community as has been defined by this paper. This definition is not limited to registered mental healthcare practitioners but may include professionals such as Social Workers, Nurses, Pastors, etc. who provide therapy and mental health support to the d/Deaf.

In order to make contact with initial respondent-assistants the researcher began by making contact with schools for the d/Deaf in the Gauteng area, and enquiring whether they knew of any professionals who fit the sample criteria that they referred students or families on to that were in need of mental health services. The researcher was able to come into contact with a psychologist working in the field of Deaf Therapy who expressed interest in the research study and was willing to aid the researcher in sample gathering. This individual became the researcher's primary respondent-assistant.

The researcher went on to make contact with d/Deaf schools throughout the country in order to gain access to other potential respondent-assistants. The reason for contacting schools for the d/Deaf was that schools often have information and access to services that may aid their student population, these services often become trusted services by members of the schools' community. Given that the d/Deaf community is typically a closed community, it was important that the researcher made contact with individuals specialised to work within the community and who were trusted service providers in order to gain access to other professionals that could form part of the research. Respondent-assistants gained through this process were asked to identify others who can be included in the identified population and enquire as to whether they would be willing to partake in the study. In this way, should the individuals who have been identified not wish to be included, their anonymity will still be maintained. Individuals who were willing to participate in the research were asked to recruit other members of the population known to them, as well as to refer the researcher on to other potential respondent-assistants they may know in other provinces. This sampling procedure is known as respondent-driven sampling and is a subtype of respondent-assisted sampling (Daniel, 2012).

An email was also sent to professionals within the Psychology, Social Work and Communication Pathology departments of the University of Pretoria, to contacts at both DeafSA and the SASMHD (South African Society for Mental Health and Deafness) as well as members of the organisation PsySSA (Psychological Society of South Africa) so as to widen the search for potential participants.

4.4 Data Collection

Being a triangulation mixed methods design, the data collection took place concurrently in the form of a survey administered to the total sample as well as interviews held with those individuals included in the research sample who were willing and able to participate in an interview (Creswell et al., 2003). The researcher had originally wanted to interview only those living in the Gauteng area, by means of face-to-face audio recorded interviews, however due to the small number of participants gained for the study and the desire to gain additional qualitative information to enrich the quantitative data, the researcher went on to invite the other participants in all provinces to be part of the qualitative phase by means of emailed interview agendas.

4.4.1 Quantitative data collection

As has been indicated above (see section 4.4), there were two differing sets of data being collected in this study. The first set of data, the quantitative set, was collected by means of a survey aimed at gathering data regarding the skills currently utilised and those believed necessary to work with the d/Deaf, by professionals who currently provide such services. These were distributed via email invite to individuals fitting the sample criteria and who had shown willingness to participate after being approached by the respondent-assistants or other participants. The participant was invited to take part in an online survey made available on a site called Survey Monkey (https://www.surveymonkey.com/). The email invite contained details of the research, the purpose of the research, as well as information regarding the voluntary nature of participation, and lastly a link which would direct participants to the survey.

4.4.2 Qualitative data collection

The second set of data, the qualitative set, was collected by means of either a semi-structured interview approximately 30 minutes long, or emailed interview agendas. These interviews aimed at exploring the challenges faced by these service providers, and what skill demands are being placed on them in order to effectively provide therapeutic support to the d/Deaf. The semi-structured interviews were tape recorded to allow transcription and analysis of the data.

4.5 Measuring Instruments

4.5.1 Quantitative survey

With regards to the survey instrument used in the quantitative phase of this study, a tailor-made instrument was designed informed by the research question and literature pertinent to this field. This survey was made available online and individuals fitting the sample description were directed to the online survey for participation. An online survey, otherwise known as a web-based survey, is a means of collecting data through the use of a questionnaire that is made available electronically, and can be accessed, completed and returned to the researcher via the internet (Archer, 2003). During the construction of the survey instrument the researcher was guided by the following recommendations cited in the work of Babbie (2008) and Gravetter and Forzano (2006); to ensure the questions are clear and their meanings are easily understood, to make sure questions remain relevant to the information the researcher wishes to gather, and to ensure questions remain unbiased in that they do not encourage a particular pattern of responding. The survey consists of 28 questions which vary between multiple choice-type formats where the participant can choose a response from a list provided, and open-ended questions. Please see Appendix B at the end of this paper to view the Survey Questionnaire.

4.5.2 Qualitative interviews

Due to the fact that semi-structured interviews do not yield to a strict interview schedule with defined questions and answers, no rigorous question schedule was developed for this portion of the study (Smith, Flowers, & Larkin, 2009). However, the researcher developed an interview agenda consisting of 10 open-ended questions that were used to guide the face-to-face interviews and were sent in an email for the emailed interviews. During face-to-face interviews the researcher was further guided in their questioning based on the participants' responses (Willig, 2008). This allowed the interviewer to gain more detailed information about the participants' particular perceptions, and also allowed the participants to speak freely (Smith et al., 2009). The questions asked by the interviewer guide and control the focus of the conversation rather than the nature of the answers, so that the interviewer may obtain the desired information (Willig, 2008). Each of the face-to-face interviews were approximately 30 minutes long. Please see Appendix C at the end of this paper to view the Interview Agenda.

4.6 Data Analysis

The data analysis process that was used consisted of three stages, each of which is discussed below:

- Stage 1: The researcher conducted separate analysis of the qualitative and quantitative data, which for the quantitative data included coding, scoring and statistical analysis i.e. descriptive statistical analysis (see section 4.6.1), and for the qualitative data

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transcribing the interviews and the development of themes i.e. thematic analysis (see section 4.6.2).

- Stage 2: The researcher then merged and compared the two forms of data answering the following questions:
  - To what extent do the two forms of data converge?
  - To what extent does the qualitative data validate the quantitative data?
  - What similarities and what differences are present between the two sets of data?
- Stage 3: Finally, the researcher interpreted the findings in the form of a discussion whereby statistical information regarding the current and preferred practice of Deaf Therapy is provided, as well as information regarding the relationship between the qualitative themes in order to support the quantitative findings (see section 6.1).

(Creswell & Plano Clark, 2007)

When looking at Stage 1 of the data analysis process, this can be divided further into different levels or steps in the process. At the outset, upon obtaining the differing sets of data, the researcher first prepared the data for analysis and inspected it for initial visible trends. In terms of the quantitative data, this entailed scoring the data according to predetermined values for each item and then reviewing and cleaning the data so as to ensure workable figures from which meaningful information was obtained (Creswell & Plano Clark, 2007).

In terms of the qualitative data, this involved preparing the audio recorded data for transcription and deciding on the particular transcription notation the researcher would like to make use of in order to capture the desired information (Creswell & Plano Clark, 2007; Willig, 2008). The researcher then also transcribed all interview material and began making records of their preliminary thoughts regarding the data (Creswell & Plano Clark, 2007). This step also involved the development of a codebook which included the general themes present in the interviews; these codes were also determined by the literature relevant to the study and were developed throughout the analysis of the data (Creswell & Plano Clark, 2007).

The next step was to begin actual analysis of the data. Here, the researcher coded qualitative data and examined trends present within and between both forms of data (Creswell & Plano Clark, 2007). From here, Stage 2 of the data analysis process began and is explained later in this paper (see section 5). Descriptive statistics are used to analyse the quantitative data, whereas thematic analysis is used to analyse the qualitative data.

4.6.1 Descriptive statistics

Descriptive statistical analysis is used to provide a description of quantitative data, which typically relies on summaries, frequencies, and measures of central tendency such as mean, medium and mode (Gravetter & Wallnau, 2002). Descriptive statistics are typically distinguished

from inferential statistics in that they are not used to make generalisations or inferences about the larger population (Gravetter & Wallnau, 2002). As a non-probability sampling strategy was used, and for the purposes of this research, inferential statistics were deemed to be inappropriate, and as such, descriptive statistical analysis has been used to describe the data which was collected from the online survey.

4.6.2 Thematic analysis

Thematic analysis is a qualitative data analysis technique used to identify emergent patterns or recurring "themes" within a data set, through a rigorous and systematic investigation of the data, allowing for a rich description of data as it pertains to the research problem (Braun & Clarke, 2006). Braun and Clarke (2006) identify six phases of thematic analysis, which include:

1) Familiarisation with data,

2) Generating initial codes,

3) Searching for themes among codes,

4) Reviewing themes,

5) Defining and naming themes, and

6) Producing the final report.

In phase one, the researcher needs to read and re-read the data in order to familiarise him/herself with it, and begin to identify patterns which occur both within and across data sets (Braun & Clarke, 2006). Transcription of the data forms part of this phase as it already provides the opportunity to actively engage with and become familiar with the data (Braun & Clarke, 2006). During the second phase, initial codes which represent areas of meaning and regularity that are of interest to the researcher are generated (Braun & Clarke, 2006). This process of reduction allows the researcher to analyse more specific units of data. In phase three, the various codes are combined by looking at the relationships between them so as to create overarching themes which accurately describe and reflect the data (Braun & Clarke, 2006). This is then followed by a stage of review in the fourth phase, whereby the researcher reviews the themes, their relation to the data, and their ability to address the research question/s (Braun & Clarke, 2006). If the themes are insufficient, additional coding and development of themes is required (Braun & Clarke, 2006). Once the researcher is satisfied with the themes that have emerged during analysis, each of the themes need to be defined in terms of what they are, what they mean, and names need to be attached to the themes (Braun & Clarke, 2006). This comprises the fifth phase of thematic analysis. Finally, in the sixth phase, the themes are incorporated into the final report which discusses the process of analysis, the themes which were identified, and what the themes can contribute to the purpose of the research (Braun & Clarke, 2006).

The identification of themes was achieved using both an inductive and theoretical approach to the thematic analysis. The researcher began with specific instances of themes and formulated patterns and themes in a bottom up approach (inductive), however was also informed by literature pertinent to the study when developing themes and looking at the relationships between codes and themes (theoretical) (Braun & Clarke, 2006). Furthermore, themes were identified at the semantic level, meaning that the researcher looked at and developed codes and themes from what participants had explicitly said or written, describing semantic content and then moving onto interpreting and theorising about the meanings of the themes (Braun & Clarke, 2006).

4.7 Data Quality

The method employed in this study (triangulation mixed methods design) aims at validating data through the use of multiple forms of data and the comparison thereof (Creswell, 2014; Creswell & Plano Clark, 2007). In the discussion section of this paper (see section 6), the quantitative and qualitative data are compared and validated. Themes and prominent topics identified in each of the data sets were converged to form a final discussion of findings and recommendations.

Validity of the research was further ensured through the careful construction of the measurement instruments (survey and interview agenda) and their items, through consultation with relevant literature and continual consideration of the aim of the study (Creswell & Plano Clark, 2007).

Reliability was ensured in this study by presenting all participants with the same survey and interview agenda (Babbie, 2008). Although interview questions were further guided by participant responses, the same interview agenda was used as a guide for participant interviews and formed the primary focus of the interviews.

4.8 Ethics

The first major ethical consideration of this study that is laid out by the Health Professions Council of South Africa (HPCSA) is that of legal compliance by the researcher (*Health Professions Act No. 56 of 1974*, 2006). The researcher therefore ensured that all activities carried out were legal and followed the international and local standards set out regarding research conducted on human participants, as well as obtained permission to carry out the research from the Ethics Committee of the Faculty of Humanities, University of Pretoria (*Health Professions Act No. 56 of 1974*, 2006).

Another ethical consideration discussed by the HPCSA (*Health Professions Act No. 56 of 1974*, 2006), is that of informed consent. Due to the nature of the online survey, it was difficult to obtain written consent from every participant for this section of the research. Therefore the researcher included in the email invitation to the survey, information relating to the confidential nature of the research as well as that their participation was voluntary and that they were able to

withdraw from the research at any stage by either exiting the survey before completion, or contacting the researcher to withdraw their information. There were no foreseeable risks to participating in the research, other than possible fatigue. With regards to those participants who formed part of the qualitative phase, participants were asked to complete an informed consent form prior to the commencement of the interview. Please see Appendix A for the consent form.

Both the quantitative and qualitative data will be stored for 15 years in the Department of Psychology archives, with only the researcher having access to the raw data and identifying information of respondents (Whitley, 2002).

5. Presentation and Analysis of Data

In this chapter both the quantitative and qualitative data is presented and an analysis of the data is put forward.

5.1 Quantitative Data

Quantitative data was collected by means of an online survey posted on the site, Survey Monkey (https://www.surveymonkey.com/). Participants were sent email invites containing a link to the site where they could partake in and submit their survey online. There were a total of six participants who took part in the survey. The demographics of the participants is provided followed by descriptive statistics for each of the questions participants were asked in the survey.

5.1.1 Demographics

Seven participants from around South Africa responded to the online survey; however one of the participants' surveys was incomplete on majority of the questions, assumedly due to technical problems and was thus removed from the data set. Due to the survey being captured and returned anonymously without extensive identifying information, it would be difficult to determine the exact identity of the individual whose survey was incomplete and contact them to determine whether they would be able to re-respond to the survey. The number of participants included in the final quantitative data analysis was therefore six (N=6). Participants were required to be professionals working in the field of Deaf Therapy, meaning that they provide therapeutic services and mental health support to the d/Deaf, in the South African context. Whilst one of the participants indicated that they do not provide therapy to the d/Deaf themselves, they do have knowledge and understanding of factors involved in working with the d/Deaf and in Deaf Therapy as they provide training to students on hearing impairment. This participants' survey was included in the data as they are a practitioner working in the greater context of Deaf Therapy and therefore can be seen as indirectly providing mental health support through the training of future practitioners possibly entering the field of Deaf Therapy; the researcher felt that their insights would therefore add value to the study. Only those categories under each item that received responses are presented below. Categories that received no responses are not presented in the figures below. The full survey containing all categories presented to participants in each of the items can be seen in the Appendix B. The demographics of participants are presented below.
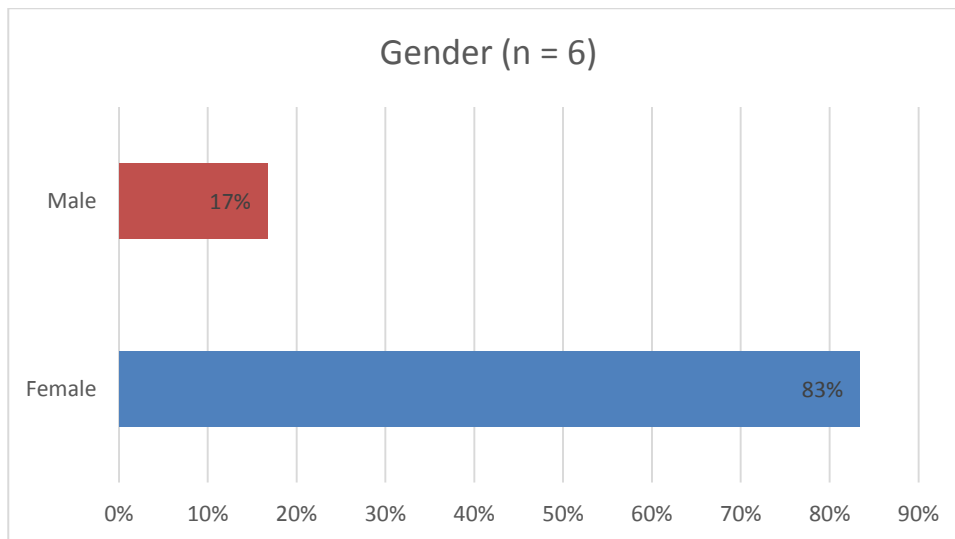
Figure 2 Gender of participants

In Figure 2 the gender of participants is displayed. From this it can be seen that the majority of participants were female (83%).

Table 1 Age of participants

Age		
Minimum Age	Maximum Age	Average Age
30	60	40.33

In Table 1 the age of the participants is presented. The minimum age of participants was 30 years and the maximum age 60 years, making the average age of participants who responded to the survey 40 years old.
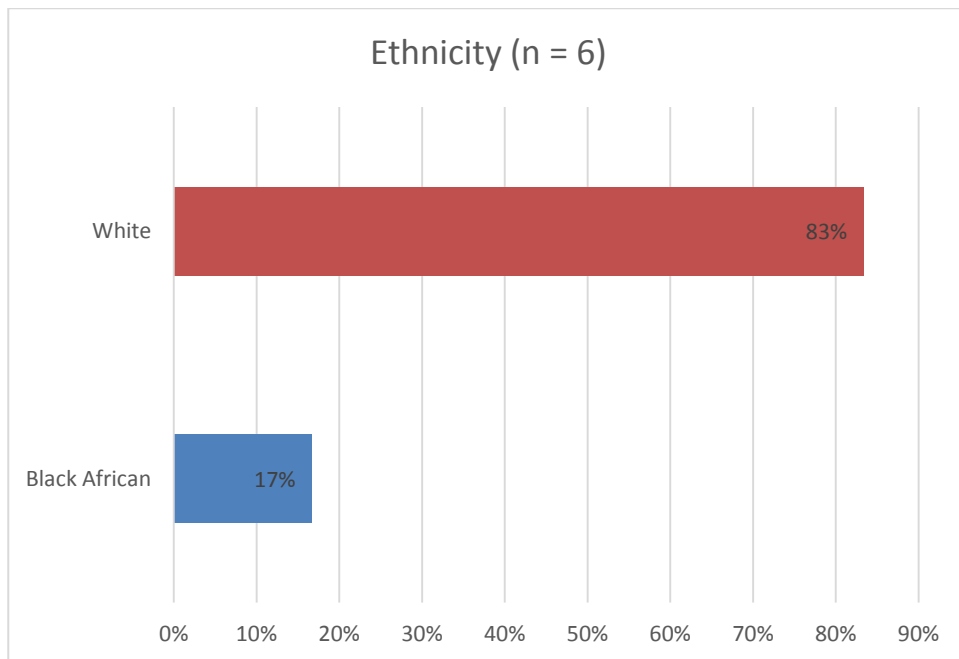
Figure 3 Ethnicity of participants

From Figure 3 above, it can be seen that participants responding to the survey were from White or Black African ethnic groups, with the majority of the participants being White (83%).
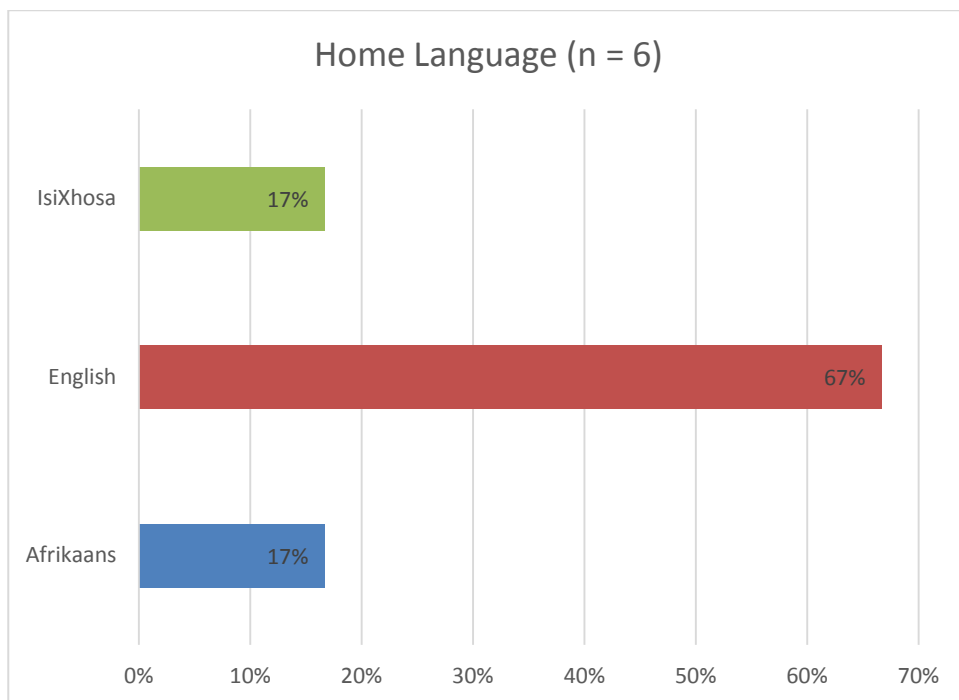
Figure 4 Home language of participants

There were more English home language speakers in the participant sample (67%) as can be seen in Figure 4 above. Of the other participants, 17% were IsiXhosa home language speakers and 17% Afrikaans home language speakers.

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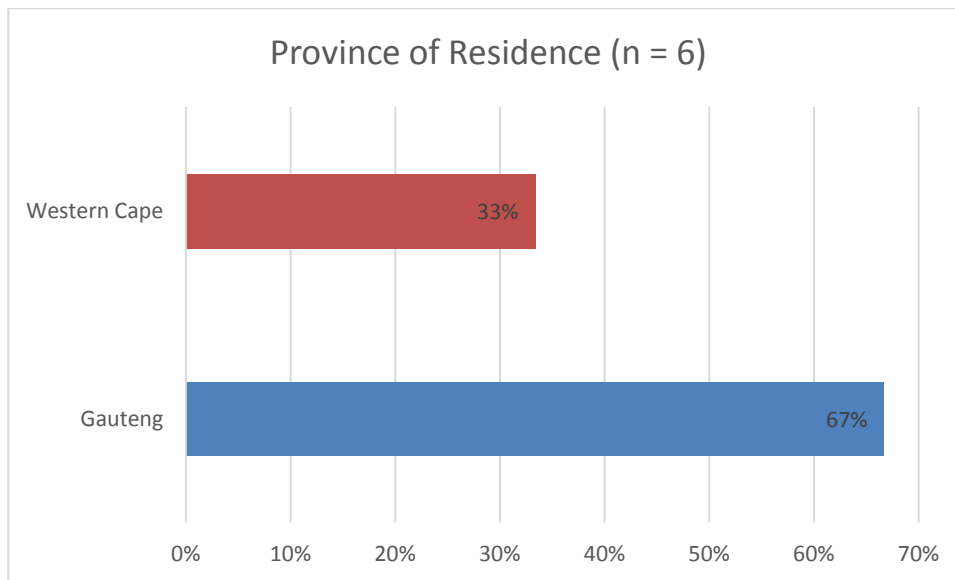
Figure 5 Province of residence of participants

Participants reside in the Western Cape and Gauteng provinces, with more than half of the participants residing in the Gauteng province (67%). Participants from the Western Cape made up the remaining 33% of the sample. This is seen in Figure 5 above.

5.1.2 Survey results

In the following section the results of participant responses on each of the non-demographic survey items will be presented and discussed.
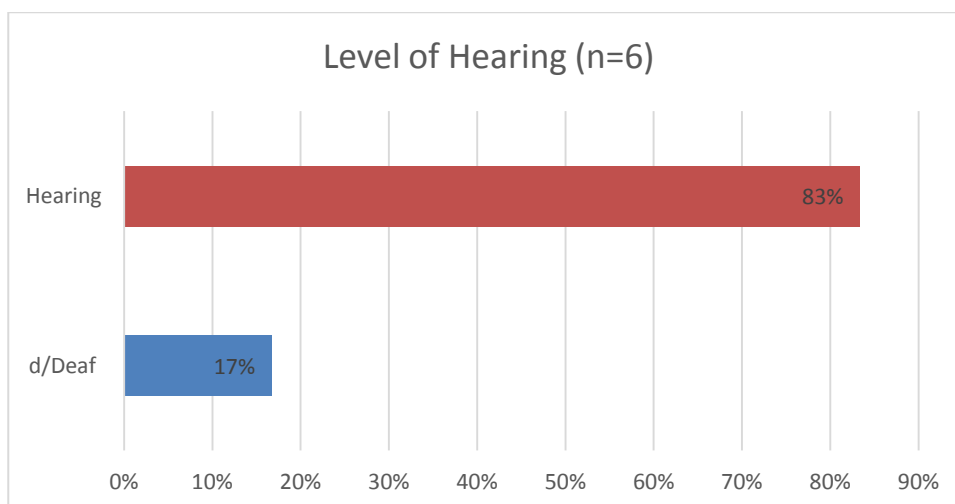
Figure 6 Level of hearing of participants

As can be seen in Figure 6 above, participants were predominantly hearing, comprising 83% of the sample, with 17% i.e. 1 participant being d/Deaf. As in the write up of this study the term d/Deaf in the survey referred to individuals who are deaf, Deaf, hard of hearing, deafened or hearing impaired.
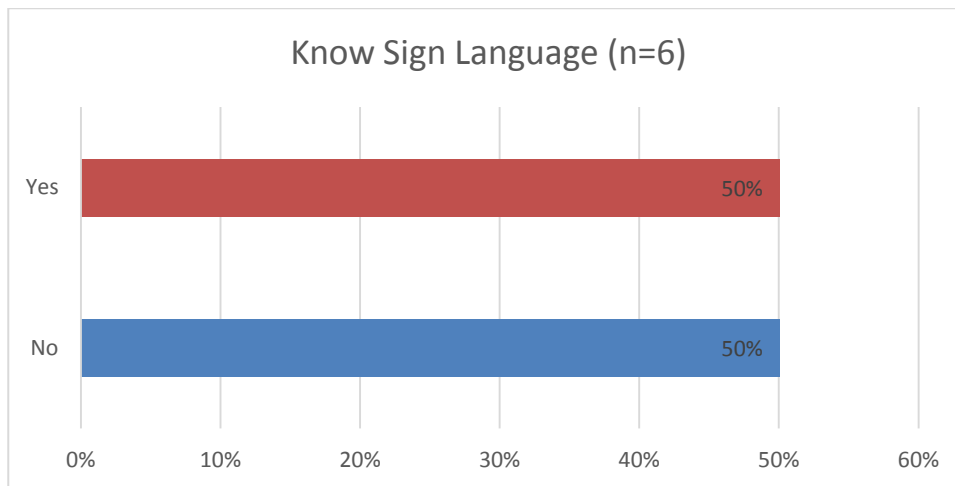
Figure 7 Knowledge of Sign Language of participants
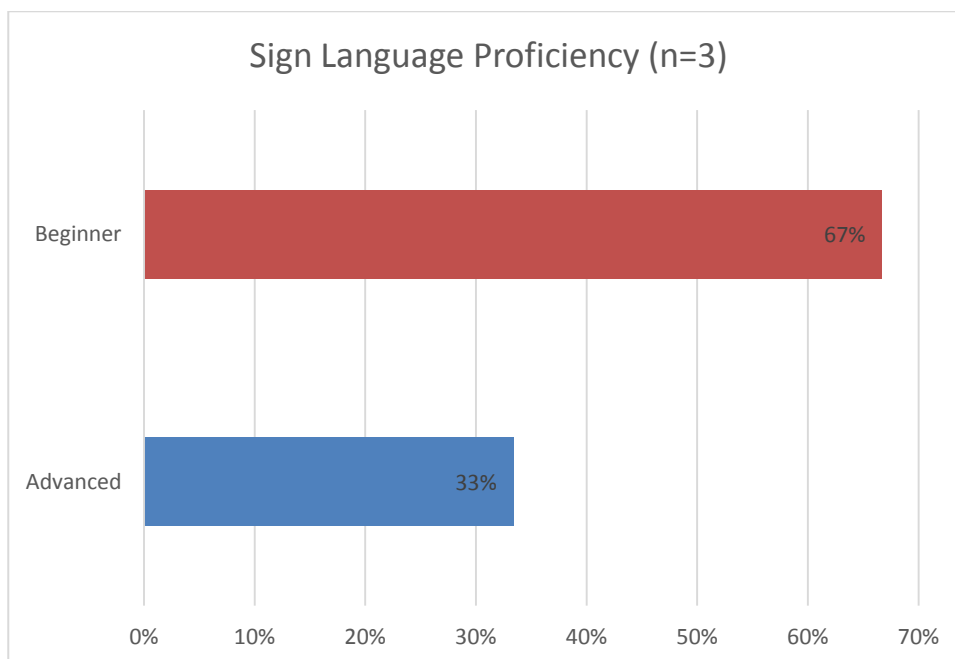
Figure 8 Sign Language proficiency of participants

Participants were asked whether or not they know Sign Language. There was a fifty-fifty split between those participants who had knowledge of Sign Language (50%) and those who did not (50%). This is presented in Figure 7 above. Of those who indicated that they had knowledge of Sign Language, they were also further asked their level of training or proficiency in Sign Language, as well as where they had received their training. Sixty-seven percent of the participants with knowledge of Sign Language indicated that their proficiency or training was at beginner level, whereas the remaining 33% indicated advanced knowledge or training, as can be seen in Figure 8 above. All participants with knowledge indicated that they learnt Sign Language in their respective fields and work contexts with the d/Deaf and through exposure to the d/Deaf community. One of the participants however indicated that they had received advanced training at a tertiary institution in Gauteng as a second major.

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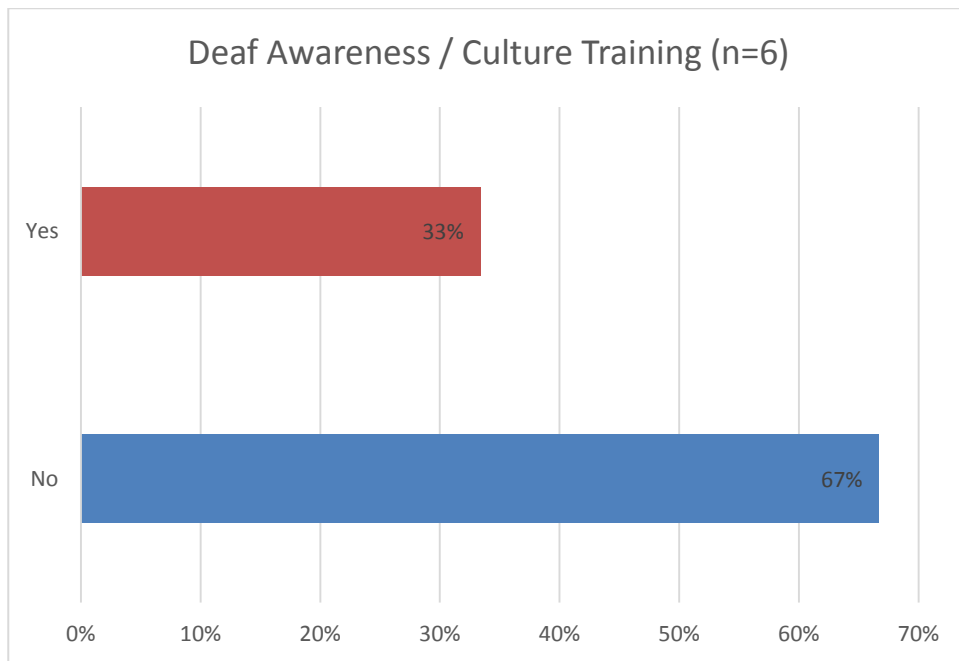
Figure 9 Participant training in Deaf Awareness/Culture

Figure 9 shows that of the six individuals who responded to the survey 33% of them indicated that they had received training in Deaf Awareness or Deaf Culture, the remaining 67% indicated no such training. Those who indicated having undergone training were also asked what training they had completed, as well as when and where they had completed this training. Training in Deaf Awareness or Deaf Culture was received by these participants during their respective undergraduate degrees during Linguistic or Sign Language courses offered at Rhodes University and the University of Witwatersrand in the years 2000 and 2006.
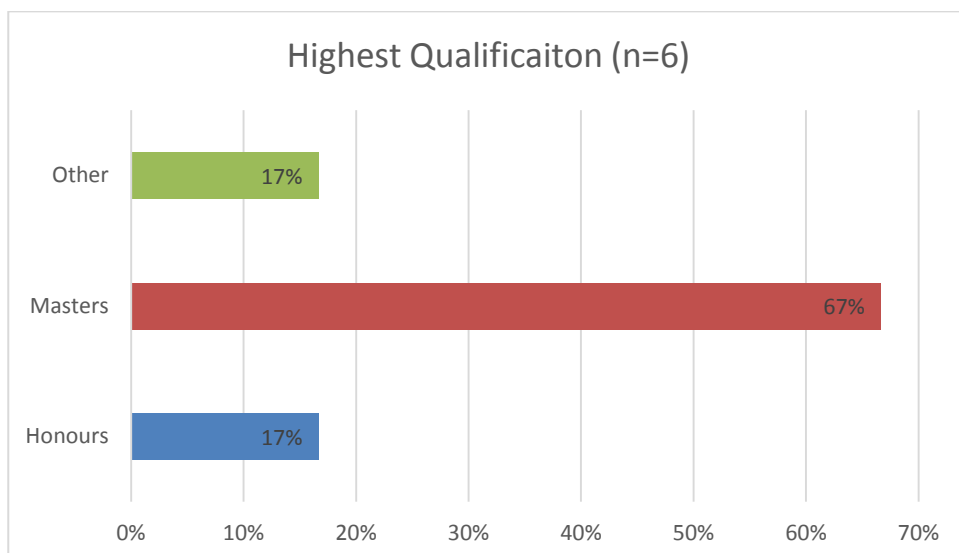
Figure 10 Highest level of education of participants

As seen in Figure 10 above, 67% of the participants indicated that their highest level of education was a masters degree, 17% indicated having an honours degree and 17% Indicated 'Other', further specifying a diploma as their highest qualification.
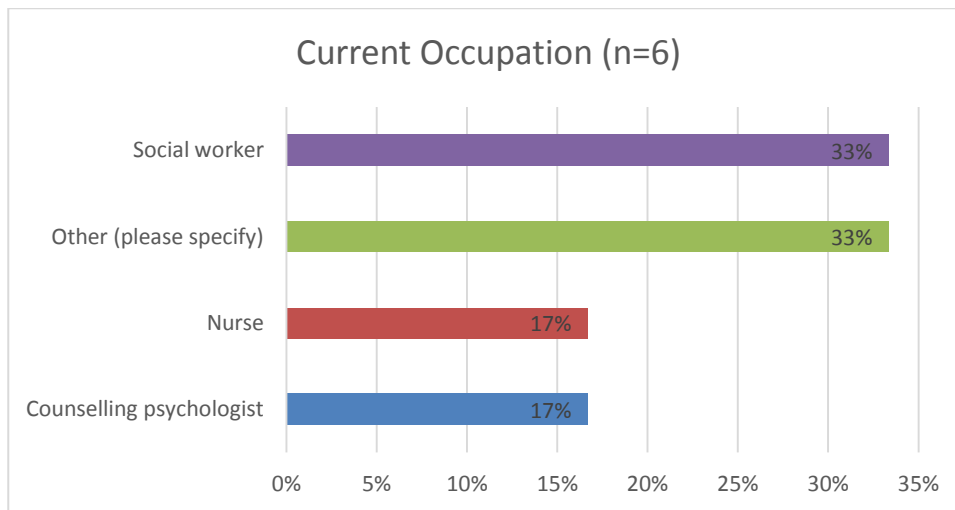
Figure 11 Current occupation held by participants

When asked about their current occupation, majority of the participants indicated either being Social Workers or Educational psychologists (represented by the 'Other' response where participant specifications for this category were signified as being Educational Psychologists), with both categories each making up 33% of the participant sample. Seventeen percent of the participants are working under the category of Nurse, and 17% under the Counselling Psychologist category. This is represented in Figure 11 above.

Table 2 The length of time participants have worked in their field

Participant Length of Time Working in Field (years)		
Minimum	Maximum	Average
3	12	6.33

Table 3 The length of time participants have worked with the d/Deaf

Participant Length of Time Working with d/Deaf (years)		
Minimum	Maximum	Average
0	10	4.33

Participants were asked how long they have worked in their current professional fields, as well as how many years working experience they had with the d/Deaf. From Table 2 and Table 3 above it can be seen that the minimum amount of time that these professionals have been working

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in their respective fields at the time of their responses is 3 years and the maximum is 12 years, with the average amount of time participants having spent in their fields being 6 years. The minimum number of years experience working with the d/Deaf amongst the participants is 0 years, indicating that less than a year's experience had been gained at the time of them taking the survey, the maximum number of years experience is 10 years with the average number of years of experience held by the participants on this survey being 4 years of experience working with the d/Deaf. This may indicate that participants generally did not go straight into practice in their fields working with the d/Deaf, but rather came to work in the d/Deaf community after already working in their field of practice for a short while.
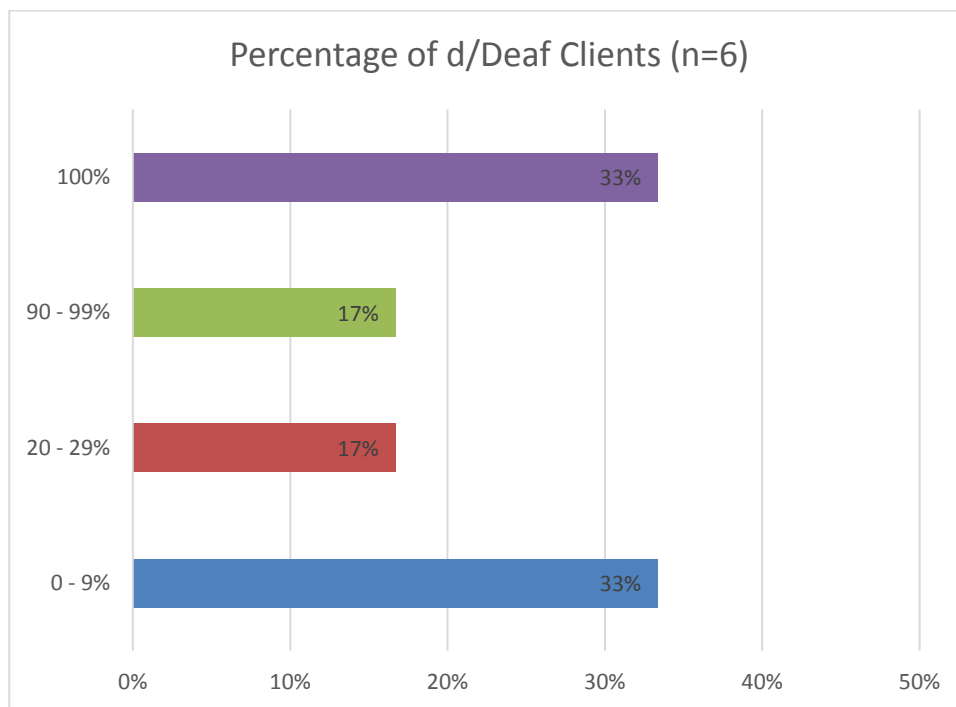
Figure 12 The percentage of participants' clients that are d/Deaf

The percentage of clients seen by the participants in their line of work who are d/Deaf is seen in Figure 12 above. Thirty-three percent of the participants indicated that 100% of their clientele is d/Deaf and 17% of the participants indicated that their clientele is made up of 90-99% d/Deaf individuals, suggesting that for half of the participants their current service provision is geared primarily towards the d/Deaf community. Another 17% of the participants indicated that their clientele is made up of 20-29% d/Deaf individuals, and lastly 33% of the participants indicated that only 0-9% of their average clientele is made up of d/Deaf individuals.
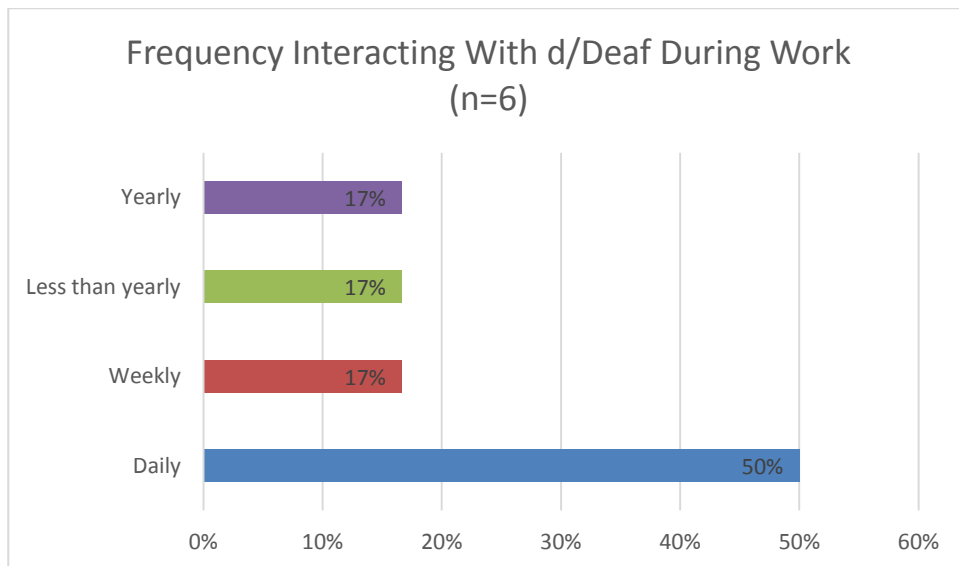
Figure 13 Frequency with which participants interact with the d/Deaf in their work environment

Figure 13 above shows the frequency with which participants interact with the d/Deaf community in their work environments. Fifty percent of the participants interact with d/Deaf individuals on a daily basis, whereas 17% interact on a weekly, 17% on a yearly and 17% on less than yearly basis with the d/Deaf community.

This furthermore supports the data above which indicates that for 50% of the participants, their work and service provision would appear to be primarily geared towards service provision to the d/Deaf. Whilst 50% might seem significant and show some promise for service provision to this community in the South African context, it only represents 3 individuals from the researchers sample population.

Figure 14 Services provided to the d/Deaf by participants

Participants were asked to describe the services they provide to the d/Deaf in an open-ended question. Participants' responses were inserted into an internet based analysis tool called Wordle (http://www.wordle.net/) which creates a 'world cloud' displaying words and giving greater prominence to those which appeared more often in the text (Feinberg, 2013). This can be seen in Figure 14 above. For the relevant frequency table, please see Appendix D. From their responses it would appear that the majority of the services provided to the d/Deaf by the participants of the study are individual therapy, particularly to children within the schooling system. Whilst therapeutic services to adult d/Deaf individuals, d/Deaf families and therapy in group contexts as well as assessment of the d/Deaf were also more prominently identified in participant responses, the majority of services would seem to be provided to d/Deaf children in individual therapy. Other services mentioned included medical care to the d/Deaf, training in disability and hearing impairment, and teaching.

Figure 15 Modes of communication used by participants when interacting with the d/Deaf outside of therapy

Figure 15 shows the modes of communication used by the participants outside of the therapeutic setting when interacting with the d/Deaf. This question allowed for multiple selections. Sixty-seven percent of responses indicated the use of oral means of communication, which refers to communication utilising spoken language where the d/Deaf individual may rely on lip reading (Hyde & Punch, 2011). Sign Language was the next most prominent mode of communication, being represented by 50% of the participants, with 17% indicating that they make use of an interpreter when communicating with the d/Deaf outside of the therapeutic setting. One of the participants indicated their response as being 'Other', reporting that they have not been trained in Sign Language. From this, the researcher can only presume that when interacting with the d/Deaf, that this participant may utilise any of the other modes of communication apart from Sign Language, however this cannot be precisely determined.
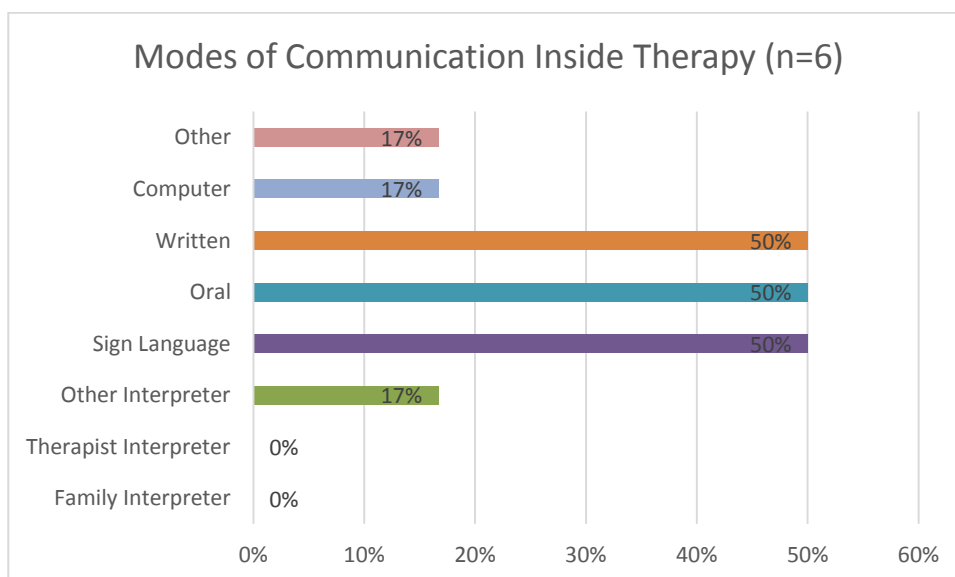
Figure 16 Modes of communication used by participants when interacting with the d/Deaf within the therapeutic context

Figure 16 displays the different means of communication used by the participants when working in the mental health context, providing mental healthcare to the d/Deaf. This question allowed for multiple selections. Participants indicated that they primarily use written communication, oral communication and Sign Language as their primary means of communication in the therapeutic context (each of these categories were chosen by 50% of the participants). Seventeen percent of the participants indicated that they make use of an interpreter other than a family member or therapist as an interpreter when working with the d/Deaf. Seventeen percent indicated that they use computer assisted communication in therapy which may include video relay services or using the computer to type out communications between therapist and client. Lastly, one of the participants indicated that they do not work directly in a therapeutic context with the d/Deaf, this accounted for the 17% 'Other' response.
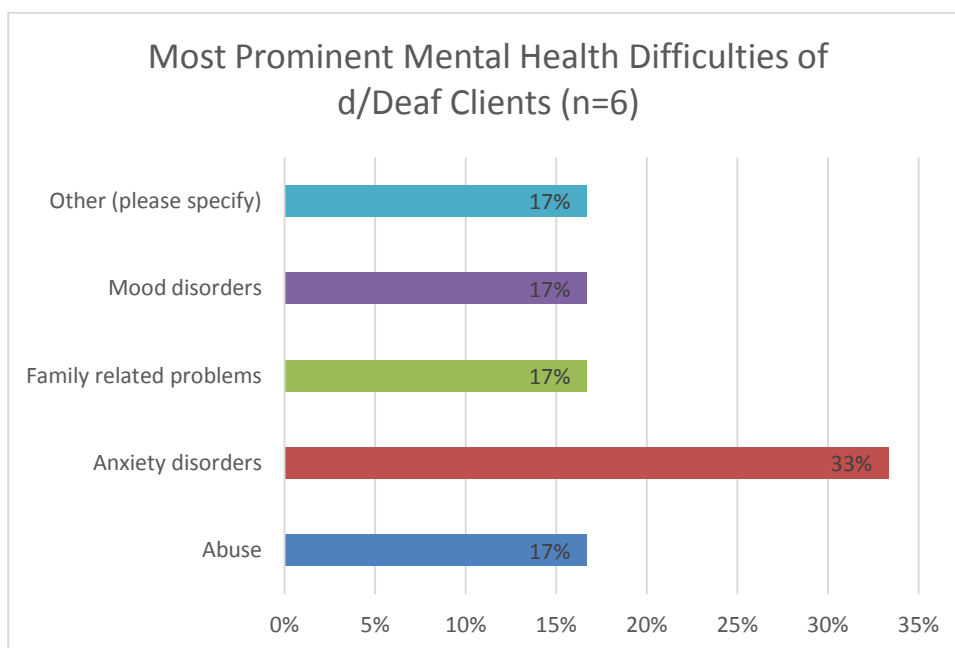
Figure 17 Most prominent mental health difficulties of d/Deaf clients seen by participants

As can be seen in Figure 17, participants indicated that the primary mental health concern they encountered working with the d/Deaf community was anxiety disorders, representing 33% of participant responses. This corroborates the research done by Landsberger and Diaz (2010) who identified in their patient sample in the United States that anxiety disorders were one of the most, although not the most, prominent mental health concerns of the d/Deaf in their study. Other prominent mental health concerns indicated by participants were mood disorders, family related problems and abuse, each being represented by 17% of the participants. Again, one of the participants chose the 'Other' category as they do not work directly with the d/Deaf and therefore are not directly confronted with the mental health concerns of the d/Deaf.
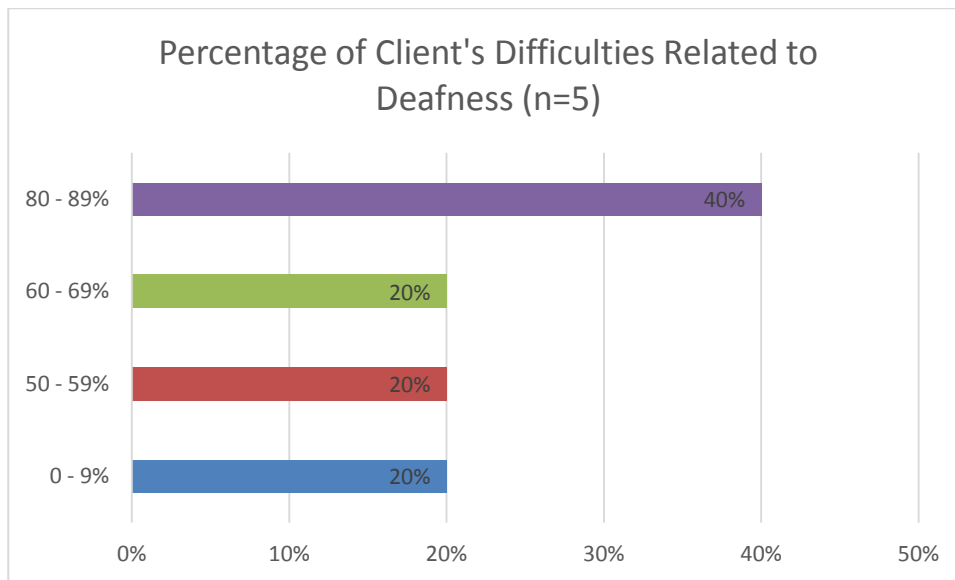
Figure 18 The percentage of clients' difficulties related to their deafness

In Figure 18, the participants' perceptions on what percentage of their clients' difficulties is directly related to their deafness can be seen. Only five of the participants' responses are indicated as one of the participants chose not to answer this question, indicating that they could not express the complexity of the relationship between deafness and mental health in narrow percentages. This may point to a possible limitation of this item which may have been better presented in an open-ended format to allow participants to express their understanding of the relationship between mental health and deafness and therefore the degree to which an individuals' deafness is potentially related to their mental health concerns.

Of the five participants whose answers were included in the analysis of this item, 40% indicated that they feel 80-89% of their clients' difficulties were directly related to their deafness. This could be seen as an indication of the increased risk of mental health problems in the d/Deaf community and therefore the importance of adequate mental health services being available to the d/Deaf community. This however cannot be conclusively deduced from the participant responses due to the limited sample size obtained. Twenty percent of the participants indicated that 60-69% of their clients' mental health concerns were directly related to their deafness, another 20% indicated 50-59% of their clients' mental health concerns were directly related to their deafness and lastly, 20% indicated 0-9% of their clients' mental health concerns were directly related to their deafness.

Figure 19 Participants' views on good training to prepare one for work with the d/Deaf

Participants were asked a number of open-ended questions regarding their recommendations concerning Deaf Therapy and the skills necessary to work with the d/Deaf. Participants were asked what they viewed as good training to prepare one to work with the d/Deaf in their respective field. Participant responses were inserted into Wordle to create the 'word cloud' seen above in Figure 19. For the relevant frequency table, please see Appendix D. It was evident from participant responses that they regarded training in Sign Language as being of primary importance before entering their particular fields and working with the d/Deaf. Training in Deaf Culture was also identified as being of importance to the participants, which included an understanding of the d/Deaf community's experience from their own point of view. Other recommendations that were mentioned were: Knowledge of visual tools that could be used when working with d/Deaf clients, training in how to work with child abuse and, knowledge of the different hearing aids used by the d/Deaf. One of the participants, working in an oral school, indicated that no prior training is necessary to work in their context.

Figure 20 Further skills development or training participants believe would aid them

Figure 20 depicts participants' responses regarding the additional skills development and/or training they believe they could benefit from and which would aid them in providing their services to the d/Deaf. For the relevant frequency table, please see Appendix D. Training in Sign Language was the most prominent skill they identified as wanting to gain and develop further, however there were a variety of differing skills identified by each of the participants; these were: being able to have weekly supervision with a senior colleague, knowledge of differing communication systems and technological aids to communicate with the d/Deaf, understanding of audiology, as well as training from speech therapists in how best to communicate with d/Deaf individuals using oral communication e.g. better pronunciation of words.

Figure 21 Minimum skills required to work with the d/Deaf

Participants were asked what they believed were the minimum skills required to work effectively with the d/Deaf in their field of work, the responses to this are represented in the 'word cloud' seen in Figure 21. For the relevant frequency table, please see Appendix D. From a review of the 'word cloud' and participant responses, it is evident that participants feel that knowledge of and training in Sign Language is seen as a minimum requirement to work effectively with the d/Deaf. Graduate degrees and training in relevant therapeutic fields, understanding of Deaf Culture and audiology were other lesser mentioned requirements in participant responses.

Figure 22 Specialised mental health services known to participants in their communities

Lastly, Figure 22 depicts a 'word cloud' which represents the specialised mental health services for the d/Deaf apart from those provided by the participants themselves that they could identify in their communities. For the relevant frequency table, please see Appendix D. As can be seen in Figure 22, the majority of participants could identify no specialised mental health services catering for the d/Deaf in their communities. This speaks of the potentially dire state of mental health service provision to the d/Deaf in South Africa and the need for this to be addressed. This however cannot be conclusively deduced due to the limited sample size acquired for this study. Of the services that participants made mention of in their responses, these were primarily services other than focused mental health services offered in government hospitals, e.g. audiologists and speech therapists.

5.1.3 Conclusion

From a review of the quantitative data it would appear that the majority of practitioners currently working in the field of Deaf Therapy are hearing and come from varying helping professions, i.e. psychology, social work and nursing, all with varying levels of qualification, from a diploma to a masters degree in their field of practice.

The most prevalent modes of communication participants utilise when interacting with the d/Deaf in and out of the therapeutic context is Sign Language and oral communication. The prevalence of Sign Language use amongst participants and it being the primary recommendation by participants for those within the field or wanting to enter the field of Deaf Therapy, would

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suggest that Sign Language training is possibly the most useful skill that can be acquired by those working with the d/Deaf. This reflects the information gathered in the literature review (see section 2.5), which identified training in Sign Language as being important for Deaf Therapy (Haskins, 2004; Middleton et al., 2010; Steinberg et al., 2006)

Whilst a primary recommendation by the participants is for practitioners within or wanting to enter the field to have some form of training in Sign Language and Deaf Culture, there was a fifty-fifty split between those who knew Sign Language and those who did not. Furthermore, the majority of participants had no training in Deaf Culture. Whilst participants indicated that their training in Deaf Awareness/Culture was gained through first-hand experience and exposure to the deaf community, the desire expressed by participants to obtain more training in Sign Language and Deaf Culture may signify the need for more training opportunities to be made available to professionals working in the field. This is once again a recommendation obtained during the literature review and is put forward by Vernon (2007).

The indication by a large proportion of participants that they believe a significant percentage of their clients' mental health concerns are related to their deafness and that a primary mental health concern of their clients is anxiety disorders (a diagnostic category in the field of mental health), would suggest that mental health services geared towards the needs of the d/Deaf and which have an understanding of the complex relationship between mental health concerns and deafness specifically, is an important need of the d/Deaf community. However, from participant responses it would appear that there is a possible lack of mental health services to the d/Deaf in the South African context, which would imply a need for this to be brought to the attention of the mental health profession and professionals, so as to determine ways in which this may be addressed.

5.2 Qualitative Data

Qualitative data was collected by means of either face-to-face interviews with participants or emailed interviews. All participants who took part in the quantitative survey were invited to participate in the qualitative interviews. Not all of the participants felt that they were comfortable participating in the qualitative section of the research, expressing that they did not feel they had enough experience with the d/Deaf to share their perceptions on the field, or provide detailed information on therapy with the d/Deaf. Interviews were conducted with four participants, two of which were conducted face-to-face and two of which were conducted via email.

5.2.1 Initial codes

Below is a description of the sixteen different codes identified in the initial analysis of the qualitative interviews. These codes are explained and examples relevant to each of the codes are provided.

5.2.1.1 Comorbidity

Participants indicated that comorbidity of deafness and hearing impairment with other difficulties such as language delay or intellectual impairment is a challenge they face in treating d/Deaf individuals. Examples of their identification of comorbidity being a challenge are:

"I'd say a lot of the d/Deaf people have additional disabilities, so there's co-morbid conditions in terms of intellectual impairment"

"And then a lot of d/Deaf people, their language is extremely delayed, because d/Deaf children only come to school much later, so a lot of the terminology used when you do reflecting, when you do interpretations, has to be very concrete"

"When you're working with d/Deaf kiddies, I see a lot of their language is delayed, a lot of them don't have language so you're not just doing therapy with a d/Deaf person you're doing therapy with a person who has a language barrier"

5.2.1.2 d/Deaf community generally belongs to a low socio-economic group

The challenge of d/Deaf individuals tending to be of a low socio-economic group was identified by the participants as a potential hurdle in their treatment as they may not be able to afford therapy, or alternatively have other basic needs which need to be met before they are able to participate in a therapeutic process. Examples of participants referring to this challenge are:

"Majority of the d/Deaf community in South Africa is a low socio-economic group, and coming from extreme impoverished backgrounds. So their basic needs, safety, water, food, housing haven't been met. So to do psychotherapy with them is not where they're at at the moment"

"If you're going to work in the d/Deaf community as a psychologist, I think you need to realise you'll be seeing them in community settings. There's about 2% that can afford to pay"

"A lot of these d/Deaf people from low socioeconomic communities, it's day to day survival skills. So it's very difficult, they're focusing still on Maslow's bottom graph"

5.2.1.3 d/Deaf not acquainted with mental health services

From participant responses it would appear that the d/Deaf community may not be well acquainted with the nature of mental health services and what help is provided or can be expected from a mental health practitioner. Below are examples where this can be seen in participant responses:

"A lot of d/Deaf people don't actually know what a psychologist is, so that's one challenge"

"You have to explain to them that's not the role, it's not what we do. Some would be wanting to be moved to a safe house and we also don't do that as psychologists"

"And then there's also a lot of expectations of the psychologist, especially if you're the only person who's now listening to them 'cause they've had no-one their whole life, so they now think that you're going to change their problems and it doesn't happen like that"

"...not much of d/Deaf and hard of hearing people knows about these kind of service..."

5.2.1.4 The importance of understanding Deaf Culture

In working with and treating the d/Deaf it would appear that there are particular cultural differences which are important to be aware of and understand. Participants identified the importance of being aware of differences in interactions and socialisation between the hearing and the d/Deaf. Examples which illustrate differences in treating the hearing and the d/Deaf are:

"I see why they're making the diagnosis, or the psychologist, you can see why they're making it 'cause the d/Deaf person will fit the category, but then once you explain to the other psychologist about the d/Deaf community and their ways, they then change their feelings about the diagnosis"

"I would often in therapy with a hearing person sit with my hand by my mouth, something I've learnt with d/Deaf people is they then think you're speaking, you know behind your hand saying something about them because they can't see your lips"

"With hearing people you break eye contact here and there, I mean you're still focused but it's still natural, you don't stare. Whereas in the d/Deaf community if you break eye contact it's seen as rude"

"Uhm, you wouldn't have any contact with the hearing patient, whereas a d/Deaf patient you might need to tap them. You know if for example they're in a waiting room and they've got their back to you, that's what's happening, there'd be that physical contact which you wouldn't do with hearing persons"

"So that basic Sign Language training is not sufficient, and also if you just do basic training you don't get the culture aspect, which you need both"

"I think the most important thing for me was the fact that I have to, my whole life I was learning to speak, I was, I didn't learn Sign Language or any kind of things like that, and I didn't quite before I work with these kind of people, I didn't understand the Deaf Culture and the more hard of hearing culture type of thing that they have"

"...learn that kind of cultural differences in d/Deaf and hard of hearing people, and the way they function in their kind of socialising skills..."

"Okay, I will say, learn about the different cultural differences between Deaf Culture and the hard of hearing, try to be in their shoes, try to understand them for the person they are"

5.2.1.5 Difficult to access d/Deaf community and gain trust

From the responses below it can be seen that the d/Deaf community does not easily accept and trust those seen as outsiders or who do not form part of the community. Participants indicated that the d/Deaf community's trust is built slowly and may be easily impacted by the opinions of others within the community. Examples of this are:

"...to get accepted the community needs to know you..."

"Uhm, so what I'm saying is if one person, if they can't handle that kind of transference relationship and they go out and spread in the community, the community will be scared to come to you"

"...it was quite hard for me to win their trust at that stage because sjoe, they see you as an outsider and won't so easily accept you always..."

"Slowly, but surely I win their (the d/Deaf community) trust..."

"and that's why I don't want to get out, uh, of it a long time (Deaf Therapy), because it was quite a way to come there"

5.2.1.6 Difficult family contexts

The family context of the d/Deaf would seem to be a particular challenge faced when working in the d/Deaf community, particularly when working with d/Deaf children. Participants indicated that the d/Deaf often do not live with their immediate or biological family which makes involving family in treatment difficult. Participants highlighted this in the following examples:

"I try and do family therapy, but it is very difficult to get families in..."

"...a lot of the d/Deaf kiddies don't live with their parental figure; they're living with an extended family member. So to get that attachment with a main parent is very difficult..."

"Getting family involvement can be very very difficult. A lot of them are living with an extended family member, because their parents have rejected them. Those who are living with a biological caregiver, a biological parent, the parents often can't come in because they're living quite far away and they've got four or five kids to look after at the same time"

"Parents not being involved is also a huge challenge"

5.2.1.7 Interactional differences

In the below examples, participants point to some of the technical differences in interactions with d/Deaf individuals and the necessary accommodations and changes to interaction that needs to be made to accommodate them. References to these interactional differences are seen in the following examples:

"If a child is playing in the room, a hearing child, you have to make an interpretation and reflect and they would still hear you. Here, if a d/Deaf child's back is turned to you, you can't reflect, you can't interpret, so that's a big problem"

"I would often in therapy with a hearing person sit with my hand by my mouth, something I've learnt with d/Deaf people is they then think you're speaking, you know behind your hand saying something about them because they can't see your lips"

"With hearing people you break eye contact here and there, I mean you're still focused but it's still natural, you don't stare. Whereas in the d/Deaf community if you break eye contact it's seen as rude"

"Uhm, you wouldn't have any contact with the hearing patient, whereas a d/Deaf patient you might need to tap them. You know if for example they're in a waiting room and they've got their back to you, that's what's happening, there'd be that physical contact which you wouldn't do with hearing persons"

"...if they've got their back to you, you'd have to tap them or you'd have to flick the lights on and off, so there's those sort of technical difficulties that come about"

"...all the time you have to have facial contact, 'cause they see face expressions and can do lip readings and all that things. Working with normal hearing community, you can just talk and they hear you..."

"...sometimes difficult for me as hearing impaired person specifically, was that some of the children talk to me and I didn't hear them because they looking back, looking away, looking at the computer and ask me questions, and then I have to make adaptions, like please if you want to talk to me, look at me or get my attention, and I come to you..."

5.2.1.8 Difficulty in communication

Participants indicated that delay in language acquisition, as well as difficulty in communication between the d/Deaf and hearing is a challenge faced by the d/Deaf in trying to access help services. This can be seen in the following examples:

"...always always comes back down to the language issue, I've got a ton of files that I can pull out on cases. d/Deaf people go to hospitals or clinics, they say "sorry we don't help d/Deaf people." They go to police stations, I have four cases actually they just happened this last month, they go to police stations to report a rape, the police say "sorry we don't help d/Deaf people." So a lot of clinics, hospitals, police stations, don't want to take d/Deaf people, because of that language barrier. That's a major major issue"

"When you're working with d/Deaf kiddies, I see a lot of their language is delayed, a lot of them don't have language so you're not just doing therapy with a d/Deaf person you're doing therapy with a person who has a language barrier"

"They need at least to be trained in how to communicate with the d/Deaf in order for them to be able to support the d/Deaf"

5.2.1.9 Limited services

Aside from the services that they provide, participants indicated a lack of help services, particularly mental health services and service providers geared toward helping the d/Deaf in their communities. This can be seen in the following examples:

"very few professionals (working in the field of Deaf Therapy)"

"...very few colleagues that we can work with, network with.... So you're sort of swimming on your own in a sense"

"Absolutely none, absolutely none there aren't any (Specialised mental health services for the d/Deaf in their community, other than the service the participant provides)"

"...the problem comes in when you talk about disabled, they clump everyone together, and the needs of the d/Deaf community are extremely different to the needs of the Autistic community, very different to the blind community. But I do think specialist services need to be improved"

"...I've got a ton of files that I can pull out on cases, d/Deaf people go to hospitals or clinics, they say "sorry we don't help d/Deaf people." They go to police stations, I have four cases actually they just happened this last month, they go to police stations to report a rape, the police say "sorry we don't help d/Deaf people""

"Just, I know a speech therapist that helps people with cochlea implants, and get new hearing aids, she gives them therapeutic sessions, ...but it's the only one that I know of"

"Nobody that I know of"

"There is hard of hearing people who don't know where to go, where they can get these kinds of services"

"...there's a lot of need for these kind of services for d/Deaf and hard of hearing people, but there is not much people giving it"

"But the barriers is, that they don't know where to go, and not much people have a heart for these people to give services to these people, or have in-service training to help these kind of people"

"Not aware of any"

"None"

"I know they settle there in Cape, and there's a few services I know in Cape Town, sorry, but not here in Gauteng, Pretoria, Tshwane area."

5.2.1.10 Limited training available to professionals

Participants indicated a specific need for training in the particular needs of the d/Deaf and the cultural differences which may impact diagnosis or treatment, as well as training in communication with the d/Deaf. From the responses below, it can be seen that participants feel that there is currently a lack of sufficient training in these aspects which needs to be addressed:

"In terms of the psychologist there's been no training, I've had to apply what I've got from supervision and apply it for my own and I've made networks with overseas institutions. So, d/Deaf universities overseas. I went to Germany to go meet some psychologists there last year. So just to share on an interactional basis, 'cause there's very few resources here"

"There needs to be training offered, I mean not only with the d/Deaf community but disabled people in general"

"I know masters courses at universities they touch on, it'll be a week module or if you're lucky mostly a day on how to work with a disabled person, and then universities generally assign a disability unit where they get someone from an NGO (Non-Governmental Organisation) to come in, it's a quick talk..."

"I think there is a lot of training that is needed..."

"So for example you see paranoid personalities usually diagnosed in the d/Deaf community, but if you have a cultural understanding you know that it's not Paranoid Personality Disorder, at all"

"I think there's quite a lot of need for that (training)"

"...more in-service, training (is needed) maybe, specific for these kinds of therapists"

"Or training during their studies maybe, to help these kind of people"

"The fact that staff are not trained in how to communicate with d/Deaf might be a barrier in them accessing mental health services"

5.2.1.11 Multiple roles

Participants drew attention to the fact that as practitioners in the field they are at times expected to fulfil multiple roles, to provide services outside of their role as psychologist for

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example, due to their ability to work with the d/Deaf community and the apparent lack of service providers able to fulfil these obligations, as has been indicated above (see section 5.2.1.9). Furthermore, they indicate the dilemma that is created when professional boundaries are challenged. This is seen in the following examples:

"I work very psychodynamically, so strictly focused on that role and I try to keep the boundaries"

"...one of the big things is boundary issues"

"...obviously the best way to learn a language is to socialise, and to get accepted the community needs to know you. But you cannot socialise in the community. So you need to socialise to learn the language, but you can't socialise to be a professional. So that boundary becomes extremely difficult"

"So where as now as a psychologist I won't be involved at all (in terms of socialising in the d/Deaf community)"

"But then you've now got that boundary, are you now an interpreter or your psychologist?"

"Another problem that comes in is the outside professional world, also, because you're a psychologist but you're specialised in this community they think that your role should be multiple"

"So for example right now I have to appear in court as an expert witness, but there was a fake interpreter in court and it caused a dilemma because I could see the interpreter was fake and I complained about it, but the judge said I'm a witness and it's not my role, and of course I'm proficient. Then the judge wanted me to interpret and the d/Deaf person wanted me to and I can't. But now if the court tells you to do something, [pause] so that created a whole dilemma"

"You have to explain to them that's not the role, it's not what we do. Some would be wanting to be moved to a safe house and we also don't do that as psychologists"

"What I'm saying here is you've got to be very cognisant that your role is still psychologist and not speech therapist so you can't focus on teaching them language"

"No, therapeutic work at that stage, but sometimes they called me in and asked me "please help with this kind of child" but not quite as a psychologist settled there" (the participant was hired as a teacher at that point but was qualified as a psychologist)

5.2.1.12 Professionals are often isolated

Participants indicated that working in the field of Deaf Therapy can be isolating as there are few professionals within the field and there is not always a strong professional link between these

professionals. This therefore leads to a perceived lack of professional support from those within the field. This is highlighted in the following examples:

"...very few colleagues that we can work with, network with.... So you're sort of swimming on your own in a sense"

"Who do you go to (for supervision), that sort of thing"

"It is very difficult, and those of us who are working are working quite in isolation at the moment, so there'll be people in Pretoria, people in Cape Town, people in Joburg, but we're not actually working together, which is a problem"

"It is also a lot of emotional draining work, so you have to make sure you've got your own support and as you are on your own, it's not like working as a psychologist in a different area, there's a lot of confinement, you are often isolated. So a lot of the research you do is on your own, a lot of the work you do is on your own"

"Really I would be grateful if there were some contacts that I could make contact with"

"I think we have to know of each other, give that kind of services so that we can talk together, compile something together..."

5.2.1.13 Small, close-knit community

It was identified by the participants that the d/Deaf community is small and that they are close, they stick together. With it being a small and close community there is a high likelihood that many of the individuals in the d/Deaf community know each other or know of each other creating the dilemma of possible overlap between clients and the professional's personal and private lives. This is observed in the following examples:

"Or, if you've got someone with a personality disorder, say for example paranoid personality disorder they don't stay in therapy long, then what they would do is then bad mouth the psychologist outside of the room, and the community is so small, so they would know who you are and then other people become scared of coming to the psychologist"

"...as any small community they're going to be instances that come up and you're going to face that, always be careful with what you disclose I suppose and you'll have to be very cognisant of how you're seen in those situations"

"Even if you're not socialising with the people that you're seeing, chances are you'll be seeing someone for therapy that knows that person"

"The relationship is always going to be there. It's sort of unavoidable. I think it's just being cognisant of it, very aware of it, bringing it into the room and discussing it with the client and from

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the start telling the patient that because this is a small community chances are you're going to see me in another setting"

"Because they are such a close community..."

5.2.1.14 The stigma of seeing a mental health professional

Participants indicated that the stigma attached to seeing a mental health professional may prevent those in need of mental health services from seeking out such services. Examples of this are:

"...and then there's of course the stigma attached to going to see a psychologist"

"...the other mom that comes to the support group gets stones thrown at her, so that might make them hesitant as well to come see a psychologist"

5.2.1.15 The stigma the hearing community have of the d/Deaf

Participants identified that the hearing community generally tend to have negative or inaccurate perceptions of the d/Deaf, creating a stigma about them. This is seen in the following examples:

"I've got a mom who, she can't come for feedback because there's no-one to look after the kids and she can't leave the kids with anybody because the community believes that she's a witch, that's why she's had this d/Deaf child"

"...and not much people have a heart for these people to give services to these people"

"People don't know how to deal with the d/Deaf and assume they are stupid and cannot communicate which isn't the case"

5.2.1.16 The stigma the d/Deaf community have of the hearing

Lastly, the participants identified that the d/Deaf too hold beliefs about the hearing community, one specifically being that the hearing community is not accepting of them and wants to 'fix' them. Examples of this are:

"...when you're a hearing person you already have all this stigma attached to you"

"...the d/Deaf community then thinks again "Oh well, this person wants to try and fix me, they're not accepting of who I am""

5.2.2 Themes

From the codes identified above, the researcher went on to observe the relationships between the codes and generated themes through combining codes in such a way that reflects the data and addresses the aims set out for the qualitative section of the research study, namely: To explore the challenges faced by these participants in their provision of mental health services to

the d/Deaf, and identify what skill demands are being placed on them in order to effectively provide therapeutic support. Three primary themes were identified and are explained below, along with examples which provide evidence of these themes.

5.2.2.1 Unique needs of the d/Deaf

From the interview data, it could be identified that the d/Deaf appear to be a unique group of individuals who tend to share some unique challenges. These challenges not only impact their functioning, but may also be important to be aware of in a therapeutic setting. The following codes were grouped together to form this theme as they highlight some of the challenges faced by the d/Deaf community and therefore the challenges and unique differences in interrelations which may impact the nature and/or course of therapy: *Comorbidity; d/Deaf community generally belongs to a low socio-economic group; The importance of understanding Deaf Culture; Difficult family contexts; Interactional differences; Difficulty in communication and; The stigma the hearing community have of the /Deaf.*

From these codes a greater theme was identified of the particular challenges faced by d/Deaf individuals, which may be therapeutically relevant to one's mental health and functioning. Challenges such as language and communication barriers as a result of delayed or rudimentary language acquisition; difficulty in affording mental health services; lack of or restricted family support and bonding and; inaccurate beliefs about the d/Deaf which restricts the interactions and support available to them by those who have a skewed understanding of the d/Deaf.

In addressing these challenges, it would appear to be important for professionals working in the field of Deaf Therapy to be sensitive to the challenges identified above and ensure that they do not compound these challenges. This may require professionals to be proficient in various means of communication with the d/Deaf or at least aware of the interactional differences between the d/Deaf and hearing, be sensitive to the challenges faced by the d/Deaf and the stigma they face in the greater community, and be sensitive to and aware of the potential socio-economic constraints of the d/Deaf who may financially require brief therapeutic interventions. Professionals may need to develop this awareness and the skills to address these challenges through exposure to the d/Deaf community or those who have a good understanding of the d/Deaf. Examples from participant interviews that fall within this theme can be seen below:

"When you're working with d/Deaf kiddies, I see a lot of their language is delayed, a lot of them don't have language so you're not just doing therapy with a d/Deaf person you're doing therapy with a person who has a language barrier"

"If you're going to work in the d/Deaf community as a psychologist, I think you need to realise you'll be seeing them in community settings. There's about 2% that can afford to pay"

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"A lot of these d/Deaf people from low socioeconomic communities, it's day to day survival skills. So it's very difficult, they're focusing still on Maslow's bottom graph"

"I see why they're making the diagnosis, or the psychologist, you can see why they're making it 'cause the d/Deaf person will fit the category, but then once you explain to the other psychologist about the d/Deaf community and their ways, they then change their feelings about the diagnosis"

"...learn that kind of cultural differences in d/Deaf and hard of hearing people, and the way they function in their kind of socialising skills..."

"Getting family involvement can be very very difficult. A lot of them are living with an extended family member, because their parents have rejected them. Those who are living with a biological caregiver, a biological parent, the parents often can't come in because they're living quite far away and they've got four or five kids to look after at the same time"

"...if they've got their back to you, you'd have to tap them or you'd have to flick the lights on and off, so there's those sort of technical difficulties that come about"

"...all the time you have to have facial contact, 'cause they see face expressions and can do lip readings and all that things. Working with normal hearing community, you can just talk and they hear you..."

"People don't know how to deal with the d/Deaf and assume they are stupid and cannot communicate which isn't the case"

5.2.2.2 The importance of expanding mental health services and forming professional networks

A prominent theme identified from the codes was that of a lack of services and service providers available to the d/Deaf community. This was seen as not only a limitation for the d/Deaf in having their needs for particular help services addressed, but also as a limitation for professionals in the field of Deaf Therapy in terms of being able to form networks and gain support. Furthermore, with limited service providers available to the d/Deaf, participants expressed that there are greater expectations of them which are not always within the realm of services they would normally be expected to provide. The following codes were identified as being linked to form this theme: *d/Deaf community generally belongs to a low socio-economic group; d/Deaf not acquainted with mental health services; Limited services; Limited training available to professionals; Multiple roles and; Professionals are often isolated.*

A challenge identified for the participants was that there are few professionals in the field with whom to form networks with and gain support from or even training. Participants expressed

that they felt isolated with few resources available to them for further training. These resources would allow professionals to be better equipped to work with the d/Deaf. For example, training in Deaf Culture which could help them better understand the interactional and socialising differences within the d/Deaf community to that of the hearing. This was also a need expressed by one of the participants who was hearing impaired themselves and who thought that despite their own experience, that they lacked detailed knowledge of Deaf Culture. With more professionals entering the field and stronger networks between them, the expectations of professionals to work outside of the designated scope or role of their profession would decrease and d/Deaf individuals could be provided services by those more equipped to meet their specific need. For example, the d/Deaf could have fully trained interpreters to interpret for them when needed as opposed to a psychologist, social worker, teacher or even family member interpret due to a lack of available interpreters. Another example would be, for the d/Deaf to have access to trained psychologists who could provide therapy to d/Deaf individuals who are preparing to receive a cochlear implant; these individuals could receive support in adjusting to a world with sound, as opposed to audiologists having to provide such therapeutic support due to a lack of trained and available psychologists.

It would appear that aside from increasing the number of professionals in the field of Deaf Therapy by increasing training opportunities, professionals in the field would benefit from forming a strong network between them so that they have support from one another and can better refer d/Deaf patients to those professionals better suited to addressing particular needs, e.g. a psychologist able to refer a d/Deaf client to a social worker who works with the d/Deaf to better address needs for housing etc., or to a speech therapist who works with the d/Deaf to address language acquisition needs. A suggestion from participants is that professionals undergoing training at a tertiary level would benefit from more detailed training focused on working with those with special needs. This would mean that professionals newly entering the workforce would be more skilled in working with disability. Furthermore, due to greater exposure at the tertiary training level, new interest in individuals to pursue further training and exposure to currently disadvantaged groups may be created.

"Majority of the d/Deaf community in South Africa is a low socio-economic group, and coming from extreme impoverished backgrounds. So their basic needs, safety, water, food, housing haven't been met. So to do psychotherapy with them is not where they're at at the moment"

"You have to explain to them that's not the role, it's not what we do. Some would be wanting to be moved to a safe house and we also don't do that as psychologists"

"...very few colleagues that we can work with, network with.... So you're sort of swimming on your own in a sense"

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"In terms of the psychologist there's been no training, I've had to apply what I've got from supervision and apply it for my own and I've made networks with overseas institutions. So, d/Deaf universities overseas. I went to Germany to go meet some psychologists there last year. So just to share on an interactional basis, 'cause there's very few resources here"

"I know masters courses at universities they touch on, it'll be a week module or if you're lucky mostly a day on how to work with a disabled person, and then universities generally assign a disability unit where they get someone from an NGO (Non-Governmental Organisation) to come in, it's a quick talk..."

"Another problem that comes in is the outside professional world, also, because you're a psychologist but you're specialised in this community they think that your role should be multiple"

"What I'm saying here is you've got to be very cognisant that your role is still psychologist and not speech therapist so you can't focus on teaching them language"

"Really I would be grateful if there were some contacts that I could make contact with"

5.2.2.3 d/Deaf community is small and weary of outsiders

The final theme identified looks at how the d/Deaf community is characterised as being small and close-knit, and that they tend to be weary of outsiders. This means that those who aren't identified as being part of the community are not easily accepted and have to take time to win the trust of the d/Deaf community before they will be accepted. This theme examines the barriers to building trust and to the d/Deaf community accessing or making use of mental health services. Codes brought together in this theme were: *Difficult to access d/Deaf community and gain trust; Small, close-knit community; The stigma of seeing a mental health professional and; The stigma the d/Deaf community have of the hearing.*

Trust of those seen as outsiders was identified as being a challenge faced by participants, who were seen as outsiders to the d/Deaf community, even if they themselves had hearing impairments. From the interviews with participants, it can be seen that they had to work towards building trust and being accepted by the community and at times were still not seen as fully part of the community. It was also identified that those from the d/Deaf community who do interact with non-group members may also be faced with the challenge of being stigmatised and mistreated by the community for having contact with non-group members. During an interview with a participant, it was mentioned that the d/Deaf tend to have the perception that the hearing community does not accept them and thus tries to fix what they view as being a disorder or impairment; whereas for many d/Deaf individuals their hearing loss is not something they feel the need to rectify in order to integrate into the hearing community. This perception may make d/Deaf individuals weary of seeking help from any hearing member of the community, even those in the helping professions,

for fear that they too will want to correct their hearing impairment as opposed to possibly dealing with what the needs of the d/Deaf individual are. Increasing service provision, and adequately trained service providers, to this population may increase the d/Deaf community's exposure to positive interactions with helping professionals (both hearing and d/Deaf) and begin challenging the negative stereotypes they have of the hearing community and helping professions. In this way they may be more willing to access services and have their needs more appropriately met. Professionals entering the field of Deaf Therapy will need to be sensitive to the beliefs and concerns of the d/Deaf and be willing to slowly build trust relationships with key community members. Furthermore, professionals need to be equipped to face the ethical dilemmas which may arise when working in a small community where there is the potential for overlap between patients', as well as professionals' lives, and those of their patients. The researcher feels however that increasing service provision to the d/Deaf may help in combating some of the ethical dilemmas as the size of the pool of service providers available to the d/Deaf community will impact the degree to which one might experience these overlaps.

"...it was quite hard for me to win their trust at that stage because sjoe, they see you as an outsider and won't so easily accept you always..."

"and that's why I don't want to get out, uh, of it a long time (Deaf Therapy), because it was quite a way to come there"

"Even if you're not socialising with the people that you're seeing, chances are you'll be seeing someone for therapy that knows that person"

"The relationship is always going to be there. It's sort of unavoidable. I think it's just being cognisant of it, very aware of it, bringing it into the room and discussing it with the client and from the start telling the patient that because this is a small community chances are you're going to see me in another setting"

"...the other mom that comes to the support group gets stones thrown at her, so that might make them hesitant as well to come see a psychologist"

"...the d/Deaf community then thinks again "Oh well, this person wants to try and fix me, they're not accepting of who I am""

5.2.3 Conclusion

From a review of the qualitative data it can be determined that professionals in the field of Deaf Therapy are currently faced with a variety of challenges and demands. The predominant challenges identified during interviews with participants were the significant cultural and interactional differences which they need to be aware of in order to work effectively with the d/Deaf, the difficulty of being isolated and having limited access to training and support resources as a

professional working in the field of Deaf Therapy, and the difficulty of being accepted into the d/Deaf community and being trusted by them to enter into their community and provide services to them.

Recommendations that can be suggested based on participant interviews and the challenges identified would be that professionals who are currently working in the field or who are interested in entering the field, need to expose themselves to the d/Deaf community whilst still maintaining appropriate professional boundaries, and to network with others who work with and have knowledge of the d/Deaf community and culture. These networks may be good resources from which to gain access to the community through an already trusted source, and could potentially lead to the development of training opportunities and knowledge share which can assist professionals in the field or entering the field to grow their knowledge and skill sets.

6. Discussion

A discussion bringing together the two different forms of data (quantitative and qualitative) will be presented in this section. Here the researcher will discuss the extent to which the two forms of data converge, the extent to which the qualitative data validates the quantitative data, as well as the similarities and differences that are present between the two forms of data. The researcher will also provide some of their personal reflections on the research process.

6.1 Discussion of Results

The aim of the study was to determine what skills are necessary to provide therapeutic services to deaf persons in the South African context. The aim of the quantitative section of the research was to determine what skills are currently utilised and those believed necessary to work with the d/Deaf in a mental health setting, by professionals who currently provide such services in the South African context. The aim of the qualitative section of the research was to explore the challenges faced by these professionals, and what skill demands are being placed on them in order to effectively provide therapeutic support to the d/Deaf.

Skills primarily identified in many of the items of the survey section and in participant interviews were training and skill development in modes of communication with the d/Deaf, particularly in Sign Language, as well as training in Deaf Culture. These were identified as important skills for professionals so that they are more able to communicate effectively with the d/Deaf community, making them more accessible to the d/Deaf, and ensuring that professionals are better able to understand some of the cultural, social and interactional differences that are present between the hearing and d/Deaf communities. Although these skills were identified as being of great importance, 50% of the participants were identified as having training in Sign Language, and only 33% as having training in Deaf Culture.

A concern raised by participants in the quantitative section is that training in Sign Language and more specifically Deaf Culture, would appear to be somewhat limited in South Africa. This was supported by participant interviews where they reported feeling isolated in the field and as having limited access to resources such as training and support.

No particular proficiency level in Sign Language was identified as being necessary; however the researcher would propose that some knowledge of terminology relevant to the field of mental health would be beneficial to work with the d/Deaf in a mental health context.

The need to understand Deaf Culture and its importance in treating the d/Deaf in a mental health setting was further elaborated on in the qualitative section. Participants gave examples of cultural and interactional differences that are important to be aware of so as to work effectively with the d/Deaf therapeutically and be more aware of their needs and differences.

Another concern and recommendation with regards to training and service provision found in both the quantitative and qualitative data was the limited mental health services participants felt are presently available to the d/Deaf. In both forms of data participants pointed to the fact that although they work in the field of deafness, their knowledge of services catering to the needs of the d/Deaf is limited, which signified to them a lack of services available to the d/Deaf community. A recommendation based on this concern was that more practitioners need to be trained and encouraged to work in the d/Deaf community so that their pool of resources may expand.

In summary, a review of both data sets identified the following list of recommendations with regards to the skills necessary to provide therapeutic services to the d/Deaf in the South African context. This can be used by those wanting to enter the field or those already in the field to determine the training that may be necessary for them to pursue, or the skills they may need to develop, to work effectively in the field of South African Deaf Therapy:

- Training in South African Sign Language (SASL).
- Training in Deaf Culture, which includes an understanding of the different modes of communication used by the d/Deaf community, and the social and interactional differences between the d/Deaf and the hearing communities.
- Exposure to the d/Deaf community to gain more practical understanding of Deaf Culture and learn about the challenges faced and the specific needs they have, from the mouths of the d/Deaf.

With regards to the development and future of South African Deaf Therapy, the following recommendations for the field were identified:

- An increase in formal training (e.g. CPD workshops) available to practitioners working in the field of deafness in different modes of communication e.g. South African Sign Language.
- An increase in formal training (e.g. CPD workshops) available to practitioners working in the field of deafness in Deaf Culture.
- An increase in professionals being introduced to the field of Deaf Therapy at a tertiary level, through greater exposure to and instruction in the treatment of mental health and deafness.
- Better marketing of available services and the formation of professional networks of service providers.
- Educating the d/Deaf community on the nature of services available and the roles of different service providers so that they may more easily identify and access the support service required for their specific needs.

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6.2 Personal Reflections on the Research Process

As mentioned in the introduction section of this paper, the researcher first became interested in the realm of deafness and Deaf Therapy a long while back, however the process of turning this interest into a research endeavour was far more recent. Initially starting the research process the researcher was unaware of the true complexity of the world of the d/Deaf and what it might entail to potentially become a mental health practitioner providing services to the d/Deaf community. The researcher's initial expectations were that they may need to simply learn Sign Language so as to bridge the communication gap they perceived as being a barrier between themselves and the d/Deaf community. Through engaging with the literature, carrying out the research and thereby gaining even greater exposure to the d/Deaf community and its service providers, the researcher has come to realise that learning a language alone will not provide sufficient enough skill and knowledge to provide effective support to the d/Deaf community. The researcher came to learn that there is an intricate cultural milieu that would appear to differ from that of the hearing community (of which the researcher is accustomed) that they would need to become more educated on and gain exposure to, and that gaining such exposure is more difficult than anticipated due to the d/Deaf community being difficult to access by those seen as outsiders.

This became a prominent theme for the researcher in their research endeavours, being an outsider and finding it difficult to access a community in which you are an unknown stranger. When attempting to access information regarding potential participants the researcher often felt like an outsider struggling to win the confidence of and gain access to those within the field of deafness, often being referred on in a never ending chain of referrals from one contact to another and many times receiving no response from practitioners or members of the d/Deaf community. The researcher was delighted to be met with the enthusiasm of their participants and their primary respondent-assistant whose involvement in the research and contact with the researcher was entirely contrary to the untrusting climate experienced elsewhere in trying to locate participants.

Another prominent experience the researcher encountered when in contact with practitioners with some experience with and exposure to the d/Deaf community, was a general lack of confidence some of them appeared to have with regards to their work with the d/Deaf. Many practitioners appeared to be weary of participating in the research and sharing their perceptions of working with the d/Deaf, or sharing recommendations they possibly have. Some expressed that they felt their knowledge was not sufficient enough to provide guidance and that they would appreciate advice and guidance from others should it be available. Many of the individuals the researcher came into contact with, both those who did and did not participate in the study, indicated interest in the outcome of the research so as to guide them in their service provision. This left the researcher with an overwhelming sense of responsibility in the dissemination of the research results and highlighted to them the dire need for further research, training and directives in the field of Deaf Therapy.

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Finally, in the struggle to locate participants for the study the researcher felt that they gained some insight not only into the isolation and trepidation possibly felt by practitioners currently within the field of Deaf Therapy, as was highlighted in the research, but also possibly the frustration many d/Deaf individuals may be met with in trying to locate and access suitable support services available to them or their loved ones.

In the conclusion of this research the researcher is grateful for the journey this research endeavour has taken them on, and the increased awareness it has brought them of a field in which they have significant interest. Although it has highlighted that in order for them to one day possibly become a practitioner in the field of Deaf Therapy, that much more work, training and exposure is needed, it has also furthered the researcher's intrigue and interest into working towards this.

7. Limitations, Recommendations and Conclusion

In the section to follow, the limitations of the research study, recommendations for future research and concluding statements on the research will be discussed.

7.1 Limitations of the Research

A prominent limitation of this study was the sample size obtained for both the quantitative and qualitative sections of the research. Due to time constraints related to the completion of the study, not being able to determine the size of the researched population (nonprobability sample) and therefore determine statistical significance of the sample, as well as difficulty accessing practitioners providing mental health services to the d/Deaf, the sample size obtained was very limited. Furthermore, web based surveys may also lower response rates due to only being accessible by those who have access to the internet. This means that the results obtained from the study are not necessarily generalisable and may not give a representative view of the true nature of mental health service provision to the d/Deaf. Although the findings may provide some insights as they are based on the opinions of those currently working in the field, and seem to show some consistency across participants and forms of data, further research with a larger sample may be required to ensure greater generalisability.

Another limitation, identified during the data analysis phase, was the structure of one of the items of the survey which did not allow for more detailed information to be obtained on participant opinions regarding the link between mental health and deafness. An open-ended item may have provided additional rich information regarding the mental health needs of the d/Deaf.

7.2 Recommendations for Future Research

A recommendation for future research into the field of Deaf Therapy would be that any research wanting to gain similar insights as this study should try to obtain a larger sample. More time should be spent on data collection and forming links with stake holders in the d/Deaf community in both the public and private sectors. This may require travel to and increased exposure to different d/Deaf communities around the country, which may also require external funding to be gained.

Another recommendation for future research would be for there to be a detailed investigation into the nature and meaning of 'Deaf Culture'. This could take a look at what is specifically being referred to when one speaks of Deaf Culture, what the term encompasses. Such an investigation would be helpful in informing training programmes on Deaf Culture and provide greater focus with regards to what specific differences are important factors to be aware of between the d/Deaf and hearing communities.

Lastly, future research into the field of Deaf Therapy would benefit from a detailed investigation into the mental health of the d/Deaf in South Africa, what their primary complaints and

concerns are in the realm of mental health, as well as a more detailed investigation into the relationship between mental health and deafness.

As has been discussed previously in this paper, research in the field of mental health as it pertains to the d/Deaf is limited in the South African context (see section 2.1), therefore more research is encouraged so as to gain a greater understanding of mental health and deafness in the South African context, and in so doing hopefully improve service delivery to this currently marginalised population.

7.3 Conclusions

The research presented above looks at what skills and training are required and will aid professionals in the pursuit of providing mental healthcare to the d/Deaf community. Research in the field of mental health focusing on the d/Deaf population is underrepresented in the South African context, making this a novel study. The study highlighted a number of recommendations for practitioners working in the field or interested in entering the field, as well as recommendations for the progression of the field of Deaf Therapy. It would appear that the d/Deaf community in South Africa is not only an under researched, but also potentially an underserviced, population in mental healthcare. Further research and development of services would appear to be needed so as to address the needs of this marginalised group.

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Appendix A

Informed Consent

Dear Participant,

I am currently a Counselling Psychology student at the University of Pretoria completing my Masters degree. As part of my course requirements I am undertaking a research study under the supervision of Prof David Maree. The title of my research is: **An exploratory study into the skills necessary to work in the field of Deaf Therapy: a mixed methods study in a South African context.**

I would like to invite you to please take part in this research by completing a short survey which can be accessed by clicking on this link https://www.surveymonkey.com/s/W6PXF5T

Should you know of any other professionals working in South Africa who currently provide therapeutic services to the d/Deaf and or hearing impaired, please could you forward this email on to them and CC me in the mail as well.

The purpose of the proposed study is to determine what skills are necessary to provide therapeutic services to the d/Deaf and hard of hearing in South Africa. This will be achieved by finding out what professionals, who currently provide therapeutic or mental health support services to the d/Deaf, feel are important skills to have, the skills they do have, as well as what skill demands are being placed on them in working in this field.

There are no foreseeable risks involved in participating in this study, other than the possibility of becoming fatigued, likewise there are no immediate or identifiable benefits involved in participating. The information obtained in the study may benefit others wanting to work in similar settings with the d/Deaf or hard of hearing. The results obtained in this study will be used in completing a Masters mini-dissertation and will be further published in the form of an article in an academic journal.

As this study is based on the voluntary participation of individuals, participants are free to opt-out and leave the study at any point without negative consequences by closing the survey window or contacting the researcher. In this case any data pertaining to such a participant will be destroyed. Furthermore, participants can be assured that all information they provide the researcher with will remain confidential and that the researcher will make every effort to maintain the anonymity of participants when referring to particular sections of data. Should participants at any stage wish to contact the researcher regarding their involvement in the study they are free to do so.

Should you be willing to participate in the above mentioned study, please click on the link below which will direct you to the survey.

https://www.surveymonkey.com/s/W6PXF5T

Researcher's contact details:

Chanel Kenney

Cell: XXX XXX XXXX

Email: xxxxxxxxxxx

Thank you for your valued participation!

Appendix B

Survey Questions

Definitions:

d/Deaf: this term is used in the survey to refer to all individuals who are deaf, Deaf, hard of hearing, deafened and hearing impaired

1. Gender
   □Male
   □Female

2. Age (Years)

3. Ethnicity
   □ Black African
   □ Coloured
   □ Indian or Asian
   □ White
   □ Other, please specify

4. Home Language

   □ Afrikaans   □ Sesotho
   □ English   □ Setswana
   □ IsiNdebele   □ Sign Language
   □ IsiXhosa   □ SiSwati
   □ IsiZulu   □ Tshivenda
   □ Sepedi   □ Xitsonga
   □ Other, please specify

5. Province of residence

□ Gauteng   □Western Cape

□Free State   □Mpumalanga

□North West   □Limpopo

□KwaZulu-Natal   □Northern Cape

□Eastern Cape

6. Are you hearing/ hearing impaired/ d/Deaf?

□ Hearing

□ d/Deaf (this term is used in the survey to refer to all individuals who are deaf, Deaf, hard of hearing, deafened and hearing impaired)

7. Do you know South African Sign Language?

□ Yes

□ No (Please skip to question 8.)

If **Yes**, please answer questions 7.1 – 7.2 below.

7.1. What proficiency or level of training do you have?

□ Beginner

□ Intermediate

□ Advanced

7.2. Where did you learn sign language?

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8. Do you have any training in Deaf Awareness or Deaf Culture?

□ Yes

□ No(Please skip to question 9.)

If **Yes**, Please answer questions 8.1 - 8.3 below.

8.1. What training have you completed?

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8.2. When did you complete this training(year)?

[ ]

8.3. Where did you complete this training?

[ ]

9. What is the highest educational qualification you have obtained?
   □ Undergraduate
   □ Honours
   □ Masters
   □ PhD
   □ Other, please specify

[ ]

10. What is your current occupation?(Please select the most accurate option)
    □ Counselling psychologist
    □ Clinical Psychologist
    □ Lay counsellor
    □ Pastor
    □ Social worker
    □ Nurse
    □ Other, please specify

[ ]

11. How long have you worked in your current professional field (Years)?

[ ]

12. How many years of working experience do you have with the d/Deaf?

[ ]

13. What percentage of your clientele or patients are d/Deaf?

□ 0 – 9%   □ 60 – 69%

□ 10 – 19%   □ 70 – 79%

□ 20 – 29%   □ 80 – 89%

□ 30 – 39%   □ 90 – 99%

□ 40 – 49%   □100%

□ 50 – 59%

14. How frequently do you interact with the d/Deaf in your work environment?

□ Daily

□ Weekly

□ Monthly

□ Yearly

□ Less than yearly

15. Briefly describe the service you provide to the d/Deaf community

16. What modes of communication you use when interacting and communicating with the d/Deaf (when not providing therapy)? (multiple selection)

□ Sign Language

□ Oral

□ Interpreter

□ Other, please specify

17. When interacting with the d/Deaf in a mental health context (providing therapy), what modes of communication do you use?(multiple selection)

□ Family therapy (using the family as interpreter)

□ Family therapy (where you act as interpreter for the family)

□ Sign language

□ Oral (lip reading)

□ Written

□ Interpreter

□ Computer assisted communication

□ Other, please specify

18. What are the most frequent mental health difficulties your d/Deaf clients or patients present with? (Please choose the most correct option)

□ Mood disorders

□ Anxiety disorders

□ Substance use disorders

□ Psychotic disorders

□ Eating disorders

□ Family related problems

□ Work related problems

□ Abuse

□ Other, please specify

19. What percentage of your clients' difficulties do you think are directly related to their deafness?

□ 0 – 9%   □ 60 – 69%
□ 10 – 19%   □ 70 – 79%
□ 20 – 29%   □ 80 – 89%
□ 30 – 39%   □ 90 – 99%
□ 40 – 49%   □100%
□ 50 – 59%

20. What would you regard as good training preparation for work with the d/Deaf before entering your line of work?

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21. What further training or skill development do you believe would aid you in providing your service to the d/Deaf?

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22. What do you think are the minimum skills required to work effectively with the d/Deaf population in your line of work?

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23. Could you please identify any other specialist d/Deaf mental health services in your area.

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Thank you for your valuable contribution to this study. Should you have any questions regarding the research that is being undertaken, please contact Chanel Kenney at XXXXXXXXXXXX or XXXXXXXXXX.

Appendix C

Interview Agenda

As with the survey the following definition applies:

Definitions:

d/Deaf: this term is used in the interview to refer to all individuals who are deaf, Deaf, hard of hearing, deafened and hearing impaired

1. How did you come to work with the d/Deaf? (Providing mental health services to the d/Deaf)

2. What role do you play in the d/Deaf community?

3. What are some of the challenges you face when working with the d/Deaf population?

4. What training did you have to prepare you for your work with the d/Deaf?

5. Over and above the training you have had, what additional skills do you feel need to be acquired to work with the d/Deaf?

6. How does therapy with the d/Deaf differ from therapy with the hearing?

7. What specialist d/Deaf mental health services do you know of in your area?

8. Do you believe any improvements need to be made to services available?

9. What barriers, if any, exist for the d/Deaf in accessing mental health services?

10. What advice would you give to people wanting to provide mental health support to the d/Deaf?

Appendix D

Word Cloud Frequency Tables

The frequency tables below represent the frequency with which relevant words and/or phrases appear within participant responses. This information was used to compile the word clouds seen in the Data Analysis section (see section 5).

Key word/phrase	Frequency
Children	5
School	4
Therapy	3
Psychotherapy	3
Emotional	3
Individual	2
Group	2
Assessments	2
Lecture	1
Lecturer	1
Medical	1
Play therapy	1
Child	1
Adults	1

This refers to the word cloud seen in Figure 14 (see section 5.1.2).

Key word/phrase	Frequency
Sign Language	3
Culture	2
Course	1
Experience	1
Visual tools	1
Child abuse	1
Hearing aids	1
None	1

This refers to the word cloud seen in Figure 19 (see section 5.1.2).

Key word/phrase	Frequency
Sign Language	2
Weekly supervision	1
Technology	1
Audiology	1
Speech therapist	1
Hearing aids	1

This refers to the word cloud seen in Figure 20 (see section 5.1.2).

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Key word/phrase	Frequency
Sign Language	3
Understanding	2
Cultural	1
Masters degree	1
Social Work skills	1
Practical	1
Audiology	1

This refers to the word cloud seen in Figure 21 (see section 5.1.2).

Key word/phrase	Frequency
None	4
Hospital/s	3
Schools	1
Audiology	1
Speech therapy	1

This refers to the word cloud seen in Figure 22 (see section 5.1.2).

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