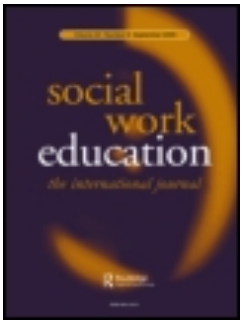

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Culturally responsive social work practice with D/deaf clients

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ABSTRACT

D/deaf individuals are often marginalized in our society. A lack of cultural understanding among social workers serving this population, coupled with communication barriers, inconsistent access to interpreters, or misperceptions of culture, adds to the potential for further marginalization. D/deaf individuals seeking mental health and social services live in a unique cultural context with which social workers may not be familiar and experience persistent issues surrounding access to mental health and social services. This article reviews some useful best practices, cultural points to be aware of, and suggests some strategies for providing culturally responsive social work when working D/deaf clients.

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Deaf; social work; cultural competence

Introduction

D/deaf individuals are referred to social workers for a variety of reasons. These reasons include but are not limited to issues associated with healthcare, mental health, vocational services and education (Glickman, 2013). D/deaf individuals also experience significant obstacles in obtaining mental health care and social services. The hinderances associated with attaining these services are attributable to several factors, the largest of which is due to the limited number of culturally and linguistically competent providers available to work with this population (Gournaris, Hamerdinger, & Williams, 2013; Steinberg, Barnett, Meador, Wiggins, & Zazove, 2006). This creates major challenges for D/deaf adults who use American Sign Language (ASL) in mental health settings because as a group they are vulnerable to isolation, poor service delivery and an increased burden of mental health challenges in comparison to other populations (Cabral, Muhr, & Savageau, 2013; Fellinger, Holzinger, & Pollard, 2012). It is estimated that 34 million adults in the United States have reported hearing loss ranging from mild to profound levels, mostly age related (Plies, Lucas, & Ward, 2009). Approximately 500,000 adults are Deaf ASL users (Mitchell, Young, Bachleda & Katchmer, 2006); with roughly 130,000 Deaf ASL users requiring mental health services (Gournaris et al., 2013).

While social work is taking an increased interest in culturally responsive practice with minority populations (e.g., Jones-Smith, 2019; Paniagua, 2014; Sue, Rasheed, & Rasheed, 2016), social work with D/deaf individuals have received little attention in our field and there are relatively few social workers who specialize in serving D/deaf individuals in the United States (Chovaz, 2013). Clinical competence for working

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with the D/deaf includes not only a strong foundation in mental health issues and sign language proficiency, but also an understanding of the biological, developmental, educational, vocational, social and cultural aspects of deafness (Glickman, 2013). This article provides best practices and reviews some useful skills needed to practice culturally responsive social work with signing D/deaf clients. The word D/deaf will be written primarily displaying D/deaf usage, except for when referencing the Deaf community or Deaf culture specifically. The word 'deaf' written using lower case 'd' denotes the physiological condition of not hearing well regardless of whether or not they choose to identify with the Deaf community. Furthermore, 'Deaf' written using an uppercase 'D' refers to an individual who identifies as a member of the Deaf community.

What does it mean to be D/deaf?

The audiological definition (commonly referred to as the medical model) for deafness, regards being deaf as a disability to be fixed or eliminated. For individuals unfamiliar with Deaf people, being deaf is considered to be a defect, handicap, or abnormality, with the focus being squarely on the sensory deprivation of being unable to hear (Glickman & Gulati, 2003).

In the United States, Culturally Deaf individuals are recognized as a sociolinguistic and cultural minority group, who consider being Deaf a part of their identity and culture that they share with friends and family members who are both D/deaf and hearing (Ladd, 2003; Padden & Humphries, 2005). The Deaf community does not consider being Deaf a disability and many do not prefer to use the term 'hearing impaired' (Holcomb, 2013; Ladd, 2003; Leigh, 2009; Padden & Humphries, 2005). Being Deaf is viewed as a community of people (which transcends geography) who are bonded together by a common culture that includes, among other things, using ASL, a visual based language that is linguistically distinct from English (Wilson & Schild, 2014).

Deaf cultural identity and intersectionality

Intersectionality is a concept that enables us to recognize that perceived group membership can make people vulnerable to various forms of bias, nonetheless because they are simultaneously members of many groups, their complex identities can shape the specific way they experience such bias (Crenshaw, 1989, 1991). Supporting this definition, intersectional identity is concerned with how marginalized identities interact with each other to shape multiple dimensions of personhood. Deaf cultural identity crosses barriers of gender, ethnicity, age and economic status, and certain D/deaf groups are at further risk for marginalization (Leigh, 2009). When working with D/deaf individuals with multiple intersectional minoritized identities, such as a woman who identifies as Black, D/deaf, and lesbian, access to culturally responsive services become an even greater challenge (Chapple, 2019; Leigh, 2009). Nonetheless, effective services should be intersectional, strengths based and culturally responsive.

Working with D/deaf clients using an intersectional strengths based culturally responsive framework

Social workers serve D/deaf clients in a variety of settings including health and mental health hospitals and clinics, social service agencies and educational facilities. The most effective and comprehensive mental health and social services are culturally responsive, and strengths based. Conversely, D/deaf individuals face significant cultural and linguistic challenges when accessing all types of healthcare services, including mental healthcare (Lesch, Burcher, Wharton, Chapple, & Chapple, 2018). This results largely from communication barriers and cultural misunderstandings both within the healthcare system and by mental health practitioners (Cabral et al., 2013). Social work professionals must be able to identify the general needs of their clients and provide a range of effective communication options to ensure that quality mental health services and social services are delivered (NASW, 2008).

The assessment of a D/deaf client should be conducted in the language preferred by the client, by a social worker or other mental health professional who has fluency in the preferred language, or with the assistance of a qualified interpreter who is trained for the context (Leigh & Pollard, 2010; Tribe & Lane, 2009). The social worker should also have basic knowledge of the Deaf community and some of the challenges associated with obtaining an accurate mental health assessment of a D/deaf client (Leigh & Pollard, 2010; Steinberg et al., 2006).

D/deaf patients often report fear, mistrust and frustration in healthcare and mental health settings, similar to other marginalized communities (Steinberg et al., 2006). Cultural competence training among mental health professions rarely include any information on working with D/deaf ASL users (Leigh & Pollard, 2010). This absence of formal training often results in substantial numbers of social workers and mental health professionals who are unfamiliar and may feel unprepared to provide appropriate care to D/deaf clients. This lack of cultural awareness can potentially perpetuate negative health and mental health outcomes for D/deaf individuals in general (Leigh & Pollard, 2010; Smeijers & Pfau, 2009).

Methods of communication

Many studies report that D/deaf patients encounter severe communication barriers when accessing health services (McKee, Paasche-Orlow, Winters, Fiscella, Zazove, Sen, Mathos & Pollard, 2016; Pearson, 2015; Smeijers & Pfau, 2009; Steinberg et al., 2006). A lack of communication with non-signing providers is a common shared experience for D/deaf individuals. In order to communicate effectively with a D/deaf client, the social worker should inquire of the client what method of communication is preferred (Mathos & Pollard, 2016). D/deaf individuals employ various methods of verbal and manual communication which may include speaking, writing and/or sign language. The key is to find which combination of techniques works best with each D/deaf individual, and to not make assumptions that the client will adapt to one method or another.

Working with sign language interpreters

If the D/deaf individual requires a sign language interpreter, a qualified sign language interpreter should be retained for social work appointments and mental health assessments. This is not only for better clinical practice reasons, but it may also be cost effective, as the costs

of inadequate diagnosis and referral might be higher than retaining a qualified interpreter (Tribe & Lane, 2009). When choosing an interpreter, the following considerations should be made to ensure an accurate message: technical language skills in both languages (ASL and English), knowledge of mental health vocabulary, cultural knowledge, interpreting experience and the most effective location for conducting the assessment (Chovaz, 2013). Additionally, the following protocols should be followed: (1) the interviewer should speak directly to the client and not to the interpreter; (2) when the interpreter is signing to the client, the interviewer should pay attention to the client's facial expressions, body language and behavior; (3) the interviewer and interpreter should be aware of their own facial expressions and body language and what they communicate to the client non verbally; (4) and there should not be side conversations between the interviewer and the interpreter, because interpreters are not permitted to add their personal opinion while working (Chovaz, 2013, p. 6).

How to interact with D/deaf clients

The following is a list of ten best practices when interacting with D/deaf clients.

(1) Ask the client about his or her preferred communicative approach. If it is sign language, collaborate with a qualified sign language interpreter, preferably one trained for mental health interpreting.
(2) A D/deaf person can find it difficult to concentrate on an interpreter for long periods of time, since communication involves constant eye-contact in order to obtain the message. Therefore, a D/deaf person may need more breaks than a hearing person.
(3) Engage the client warmly and directly, with eye-contact as often and for as long as possible. Make it clear when focus needs to shift away from the client to look at the computer or to write something down so it is clear what you are doing.
(4) Be aware of the limited effectiveness and fatigue of lip reading. Add clear visual elements to discourse—e.g., gestures; writing notes; and use of simple, key words and grammar, drawings, and many visual aids.
(5) When speaking, ensure that the client has the best possible view of your face. Do not stand in front of a light source (e.g., a window or lamp).
(6) When speaking, use simple language and short sentences. Speak at a natural speed and volume. Give clear, concrete examples, and avoid vague, general terms and jargon. This will assist the interpreter to get your message across accurately and clearly.
(7) Avoid multitasking when in a session with a D/deaf client; effective communication should be the priority. Communicate first, then act.
(8) Accept that good communication with a D/deaf client takes more time than it does with a hearing client. Plan for long client visits because of greater communication and educational clarity needs.
(9) Check for comprehension of the message. Do not assume a D/deaf individual understood your message if they nod their heads in acknowledgment. An appropriate response to an open-ended question ensures that your information has been communicated effectively. Research has shown that D/deaf individuals will adapt

their communication style to the professional with whom they are working rather than ask the professional to adapt to them (Glickman & Crump, 2013).

(10) Write down any key instructions for the D/deaf client to follow including any follow up appointments or other coordinated information from other providers.

Conclusion

This article reviewed some of the skills needed for social workers to practice culturally responsive social work with signing D/deaf clients. D/deaf individuals are marginalized in our society, the lack of social workers trained to work with D/deaf individuals, combined with communication barriers and inconsistent access to interpreters adds to the potential for further marginalization. The National Association of Social Workers [NASW] Code of Ethics (2008) calls for social workers to be '…sensitive to cultural and ethnic diversity and strive to end discrimination oppression, poverty and other forms of social injustice' (p. 1). As such, social workers must employ culturally relevant approaches when working with D/deaf clients. Utilizing an intersectional, strengths-based culturally responsive framework is a cornerstone of social work practice. Additionally, the social worker should seek to understand how the client's deafness and other marginalized identities (i.e. race, gender, sexual orientation) may impact aspects of his or her life.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Reshawna L. Chapple, PhD, LCSW, is an assistant professor in the School of Social Work at the University of Central Florida. Her mixed methods research currently focuses on identity, equity and access for Black women, deaf women and other marginalized groups, using an intersectional lens.

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References

Cabral, L., Muhr, K., & Savageau, J. (2013). Perspectives of people who are deaf and hard of hearing on mental health, recovery, and peer support. *Community Mental Health Journal*, *49* (6), 649–657.

Chapple, R. L. (2019). Towards a theory of black deaf feminism. The quiet invisibility of a population. *Affilia: Journal of Women and Social Work*.

Chovaz, C. (2013). Intersectionality: Mental health interpreters and clinicians or finding the "sweet spot" in therapy. *International Journal on Mental Health and Deafness*, *3*, 1.

Crenshaw, K. (1989). Demarginalizing the intersections of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum*, *1*(8), 139–167.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Sanford Law Journal*, *43*(6), 1241–1299.
Fellinger, J., Holzinger, D., & Pollard, R. (2012). Mental health of deaf people. *The Lancet*, *379* (9820), 1037–1044.
Glickman, N. (Ed). (2013). *Deaf mental health care*. New York, NY: Routledge.
Glickman, N., & Crump, C. (2013). Sign language dysfluency in some deaf persons: Implications for interpreters and clinicians working in mental health settings. In N. S. Glickman (Ed.), *Deaf mental health care* (pp. 125–155). NY: Routledge: New York.
Glickman, N. S., & Gulati, S. (Eds). (2003). *Mental health care of deaf people: A culturally affirmative approach*. Mahwah, NJ: Lawrence Erlbaum Associates.
Gournaris, M. J., Hamerdinger, S., & Williams, R. (2013). Creating a culturally affirmative continuum of mental health services. In N. Glickman (Ed.), *Deaf mental health care* (pp. 138–180). New York, NY: Routledge.
Holcomb, T. K. (2013). *Introduction to American deaf culture*. New York, NY: Oxford University Press.
Jones-Smith, E. (2019). *Culturally diverse counseling: Theory and practice*. Thousand Oaks, CA: Sage Publications, Inc..
Ladd, P. (2003). *Understanding deaf culture*. Clevedon, UK: Multilingual Matters.
Leigh, I. W. (2009). *A lens on deaf identities*. New York, NY: Oxford University Press.
Leigh, I. W., & Pollard, R. (2010). Mental health and deaf adults. In M. Marschark & P. Spencer (Eds.), *Oxford handbook of deaf studies, language and education* (pp. 2). New York, NY: Oxford University Press.
Lesch, H., Burcher, K., Wharton, T., Chapple, R. L., & Chapple, K. (2018). Barriers to healthcare services and supports for signing deaf older adults. *Rehabilitation Psychology*.
Mathos, K. K., & Pollard, R. Q. (2016). Capitalizing on community resources to build specialized behavioral health services together with persons who are deaf, deafblind or hard of hearing. *Community Mental Health Journal*, *52*(2), 187–193.
McKee, M. M., Paasche-Orlow, M. K., Winters, P. C., Fiscella, K., Zazove, P., Sen, A., … Pollard, R. Q. (2016). Capitalizing on community resources to build specialized behavioral health services together with persons who are deaf, deafblind or hard of hearing. *Community Mental Health Journal*, *52*(2), 187–193.
Mitchell, R. E., Young, T. A., Bachelda, B., & Karchmer, M. A. (2006). How many people use ASL in the United States? Why estimates need updating. *Sign Language Studies*, *6*(3), 306–335.
National Association of Social Workers. (2008). Code of ethics. Retrieved from https://www.socialworkers.org/pubs/code/code.asp
Padden, C., & Humphries, T. (2005). *Inside deaf culture*. Cambridge, MA: Harvard University Press.
Paniagua, F. (2014). *Assessing and treating culturally diverse clients: A practical guide* (4th ed.). Thousand Oaks, CA: Sage Publications, Inc.
Pearson, T. (2015). Assessing health literacy in deaf american sign language users. *Journal of Health Communication*, *20*(sup2), 92–100.
Plies, J. R., Lucas, J. W., & Ward, B. W. (2009). Summary health statistics for U.S. adults: National health interview survey, 2008. National Center for Health Statistics. *Vital Health Statistics*, *10*(242), 7.
Smeijers, A., & Pfau, R. (2009). Towards a treatment for treatment: On communication between general practitioners and their deaf patients. *The Sign Language Translator and Interpreter*, *3*(1), 1–14.
Steinberg, A., Barnett, S., Meador, H., Wiggins, E., & Zazove, P. (2006). Health care system accessibility. *Journal of General Internal Medicine*, *21*(3), 260–266.
Sue, D. W., Rasheed, M. N., & Rasheed, J. M. (2016). *Multicultural social work practice: A competency-based approach to diversity and social justice*. Hoboken, NJ: John Wiley & Sons.
Tribe, R., & Lane, P. (2009). Working with interpreters across language and culture in mental health. *Journal of Mental Health*, *18*(3), 233–241.
Wilson, J. A., & Schild, S. (2014). Provision of mental health care services to deaf individuals using telehealth. *Professional Psychology: Research and Practice*, *45*(5), 324.