Exploring the Potential of Constructionist Therapy: Deaf Clients, Hearing Therapists and a Reflecting Team

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This article explores the use of constructionist therapy with a reflecting team of hearing therapists seeing deaf clients. Using findings from two in-depth interviews, postsession reflections and a review of the literature, we propose that this model has the potential to cater to the diversity of the lived experiences of deaf people and also to address issues of power and tensions between medical, social, and cultural models of deafness. The interviews found there was real value in sharing multiple perspectives between the reflecting team of hearing therapists and these deaf clients. In addition, the clients reported feeling safe and comfortable with this model of counseling. Other information that emerged from the interviews supports previous findings regarding consistency in interpreting and the importance of hearing therapists having an understanding of the distinctions between Deaf and hearing worlds. As the first investigation of its kind in Australia, this article provides a map for therapists to incorporate reflecting teams with interpreters, deaf clients, and hearing therapists. The value of this article also lies in providing a much needed platform for future research into counseling outcomes and the efficacy of this constructionist model of therapy.

It is estimated that more than 2 million Australian people experience partial or complete deafness (Australian Institute of Health and Welfare, 2004). The Deaf community is a subgroup of deaf people whose identity is based on sharing common values, beliefs, and norms and, perhaps more crucially, a common and distinct language. The language of the Deaf community in Australia is Auslan (Australian Sign Language). Estimates of the signing Deaf community in Australia range between 6,500 (Johnston, 2004) and 15,400 (Hyde & Power, 1991). There is much debate

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about these figures and the methods used to determine them. Currently, the Australian Association of the Deaf (the peak advocacy body for Deaf people in Australia) endorses the Hyde and Power study, indicating numbers around 15,400.

In Australia, most graduate psychologists, therapists, and psychiatrists, are ill-equipped to meet the mental health needs of deaf people. Research by Briffa (1999) reveals that there is little awareness among clinicians of the cultural and linguistic dimensions of deafness. In large part, this is due to the lack of research available on mental health interventions and outcomes for deaf and hard-of-hearing people. Furthermore, there is no published Australian research into psychotherapy styles, outcomes, or efficacy to guide new practitioners, and, as yet, there are no signing deaf psychologists or psychiatrists in Australia to represent the interests of the Deaf community in the peak professional bodies for mental health. Internationally, the research into outcomes for deaf clients in therapy is almost nonexistent. The vast majority of published papers are theoretical or focus on guidelines for therapists and interpreter qualities. To date, only limited attention has been given to the deaf client's assessment of the real-world therapy they receive.

Constructionist therapy and reflecting teams are innovative counseling methods that have been recommended for use in cross-cultural psychotherapy. However, the application of these methods with Deaf clients has not been explored. Being innovative approaches, many therapists are unfamiliar with the process, theoretical background, and philosophical

foundations of these frameworks. To further complicate matters, few Australian clinicians are conversant with the political, cultural, and philosophical issues that impact on deaf people.

How Do Therapists Understand Deafness?

Senghas and Monaghan (2002) report that, over the past 25 years, there has been a shift of emphasis from pathology and cure to embracing a broader range of frameworks for understanding deafness, including sociocultural, anthropological, ethnographic, and linguistic perspectives. In addition, specific contributions, such as those by deaf academic Mairian Scott-Hill (previously Mairian Corker), highlight the connections and tensions between cultural and disability perspectives on deafness (Corker, 1995, 1998; Scott-Hill, 2003). At the same time, the social model of disability has also gained prominence (Barnes, Oliver, & Barton, 2002; Oliver, 1996; Swain, French, & Cameron, 2003). One of the key features of the social model is its distinction between disability and impairment, and in Australia, this model is also gathering momentum (Robinson & Adam, 2003).

The social model proposes that disability is a form of marginalization or social oppression where people are disabled not by their impairment but by their physical, social, and attitudinal circumstances. As such, medical models are focused on correcting the impairment, whereas social models direct their energy toward addressing the disabling barriers. Moreover, a key tenet of the social model is the valuing of difference or human diversity rather than the sole emphasis on repairing the impairment. In effect, the struggle is to remove the stigma from disability so that it becomes simply a variant of the human condition.

The increasing appreciation of deafness from multiple perspectives makes it imperative that therapists examine their frameworks for service delivery in line with these changing conceptions of deafness. For example, clinicians operating from the perspective of deafness as a disability may have difficulty building rapport with the client who identifies more closely with the cultural model of deafness. More concerning is Reeve's (2002) suggestion that many counselors are unaware of their "disablist" attitudes.

In Australia, reports on mental health service delivery in the public health system reveal a lack of understanding in relation to deafness and Deaf culture among mental health professionals (Victorian Department of Human Services, 2000). These reports highlight the dangers of not using fully accredited Auslan interpreters, using written English to pass notes between clinicians and clients, relying on lipreading, and using family members or friends to interpret (Munro, Philp, Lowe, & Biggs, 2005).

Even less research has been conducted into the experiences of deaf people in therapeutic settings, making it difficult for psychologists and therapists to access information about how to work effectively with deaf people. A review of Australian and international research reveals the following recommendations in relation to counseling and psychotherapy with deaf clients:

• Mental health interventions should be culturally sensitive (Corker, 1995; Freedman, 1994; Glickman & Harvey, 1996; Isenberg, 1996; VicDeaf, 2001).

• Storytelling, externalizing, and using metaphors as counseling tools have been identified as culturally sensitive interventions (Freedman, 1994; Hindley, Dettman, & Beeson, 1998; Isenberg, 1996) and as intrinsic parts of Deaf culture and sign language (Phillips, 1996).

• Deaf people want to be able to communicate with a therapist using their first language and where this is not possible they want to use a skilled sign language interpreter (Freeman & Conoley, 1986; Haley & Dowd, 1988; Henwood & Pope-Davis, 1994; Steinberg, Sullivan, & Loew, 1998).

• Those deaf people identifying as culturally Deaf want therapists to recognize them as a part of a cultural group and not as a disabled group (Corker, 1998).

• Deaf people want therapists to have an awareness and understanding of Deaf culture (Steinberg et al., 1998; VicDeaf, 2001).

The common thread in these findings is the focus on issues of communication, language, and culture. Unfortunately, there are currently no deaf psychologists registered in Australia, and few, if any, hearing psychologists who are fluent in Auslan. Consequently, the vast majority of deaf people will consult a hearing clinician, which is increasingly recognized as a

cross-cultural situation requiring an Auslan interpreter. Previously, access to psychotherapy for deaf people was made more difficult economically, due to the additional cost for interpreting. However, with the introduction in Australia in 2005 of the federally funded National Auslan Booking and Payment Service, the burden of interpreting fees in this cross-cultural context has been removed.

In recognition of the growing number of cross-cultural therapeutic situations, contemporary psychology and counselor training is increasingly concerned with issues of diversity (Leigh, Corbett, Gutman, & Morere, 1996; Maltzman, 2001). Professional development and further study aimed at improving cultural competence are widely promoted. The American Psychological Association goes further by stating that "psychologists should attempt to modify interventions or assessments based on client attributes such as gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status" (cited in Maltzman, 2001, p. 259). Maltzman, drawing from Stanley Sue's (1998) definition of culture, recommends that "the additional variable of culture, defined as shared identity, values, attitudes, and beliefs, can be added to this list" (p. 259).

Effective Psychotherapy and Counseling with Deaf Clients

Despite the recommendations for culturally and linguistically appropriate therapy, there is no convincing, rigorous outcome data on the efficacy of any psychotherapeutic interventions with deaf people. There are research papers on Deaf culture, deaf identities, psychometric assessments such as IQ, self-esteem, depression rates, and literacy levels, but there is no published evidence that empirically supported treatments (also known as evidence based practice) are equally effective when working with deaf people using interpreters. Essentially, there are no large-scale randomized controlled trials or direct comparison designs published with deaf clients. Further complicating the lack of data on outcome is the lack of norms for outcome measures in deaf populations.

In contemporary counseling psychology, support for the common factors theory is gaining momentum.

Recent meta-analyses reveal that the efficacy of any treatment stems not from its unique treatment ingredients but from those factors common to all psychotherapies that are intended to be therapeutic (Wampold, 2001). These factors are variously described as building rapport, agreeing on goals, developing trust and warmth, acceptance, client expectations of therapy, and therapeutic alliance, etc. However, seminal authors and researchers in multicultural psychology, Sue et al. (1998), state that "many multi-cultural psychologists have begun to believe that the focus on empirical reality is overly restrictive, narrow, and represents only one world view" (p. 4). In Cohen's (2003) research on deaf clients' perceptions of psychotherapy, she highlights the connection between therapeutic alliance and cross-cultural treatment interventions concluding that "although unconditional acceptance is the most important/significant factor in the therapeutic relationship, understanding and clinical interventions related to the transcultural relationship (deaf/hearing) enhance the treatment process" (p. 41). As a corollary of these findings, it is the contention of the current paper that therapists explore ways to work that are culturally and linguistically appropriate rather than rely on empirically supported treatments that have no basis in evidence when used with deaf people.

At the 1998 First World Conference for Deafness and Mental Health, a number of innovative counseling methods were presented for counseling with deaf people. Ouellette (1998) argued specifically for constructionist approaches such as solution-focused therapy. She states that "a social constructivist paradigm fits well with the way Deaf people are currently constructing the experience of deafness, and the congruence between the changing social construction of Deafness and the therapeutic approach creates an environment that is likely to yield collaborative and productive therapy" (Ouellette 1998). Where the goal of more traditional or modernist therapies is to apply curative factors to some corrective end, constructionist approaches are not concerned with predefined pathologies. Instead, they focus on creativity in the search for new understandings and new constructions of ideas and experiences that clients find are more useful to them in the way they understand their lives.

In short, constructionist frameworks focus on client strengths and resources (Bertolino & O'Hanlon, 2002; Ouellette, 1998). Social constructionist and constructivist philosophies share much common ground; however, for more detailed discussions on the finer distinctions between social constructionist and constructivist approaches to therapy, see Neimeyer (1993) and Gergen (1985).

Also at this landmark conference, Hindley, Dettman, and Beeson (1998) presented a paper on the use of reflecting teams with deaf clients. In their paper, they describe a team of deaf and hearing professionals who discuss a client's situation in the presence of the client, who, in turn, is given the opportunity to comment on these reflections. This type of "reflecting" uses an open, transparent style of communication that values the multiple perspectives expressed by clients, team members, and the primary therapist. As such, the therapeutic conversations that emerge do not privilege the views of the therapist or the team over those of the client. By respecting the expertise of the client, reflecting teams can help to minimize the power gradient (Haley, 2002). Furthermore, when the client is fully supported by their primary therapist to comment on the ideas that this audience has offered, it can be an empowering experience. This is an example of how therapy can be congruent with the changing constructions of deafness, as Ouellette (1998) suggests, by privileging the voice of each individual client.

This type of reflecting team is based in constructionist philosophy and derives primarily from the work of Tom Andersen (Andersen, 1987). It is important to distinguish the Andersen model from more traditional uses of teams in family therapy, whereby clients are not privy to the team discussions and, instead, the team devises a message or task that is delivered to the clients as an intervention. Other formulations of team processes also exist in a variety of configurations; however, those not grounded explicitly in constructionist philosophy do not address the issues of power and marginalization that Hindley et al. (1998) recognized as valuable in their use of the reflecting team process with deaf clients.

Narrative therapy is another constructionist approach that has been suggested as a linguistically appropriate style of therapy for use with deaf and hard-of-hearing people (Freedman, 1994; Furlonger, 1999; Glickman, 1996). Techniques in narrative therapy (see White & Epston, 1990), such as externalizing, generating metaphors, and storytelling, are congruent with the visual aspects of Deaf culture and sign languages. Externalizing, as it applies in narrative therapy, is a highly visual questioning intervention where clients are encouraged to create visual representations of *problems* so that the issue is seen as separate from the individual.

This process positions the client as having a relationship with a problem, rather than being identified with their problems. For example, conventional questions such as "how often are you anxious? … do you feel overwhelmed with anxiety?" could be asked in an externalizing way such as "how often does this feeling you call anxiety come into your life?" and further, "how big is anxiety in relation to you" and "are there times when you are able to make anxiety smaller or push anxiety away?" As the sessions progress, simple whiteboard drawings can be made as stories about a client's relationship with anxiety emerge, and the struggles and triumphs over anxiety are explored. This type of questioning lends itself to visual and metaphoric representations of the externalized problem or issue. Hindley et al. (1998) identified that "the emergence of visual metaphors in therapy, can have an important role in facilitating change."

Glickman (1996) describes how the visuospatial nature of sign language enables clients to externalize problems by placing abstract notions such as depression and anxiety in space. These signs can be positioned using space and gesture to represent the size, frequency, distance, or intensity of a problem or issue. As new stories emerge, signs can be placed in space differently to demonstrate how clients experience changes in their relationship to the externalized representation of the problem. Glickman (1996) cites narrative therapy as "precisely the kind of creative, culturally affirmative treatment we need to see more of" (p. 48).

Wax (1999) also discusses the potential that constructivist therapies offer deaf women in particular. She reviews critical factors in the success of psychotherapy between clients and therapists from different cultures and highlights the importance of

"constructing shared meaning about elements of culture through a psychotherapeutic process of ongoing dialogue and revision of narratives" (p. 72). She proposes that "such mutual construction of meaning/rapport would be maximized when both client and therapists share similar characteristics (e.g., both deaf and female), there is also a risk that both would bring similar negative or destructive perspectives to the therapeutic encounter" (p. 72).

One way to minimize this risk is to use a reflecting team that represents diversity in terms of age, gender, life experience, etc, so that clients are offered a variety of dialogues and diverse "revisions of narratives." Reflecting teams have been widely used to train counselors, psychologists, and marital and family therapists (Lebensohn-Chialvo, Crago, & Shisslak, 2000). They are ideal for university and teaching settings where therapists can learn from doing and watching and through supervision and debriefing. Griffith (1999) describes this method as both economically and pedagogically effective.

In Australia, reflecting teams are also being used outside university and teaching settings. Individual agencies have developed a range of creative and cost-effective ways to incorporate reflecting team processes into their service delivery. These include; using small teams of one or two people, offering some clients a single session with a team, providing a team for every third or fourth session, inviting teams to reflect when clients seem to be "stuck" or making minimal progress, and training previous clients with an interest in particular issues (e.g., substance abuse or eating disorders) to be peer reflectors.

Despite these diverse applications and benefits, the use of reflecting teams is still very innovative in Australia, and to date, there is no published research on their use with deaf clients. In an effort to provide a contemporary, culturally relevant service for deaf clients, this model for using reflecting teams with deaf clients and hearing therapists was developed and trialled over a period of 9 months. The model was developed with attention to issues of access, power imbalances, linguistic relevance, and cultural sensitivity. Haley (2002) provides a thorough description of the links between constructionist therapy and the use of reflecting teams.

The Current Research Objectives

Due to the lack of awareness and training with regard to cultural and linguistic aspects of deafness in Australia, access to deaf-friendly counseling services is extremely limited and in many areas, nonexistent. Using an existing counseling clinic with a reflecting team, provided an opportunity for a number of therapists to simultaneously gain experience and knowledge about working with deaf people and sign language interpreters.

The primary objective of our current research was to explore if the use of a constructionist model of counseling with a reflecting team for deaf clients was possible, given the added complexities of having a team of hearing therapists and the challenges for interpreting in this unique setting. Although the literature indicates that the social constructionist framework with a reflecting team may address a number of philosophical, cultural, and therapeutic issues, this research provides a real-world application of these ideas.

Method

The Study Setting and Participants

The setting for our research was an Australian University teaching clinic for counseling and family therapy. The clinic primarily uses competency-based and constructionist counseling approaches with a reflecting team. The therapists are professional counselors undertaking a Master of Counseling degree at the university. The team members had no experience working with deaf clients; however, the primary counselor had been working with deaf clients for approximately 2 years.

Referrals were accepted from deaf people and their families for one day each week over a period of 38 weeks. During this period, 11 deaf clients self-referred or were referred via community agencies. Six of these clients had three or more sessions and were invited to be interviewed about their counseling experiences. Two clients accepted the invitation, and consent processes were carefully negotiated using a qualified Auslan interpreter. To protect client identities, the participants we interviewed will be referred to as "Abby" and "Rhianne." Both women were aged
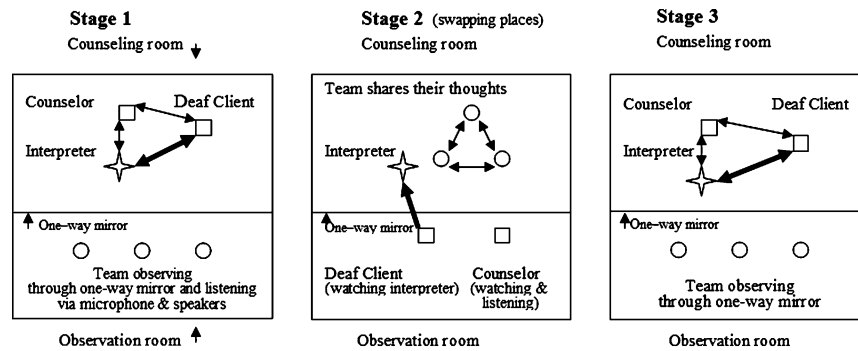
Figure 1   The reflecting team process: stages and configuration.

between 35 and 45 years and were not known to each other. Abby attended seven sessions throughout the year and Rhianne attended nine sessions.

The Counseling Process Under Investigation

Each session was 1 hr in duration, conducted by the primary counselor (a hearing psychologist) in conjunction with an Auslan interpreter. Before the first session, the therapist explained to the clients the process of working with a reflecting team and the logistics of swapping between the counseling and observation rooms. Figure 1 outlines the geography of using the Andersen model of a reflecting team (1987) that we adapted for working with deaf clients and an interpreter. This figure also illustrates the changing arrangements for each of the three counseling stages, swapping rooms and ensuring that the interpreter is placed appropriately in each of the three stages.

Prior to the commencement of each session, the counselor took the client to the observation rooms to meet the members of the team working with them that day. The counselor then moved through the following three stages involving the use of the reflecting team.

In stage one, the counselor begins the session with the client, while a team of between two and four counselors observe the session from behind a one-way mirror in the observation room. The counseling room has audio equipment that allows the session to be heard in the observation room via speaker systems. The second stage is marked by inviting the team into the counseling room to reflect on their impressions of the session. During this stage, the counselor and client move into the observation room in order to observe the team's discus-

sions from behind the one-way glass. This stage enacts the reflecting team process. During this part of the session, the interpreter remains in the counseling room with the team and interprets to the deaf person through the one-way mirror. In the third and final stages of the session, the team moves back into the observation room and the counselor and the client discuss the team's reflections.

For the current research, the same counselor (first author) conducted each counseling session. Teams of between two and four members were drawn from a pool of eight counselors working in the clinic that year. This arrangement enabled the client and counselor to develop their relationship together as the primary connection but also provided some variation in perspectives due to the changing team sizes and personalities. Being a teaching clinic, this arrangement also provided each team member with the opportunity to experience working with an interpreter and a deaf client through their role on the reflecting team.

It has been found that deaf people highly regard attempts by hearing people to use sign language (Steinberg, Wiggins, Barmada, & Sullivan, 2002; Young, Ackerman, & Kyle, 2000). In light of this, the counselors working with deaf clients in the clinic learned to say *Hello* and to introduce themselves in Auslan.

After the counseling session, the counselor and the team would come together for peer supervision facilitated by the clinic supervisor, an experienced clinician in the use of constructionist approaches and collaborative reflecting teams. The purpose of this supervision was to critically reflect on the sessions in an effort to increase understanding about working with deaf

clients, make adjustments, and ultimately improve the counseling service.

Philosophical and Methodological Approach to the Research

Social constructionist research principles (Crotty, 2003; Guba & Lincoln, 1989) with their appreciation for multiple perspectives and acknowledgment of power imbalances, provided the framework for the research design. Social constructionist theory also recognizes the role of language in the construction of meaning, and this is particularly relevant where language is being interpreted from the visual spatial mode of sign language to the auditory verbal mode of English (see Temple & Young, 2004). Much of the existing counseling research privileges the voices of clinicians with regard to what is effective for clients, whereas our research design places the experiences of deaf clients at the center of the inquiry.

The in-depth interview, described by Hesse-Biber and Leavy (2006) as "a meaning-making endeavor embarked on as a partnership between the interviewer and his or her respondent" (p. 119), was considered the most appropriate technique to garner the views of participants on their experiences of this counseling process. Consistent with the constructionist approach adopted, an interview guide provided suggested rather than defined topics to be explored in the interview. This format provided participants the opportunity to express their experiences of the counseling process in their own words and on their own terms.

Topics included on the interview guide were as follows:

- The counseling experience.
- What was it like to have a "reflecting team."
- Their experience of safety, comfort, and trust.
- Contrasting previous counseling experiences.
- The processes of interacting with clinic staff to make appointments.
- Other issues clients wished to raise.

The interviewer was careful to frame questions as neutrally as possible in order to minimize the risk of leading participants in any particular direction, for example "what was it like when you met the team?" This approach allowed the issues and themes to emerge from the expertise of the participants and the facilitation of this expertise by the interviewer (Hesse-Biber & Leavy, 2006; Minichiello, Aroni, Timewell, & Alexander, 1995).

Procedure

It was decided that the interviews would not be conducted by the counselor or any of the interpreters who had attended sessions at the clinic, so that interview participants might feel more able to critically and freely comment on their experiences of the counselor and the interpreters. However, the need for the interviewer and interpreter to be people who the participants trusted was also imperative. In recognition of these issues, interviews were conducted by two people: the clinic supervisor, who was experienced in working with deaf clients; and a very experienced Level 3 Auslan interpreter (qualified at the highest level in Australia) who also had previous experience in research settings and was approved by the participants.

Being an experienced constructionist counselor, the clinic supervisor was skilled in constructionist interviewing. Each interview lasted approximately 1 hr and, throughout the interview, checks were made with the participants to clarify interpretations and to provide space for the participants to add, modify, or further develop their views. The interviews were videotaped in the university clinic setting, with the consent of participants. One researcher (first author) with specific knowledge about the university clinic, the counseling process, and the ability to read Auslan responses viewed the video data and transcribed the interviews from the taped spoken English to written English. The second researcher (second author) was a university academic, well-versed in qualitative research, who was unknown to the participants, unfamiliar with the clinic's constructionist counseling process, and possessed no sign language skills. In the interests of rigor, these two researchers analyzed the data.

Qualitative methods of constant comparative analysis outlined by, among others, Glaser and Strauss (1967) Strauss and Corbin (1990) and Miles and Huberman (1994) directed the data analysis. The two researchers pooled their lists of emergent themes and generated ideas about how these themes, and the relationships between them, reflected the experiences

of the interview participants in the clinic with reference to the research objectives. The procedure for this research was approved by the university ethics committee.

Issues of Rigor

Constructionist research frameworks recognize the importance of rigor in qualitative methods, but they are conceptualized quite differently from the more commonly used quantitative approaches to research in psychology. Constructionist philosophy acknowledges the existence of multiple truths, realities, and accounts and is not therefore concerned with uncovering a single, undeniable, unbiased, or generalizable truth. Crotty (2003) defines constructionism as "the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (p. 42).

Given this, reliability, validity, and bias, as they are conceptualized in positivist quantitative research, are replaced by attention to issues of trustworthiness and credibility (Denzin & Lincoln, 2000; Golafshani, 2003; Morrow, 2005; Patton, 2002). Trustworthy research is characterized by meeting a number of credibility criteria. Morrow (2005) and Patton (2002) identify numerous ways to achieve credibility in qualitative research. The current research used five of these methods to achieve credibility.

1. Prolonged engagement—The interviewer was known to the clients and had demonstrated an ability to build rapport with them over a period of 9 months in a confidential setting. As director of the university clinic, she was introduced to all clients at their first presentation as the appropriate person to direct both positive and negative feedbacks regarding their experiences. We believe these qualities provided a sense of safety and trust for participants to be honest in their responses.

2. Reflexive questioning—The use of open-ended questions enabled the interviewer and participants to co-construct the data, where other styles of questioning may have resulted in data that have been more narrowly drawn about by the interviewer. Reflexive questioning seeks to uncover not just what a person thinks but how they know this, where the knowledge comes from, and explores how this knowledge has been shaped by experiences. Reflexive questions explore how filters such as age, gender, socioeconomic status, political position, social identity, etc, impact on the expression of thoughts and ideas (Patton, 2002). For example, when discussing the idea of feeling comfortable in the clinic, the interviewer asked the participant questions about other places they experienced comfort and to compare levels of comfort. The intention behind this reflexive questioning is to provide a context for the experience of comfort and to explore how the experience of comfort might be related to experiences of age, or gender, or geography, or culture, etc.

3. Data quality—The process of capturing, interpreting, transcribing, and analyzing the data is an important consideration with respect to rigor. The interviewer was experienced in constructionist questioning and bracketing. Specifically, these skills involve asking questions in a nondirective manner, being cautious not to make assumptions as to the meaning of content, regularly reflecting back content and checking for understanding, and maintaining a persistent curiosity to encourage deeper exploration of the interview content, as outlined in Reflexive Questioning. From a constructionist perspective and considering the current research questions, bias due to the Rosenthal effect is minimized when there is no hoped-for response. All content is considered valuable in constructing shared meaning about the experience or phenomena being discussed.

A fully qualified and professionally accredited interpreter with more than 20 years experience interpreting in general, legal, and research settings was chosen to interpret for the interviewer and the participants. Interpreters with this type of experience and skill understand the importance of professionalism, ethics, and accuracy in interpreting. The interviews were videotaped, and transcripts were produced based on the voicing in the videotapes. In addition, the transcriber (first author) was conversant in sign language and familiar with the physical dimensions of the university setting and was therefore able to provide

a further check on accuracy of the interpreted content. This is an important consideration when viewing a signed conversation that typically makes reference in space to particular experiences requiring knowledge of who was present at the time or where they were sitting.

4. Investigator triangulation and reflexivity—The constructionist approach of valuing of multiple perspectives is brought to bear on the data analysis itself. Two researchers with differing academic backgrounds (one a sociologist and one a psychologist) analyzed the data separately. One researcher has signing skills and one does not. One researcher was familiar with the university clinic and counseling framework and the other came to the interview data with a naïve perspective on the counseling experience under investigation.

Lastly, the relationship between the researchers and participants was also a point of distinction. One researcher was a participant in the therapeutic journey of these interviewees and was able to bring an insider perspective to data analysis process. The other researcher had never met the interviewees and was not privy to any information about their therapy or their lives. These distinctions provided balance to the research with both an intimate perspective on the data and also enabled the researchers to debrief each other about biases. The two data analysts met regularly to discuss the interview content and coding. By bringing different academic and professional perspectives to the data, a range of ideas were discussed, and the role of devil's advocate was used to actively challenge potential biases in the interpretation and co-construction of meaning in the data.

5. Participant checks—(also referred to as member checking).

Ideally, transcripts can be given to participants to review as a further check. However, the participants in the current research were unable to assess the accuracy of the written transcripts due to compromised English literacy skills. This is indeed a limitation in the current research. Instead, the use of continuous real-time checking with participants at various times through the interview was used. For example, "let me just check that what I am hearing is what you mean …?"

In addition to these criteria for credibility, the intent of the current research is exploratory and does not seek to test hypotheses, demonstrate clinical outcomes, or propose findings that can be generalized to the other settings. As such, there is no investment in any particular outcome, despite the first author and the clinic supervisor being involved in both service delivery and research. The most obvious threat to the credibility of this research is that it is was not possible to recruit a deaf person to assist with the data analysis. The number of deaf professionals working in academia or allied health in Australia is extremely limited, and we were unable to engage anyone with the appropriate research experience at the time. As hearing people, we are not able to fully grasp the intentions and meanings of the interviews from the linguistic and cultural perspectives of a deaf person. In recognition of this, we have focused our results on what was clearly stated in the interview data and we have largely avoided making any inferences. Based on these considerations, philosophically and methodologically, we are satisfied that the data presented are both trustworthy and credible.

Results

Even though this model was unfamiliar to these clients, both women talked about feeling comfortable in the university clinic and finding positive value in the role of the reflecting team. The responses indicated that this model is possible to use with deaf clients, hearing therapists, and interpreters.

The five key findings were as follows:

1. The clinic was experienced as a safe and comfortable place to be honest and open about problems and feelings.

2. The reflecting team was useful.

3. The overall counseling experience was positive.

4. Understanding that Deaf culture is different from hearing culture and other cultures was important.

5. Service issues and making adjustments:
- Access: Using mobile phone text messaging and Fax to make appointments was appropriate.
- Timing: Hour-long sessions were appropriate.
- Interpreting: Using the same interpreter was preferred.

- Flexibility: Being flexible during the sessions and checking in with the client were described as *acceptance*.

1. Safety and Comfort: "I felt comfortable here"—"I didn't feel safe in other places"

Both Abby and Rhianne indicated that they felt comfortable coming to the university counseling clinic and both contrasted this with previous experiences where they did not bother to continue or did not feel that the therapists understood them. Abby expressed this well with her comment:

> Yes I did feel safe. But one thing … this place here, I can see what its like. Its very different to other counseling settings. I didn't feel safe in other places ….

> I feel with this clinic here you have been very accepting, so when I have asked for clarification you've listened. Previously people didn't really understand what I was on about. Like other counselors … if I asked what something meant they kind of couldn't be bothered with giving me that bit of assistance, they wouldn't change to help me, I didn't feel … they would just keep going on and on with what they were talking about.

Abby spoke at length about her years of struggling to find a counseling setting where she felt the therapist understood her and understood what it meant to be deaf. She described one particular encounter in a previous counseling setting where she believed that the therapist thought she was "a stupid, deaf person." She also described the use of inappropriate techniques: "They'd give me the handouts with the terminology and, I'd try to understand the words, that was frustrating in itself." Abbey's comments highlight the importance of using a range of different approaches that might help in communicating ideas between the therapist and the client rather than using written material. Typically, constructionist approaches invite clients to use the whiteboard or other methods of externalizing issues in order to communicate thoughts and feelings.

Rhianne described a previous experience of counseling that she discontinued. However, unlike Abby

who persisted with different settings and therapists, Rhianne blamed herself for not continuing.

> Int: We're interested in the differences between what you have experienced in this service and what you might have experienced in other services. Have you ever had any other counseling before?

> Rhianne: Before I went to (name deleted), but I went there by myself and that was about ten years ago. I went to counseling sessions there and also to the women's health clinic. That was about … I'm not really sure. I think that was more than ten years ago or five years ago—I really can't remember. And also they prescribed tablets, because, I had a lot of worry, a lot of sadness, a lot of depression. So I was able to get some tablets, St John's Wort tablets, they gave me tablets. So that was the result of my visit there. I should have really kept going, I should have kept going but I didn't bother, so it was my own fault.

In contrast to this previous experience, Rhianne consistently came to every appointment she made at this university clinic.

> Int: You made a number of appointments, what was it that kept you coming back here?

> Rhianne: Because in my mind and body I know I need the help. I have problems and I needed somebody to help me and I needed the ideas and I needed the help from counselors and I felt comfortable here.

People who have not experienced working with a reflecting team often express surprise to learn that clients (whether hearing or deaf) are willing to share their stories in front of an audience. Abby and Rhianne were clear about feeling safe and comfortable in the reflecting team setting.

2. The Reflecting Team: "Having the team is a good idea"

The experience of the reflecting team was completely new to both participants, but both found it to be a valuable part of their counseling experience. They also said that this counseling was better than previous

counseling experiences. When Abby was asked how she felt about having the team she responded:

> When I came here first of all, because I hadn't heard about the team I was really surprised, and the counseling here is the best I've had because there is a lot of information shared (pointing to where the team is usually seated when they provide their reflections).

Rhianne supported Abby's views and suggested that the team contributed to her feeling comfortable in the clinic.

> Int: …you said that you felt comfortable here. What do you think it was that made you feel comfortable? It could be something in the environment, it could be about the people, it could be something about having interpreters? What was it?
>
> Rhianne: I think having the team is a good idea, like you have different ideas coming forward to provide help. I noticed different comments and I felt very comfortable with that and I could understand what was being said and I thought yeah that was good.

Both participants also talked about being able to choose from the information provided in the team's reflections. Some ideas made sense for them and others did not. This gave them a range of perspectives from which to generate new ideas about their problems and their lives. Rhianne captures this:

> They had really good ideas about things, I could see they had good ideas, they were different ideas, some I'd agree with some I didn't agree with, sometimes they weren't perhaps the ideas that I would come up with but they were good ideas.

The participants were also asked how they felt about having all hearing people on the team. Abby said that she preferred them to be hearing as the Deaf community was small and she was concerned about issues of confidentiality.

> If there were deaf people on the team I would feel my confidentiality could be breached … I would be really concerned about them talking because the Deaf community is very small.

This is an important information to consider when using reflecting teams. Ideally, teams would have deaf and hearing people working together, but Abby's concern about confidentiality highlights the need to carefully explain the role of the team and the confidential nature of the setting. Team members need to be professionals who are cognizant of ethical conduct. This information needs to be explained to deaf clients particularly where communities are close and dual relationships are more likely. If possible, clients can also be given a choice regarding the composition of the team. In contrast, Rhianne indicated no preference for either deaf or hearing team members.

3. Overall Counseling Experience: "I felt I was getting help"

As part of the investigation into the participants' experience of this counseling model, they were asked about the success of their counseling sessions. Abby and Rhianne both reported positive experiences of the counselor, the team, and the clinic generally. Rhianne said:

> That's one of the reasons I came, because I felt I was getting help, I felt things were improving.

When asked about achieving her goals she said:

> I think some things were successful and some were not successful. So I think both of those …. I needed more time so that we could find the appropriate place for my goals to be realized….

Rhianne indicated that although she had not fully reached her goals, she felt she was making progress in this university clinic. Rhianne also said that she intended to continue with more counseling when the clinic resumed after the summer recess. This contrasts with Rhianne's previous experience of counseling where she only attended one session.

Abby described the overall outcome as being successful. When asked about whether she felt she had achieved her counseling goals she said:

> Yes I have. It was a real shock to me because I didn't realize … In the past I thought that hearing people were right. Now I realize that they weren't, it was their own way of working; they didn't understand the cultural differences. Here I've been provided with answers and explanations.
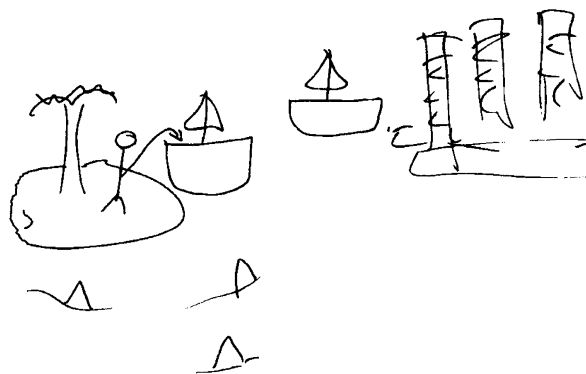
Figure 2 Abby's picture of Deaf and hearing worlds.

4. Issues of Culture: "Deaf and hearing people are very different, they have different cultures"

Both participants talked about the difficulty in bridging the distance between Deaf and hearing cultures. They said that it was important for the counselor to be aware that Deaf culture and hearing culture are very different and spoke about how isolated they believed they were from information and access to services. Both participants talked about the frustration they experienced in settings where hearing people had no understanding of deafness or Deaf culture. This experience was relayed in detail by Abby, who described being deaf as an extremely isolating experience. In this regard, Abby gave an example illustrating the distance between Deaf and hearing cultures:

> (Abby draws an island with water and sharks surrounding it, separate from a mainland, see Figure 2) so these are sharks … and these are buildings (Abby draws these on the mainland). So here (pointing to the mainland) you have Aboriginal, you have white people, you have Asian people as well, all living there. So when they hear someone speaking, well, they will know, but here you have this person, like a deaf person is isolated, they're not able to access information they're hurt, they're suffering, and this is their life, they suffer, but these other people have support, but deaf people suffer, they are isolated and they don't know, they have no information coming through to them, they live here on this island without any knowledge, we grow up without having all the input, without

having any of the same information, or experiences like these other groups that live in Australia over here. So I said this to the counselor and I said what we need, (adding to the drawing) we need to have a little ship that will come out to the island … this is how I feel about getting information. I have waited for so many years to get information, and at last now I am getting some information….

> This clinic has provided a lot of answers for me. I'm really surprised because here the counselor has a lot of experience, and with the other people (pointing to where the team sits) who are dealing with (she names her problem issues). This is what I've noticed the counselors have demonstrated.

Abby's story and picture describe a distinct sense of feeling isolated from hearing people and hearing culture, but she also details how previous counseling has not been able to bridge this gap. In her description, she contrasts her previous experience of having to teach the counselor about Deaf culture with her current experience, where she says that this clinic was able to provide her with answers and information. She described this in her drawing as "a little ship" that provided her with a link between Deaf and hearing worlds.

Abby said that she felt the counselors in this clinic had a lot of experience with her issues, despite them being new to working with deaf clients. Constructionist approaches are characterized by taking a very curious, tentative stance as opposed to providing answers for people as such. This stance, along with the questions and thoughts posed by the team in Abby's counseling sessions, seems to have provided her with the link she says was missing in the past and she described that link using the terms "answers and information."

Rhianne also described the divide between hearing and Deaf culture and indicated that the clinic was a place for sharing information about Deaf and hearing cultures:

> Int: So coming to a clinic where people were hearing, was there any difficulty in that for you? Or was that easy for you? What was that like?

> Rhianne: It wasn't really difficult with all the people being hearing. Like I've never been (pause) I've

never been working with a lot of hearing people, do you know what I mean? So it was new for me. I think it's important for both deaf and hearing people to learn because deaf and hearing people are very different, they have different cultures. And I think, like for me, for me I've grown up with a very strong Deaf culture … for me it's good to learn about hearing culture as well.

Both participants described the idea of bridging the divide in their own words, and they also talked about needing to function in both cultures. However, at the same time, they said they felt more comfortable in situations where there was an understanding of Deaf culture.

5. Service Issues and Making Adjustments: "…it was good, so I asked to check, and if something needed to be adjusted, well, we could do that"

Access.   When we began taking referrals for deaf clients, we considered a number of aspects we would need to adjust in order for deaf people to access the service easily and feel comfortable in a setting staffed entirely by hearing people. We used a mobile phone or a fax to contact and communicate information about appointments, adjusted seating positions, and provided a plain background behind the interpreter where possible to decrease visual noise and distraction. We asked the clients about making and rescheduling appointments and organizing interpreters, and both clients said that they had no trouble using fax or a mobile phone for text messages. Even though the contact methods were experienced as convenient, Rhianne highlighted the extra stress on deaf people if they do have to cancel an appointment at late notice with her comments:

> Like if something happens on the same day as the appointment, well I'd have to phone straight away. I know that one day is very short notice, the interpreter comes here for nothing.

Timing.   At the clinic, we are often asked how we fit the reflecting team into a standard 1-hr session. Over the 6 years that the clinic has been operating, we have found 1 hr to be adequate. When we began taking referrals for deaf clients, we decided to stay with the 1-hr session length and see if we needed to make changes based on the client feedback. Clients, interpreters, and therapists all agreed that the hour-long session also seemed adequate working with deaf clients and interpreters. We checked this with Rhianne when she talked about the length of sessions:

> I think one hour was fine, that amount of time was fine. Half an hour would not have been enough time but an hour was fine.

Interpreting.   Rhianne had three different interpreters due to interpreter shortages and booking difficulties. She described the difficulties inherent in this inconsistency as:

> I would prefer to have the same interpreter because if you have different interpreters all the time that can become confusing, so if you have the same interpreter on a regular basis it would be better, because sometimes if you have a series of different interpreters I wouldn't feel comfortable. Like, if you first meet the interpreters for the first consultation and then the second one… it can be confusing.

When Rhianne was asked about any ideas for what would make the counseling at the university clinic better for deaf people, her response was clear:

> I prefer to have the same interpreter on a regular basis because then the interpreter would know more.

With no precedent for where to position the interpreter during stage two when the team and the client swap places, we decided that the interpreter would remain in the counseling room for each of the three stages and interpret the team's conversation through the mirror to the deaf client who was seated on the other side with the therapist. As far as being able to access the information from the team and the counselor via the interpreter, both Rhianne and Abby said that they were happy with the visual positioning of the team and interpreter during each of the three stages of counseling (see Figure 1). Our intention was to keep

the interpreter in the same space as where the conversations were taking place, that is, the counseling room. We also wanted to reinforce the primary therapeutic relationship between the therapist and the client.

Flexibility.   In terms of adjustments to the therapeutic process, these decisions were made with the clients during sessions by checking for understanding and eliciting feedback from the client as part of the closing stage. Examples of questions commonly asked included, "What was useful for you today? Was there anything that you didn't like about the session? Is there something you think we could be doing differently?" Key to constructionist approaches is the importance of adjusting to fit with the needs of the client.

At one stage, Abby requested that we adjust the positioning of the team. In the third stage of counseling, Abby wanted to ask the team about some of their ideas directly, rather than move to observation room.

> Int: So it was better for you when we changed things a bit and you stayed in here in the room with the team?
>
> Abby: Yes, I sat here and the team was there so if I needed clarification I could have that and we could have more discussion.

Some other adjustments were made based on reflections from the team and the counselor in postsession discussions. For example, it was noticed that in Abby's early sessions, there was a lot of time spent listening to Abby tell her story, more so than with other deaf clients. The way Abby told her story in the first few sessions was detailed and lengthy and left few pauses for input from the counselor.

Postsession, the team and the counselor reflected on how useful they were to Abby in just listening to her talk about her life. The team raised the possibility that deaf people who have grown up in a nonsigning family or who have had limited contact with a Deaf community may have had few opportunities to talk about their life in detail, and storytelling is purported to be an important aspect of Deaf culture. Given this, we made adjustments to the way we perceived our role in counseling with Abby. We asked Abby if it was

helpful to use the team as an *audience* who could hear her story and provide reflections about the content that might help to reveal her strengths and triumphs as well as acknowledging her pain and suffering. Abby talked in the interview about her experience of being listened to in this way by the team and the counselor:

> With previous counselors I hadn't really had the opportunity and I hadn't really spoken openly about it. But here I was able to divulge a lot of information, I was able to talk about my family, and the counselor listened to what I had to say and then because of that I was able to bring out a whole lot of information. I was able to explain a lot of things, because I was listened to. I was able to bring out this information, actually, this was the first time I could do this because previously I had only been able to bring out some things that I was angry about, but I couldn't bring out the full information.

Sometimes, the language we used did not easily interpret into sign language, and some English idioms did not have any equivalent meaning in sign language. As a result, we tried not to use more obscure idioms like "using elbow grease" and stayed with language that was clear, giving a range of visual examples using the whiteboard, or figurines, and we were mindful that our words were being interpreted into signs. Our intention was to be responsive to the needs of deaf people as a group, making adjustments for general issues of access, lighting, etc, but also adjusting to the individual needs of each client. This counseling model allowed for flexibility in language, process, and mediums for communication.

We asked Abby if there were any changes she could recommend to improve the service for deaf people at the clinic. She describes our commitment to being flexible and making these individual adjustments as an indication that we are accepting of deaf people:

> I think great changes have been made already, I think it's amazing. You're most accepting for deaf people. Other counselors won't make the changes to make it a more accepting environment.

Discussion

The purpose of this article was not to demonstrate clinical efficacy or superiority but rather the therapeutic possibility as a basis for establishing "first principles" in this innovative practice. These findings make a meaningful and significant contribution to understanding the role and application of constructionist therapy and using reflecting teams with deaf clients. We propose that this model has potential to provide a culturally and linguistically appropriate counseling service for deaf clients consulting with hearing therapists.

The clients interviewed described their experience of this model of counseling in positive terms and said that they felt comfortable and safe with the reflecting team. Both clients said that the information sharing provided by the reflecting team was useful. One client said that the addition of the team and their ideas contributed to her sense of comfort. Hour-long sessions were sufficient, and as previous research has identified, consistency in interpreting was identified as important. The process of making adjustments at both a practical and a process level was valued by these deaf clients. We would recommend the use of a mobile phone for text messages and Fax to contact clients and that counselors learn to introduce themselves in sign language.

Although the interviews revealed the importance for counselors to recognize that Deaf and hearing cultures are different, we are not prepared to make any further inferences about these statement based on the current data. However, we have identified some interesting research questions that have emerged from the interviews. First, how do deaf people determine that therapists understand Deaf culture? And second, is it necessary to understand Deaf culture per se or could the experience of feeling as though you were really being listened to and understood, as described by Abby, be sufficient for a good therapeutic outcome? In the current research setting, the therapists' experience of Deaf culture was limited and yet Abby, who had seen a number of different therapists in the past, found that this clinic was the most accepting and provided her with answers she had been searching for over many years. This idea is consistent with the meta-analyses that point to the importance of having a strong therapeutic alliance.

These findings are encouraging and suggest that there is merit in a broader investigation into the use of this counseling model with deaf clients; however, there are two important limitations. First, although the use of qualitative methods has proven ideal for this initial exploratory research, we recognize that the findings cannot be generalized. In order to expand the potential of the current research, we plan to assess this counseling model using a quantitative approach to measure counseling outcomes across a larger sample size. Our future research goal is to use established measures of therapeutic alliance and counseling outcomes that have been interpreted into Auslan. These instruments will be used to measure counseling efficacy in the same university clinic over a 12-month period. Currently, no such measures have been interpreted into sign languages, and this is probably why so little research has been done in this area.

Second, there were no deaf therapists or researchers involved in this study. In our next project, we intend to include a deaf person on the reflecting team. This addition would mean that deaf clients have a deaf perspective to draw upon when considering the comments proffered by the reflecting team. Furthermore, a deaf team member could facilitate valuable learning to the hearing therapists. Issues of confidentiality, professional ethics, and dual relationships will be important considerations given the small size of the Deaf community in this region.

Ideally, the Deaf community should be able to access a full range of linguistically and culturally affirmative, quality, counseling services. To that end, this model of counseling enables more graduates to leave university settings with beginning skills for working with deaf clients. It is our hope that through this research, we have provided a map for the implementation of reflecting teams with deaf clients and contributed to a deeper understanding of cross-cultural therapy with hearing therapists and deaf clients.

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