MENTAL HEALTH SERVICES FOR THE DEAF: USE, BARRIERS
AND PREFERENCE OF PROVIDER

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By
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CERTIFICATION OF APPROVAL

MENTAL HEALTH SERVICES FOR THE DEAF: USE, BARRIERS
AND PREFERENCE OF PROVIDER

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ABSTRACT

The purpose of the present study was to assess if there is a relationship between a Deaf and/or hard of hearing individual’s level of identification with the Deaf culture and their past and current use of therapy. Participants were 25 Deaf and/or hard of hearing individuals, ages 18 to 73 recruited from a local Deaf and hard of hearing service center. Identification was assessed using the Deaf Identity Development Scale. It was hypothesized that individuals that scored highest in the immersed subscale would use less mental health services, perceive more barriers to accessing services, and would be less likely to use a hearing or non-signing therapist than those that scored highest in the marginal, bicultural or hearing subscales. Because there were not enough participants to adequately fill the identity categories, immersed (4%), bicultural (88%), hearing (0%), marginal (4%), the hypotheses could not be statistically tested. More participants indicated that he or she agreed they want more mental health services than those who did not agree, it failed to reach statistical significance (p = .064). Although the most endorsed first contact for a mental health issue was family or friends, if they were to use a mental health professional, a majority of participants stated they would prefer someone who can sign or is Deaf.
CHAPTER I
INTRODUCTION

Based on data from the U.S. Census Bureau, Brault (2005) estimates that there are over 7.5 million people who have difficulty hearing, one million of whom reported they were unable to hear at all. Difficulty hearing and communicating with others may make it more difficult for Deaf and hard of hearing individuals, like other cultural minority groups, to access many valuable community resources that are available. The present study was designed to assess whether there may be a connection between a Deaf and/or hard of hearing person’s level of identification with the Deaf culture and his or her current and past use of therapy, barriers to accessing mental health services, and preference of mental health professional (signing, non-signing, non-signing with an interpreter).

What is Deafness?

There are several definitions of deafness. It can be identified and quantified by a person’s ability or inability to physically hear a certain decibel range, discussed as a disability, or be defined based on a cultural identity. The definition of deafness, which is essential to effectively work with Deaf clients, is something that some mental health professionals do not understand. Thus there are many Deaf individuals who are not getting the mental health services they want because there are a limited number of mental health professionals trained to work with the Deaf.

Since 1968, the Research Institute at Gallaudet University, a liberal arts university for the Deaf, has collected data on children with hearing impairment
(Hotto, 1999). In that time, they have surveyed 43,861 students nationwide who were from under three years old to over 18 years old (Gallaudet, 2001). Of these students, 37,588 reported their degree of hearing loss. Levels of hearing loss were divided into six categories based on the lowest decibel (db) rating they were unable hear. The reported percentages of participants in each category were: 15% for normal hearing (less than 27db), 10.8% for mild hearing loss (27 - 40 db), 12.3% for moderate hearing loss (41 – 55 db), 12.3% for moderate – severe hearing loss (56 - 70 db), 16.5% for severe hearing loss (71 – 90 db), and 33.2% for profound hearing loss (91 db and above). There was no indication of their sampling methods and what locations they sampled from, but it seems that there are many children affected by hearing loss. Knowing the age when a child lost his or her hearing is also important because if a child is prelingually Deaf (before they began speaking) he or she could have severe language deficits in his or her best language or communication modality (Glickman, 2007). This deficit may make it more difficult to work with a non-signing mental health professional because the client may not be able to convey the message that they are trying to get across. It may also make it more difficult to find a qualified and culturally competent therapist.

Brault (2005) used the U.S. Census Bureau’s self-report data to assess levels of hearing ability. These data showed that of people age 15 and older, an estimated 7,809,000 people had difficulty hearing a conversation even when wearing a hearing aid. Of those people, 992,000 had severe difficulty hearing or were unable to hear at all. There were also 2.5 million people with difficulty having their speech understood.
Of children from 6 to 14 years old, approximately 244,000 had difficulty hearing a conversation even with hearing aids, of whom 16,000 had a severe hearing difficulty. There were also 719,000 children who had difficulty with speech. In addition, Gallaudet University’s Research Institute took data from the 2003 National Health Interview Survey and the Survey of Income and Program Participation and the 2001 Survey of Income and Program Participation to compile information on the number of adults who were affected by hearing loss (Mitchell, 2005). This information was summarized by Gallaudet University to indicate that

1 out of every 1,000 people in the United States became deaf before 18 years of age… anywhere from 9 to 22 out of every 1,000 people have a severe hearing impairment or are deaf… [and] anywhere from 37 to 140 out of every 1,000 people in the United States have some kind of hearing loss, with a large share being at least 65 years old. (Mitchell, 2005)

This shows that there are many Deaf children and adults in the United States. This large population could benefit by having access to a therapist who is knowledgeable in working with clients that are Deaf or hard of hearing.

**Deafness as a Culture**

For many hearing people, deafness is seen as a disability. However, Philips (1996) said that the primary attitude and identity shift that has occurred within the Deaf population was from one of a disability to one of a culture. Philips states that a cultural group is a group of individuals that share common knowledge, beliefs, attitudes, language and values; the American Deaf culture shares a common language,
behaviors, norms, patterns, traditions, and values. They see themselves as a linguistic minority who, like any other minority group for whom English is not the native language, they are only disabled when they are in the presence of the majority culture. Philips also made a clear distinction between the “big D” Deaf (with a capital D), who are made up of culturally Deaf individuals, and the “little d” deaf (lower case d), those who are deaf by audiologic measures only. This difference may present a challenge to a hearing therapist who sees a Deaf client because they may facilitate communication with their Deaf client with the assistance of an interpreter, but still knows nothing about the Deaf culture that is an important part of this individual.

It seems that the acknowledgement of the presence of a Deaf culture has not had much of an impact on the current state of mental health services for the Deaf. Currently, Vernon and Leigh (2007) report that there are children being seen in school by psychologists who cannot sign and who have little training in deafness and tend to be inexperienced in evaluating children with hearing loss. There are only four or fewer residential facilities that treat the Deaf in a culturally affirmative way in the United States; some of which primarily treat hearing patients, but have some staff that sign and who have experience working with the Deaf.

Vernon and Leigh (2007) discuss several issues facing Deaf youth with severe mental illnesses. The programs that do exist can only help a small percentage of those that need the help, and because the cost of these services is so high, few parents can afford them. On top of that, many times insurance policies do not cover the long term treatment needed. Even when a program to provide services for the Deaf is
considered, there is often a lot of red tape to cut through to get to the government funding necessary for these programs that are intended to help. In some cases, attorneys and legal procedures are required to combat these issues. Still many children end up in state hospitals receiving mostly custodial care with no fellow patients or staff who can sign. Still others are kept at home with no formal treatment other than medication. Adults are facing many of the same issues, although there are some state hospitals that still have separate units for the Deaf. With appropriate treatment still difficult to find, there may be some helpful alternatives to using facilities that have Deaf and signing mental health professionals.

When non-signing therapists are the only ones available, Vernon and Leigh (2007) suggest that the use of a certified Sign Language interpreter is the easiest and most obvious solution. However, this may be an expensive solution because it requires a qualified, fully certified interpreter to assure accurate communication during therapy. But even when an interpreter is there to facilitate communication, there may be other problems that are affecting a Deaf client’s willingness to use mental health services. In fact, Vernon and Leigh (2007) have said that equal access to mental health services will never happen until psychologists are provided with the training needed to work with the Deaf population. Thus the necessary training should include information about cultural aspects of the Deaf population.
Culture-Centered Issues

Among the hearing population, there are many cultural groups that have been found to have inadequate mental health services. Because research with Deaf adults is still relatively new, we can draw parallels between the Deaf and other cultural and linguistic minorities in the United States.

For example Cardemil et al. (2007) conducted a mental health needs assessment for the Latino population. These researchers stated that Latinos were less likely than non-Latino Whites to acquire mental health treatment for major depressive episodes, panic disorders, and bipolar disorder. They also state that this could be for several reasons, such as a lack of Spanish-speaking clinicians, lack of culturally competent services, a client’s concern of stigma attached to a disorder, and a client’s view on mental health in general. Results of their needs assessment showed that of those that identified having a mental health problem, over 42% reported that they did not seek help. Participants in this study reported several reasons why they did not do so. It was found that those who had insurance were more likely to have sought services than those who did not have insurance. Also, over 51% of participants stated they thought they could handle the problem themselves, over 29% stated they did not need help, over 25% stated there was a language or cultural barrier that prevented them from seeking help, thirteen percent stated that he or she was too busy and 13% stated that transportation was preventing them from seeking services. Of the individuals that did not seek help from mental health professionals, over 24% sought help from priests or traditional indigenous healers. Latino individuals are a linguistic
minority, much like the Deaf, and this language and cultural barrier to seeking mental health services may become greater for Deaf individuals for the mere fact that many hearing professionals do not view Deafness as a culture. This may lead to even more reasons why these underserved Deaf individuals do not utilize mental health services.

Vasquez (2007) states that the therapeutic alliance, which has been identified as one of the most important factors in therapeutic effectiveness, needs special consideration when working with minorities. Vasquez also suggests that the reason minorities underutilize psychotherapy and have high drop out rates may be in part because these clients do not experience this therapeutic alliance. Vasquez also states that clinicians need to be aware that one threat to the building of this therapeutic alliance may be the fact that clinicians and clients with differing cultural backgrounds may have cultural misunderstandings and miscommunications. Clinicians must continue to become aware of potential biases or stereotypic attitudes that they may hold. With the diverse population in the United States, there is a clear need for well-trained and multiculturally sensitive counselors.

Another cultural consideration mental health professionals must be mindful of is that this large population of Deaf individuals has had a turbulent past with the mental health field. Vernon and Leigh (2007) looked at the changes in psychological services for Deaf individuals over the past 50 years and reported some surprising findings. Until the mid-1960s Deaf individuals with serious mental health issues received no specialized mental health services. In fact, these individuals were typically placed in psychiatric hospitals with normally hearing patients and staff that
had no knowledge of Sign Language. Rarely were they in the vicinity of other Deaf individuals that they could communicate with. To these Deaf individuals, the experiences in the hospital could be perceived as frightening or abusive. It would be as if an English speaking person was admitted into a psychiatric hospital where everyone spoke a different language. Before the mid-1960s there were many cases of misdiagnosis and longer stays in hospitals for Deaf individuals than hearing individuals. Things began to change during the mid-1960s.

During the mid-1960s Vernon and Leigh (2007) report a change in mental health services for the Deaf. Research began to improve the understanding of Deaf individuals with psychiatric disorders and led to the establishment of separate units for Deaf individuals in hospitals. In the year 2000, the first residential treatment center, the National Deaf Academy, was established. It was staffed only by therapists who could sign, over half of whom were Deaf themselves. This action reinforced a culturally affirmative environment for their clients. This by no means represents the norm, but it shows how the mental health field has made a shift in the treatment of Deaf individuals.

**Interpreter-Centered Issues**

One way hearing mental health professionals can work with Deaf clients is to use an interpreter to facilitate communication between the two. Along with the advantages of being able to understand a client that uses a different language to communicate, there come disadvantages and potential harmful situations of which mental health professionals must be aware.
Many of the problems inherent in using an interpreter may be directly attributed to the interpreter’s training, and knowledge of the therapy process (Roe & Roe, 1991). Roe and Roe state that when all parties are aware of the codes of ethics that are expected to be followed before counseling occurs, the process is made easier. Language issues may still arise, however, because it is difficult for the interpreter to convey verbal communication, nonverbal communication, and body language between the parties involved (Culross, 1996). In fact, one of the ethical mandates held by professional interpreters is that if the session requires a skill level that is beyond the scope of the interpreter, the interpreter must not accept that assignment (Roe & Roe). This is important because interpreters can unintentionally impede the therapeutic process through lack of knowledge of the concepts being discussed or skill to accurately interpret these messages (Culross, 1996). Roe and Roe stated that to combat some of these issues, a therapist should find an interpreter with the highest skill available.

**Mental Health Professional-Centered Issues**

There are also specific training issues that may need to be addressed with therapists who are planning to work with Deaf clients. As with other cultural groups, a therapist must be aware of the culture of the client they are working with, and aware of possible biases they hold. They must also be aware of how to facilitate communication with their client in a way that is ethical, and consider some of the possible issues that could arise from the use of a third party to facilitate communication.
Roe and Roe (1991) state that a lack of trust is a potential issue that can hinder the therapeutic relationship. A potential threat to trust is a therapist’s lack of knowledge of Sign Language. A therapist may not understand that it may only take a few signs to convey a message that takes a few sentences to explain or vice versa which may lead a therapist to think that his or her message is not being delivered. Roe and Roe also state that a therapist, when working with a highly skilled interpreter, must trust that the interpreter is accurately conveying both the therapist’s message and the client’s message. Another potential threat to trust when working with an interpreter in session pointed out by Roe and Roe is connected to the fact that there is another person in the room. A common therapist reaction during their initial experience with an interpreter is the feeling of being self-conscious (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Roe and Roe state that a therapist may resent merely having a third person present in a therapeutic situation. Therapists instead should know that it is his or her job to direct the therapy session, but also rely on the interpreter to facilitate communication. Therapists may also use interpreters as a resource to learn about aspects of deafness of which they may not have knowledge.

Therapists must also be aware that they are not immune to the cultural biases about their clients (Phillips 1996; Williams & Abeles, 2004). Williams and Abeles state that these biases need to be addressed to ensure they do not hinder the therapeutic process. For example, nonverbal messages are an integral part of manual communication (such as American Sign Language) and the Deaf culture. Deaf individuals are also traditionally in a one down position when it comes to mainstream
hearing society because they are seen as having a disability, rather than part of a distinct culture. During therapeutic situations, such as the interaction between a hearing mental health professional and a Deaf client, many Deaf individuals are more attuned to nonverbal cues, and will be quick to perceive the therapist’s anxiety or discomfort.

Another potential problem when working with Deaf clients may occur even when a therapist can sign. Feldman, Kluwin, and McCrone (2005/2006) attempted to assess whether the counselor’s communication mode (Signed English or American Sign Language) was a factor in a client’s response to a counselor. They did not find evidence for any such link. One hypothesis for why no link was found was because 25% of the participants in the study were hard of hearing. Hard of hearing individuals rely on the use of a manual language to differing degrees; therefore, hard of hearing individuals are more tolerant to signing differences than Deaf individuals who may be less tolerant of these differences. Moreover, the knowledge of Sign Language does not guarantee the knowledge of the Deaf culture. Like working with any other client that is of a different cultural background, care must be taken to understand not just the language of the client, but to also educate one’s self about the Deaf culture.

**Client-Centered Issues**

Deaf clients may also have some issues when it comes to seeking and utilizing mental health services. As mental health professionals, we should strive to make ourselves knowledgeable about the various issues that Deaf client’s may have when
considering the use of therapy and what can be done, if anything, to alleviate those concerns in the client.

As previously shown, the use of an interpreter can affect the therapist in a variety of ways, but one must also be aware of the impact on the client. Culross (1996) states that having an interpreter for therapy sessions may be frustrating because it slows down the speed of communication and, at times, distorts the content of what is being communicated. A Deaf client’s resistance to the use of an interpreter may arise for many reasons including the feeling that using an interpreter is an impersonal way to communicate, it may be uncomfortable to have the interpreter present for sensitive psychological counseling, the client may feel that the interpreter is someone not to be trusted or is an unwelcome presence, or the client may feel the interpreter is another barrier to their independence (Culross, 1996; Roe & Roe, 1991).

Roe and Roe (1991) report that another problem could arise because professional interpreters must distance themselves from the therapeutic situation as much as possible. Some clients who are unaware of this might experience mixed feelings when interpreters are unable to give their own direct input, as opposed to solely interpreting what is being said, before, during, or after therapy sessions. Also, a Deaf client may also lose confidence in the interpreter if everything is not interpreted including things that are overheard, smiles, jokes, and a shake of the head between the interpreter and mental health professional. This may lead to a breakdown of trust, foster suspicion in the client, and add to the mistrust and suspicion that the Deaf
individual may have toward the mental health professional, much like other cultural
groups that have been marginalized (Phillips, 1996)

All of this information is helpful, but is not important unless Deaf individuals
actually want mental health services. Feldman and Gum (2007) conducted a study to
better understand Deaf adult’s needs for mental health services and their perceptions
of these services. They found that older adults, aged 55-65, were less trusting of
mental health professionals, less likely to know where to acquire appropriate mental
health services, and less aware of existing mental health services than Deaf adults
who were not in this age group. Adults between the ages of 35-54 and 66 and older
were split between wanting professional mental health services and preferring to use
friends and family to get support. Some of these clients may not be aware of the
services that mental health professionals provide, and others may not even trust the
mental health profession. It seems that certain generations of Deaf adults have
differing perceptions of the mental health profession which should be taken into
consideration when working with these clients.

**Lack of Qualified Providers**

One of the difficulties Deaf individuals face when attempting to find mental
health services, is finding a provider who understand deafness first hand. Miller and
Moores (1990) report that some Deaf clients prefer, and feel more comfortable with, a
Deaf, rather than hearing counselor. These are difficult to come across, so when a
Deaf therapist is not available, a counselor who is skilled in American Sign Language
(ASL) is also preferred. In preparation for the present study, a search of the word
“Therapist” was conducted on the website yellowpages.com and it showed that there were a total of 176 businesses listed that served Merced, California (where the present study was being conducted). These included Marriage and Family Therapists, Marriage Therapists, Family Therapists, Child Therapists, Individual Counselors, and Psychotherapists, yet none of the advertisements indicated a specialty of working with Deaf or hard of hearing clients.

Although having a therapist who is fluent in Sign Language, and who is educated about the Deaf culture is the most ideal situation, that is often impossible because professionals such as these are very difficult to find. Wyatt and White (1993) assessed the availability of adequately trained mental health workers for the Deaf. They found ten training centers nationwide that specifically train therapists to do therapy with the Deaf. The number of annual graduates ranged from four to 30 individuals. The researchers wanted to see what types of jobs were sought by these students after graduation, and they found that many of the graduates sought employment within a rehabilitation setting for the Deaf. This included schools for the Deaf, state vocational centers, rehabilitation centers, child protective agencies, and independent living programs. Two training programs reported employment outcomes for their programs. Western Oregon State College reported that only 15% of their graduates found employment in mental health, and Northern Illinois University reported that of their 78 graduates, fifteen were employed in counseling positions and two in mental health.
Vernon and Leigh (2007) found a similar state of affairs. They state that the Deaf are underserved because those who communicate using Sign Language have limited or no access to appropriate services. There are few psychologists, psychiatrists, or social workers who are fluent in Sign Language, but to properly provide psychotherapy, psychodiagnoses, or counseling requires either a competence in Sign Language or the skilled use of an interpreter. In 1977, they also found that there were only 178 individuals working as therapists with Deaf children and adults; only nine of them had proper credentials as psychologists, and most had no training on deafness. A clinical psychology program at Gallaudet University may change this. These graduates are moving into leadership roles in the field of mental health and deafness which will hopefully make appropriate services easier to find.

**Laws that Impact Mental Health Services for the Deaf**

With all of the barriers society has in place that make it more difficult for Deaf individuals to acquire mental health services, the American government has tried to offer some protections. Over the years, there have been several laws enacted that have attempted to ensure equal access to various services such as health care, education, and mental health services (Lee, Batal, Maselli, & Kutner, 2002). Mental health professionals that know the laws that are in place will help him or her ensure that they are providing services that are in accordance with these laws. Below are a few of the applicable laws and some of their implications for the Deaf.

Title VI of the Civil rights Act of 1964 prohibits discrimination by federally funded entities based on race, color, or national origin (Lee, et al., 2002; United
States Department of Justice, 2003). This has been interpreted in such a way that these entities must provide language assistance that result in accurate and effective communication at no cost to the patient. Using interpreters is a way to address this gap in care (Dysart-Gale, 2005).

The United States Department of Justice Civil Rights Division’s guide to disability rights laws (2005) indicates that Title II of the Americans with Disabilities Act requires government agencies to adjust their policies, practices and procedures to allow effective communication with individuals with hearing impairments. Public agencies are required to make reasonable modifications to avoid discrimination.

The United States Equal Employment Opportunity Commission’s (2002) Executive Order 13166 directs all federal agencies to examine the services they provide so people with limited English proficiency can access their services.

Based on Public law 94-142 from the education of all handicapped children act of 1975 and Public law 93-12 based on the Rehabilitation act of 1973, interpreting services must be available free of charge to Deaf persons seeking to use facilities that receive federal or government assistance in any form (Roe & Roe, 1991).

Although there are many laws in place to alleviate some of the barriers Deaf individuals face when seeking adequate mental health services, there is certainly a gap between what the law requires of therapists and true equal access to these services. Regional support services for the Deaf are attempting to address this gap in care.
Support Services for the Deaf and Hard of Hearing

There are a number of support services in place to assist the Deaf and hard of hearing community including the Deaf and Hard of Hearing Service Center which serves clients in Merced County, California among other communities (DHHSC) (Deaf and Hard of Hearing Service Center, Inc., 2005). This program offers advocacy, interpreting services, peer counseling, job counseling, and many more services. This gives the Deaf a place to go if they feel they need help. However, if a client would like to receive therapy from a licensed counselor, they would have to attend counseling sessions with an interpreter (M. Mackenzie, personal communication, March 26, 2009). Thus, they are within the law but clearly the lack of a qualified signing therapist who is knowledgeable about Deaf culture is apparent. Even though knowledge of the Deaf culture as a whole is crucial to adequate therapy for the Deaf, another aspect of Deaf culture may have been overlooked thus far. The knowledge of Deaf culture as a whole may not be enough because each individual client has a different connection, or identification with their Deaf culture.

Development of the Deaf Identity Scale

There has been an attempt to measure and assess the presence of a Deaf culture. To do this, Glickman and Carey (1993) conducted a study to design and test a Deaf identity scale. This scale was created to assess how Deaf individuals identify with the Deaf culture. They created a model of Deaf identity that includes four types of Deaf cultural identities. The first type of identity is culturally hearing. Their frame of reference is the dominant hearing culture. Those in this category typically view
deafness as a disability or pathology rather than a culture. These individuals value oral forms of communication and claim to be a person with a hearing impairment, rather than a Deaf person. The next type of identity is marginal which indicates a culturally marginal individual. This means that the individual fits between the hearing and Deaf worlds, but they do not feel comfortable in either one. The third identity is immersed which indicates that a person immerses themselves in the Deaf world. They have a positive, uncritical identification with Deaf people and believe that only Deaf individuals should guide and serve other Deaf people. They may feel anger and resentment towards hearing people, and they may also view hearing people as oppressive or malevolent towards Deaf individuals. They also discourage anyone acting as if they are hearing by using their voices, wearing hearing aids, and signing in English word order. The last identity is bicultural indicating an individual who feels comfortable in both the hearing and Deaf worlds. They have pride in their Deaf culture and community, but they also feel comfortable with hearing individuals and see them as supportive.

Glickman and Carey (1993) then created a pool of 85 items based on theories of minority identity development, literature on Deaf culture, and information from Deaf and hearing experts knowledgeable about Deaf cultural identities. These 85 items along with a brief description of each of the four types of Deaf identity were then given to a panel of three Deaf judges and eight non Deaf judges. These judges then matched each of the 85 items to one type of Deaf identity. From there the 15 items for each Deaf identity that had the greatest inter-rater agreement were used for
the final survey. This survey was then distributed to two groups. One was a group of students from Gallaudet who were mostly Deaf from birth or a few years after birth (hearing $M = 1.75$, $SD = .51$; marginal $M = 1.99$, $SD = .59$; immersion $M = 2.66$, $SD = .64$; bicultural $M = 4.18$, $SD = .41$). The second group consisted of individuals who became Deaf later in life, and who were presumed to be more culturally hearing than the first group (hearing $M = 2.44$, $SD = .72$; marginal $M = 2.23$, $SD = .57$; immersion $M = 2.15$, $SD = .50$; bicultural $M = 3.58$, $SD = .62$). After statistical analyses, six items were deleted and two items were reassigned to other subscales. This survey can give some insights on how a Deaf person may identify with their Deaf culture.

**The Present Study**

As reviewed, many factors may influence accessibility of mental health services such the historically difficult relationship between Deaf individuals and the mental health field, difficulties that arise when working with an interpreter in a mental health setting, and a lack of qualified mental health providers. Although there are laws in place to help insure equal access to services, there is something that is influencing Deaf individuals to underutilize these services. One factor that has not been looked at is if, and how, Deaf or hard of hearing individual’s perception of the availability of psychological services is influenced by their level of identification with the Deaf culture. First, it was hypothesized that participants with an immersed level of identification with the Deaf culture will use fewer mental health services than those with a marginal, bicultural, or hearing level of identification with the Deaf culture. Secondly, it is hypothesized that the participants with an immersed level of
identification with the Deaf culture would perceive more barriers to using mental health services than those with a marginal, bicultural, or hearing level of identification with the Deaf culture. Lastly, it is hypothesized that participants with an immersed level of identification with the Deaf culture would be less likely to use a hearing or non-signing therapist than those with a marginal, bicultural, or hearing level of identification with the Deaf culture.
CHAPTER II

METHOD

Participants

Participants were recruited through the Deaf and Hard of Hearing Service Center’s (DHHSC) Fresno office \((n = 2)\) and Merced outreach office \((n = 18)\) with the use of flyers in their office, as well as flyers distributed through the DHHSC email community. Five participants indicated that they received the study information from “other” sources. Each flyer included the requirements to participate, the online survey website address, and the researcher’s contact information. DHHSC also distributed a flyer with meeting places and times for those who preferred to take the survey via paper and pencil. Three meetings were scheduled to take place after DHHSC events in the Merced office and one meeting was scheduled in the Fresno office that was not connected with an ongoing event. A video with the study information via Sign Language was provided to DHHSC, but was not distributed by the agency. Three participants indicated that they received the online survey information through word of mouth. Twelve participants completed the survey with no incentive given but to help provide information that could be used to improve the psychological services available to the Deaf and hard of hearing community. It was later necessary to include an incentive of a drawing for one of three $25 gift cards. Of the 29 surveys that were completed, the data from only 25 were analyzed. Three were excluded because most of the data were missing and another survey was excluded because an online participant indicated that he or she was under the age of 18.
Participant’s ages ranged from 18 years old to 73 years old ($M = 35.72$, $SD = 17.40$). Twenty participants completed paper surveys and five completed online surveys. Nine participants (36%) were male and 16 (64%) were female. Most of the participants were Hispanic ($n = 10, 40\%$) or Caucasian ($n = 9, 36\%$). There were also three African American participants (12%), one Asian participant (4%) and two (8%) who endorsed “other” under ethnicity. Most of the participants, twenty (80%), stated that he or she had insurance while 20% stated that he or she did not. Sixty percent of participants indicated that he or she is Deaf, thirty six percent indicated that he or she were hard of hearing, and one participant indicated that he or she was deaf or hard of hearing with a cochlear implant. Fourteen participants (56%) indicated that they lost their hearing under the age of 18 months, five (20%) indicated that they lost their hearing between the ages of 3-7, and 6 (24%) declined to state when they lost their hearing. Sign Language was the method that most participants (76%) preferred to receive communication, and to express communication (72%). Some participants indicated that they prefer to use both Sign Language and speech to receive communication (16%) and express communication (20%). Two participants (8%) indicated that they prefer to use speech to receive and express communication.

**Materials**

**Demographics.** Demographic information was collected (See Appendix A) including age, gender, whether the participant is hearing, hard of hearing, or Deaf, the age of initial hearing loss, how they communicate best (Sign Language or speech), how they prefer others communicate to them (Sign Language or speech), highest
level of education completed, ethnicity, and where they received the study information. Participants were also asked if they currently had insurance and if their insurance covers mental health services.

**Deaf identity scale.** The Deaf Identity Scale was developed by Glickman and Carey (1993) to assess the level of identification with the Deaf culture: hearing, marginal, immersion and bicultural. This scale was revised by Fischer and McWhirter (2001) to improve reliability and validity (See Appendix C). Fischer and McWhirter eliminated items with a factor loading less than .30 in the final version. A computerized version of this assessment was used for the current study. This assessment consists of 47 items and includes four subscales. The hearing scale has 10 items, the marginal scale has 12 items, the immersion scale has 12 items, and the Bicultural scale has 13 items. Hearing identity is assessed using items such as “I feel sorry for deaf people who depend on Sign Language.” and “I don’t like when deaf people use Sign Language.” Marginal identity is assessed using items such as “I don’t know how I feel about deaf people.” and “I don’t know whether to call myself ‘hearing impaired’ or ‘deaf’.” Immersion identity is assessed using items such as “Deaf people should only use ASL.” and “Deaf people do not need hearing aids.” Bicultural identity is assessed using items such as “I enjoy both deaf and hearing culture.” and “I support deaf culture without insulting hearing people.” Items were rated on a 5 point Likert scale (1 = Strongly Disagree, 3 = Neither Agree nor Disagree, 5 = Strongly Agree) with higher scores indicating more of that factor. Fischer and McWhirter report Cronbach’s alpha for each subscale as the following:
hearing, .81; marginal, .84; Immersion, .87; and bicultural, .78. These reliabilities were considered to be in the acceptable range. Unfortunately it was unstated whether the distribution was expected to be equal across groups.

*Past and current use of counseling services and barriers to use of counseling services.* An adaptation of Feldman and Gum’s (2007) survey assessing the need for psychological services for Deaf and hard of hearing individuals was used to assess past and current use of counseling services and barriers to using counseling services (See Appendix B). This computerized survey was used to assess the participants’ past and current use counseling services with items such as “Have you seen a mental health professional in the last 6 months?” and “Have you ever seen a mental health professional?” These items were answered as “Yes” or “No.” Barriers that may be stopping the participant from using mental health services were assessed with items such as “I do not trust mental health professionals” and “I do not have transportation to go to appointments.” The participant’s perceived need for counseling services was assessed using items such as “There are enough mental health services for the deaf.” and “I would like to have more access to mental health services.” The preferred type of mental health professional was assessed using items such as “I do not trust hearing mental health professionals.” and “I doesn’t matter to me what kind of mental health professional I see (signing, not signing, needs an interpreter).” These items were rated on a 5 point Likert scale (1=Strongly Disagree, 3=Neither Agree nor Disagree, 5=Strongly Agree).
Procedure

Participants who chose to complete the online survey received the study information from the various distribution sites which included the requirements for participation and the web address for the survey. When participants logged on to the survey website, they first agreed to the terms in the informed consent. They then filled out the demographic page, followed by the past and present use of counseling services questionnaire, and finally the Deaf Identity Scale (2001). Once the questionnaire was completed, the participants had the option of providing their contact information, such as email address, phone number, or mailing address so they could be contacted in the event they were chosen in the drawing for the gift card incentive. They were then directed to a “thank you” page, which debriefed the participants, thanked them for their participation, and gave the researcher’s contact information. This page also provided a website that had information regarding where to find mental health services, which locations have a sliding fee program, and which only accept clients with insurance.

Participants who chose to complete the paper survey at one of the DHHSC meetings were each given a packet that included two informed consent forms (one to sign and one to keep for their records), the survey, and a sealed envelope that contained the debriefing form. The researcher explained, in Sign Language, the purpose of the study and any questions that participants had were answered. Certified interpreters and the researcher were available while the participants were completing the survey to provide document translation from written English to American Sign
Language. The informed consent form was collected once signed and once the survey was completed, participants were debriefed.
CHAPTER III

RESULTS

The Deaf Identity Scale has four subscales. The hearing subscale has 10 items \((\alpha = .81)\), the immersion subscale has 12 items \((\alpha = .68)\), the marginal subscale has 12 items \((\alpha = .83)\) and the bicultural subscale has 13 items \((\alpha = .84)\). The mean score for each subscale was calculated and the participant was categorized into one of the four levels of identification with the Deaf culture based on which Mean subscale score was the greatest. There were 24 participants who completed the Deaf Identity Scale. Out of these participants, twenty-two (88%) scored highest in the Bicultural subscale \((M = 4.14, SD = .72)\), one participant (4%) scored highest in the Marginal subscale \((M = 2.37, SD = .78)\), one participant (4%) scored highest in the Immersion subscale \((M = 2.81, SD = .68)\), and none of the participants scored highest in the Hearing subscale \((M = 2.18, SD = .79)\).

The hypotheses proposed were dependent on a sample that provided participants who scored in the immersed level of identification with the Deaf culture, against which all other groups would be compared. Unfortunately the sample did not allow for this comparison in this way. Instead, the data were analyzed descriptively comparing those who agreed that more mental health services are needed for the Deaf with those who do not agree.

Three items were used to assess whether the participants wanted more mental health services for the Deaf. One item, “There are enough mental health services for the deaf” \((M = 3.42)\) was reverse coded and was combined with the items “I would
like to have more access to mental health services” ($M = 3.42$) and “I am interested in having more mental health services for the deaf” ($M = 3.96$) to create a variable where a higher score meant the participant wanted more mental health services for the Deaf. The data were then split and grouped as those who scored 3.1 or above (indicating that participants agreed that they wanted more mental health services for the Deaf) and those who scored 3.0 or below (indicating that they did not agree). Twenty-four participants completed the survey items relating to a need for more mental health services for the Deaf. A binomial test showed that although the data were in the expected direction, with more participants (71%) indicating that he or she agreed that they want more mental health services than those who did not agree (29%), it failed to reach statistical significance ($p = .064$).

A frequency count was used to assess where participants prefer to obtain mental health services (see Table 1) and whether participants used mental health services in the 6 months before completing the survey, or if the participant had ever used mental health services in the past. Twenty-five participants completed the item assessing whether the participants had seen a mental health professional in the 6 months prior to completing the survey, twenty-three (92%) stated that they did not. Twenty-one participants completed the item assessing whether he or she had ever seen a mental health professional and 13 (61.9%) indicated that they had not.
Table 1

*Preferred First Contact for Mental Health Services*

<table>
<thead>
<tr>
<th>Preferred Contact</th>
<th>Frequency agreed</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I had a mental health problem, I would first contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My family or friends</td>
<td>12</td>
<td>48%</td>
</tr>
<tr>
<td>A Medical/primary care doctor</td>
<td>9</td>
<td>36%</td>
</tr>
<tr>
<td>A psychologist</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>A vocational rehabilitation counselor</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>A psychiatrist</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>A nurse</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>A clergy/religious leader</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>A social worker</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>If I had a mental health crisis, I would go to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The hospital</td>
<td>9</td>
<td>36%</td>
</tr>
<tr>
<td>The Deaf community association</td>
<td>8</td>
<td>32%</td>
</tr>
<tr>
<td>A community health center</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>My primary care doctor</td>
<td>3</td>
<td>12%</td>
</tr>
</tbody>
</table>

*Note.* Percentages are based on the number of participants who answered each item.

The barriers endorsed by participants were then analyzed. Participants responded to these items on a Likert scale indicating to which degree they agreed or disagreed with each statement. These items were then recoded into a dichotomous variable as “agree” or “disagree”. As seen in Table 2, the barrier that was agreed to the most was “I can not afford to pay for mental health services.”
Table 2

**Barriers Endorsed as “Agree”**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Frequency Agreed</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can not afford it</td>
<td>11</td>
<td>46</td>
</tr>
<tr>
<td>Insurance does not cover it</td>
<td>9</td>
<td>39</td>
</tr>
<tr>
<td>I can solve my own problems</td>
<td>9</td>
<td>38</td>
</tr>
<tr>
<td>Do not trust hearing mental health professionals</td>
<td>9</td>
<td>38</td>
</tr>
<tr>
<td>Afraid people will find out</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>Afraid of being sent to a mental hospital</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>No time</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>Do not know how to get services</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Do not trust mental health professionals</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>No transportation</td>
<td>5</td>
<td>21</td>
</tr>
</tbody>
</table>

*Note.* Percentages are based on the number of participants who responded to each item.

There were five items assessing the types of mental health professionals each participant would be willing to utilize. The Likert scaled responses were recoded into a dichotomous variable as “agree” or “disagree” and are displayed in Table 3. The types of mental health professionals that were endorsed the most as “agree” were signing professionals (64%) and Deaf professionals (52%). The type of professional that was endorsed as “disagree” most frequently was a professional that uses speech only with no interpreter (76%).
<table>
<thead>
<tr>
<th>Type of Professional</th>
<th>Agree Frequency (Percent)</th>
<th>Neither Frequency (Percent)</th>
<th>Disagree Frequency (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signing</td>
<td>16 (66.7)</td>
<td>6 (25)</td>
<td>2 (8.3)</td>
</tr>
<tr>
<td>Signing With Interpreter</td>
<td>11 (47.8)</td>
<td>6 (26.1)</td>
<td>6 (26.1)</td>
</tr>
<tr>
<td>Non-Signing (Interpreter Only)</td>
<td>9 (39.1)</td>
<td>6 (26.1)</td>
<td>8 (34.8)</td>
</tr>
<tr>
<td>Speech Only (No Interpreter)</td>
<td>3 (12.5)</td>
<td>2 (8.3)</td>
<td>19 (79.2)</td>
</tr>
<tr>
<td>Any (Signing, Non-Signing, Interpreter)</td>
<td>6 (25)</td>
<td>10 (41.7)</td>
<td>8 (33.3)</td>
</tr>
<tr>
<td>Hearing</td>
<td>7 (29.2)</td>
<td>5 (20.8)</td>
<td>12 (50)</td>
</tr>
<tr>
<td>Deaf</td>
<td>13 (54.2)</td>
<td>7 (29.2)</td>
<td>4 (16.7)</td>
</tr>
<tr>
<td>Hard of Hearing</td>
<td>9 (39.1)</td>
<td>8 (34.8)</td>
<td>6 (26.1)</td>
</tr>
<tr>
<td>Any (Deaf, Hard of Hearing, Hearing)</td>
<td>12 (50)</td>
<td>4 (16.7)</td>
<td>8 (33.3)</td>
</tr>
</tbody>
</table>

*Note.* Percentages are based on the number of participants who responded to each item.

An open ended question was also posed asking if seeing a mental health professional was helpful and why. Several individuals stated that it helped them in one way or another. One participant stated that it helped him or her gain perspective on things. One participant stated it helped with his or her marriage and communication. Another participant thought that just talking to someone helped them, and another said it helped them think clearly and make important decisions in their life.

Several individuals also indicated that seeing a mental health professional did not help. One individual responded that he or she did not think therapy helped because of a communication breakdown. This individual stated, “no, not make a
sense there talk sound different story not correct match” which seemed to indicate that what was being said was not being interpreted correctly.
CHAPTER IV

DISCUSSION

There were several interesting findings from the data gathered. Although the reported need for more mental health services for the Deaf failed to reach statistical significance, the data did lie in the expected direction with more participants indicating that they do want more mental health services. Furthermore, a majority of the participants also indicated that they were not currently seeing a mental health professional and that they have never seen a mental health professional. There seems to be a gap in what the participants want, more mental health services, and their usage of these services. It may be that although these individuals also wanted mental health services, they just do not know where to get them. In fact, 25% of the participants in the current study indicated just that.

In addition, Deaf individuals may have barriers holding them back from seeking mental health services in the first place. Several barriers were endorsed by participants in the present study; the most frequently endorsed barriers being that participants feel they can not afford mental health services, they do not have insurance, and that they feel they can solve their own problems. These findings support Cardemil et al.’s (2007) study of the latino population, and would probably be endorsed similarly for any population that was asked these questions; however, with a large portion of this sample identifying as Hispanic, it is very interesting that none of the participants indicated that they would seek mental health services from clergy. This information contradicts Cardemil et al.’s findings. This may speak to the
above point that mental health issues may be seen as medical issue, but it may also speak to the lack of religious services offered to the Deaf in their own language. One may want to seek religiously based guidance through a crisis, but if there are no clergy that sign (or know how to work with interpreters) then this outlet is perceived as closed to them.

There was another interesting difference between two slightly different barriers. More participants indicated that they do not trust hearing mental health professionals (38%) than those that indicated that they do not trust mental health professionals in general (25%). There are several possible reasons why there is a difference between the two. This could speak to the lack of trust in the hearing world, or may stem from the difficult past that the Deaf have had with the mental health field. It may also be related to Vasquez’s (2007) suggestion that mental health professionals should pay special attention to the therapeutic alliance when working with minority groups. With special care and attention to the therapeutic alliance, trust may be bolstered.

The type of mental health professional also has an impact on whether Deaf individuals use mental health services. A larger percentage of participants indicated that they would see a mental health professional who can sign, and who is Deaf, than any other type of mental health professional. Deaf individuals would prefer to see a mental health professional who they can speak directly to. This supports Feldman and Gum’s (2007) study which also found that Deaf adults of all ages preferred Deaf and signing mental health professionals, which was supported by the present study. This
may be because they do not want a third party in the room, or it may simply be because they just want to convey their story directly to the mental health professional in a way that they know will be understood as accurately as possible by someone who understands what it is like to be Deaf.

There were several additional findings that were interesting, including the various barriers to seeking mental health services. There were several barriers endorsed as “agree” by those who completed each item such as: not being able to afford it (45.8%), insurance does not cover mental health services (39.1%), not knowing how to get mental health services (25%), afraid people will find out (33.3%), afraid of being sent to a mental hospital (33.3%), no transportation (20.8%), having no time (30.4%), feeling he or she can solve their own problems (37.5%). This information strongly suggests that while we can strive to create a world where there are mental health providers who are fluent in Sign Language, who are educated about the Deaf culture, and who are available in any given area; for those who want mental health services there are some economic, logistical, and stigma related issues that are not as easy to resolve.

When asked who participants would contact if he or she had a mental health problem, forty-eight percent stated that they would seek friends or family, thirty-six percent stated they would see a medical or primary care doctor, and only four percent stated they would see a psychologist. It seems that friends and family are the first place that participants seek help from, but what is interesting is that the medical profession is the next most endorsed item. This may be because mental health
problems are being seen as a medical issue that requires medication rather than a psychological issue that may be able to be worked through in therapy.

Also, the researcher recruited from DHHSC which is an organization that provides several support services to the Deaf community, and which strives to reach out to the hearing population as well. This seemed to be supported by the data collected because 88% of the participants scored higher in the bicultural subscale.

Another interesting piece of information that was gathered were the responses given for an open ended question that asked participants if seeing a mental health professional was helpful. Several individuals stated that it helped them in one way or another. It helped one individual get another perspective on things, it helped another with his or her marriage and communication, another thought that just talking to someone helped them, and another said it helped them think clearly and make important decisions in their life. One individual responded that he or she did not think therapy helped because of a communication breakdown. This individual stated, “no, not make a sense there talk sound different story not correct match” which seemed to indicate that what was being said was not being interpreted correctly.

Limitations

There were several limitations to this study, one of which was the sample itself. The hypotheses were unable to be tested because the sample consisted of only one individual with an immersed level of identification with the Deaf culture. The inability to answer the hypotheses may be due to the small sample size, how
participants were recruited, how the survey was administered, and where participants were recruited from.

The recruitment problems may have occurred for several reasons, which future researchers may want to attempt to correct. When the study was first distributed, it was done without the inclusion of an incentive. Later, an addition of snacks and refreshments was added based on the advice of a DHHSC client coordinator. This did not seem to encourage participation. Next, an incentive of a drawing for gift cards was added. Several more participants decided to participate once the monetary incentive was included, but not as many as were needed.

Another possible reason why participation was limited could have been related to the fact that the survey was in written form as opposed to signed. A majority of the participants who completed the survey stated that the way they most prefer to receive communication is with Sign Language, and even though there were certified interpreters available to assist participants who completed the survey in the DHHSC office, there were not enough for one-on-one assistance for each participant. Future researchers may want to use a signed survey online or in video form rather than in written form. Also, the study recruitment information was provided in writing in the form of flyers and emails. This may have also had an impact on the number of participants who decided to attempt the survey. A signed “video flyer” was attempted, but was not able to be posted onto the DHHSC website because of logistical reasons. Future research may need to be advertised with the use of signed recruitment material in the form of an online video that participants can easily access.
Another reason for the difficulty recruiting participants could have been because the researcher was hearing. As stated earlier, the Deaf culture as a whole has had a difficult past with the mental health field. Some of the data provided indicated that a higher percentage of participants stated that they do not trust hearing mental health professionals (37.5%) than those that do not trust mental health professionals in general (25%). One mitigating factor could have been because the current researcher is an interpreter for the Deaf in one of the communities (Merced, CA) where the researcher was recruiting. Several participants stated during the DHHSC meetings that they were only taking the survey in support of the researcher. The participants from Merced made up 69.2% of the sample. It was much more difficult to recruit participants in the location (Fresno, CA) where the researcher was not involved directly in the community and where the researcher may have been seen as an outsider.

Several research questions were not able to be answered because there were not enough participants in the immersed level of identification with the Deaf culture. This could have been for several reasons. The very nature of the immersed individual would make it unlikely that they would take a survey given under the conditions that they were given. An individual immersed in the Deaf culture sees hearing people as oppressors which would make it more unlikely that they would have participated in a study being conducted by a hearing researcher.
Conclusion

The most important information gathered through this study is that Deaf individuals do want access to mental health services. These services should be provided in such a way that the client and the therapist can understand each other, and in a way that is sensitive to the client’s identification with their Deaf culture. More mental health professionals are needed that are knowledgeable about the Deaf culture, and who know how to work with Deaf clients even if they themselves do not sign. This will ensure that if a Deaf individual has a need for mental health services, the mental health field will have an appropriate option for them.
REFERENCES
REFERENCES


M. Mackenzie, personal communication, March 26, 2009.


APPENDICES
APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

1. Age:
2. Gender:
   a. M
   b. F
3. Hearing status:
   a. Deaf
   b. Hard-of-hearing
   c. Deaf or hard of hearing with a cochlear implant
4. At what age did you first lose your hearing?
5. How do you communicate best with others?
   a. Speech/voice
   b. Sign Language
   c. Other
6. How do you prefer other to communicate with you?
   a. Speech/lip reading
   b. Sign Language
   c. Other
7. Highest level of education completed?
   a. Less than Jr. High school
   b. Jr. High school
   c. High school or GED
   d. Some college
   e. Associates degree
   f. Baccalaureate degree
   g. Masters degree
   h. PhD
8. Ethnicity
a. Caucasian
b. Hispanic
c. African American
d. Asian
e. other

9. What city do you live in?

10. Do you have insurance?
   a. Yes
   b. No

11. Does your insurance cover mental health services?
   a. Yes
   b. No
   c. I don’t know

12. Where did you get the website for this survey?
   a. Merced DHHSC flyer
   b. DHHSC community email
   c. Merced College DSS flyer
   d. UC Merced flyer
APPENDIX B

PAST OR CURRENT USE OF COUNSELING SERVICES

Answer these items with only one number from 1 to 5. One means that you strongly disagree with the statement, 2 means you only slightly disagree with it, 3 means you are neutral (you do not disagree or agree), 4 means you slightly agree with the statement and 5 means that you strongly agree with the statement.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Slightly disagree</th>
<th>Neither disagree or agree</th>
<th>Slightly agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. There are enough mental health services for the deaf.
2. I can not afford to pay for mental health services.
3. My insurance does not cover mental health services.
4. I do not know how to get mental health services.
5. I do not trust mental health professionals.
6. I do not trust hearing mental health professionals.
7. I would like to have more access to mental health services.
8. I am afraid other people will find out if I am using mental health services.
9. I am afraid of being sent to a mental hospital if I see a mental health provider.
10. I do not have transportation to go to appointments.
11. I do not have time to get mental health services because of Work.
12. I am interested in having more mental health services for the deaf.
13. I can solve my own problems; I do not need mental health services.
14. I would see a mental health professional who can sign.
15. I would see a mental health professional who can sign for themselves, but needs an interpreter to understand me.
16. I would see a mental health professional (who can not sign) who uses an interpreter only.
17. I would see a mental health professional that uses speech only (no interpreter).
18. I doesn’t matter to me what kind of mental health professional I see (signing, not signing, needs an interpreter).

19. If I had to see a mental health professional, I would see a hearing therapist.

20. If I had to see a mental health professional, I would see a deaf therapist.

21. If I had to see a mental health professional, I would see a hard of hearing therapist.

22. It doesn’t matter to me what kind if mental health professional I see (deaf, hard of hearing, hearing).

23. If I had a mental health problem, I would first contact
   a. my family or friends
   b. a Medical/Primary Care Doctor
   c. a psychologist.
   d. a vocational rehabilitation counselor.
   e. a Psychiatrist.
   f. a Nurse.
   g. a Clergy/religious leader (priest, pastor…).
   h. a contact Social worker.

24. If I had a mental health crisis, I would go to
   a. the hospital.
   b. the Deaf community association (like DHHSC).
   c. a Community health center.
   d. my Primary care doctor.

25. Have you seen a mental health professional in the last 6 months?
   a. Yes
   b. No

   If yes, how many sessions (appointments)?

26. Have you ever seen a mental health professional?
   a. Yes
   b. No

27. If yes, was it helpful?
   a. Yes why?
b. No why not?
APPENDIX C

DEAF IDENTITY SCALE

Answer these items with only one number from 1 to 5. One means that you strongly disagree with the statement, 2 means you only slightly disagree with it, 3 means you are neutral (you do not disagree or agree), 4 means you slightly agree with the statement and 5 means that you strongly agree with the statement. For Example:

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Slightly disagree</th>
<th>Neither disagree or agree</th>
<th>Slightly agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. I enjoy both deaf and hearing culture. (Bicultural)
2. I don’t know how I feel about deaf people. (Marginal)
3. Deaf people should only use ASL. (Immersion)
4. I support deaf culture without insulting hearing people. (Bicultural)
5. Deaf people do not need hearing aids. (Immersion)
6. I feel sorry for deaf people who depend on sign language. (Hearing)
7. It’s hard for me to make friends. (Marginal)
8. American Sign Language and English are different languages of equal value. (Bicultural)
9. There is no place for hearing people in the deaf world. (Immersion)
10. I don’t like it when deaf people use sign language. (Hearing)
11. I want to help hearing people understand and respect deaf culture. (Bicultural)
12. I don’t know whether to call myself “hearing impaired” or “deaf.” (Marginal)
13. Only deaf people should teach deaf children. (Immersion)
14. Deaf people should not marry other deaf people. (Hearing)
15. When I see deaf people use sign language, I walk away. (Hearing)
16. I can change between ASL and Sign English. (Bicultural)
17. Neither deaf nor hearing people accept me. (Marginal)
18. Deaf people are satisfied with what the deaf world has to offer. (Immersion)
19. I am always alone. (Marginal)
20. I don’t understand why deaf people have their own culture. (Hearing)
21. I have both deaf and hearing friends. (Bicultural)
22. When I am with hearing people, I remember my pride as a deaf person. (Bicultural)
23. The focus of deaf education should be teaching deaf children to speak and lipread. (Hearing)
24. I don’t know whether to think of my deafness as something good or bad. (Marginal)
25. I feel comfortable with my child being either deaf or hearing. (Bicultural)
26. It is best for deaf people to communicate with speech and lipreading. (Hearing)
27. Teaching deaf children to speak is a waste of time. (Immersion)
28. I don’t know whether to respect or resent hearing people. (Marginal)
29. I only socialize with hearing people. (Hearing)
30. It is wrong to speak while signing. (Immersion)
31. I have thought a lot about what it means to be a proud, strong deaf person. (Bicultural)
32. I try to communicate well in both English and ASL. (Bicultural)
33. Hearing counselors, teachers, and doctors who specialize in treating deaf people can give me the best advice. (Hearing)
34. I feel comfortable with both deaf and hearing people. (Bicultural)
35. Only deaf people should run deaf schools. (Immersion)
36. I feel good about being deaf, but I involve myself with hearing people also. (Bicultural)
37. I can’t trust hearing people. (Immersion)
38. I call myself “hearing impaired.” (Hearing)
39. Learning to lipread is a waste of time. (Immersion)
40. I don’t know what is the best way to communicate. (Marginal)
41. Deaf people should only socialize with other deaf people. (Immersion)
42. I do not fit in with either hearing or deaf people. (Marginal)
43. My hearing friends will fight for deaf rights. (Bicultural)
44. Sometimes I’m happy to be deaf, but most of the time I wish I could hear. (Marginal)
45. If an operation could make me hearing, I would not accept it. (Immersion)
46. I don’t know whether I’d rather be with deaf or hearing people. (Marginal)
47. Sometimes I wish I were more part of the deaf community. (Marginal)
APPENDIX D

INFORMED CONSENT

1. I understand that this study involves research about mental health needs of deaf adults. If I agree to participate, I will be asked to complete 3 questionnaires. The first one asks general information such as my age, ethnicity, etc., the second one asks about my usage and opinions about mental health services, and the third one pertains to how I see deaf culture.

2. I understand that my participation in this study is completely voluntary, without compensation of any kind, and I may withdraw my participation for any reason without penalty.

3. I understand that participation in this research does not guarantee any benefits to me.

4. I understand that if I agree to participate, the questionnaires will take one, approximately 20 minute session to fill out.

5. I understand that only authorized personnel, the researcher and her committee, will have access to the data collected.

6. I understand that, if I wish, I may obtain written information about the outcome of the research at the end of the study.

7. The present study is designed to reduce the possibility of any negative experiences as a result of participation. I understand that answering questions related to my past and present use of mental health services may make some people anxious or uncomfortable. Risks to participants in this study are kept to a minimum. However, if my participation causes me concerns, anxiety, or otherwise distresses me, I understand that I may contact my local county mental health center. In Merced County that number is (209) 381-6800 or (888) 334-0163 or TDD/TTY (888) 293-1818. If I am a student at CSU Stanislaus, I can also contact the Student Counseling Center for assistance at (209) 667-3381.

8. I understand that I will be provided with a copy of this form.

9. I understand that I may contact the researcher, Cynthia Lopez at mhneeds4deaf@yahoo.com or at CSU, Stanislaus Psychology Department at (209) 667-3387, or the research supervisor Dr. Myers at (209) 667-3722 if I have any questions or concerns regarding my participation in this study.

10. If I have any questions about my rights as a participant in this study, I may contact the Campus Compliance Officer, CSU, Stanislaus at (209) 667-3747.

11. I have freely consented to participate in scientific research being conducted by Cynthia Lopez.

12. I attest that I am at least 18 years old.

Print name:_________________________________________________________________ Date: ________________
Signature:_________________________________________________________________
APPENDIX E

DEBRIEUFING

Thank you for your participation in this study. The history of mental health service provided for the deaf has changed over the last 50 years. In the past, there were no facilities to treat deaf individuals who had mental health problems. There are currently only a few residential treatment facilities for the deaf in the United States and deaf individuals continue to be underserved.

Recently there has been some research into Deaf identity that shows four stages of Deaf identity development (Hearing, marginal, immersed, and bicultural). The purpose of this study is intended to see if there is a relationship between Deaf identity and the use of counseling services. Your participation is a vital part of understanding how deaf individuals in the community feel about mental health services for the deaf. With the answers collected, we can hopefully make the mental health field more aware of your needs.

All the information that is collected in these questionnaires will be kept from inappropriate disclosure and only authorized personnel, the researcher and her committee, have access to the data. This researcher uses code numbers for the participants and their names are never associated with their responses. This researcher is not interested in individual responses, but the overall trend in the data. This researcher strictly follows the legal and ethical guidelines of the American Psychological Association with respect to our research findings.

This researcher appreciates your participation. If you have further questions or concerns please contact Cynthia Lopez by email at mhneeds4deaf@yahoo.com, through the Psychology Department of CSU, Stanislaus (209) 667-3387, or the research supervisor, Dr. Myers, may be contacted at (209) 667-3722. Please remember that if your participation in this research has caused you concerns, anxiety, or distress you may contact Merced County Mental Health if you live in the county. That number is (209) 381-6800 or (888) 334-0163 or TDD/TTY (888) 293-1818. Network of care also has a listing of mental health providers and whether they accept Medi-Cal, Insurance, or have a sliding fee program.
(www.networkofcare.org). If you are a student at CSU Stanislaus, you can also contact the Student Counseling Center for assistance at (209) 667-3381.