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Read My Hands: Evaluating the Deaf Community's Perception of Survivor Access to Mental Health Services

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READ MY HANDS: EVALUATING THE DEAF COMMUNITY'S PERCEPTION OF SURVIVOR ACCESS TO MENTAL HEALTH SERVICES

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ABSTRACT

The limited research done on the Deaf community depicts inflated rates of mental illness and trauma compared to the general population. However, overall, members of the Deaf community are less likely to seek help due to perceived barriers in obtaining adequate mental healthcare. This study aimed to investigate the modern-day American Deaf community's rates of mental illness and traumatic events and experiences with behavioral and mental healthcare systems. Barriers related to seeking treatment as well as receiving adequate care are explored as well. It was hypothesized that the Deaf community still faces an increased likelihood of trauma and mental illness as well a reluctance to seek treatment. To examine this, an online survey was distributed to a group of Deaf/Hard of Hearing individuals in Kentucky and neighboring communities in Tennessee. Though the results showed that 42% of participants experienced a traumatic event, only 32% of those participants sought treatment services for their trauma. Furthermore, participants indicated they were significantly more willing to visit a Deaf therapist or a hearing therapist who is ASL-competent compared to a hearing therapist. The most commonly cited barriers to seeking service or receiving quality treatment largely centered around communication issues and/or a lack of knowledge of available services. These results suggest an increased need for therapists with ASL knowledge as well as better outreach and inclusivity efforts by the behavioral healthcare system as a whole.

I dedicate this thesis to the many professors who have shaped my passion for ASL and mental health. You have opened my eyes to a whole new world.

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INTRODUCTION AND LITERATURE REVIEW

The Deaf community is a vibrant and beautifully unique group of individuals living in the United States; however, the field of mental health services seems to focus much of their care and attention on the hearing majority rather than the Deaf community. Several barriers stand in the way of fully comprehending mental health issues and traumatic experiences in the Deaf community and sufficient provision of mental health services to treat these issues. These obstacles include a greater likelihood of both mental health issues and traumatic experiences for the Deaf individual, trauma that is unique to the Deaf community and is therefore inadequately understood by hearing mental health service providers, and a general feeling of inaccessibility to mental health services commonly reported in the Deaf community (Fellinger et al., 2012). These issues are not to be taken lightly, but are to be treated with an urgent importance due to the severe impact on quality of life, daily functioning, and overall well-being that traumatic experiences and mental illness have.

The current research aims to further explore the modern Deaf community's perception of access to mental health services, especially in light of traumatic experiences, by surveying a range of Deaf individuals using the Consumer Assessment of Healthcare Providers & Systems (CAHPS) Experience of Care and Health Outcomes (ECHO) survey. This research will analyze the Deaf community's current knowledge and opinion of mental health services as well as examine the continuity of barriers the literature describes the community as historically experiencing in relation to receiving mental health services. The ECHO survey is a well-researched and widely supported survey instrument used to collect information on patients' experience and satisfaction with the behavioral healthcare system. This instrument was an especially ideal choice due to its unique utility with vulnerable populations and reputation of providing objective, accurate information of patience experience across a variety of settings. After obtaining a thorough understanding of these issues, suggestions may be offered to current mental health service providers regarding improvements for inclusive efforts to their Deaf clients. This research is of paramount importance due to the inherent value that mental health services providers, namely their ability and duty to assist any and all individuals in dealing with issues that may be preventing one from living a healthy and satisfied life.

The existing literature expounds upon many of the topics pertinent to this study, including trauma, the Deaf experience, Deaf mental health, and Deaf-specific trauma. The following sections first detail general traumatic experiences and their negative impact on mental health, including the development of PTSD. A general picture of what Deaf culture is and means is provided next, with an emphasis on the Deaf community's utility. Special consideration is also paid to the Deaf community's unique experience of oppression as well as its ongoing discrimination through the persistent practice of audism. Considering these factors, Deaf mental health is next discussed, especially in relation to mental illness prevalence and vulnerability within Deaf individuals specifically. Deaf trauma is next examined, in terms of both general traumatic experiences that Deaf individuals may experience as well as trauma that is specific to an aspect of the Deaf experience. Finally, Deaf individuals' perceived level of access to mental health services, especially in relation to barriers experienced for service acquisition.

Traumatic Experiences and Their Effect on Mental Health

Specifically studying events that are considered traumatic holds much significance due to these events' profound impact on the individual's wellbeing. A traumatic event has three key features: it is out of the control of the person experiencing it (uncontrollability), it is perceived as negative due to the physical or emotional pain caused (negative valence), and it happens suddenly (suddenness) (Carlson & Dalenberg, 2000). Many events can fall under the umbrella term of "traumatic," including but certainly not limited to: warzone combat, physical/sexual assault, death of a significant other, and disaster (Kilpatrick, 2013). When an individual is exposed to an event that is considered "traumatic," they are at risk for developing Post-Traumatic Stress Disorder (PTSD), which is defined by the American Psychiatric Association as "a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or who have been threatened with death, sexual violence or serious injury" (American Psychiatric Association, 2020). Experiencing such traumatic events can cause a plethora of issues for the victim, even if they do not specifically develop PTSD.

Some additional negative side effects of experiencing traumatic events include aversive emotional, physical, and cognitive reactions. The effect on individuals differs depending on unique characteristics, such as genetic predispositions to either a vulnerability or resilience to trauma, the developmental level and age of the individual at the time of the trauma, community/family environment, and past and future life events (Carlson & Dalenberg, 2000). However, in general the victim of a traumatic event may experience several emotional difficulties, classified as emotional dysregulation problems, such as developing unhealthy coping mechanisms or self-medicating with illicit substances as well as either feeling overwhelmed or feeling numb; (Substance Abuse and Mental Health Services Administration (US), 2014). Victims may even have a physiological response to trauma, often suddenly complaining of a host of health problems, bodily pains, and sleep disturbances shortly after a traumatic event. Finally, survivors may experience cognitive distortions, such as intrusive thoughts, particularly flashbacks reliving the traumatic experience, inflated feelings of guilt, repression of aspects of the traumatic event, amongst others (American Psychiatric Association, 2020). Survivors also commonly engage in avoidance of situations that resemble the traumatic event and sensations that trigger them in some way to the environment where the trauma occurred (SAMHSA (US), 2014). While some individuals form adaptive and resilient responses to trauma, most trauma survivors experience a host of negative effects that follow the traumatic event. Therefore, it is imperative to give trauma survivors the best attention and care that mental health service providers have to offer. Certain groups of people experience traumas that are unique to their life and experiences. One such group is members of the Deaf community.

Deaf Culture

The Deaf community is a diverse, multi-faceted group of individuals who share a common cultural identity rooted in shared language, customs, and norms. There are two main deaf identifications, differentiated in terms of a capitalization. The lowercase “d” deaf is indicative of a medically deaf individual, meaning they have an impaired ability to hear, “the audiological condition of not hearing,” but that is the extent of their identification of being deaf (Padden & Humphries, 1988, as cited by National Association of the Deaf). On the other hand, the uppercase “D” Deaf implies a cultural affiliation with the Deaf community and an intimate tie to and pride of your deafness. Individuals who identify as Deaf share a language, American Sign Language (ASL), as well as a culture (Padden & Humphries, 1988, as cited by National Association of the Deaf). Thus, while a lowercase “d” indicates a medical diagnosis, an uppercase “D” is indicative of a cultural affiliation.

Those who identify as culturally Deaf are said to be a part of the “Deaf community.” Fellinger et. al (2012) define the Deaf community as “communities [that] are made up of individuals with severe deafness who prefer to use sign language and whose social intercourse defines a distinctive culture” (p. 1,037). This definition is important because viewing this population as a *community* with a distinct culture is vital when examining Deaf attitudes and interactions with mental health professionals. Knowing that a client is from a particular cultural background may help service providers be more aware of behaviors that are typical of Deaf people as well as remain sensitive to cultural norms in order to interact with these clients in the most respectful and culturally appropriate way possible. For example, Deaf individuals often must stand/sit at a distance from the other person who they are in conversation with to facilitate good visual communication (Gallaudet University, n.d.). Deaf individuals also expect whoever they are communicating with to be very expressive, especially in their facial expressions, as this is a cornerstone to conveying meaning in ASL (Anderson et al., 2016). Mental health professionals must be aware of unique behaviors and customs present in the Deaf community such as these in order to provide a service that is most amenable to their Deaf clients.

Audism and the History of Deaf Oppression

In acknowledging the unique aspects of Deaf culture and community, it is imperative to also briefly acknowledge the long-standing history of stigma, oppression, and the fight for equality for Deaf citizens, which shaped the Deaf community into what it is today. In the 1900s, there began "intense efforts to acculturate many marginal groups," including Deaf people (Nielsen, 2003). This included a focus on instilling American values and the English language into members of these populations. For the Deaf community, this equated to the emergence of oralism, the movement that forced Deaf pupils to communicate via oral speech and lipreading while depriving students of the use of sign language (Nielsen, 2003). Sign language, rather than being viewed as a rich language and most useful mode of communication for Deaf people that it is today, was perceived as "was primitive, un-American, a sign of intellectual inferiority, and abnormal" (Nielsen, 2003, p. 597). Depriving Deaf children of the best way to communicate represents some initial discrimination and crippling of the Deaf community. Schools that endorsed the ideology of oralism are today blatantly recognized for their abusive conditions, being both physically and mentally abusive to Deaf pupils so much so that Deaf individuals today still cite these abusive conditions as traumatic experiences (Anderson et al., 2016).

Oralism, though a prominent example, is unfortunately merely one instance of overt discrimination and abuse towards the Deaf community. There have been multiple other historical efforts to abuse, ignore, and discriminate against Deaf individuals. This type of prejudice is today referred to audism: the notion of hearing superiority and privilege based solely on one's ability to hear and the subsequent discrimination and inferior view of Deaf people (Dirksen & Bauman, 2004). The effects of audism have reverberated throughout Deaf history, in instances ranging from deprivation of basic rights such as owning property or a car, to having children to being labeled as disabled, dumb, etc. (Dirksen & Bauman, 2004). While some of this discrimination has diminished in mainstream culture, many Deaf individuals live today carrying the burden of this past oppression of their people and fear that not all of hearing society has moved on from these outdated, prejudiced notions.

Mental Health in the Deaf Community

The Deaf community's oppressive history is important to first understand before analyzing both mental illness in this community as well as its root causes, which may include years of experience in oppressive conditions such as those just detailed. However, few prevalence rates of mental disorders in the Deaf population at large are available, and this is part of the bigger problem—the Deaf community is underrepresented in research and outreach in relation to the mental health field (Fellinger et al., 2012). A report from the National Association of the Deaf (NAD) confirms that there is an overall lack of incidence rates for specific mental illnesses in the Deaf community, and most reports are estimates based on rates found in the general population. Though this report was published in 2019, the numbers they discuss in it are from 1996 (the most recent data available). The report estimates that around 40,000 Deaf individuals in the United States had some form of a severe mental illness. Mental health concerns in the Deaf community are similar to those seen in hearing society, including issues with clinical depression, anxiety, sexual identity issues and/or deaf identity issues, Schizophrenia, Bipolar disorder, substance abuse, relationship or family conflicts, and family trauma related to domestic violence. Furthermore, the Deaf community appears to have a higher prevalence of impulse control disorders, learning disabilities, and pervasive developmental disorder (Fellinger et al., 2012). These inflated rates of mental health issues in the Deaf community stem from a variety of factors. Some are unique to the Deaf experience, like struggles to communicate and therefore to feel understood and reluctance to accept hearing loss; others are causes seen across all populations, such as low self-esteem and traumatic/abusive situations (Fellinger et al., 2012). Deaf people are also generally subject to more numerous mental health risks than their hearing counterparts, through experiences such as lack of communicative access to society and less access to mental health services. Pulling from the same 1996 data, the NAD reports that less than 2% of Deaf people who needed mental health treatment received it (and the number is even lower for Deaf people who also identify with an ethnic minority).

In addition to mental disorders, the Deaf community also exhibits higher rates of social-emotional difficulties (rates 2-3x higher than hearing people) as well as serious emotional disturbances (rates 3-5x higher) (National Deaf Center on Postsecondary Outcomes, 2019). The NAD’s research suggests that internalizing mental health disorders (like depression and anxiety) do not differ in prevalence between hearing and Deaf communities, but that personality disorders and child behavior issues are significantly more prevalent in the Deaf population. There is also evidence to support that autism occurs in higher rates in the Deaf community, though there is some debate over the accuracy of diagnoses due to autism's shared characteristics with hearing loss. Especially in childhood, deafness and autism may share similar features, such as "neuro-atypical cognitive processes, atypical social responses to communication and over-sensitivity to sensory input" (Austen, 2015). For example, both autistic and deaf children may be sensitive or unresponsive to noise and may struggle to verbally communicate. Both also experience isolation and education/learning difficulties. Thus, diagnoses of autism are often confounded by its symptoms' similarities with deafness, so these supposed elevated rates of autism for deaf individuals should be interpreted with caution.

It is also worth noting at this point that there is some debate over the accuracy of these high prevalence rates of mental health issues in the Deaf community. Some argue that professionals may be over-pathologizing behaviors that are a reflection of a Deaf cultural background and upbringing rather than a mental disorder. This underlines the importance of accurately defining and viewing the Deaf population as the Deaf *community* to better understand what behaviors are indicators of mental health issues and what behaviors are simply common Deaf behaviors. Whether the high prevalence of mental health issues in the Deaf community is accurate or is inaccurate due to an over-pathologizing of Deaf behavior, both reflect reasons that more study of the relationship between this unique population and mental health should be further explored (Fellinger et al., 2012).

Deaf Community's General Traumatic Experiences

In addition to exploring mental health issues in the Deaf community, Deaf individuals report trauma at almost twice the rate of their hearing counterparts. Though reported traumatic experiences undoubtably vary for each unique Deaf person, some commonly reported traumas are transportation accidents, unexpected deaths, physical assaults, and natural disasters as well as interpersonal traumas like child abuse, intimate partner violence, sexual assault, and crime victimization (Anderson et al., 2016). In Anderson et al.'s (2016) study conducted with 17 Deaf trauma survivors from Massachusetts, participants reported an average of *six* unique trauma types that they experienced throughout their lifetime. In addition, not a single participant reported only one trauma type experienced in their lifetime; they had all been subject to more than one traumatic experience. Out of these respondents' traumatic experiences, the most commonly reported trauma type was physical assault, with 82% of respondents reporting having experienced this firsthand at some point in their lifetime. Anderson et al. (2016) also reported that more than two-thirds of participants had experienced at least one of the following traumatic events: transportation accidents, unexpected deaths, physical assaults, or natural disasters. These studies also suggest that Deaf individuals may be especially vulnerable to physical assault when compared with their hearing counterparts (Anderson et al., 2016). Specifically, Deaf children and Deaf female undergraduate students are two populations that are both twice as likely to experience physical abuse (Tate 2012).

In addition, the Deaf community has overall higher (1.5-5 times) rates of domestic and sexual violence than their hearing counterparts and are twice as likely to experience intimate partner violence. In addition, upwards of 40% of Deaf men and 50% of Deaf women report having suffered a sexual assault (Smith & Hope, 2015). Thus, the Deaf community experiences a higher number and more severe interpersonal traumatic experiences (Tate, 2012). The Deaf community also reports higher rates of victimization for a number of crimes. According to the 2015 National Crime Victimization Survey, 16.9 per 1,000 persons with a hearing disability experienced a violent victimization, of which 8.4 people experienced a serious violent victimization (such as rape, robbery or aggravated assault). Based on these findings, Deaf individuals may be more subject to polyvictimization, or experiencing victimization of multiple types or occurrences. However, a large quantity of research does not distinguish Deaf people from people with disabilities, so our current understanding of the nature and prevalence of uniquely Deaf victimization is limited.

There are many reasons that the Deaf community may face an increased vulnerability to trauma, including increased family conflict, deprivation of language development, poor parental involvement, or social isolation (Anderson et al., 2016). Also, the Deaf community may have limited knowledge about violence and violent victimization experiences and available supportive services due to an underwhelming effort by hearing service providers to reach the Deaf community through community education and outreach efforts. This limited knowledge of what is occurring and how to deal with it may also contribute to this increased vulnerability (Vera Institute of Justice, National Resource Center for Reaching Victims, n.d.).

Trauma Unique to the Deaf Experience

Members of the Deaf community are uniquely subjected to types of trauma that are “distinct to being a Deaf child raised in a hearing world” (Anderson et al., 2016). When asked to choose which traumatic events they had experienced from the assessment tool the Life Events Checklist, many participants selected the “Other” category. When analyzing responses for what traumas respondents had experienced that were unlisted, many were experiences unique to the Deaf community, for example punishment (physical or verbal) at an oral/aural school if caught signing rather than speaking and experiences stemming from a lack of communication access. In addition, literature on Deaf childhood development cites that Deaf children who have hearing parents are more vulnerable to “early attachment disruptions” through lack of parental communication, isolation, or parental attempts to “cure” the child’s deafness (Anderson et al., 2016).

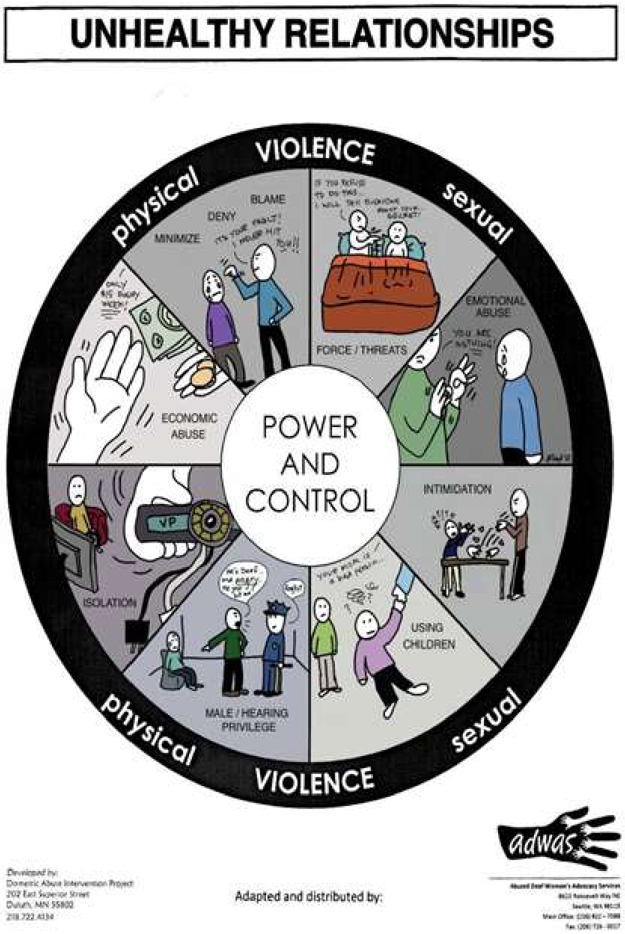
Several additional factors may be considered traumatic events in Deaf childhood. Deaf children are overwhelmingly born to hearing parents; thus, the issue of communication challenges is apparent immediately (Schwenke, 2011). If deaf children are unable to accurately communicate with their parents, this may lead to communication isolation and language deprivation, which can negatively affect emotional health, interpersonal relationships, and social isolation. Language deprivation has a detrimental effect on a deaf child, such as causing lasting cognitive damage. It can also cause issues later in life if the individual endures a traumatic event, as being deprived of language may lead to a lack of development in emotional and social skills that act as preventative or resiliency tactics during a traumatic event (Tate, 2012). For example, a language deprived individual may have a harder time describing a traumatic event to others or due to the initial lack of interactions with others they be less aware of what behaviors are considered inappropriate. Another deprivation which negatively affects Deaf individuals who are survivors of trauma is Information Deprivation Trauma, which occurs when an event is experienced as more traumatic because information surrounding the details of the event is limited. For example, lacking proper access to communication may make finding out information about the well-being of loved ones in a disaster more difficult, which could in turn lead to the individual having a heightened traumatic response (Tate, 2012).

The hearing parent-deaf child communication dynamic also creates a strain in the relationship between parent and child, and increasing frustration on the parental end may lead to a greater propensity to use physical discipline that has the potential to lead to abuse (Schenkel et al., 2014). A survey of behavioral health therapists for Deaf clients revealed that an astonishing 69% of these clients reported childhood abuse or some type of maltreatment (Tate, 2012). Deaf children may also experience mistreatment by peers, especially an increased likelihood of bullying. Due to social isolation, potential deficits in prosocial behaviors, and being perceived by peers as “different,” Deaf children are prone to strained and potentially harmful relationships with peers (Schenkel et al., 2014). Thus, Deaf children are more prone to traumatic childhood experiences with both parents and peers.

In addition to having a unique experience with trauma, the Deaf community also has several unique aspects of domestic violence in particular. For example, abusers of Deaf people often try to limit their ability to communicate through acts like injuring the survivor’s hands to make it more difficult to sign or to steal/destroy communication devices like phones and tele-typewriters (TTYs) (Smith & Hope, 2015). Abusers may also attempt to isolate the victim, through mechanisms like physically moving the victim away from their local Deaf community to an area with less Deaf people or spreading rumors to lessen social interaction. Finally, some may justify abuse by claiming that their behavior is “culturally appropriate behaviors within the Deaf community” (Smith & Hope, 2015). For example, an abuser may use an aspect of Deaf culture, such as using intimidating body language and standing in close proximity when signing, in a way that is manipulative and exaggerated, while claiming their behavior is within the realm of Deaf culture. The Abused Deaf Women’s Advocacy Services created a separate power and control wheel, a tool used to explain the dynamics in abusive relationships and the mechanisms abusers may use to maintain control over the other individual, that depicts some of these domestic abuse tactics described above; it is pictured in Figure 1. These are unfortunately only a few of the tactics that abusers may employ specifically with a Deaf victim and goes to show that the Deaf community deserves special attention given to study and aid their traumatic and victimization experiences due to their inherently unique aspects that are tied to the Deaf experience.

Figure 1

ADWAS Power and Control Wheel



Note. From Abused Deaf Women's Advocacy Services.org.

Though these traumas are highly prevalent, mainstream assessment tools fail to measure these Deaf-specific traumas, and thus Deaf experiences with trauma may go undetected due to underreporting and thus may not be adequately addressed in therapy and other services (Anderson et al., 2016). One reason for this tendency to underreport traumas in the Deaf community is due to being under-informed about what abuse is/looks like, as well as institutional barriers, such as anticipated miscommunication or hesitance to trust authorities (Schenkel et al., 2014). Thus, self-report is not likely to uncover Deaf trauma; however, trauma assessment is less likely to identify Deaf trauma as well due to its unique presentation and tendency to be hidden or overlooked. This is concerning because though Deaf survivors are hesitant to identify and report trauma and most trauma assessment tools do not specifically measure these Deaf-specific traumatic experiences, they are nonetheless a reality to the Deaf community and have a potential to create trauma-related behavioral health problems later in life (Vera Institute of Justice, National Resource Center for Reaching Victims, n.d.).

Additionally, there are several other limitations to the data that does exist on Deaf victimization. First of all, there is still little ongoing data collection for crime victimization of the Deaf, whether on a local, state, or national level. As mentioned above, the National Crime Victimization Survey (NCVS) does collect data from the Deaf population regarding their victimization experiences, directly separating out Deaf individuals in their data output.; however, this data reflects broad, national rates and lacks useful specificities, such as the place and time that victimization is most likely to occur. In addition to the NCVS, the Uniform Crime Report (UCR) also collects data on crime, which one may presume would offer some insight into Deaf crime and victimization. However, the UCR's only somewhat relevant contribution to this subject matter is their data collection on hate crimes against victims with disabilities; yet, even in this instance, Deaf and hard of hearing people are not differentiated from people with disabilities. Thus, even the professional and widely accepted tools used to measure crime and victimization do not offer much insight into *Deaf-specific* crime victimization experiences (Smith & Hope, 2015).

Overall, the Deaf community experiences elevated rates of traumatic experiences that are unique to the Deaf experience. Traumatic experiences can result in a plethora of psychological, emotional, and physical difficulties for the individual experiencing them. These negative effects may be amplified within a minority group such as the Deaf community who likely already experiences daily challenges. Thus, it is of paramount importance to provide quality service to address the aftermath of these traumatic experiences to any and all individuals, but especially to members of the Deaf community who are easily overlooked and underserved. In order to provide quality service, members of the Deaf community must have access to mental health services.

Access to Mental Health Services

Professionals in the mental health field provide a critical, potentially life-saving service which is fundamental to every human being's happy and healthy human experience, whether Deaf or hearing. The limited research on mental illness in the Deaf community has shown there is an urgent need for immediate and quality mental health services; however, research has shown that many Deaf people feel that there are a variety of factors which hinder obtaining quality mental health care. Some of these hinderances are shared by their hearing counterparts who are seeking the same services, and others which are unique to the Deaf experience. Several commonly reported concerns with mental healthcare cited in the literature center around aspects and dynamics present in the Deaf community specifically. As previously mentioned, the Deaf community is unique in that it has many shared norms and distinct qualities common among its members. For example, because the Deaf community is so tight-knit, this creates a phenomenon known as the “Deaf grapevine,” an expression used to indicate how word quickly travels between members, or “down the grapevine,” in this community. While this can be a beneficial aspect at times, Steinberg et. al (1998) describe the dynamics as “familial”) when it is used to spread awareness, good news, or vital information, it can also create an atmosphere where gossip spreads rapidly. For this reason, some Deaf individuals are hesitant to pursue counseling or other mental health services for fear that word of their actions will spread quickly in the Deaf community and they may be judged, stigmatized, or gossiped about (Anderson et al., 2017).

The “small community dynamics” present additional barriers to Deaf members seeking mental health treatment, such as a fear of breached confidentiality. For example, if a Deaf client receives treatment from a Deaf therapist, there is an underlying fear that the client may see their therapist at a Deaf community event, which some clients may feel is an awkward or embarrassing situation. Because of this, some Deaf clients actually cited preferring seeing a hearing therapist over a Deaf one due to the hearing therapist’s lack of involvement in the Deaf community (Anderson et al., 2017).

Communicative issues, which can take many forms, are one of the most commonly cited hindrances that Deaf people report in receiving quality mental health services. Though some Deaf clients prefer a hearing therapist for confidentiality reasons, many others prefer a Deaf therapist or at least one who is fluent in ASL. This is not shocking, as it is likely that most people prefer services, and especially a service like counseling or mental health treatment, to be given in their native language for the sake of cultural comfort and clarity (Vera Institute of Justice, National Resource Center for Reaching Victims, n.d.). In addition, the VERA Institute of Justice notes that, in relation to traumatic experiences and victimization, “it is difficult to exchange information in a person’s non-native language in the best circumstances, and it becomes even more difficult if that person has experienced trauma, is in crisis, or if the information being conveyed is complex.” Therefore, another prevalent issue of seeking mental health treatment for the Deaf community is mental health care providers’ lack of shared communication, namely a lack of fluency in American Sign Language (ASL). Though interpreters seem like a logical solution to this problem, there are additional issues present when using an interpreter, such as potential for miscommunication or breach of confidentiality; the clients’ desire to see a therapist that has appropriate knowledge of the culture and customs that accompany ASL and not just the language itself; and the overall lack of qualified interpreters available and thus accompanying long wait times or difficulty securing one of them (Anderson et al., 2017).

Additionally, if Deaf individuals do attempt to receive a behavioral health service, there are diagnostic barriers they may encounter which again confound their experience. There is a higher likelihood of misdiagnosing a Deaf client, particularly when dealing with diagnosing personality disorders (Tate, 2012). Misdiagnoses may occur due to a difference in hearing and deaf cultural norms and a tendency for hearing professionals to misinterpret these cultural and linguistic differences; this can be considered institutional abuse that may even worsen the symptoms of trauma, having the reverse effect of treatment’s intentions. Inaccurate diagnoses can also be the result of the difference in presentations and symptoms of mental illness between Deaf and hearing. For example, since ASL is a much more emotionally expressive language than English, counselors may over-diagnose mania or under-diagnose depression (Tate, 2012).

In addition to communication problems, there is also the issue of a lack of awareness of service options in the Deaf community. It is important to establish if the Deaf community is overall knowledgeable and aware of the services that are available to them before one can properly evaluate this population's opinions of these services. The literature cites being unaware of treatment options or how to properly access them as another barrier Deaf people feel towards accessing mental health treatment. In Anderson et. al's interviews with Deaf trauma survivors, one respondent noted, "[Therapists should] go to Deaf events and workshops because many Deaf people do not know about available services." Several other respondents agreed with this notion, urging mental health service providers to better their outreach to the Deaf community. Steinburg et. al's (1998) report likewise urges, "Community outreach programs are clearly needed to familiarize both deaf consumers and providers with available resources." They offer up the suggestion of service providers making use of the already existing information pathways in the Deaf community, such as Deaf services agencies and Deaf schools.

An additional issue deals with a group of deaf people who do not take advantage of behavioral health services because they do not generally recognize that they have been through a traumatic event and therefore do not believe they even need a service. In general, much of the language surrounding trauma and treatment is abstract and language-based, which may be difficult for any language minority to understand, but especially the language dysfluent group in the deaf population (Tate, 2012). For example, translating the concept of a "flashback" will require a conceptual translation into a format that makes sense with Deaf cultural norms and into ASL, which is no easy feat. Even the concept of trauma itself proved difficult to translate into ASL and to differentiate an “emotional pain” from physical pain; the best translation according to Tate (2012) was ‘HEART TOUCH-HURT.’ Abstract trauma-related concepts such as these may be another barrier which especially affects the language dysfluent population. Additionally, this group that lacks a solid language foundation may have difficulty or be unable to partake in public education regarding trauma.

Deaf individuals may also feel too isolated, physically, culturally, or linguistically, to even attempt to seek out and access trauma care. However, even if they do reach out, their experience is negatively compounded by communication barriers and even if the service they are receiving is not fulfilling their unique therapeutic needs, they will often stay because it is their only service option (Tate, 2012). Additionally, for members of the Deaf community that are aware of services, they may feel a general distrust towards these services and their providers. This negative perception of mental health service providers may have roots in the long-standing history of abuse and degradation of the Deaf community by hearing society at large, as previously discussed. Like other minority groups, even when conditions have bettered and relations to the majority group are largely less abusive, there can remain a tension or hesitation to trust members of this group due to a history of poor relations with them. Though perceptions have likely improved in the past couple decades, this mistrust and negative characterization of mental health service providers can quickly be seen in a report from 1998, where Deaf interviewees used the following signs to describe mental hospital (ASL signs are typed in all capital letters): PRISON, STRAIGHT-JACKET, and CRAZY-

HOUSE. This same report cites that participants described mental health services and providers as overall authoritarian, restrictive, and prejudiced (Steinberg et al., 1998). Clearly, a mistrust and negative perception of mental healthcare is likely to be still prevalent in the Deaf community, due to a not-so-distant past that is filled with feelings of distrust. Thus, if barriers are to be lessened between the Deaf community and mental health services, it is imperative that modern mental health service providers be aware of their negative images within the Deaf community, as well as the cultural and historic basis for these fears, and begin to work towards improving their relations.

Another issue prevalent in the American population as a whole but that is magnified in the Deaf community is health illiteracy. Health literacy is defined as "an individual's ability to understand healthcare information to make appropriate decisions" (Cutilli & Bennett, 2010). According to the National Assessment of Adult Literacy, 36% of adults surveyed had basic or below basic health literacy, with literacy rates being even lower for participants who spoke a language other than English prior to beginning school. Thus, health illiteracy is a problem for hearing America already, and the issue is compounded when dealing with a population such as the Deaf community who is already an English as a second language population. According to a Deaf health literacy study using the Newest Vital Sign, Deaf individuals were 6.9 times more likely than their hearing counterparts to have inadequate health literacy (Cutilli & Bennett, 2010). This is largely due to information marginalization, defined as, "the systematic, interactive socio-technical processes that can push and hold certain groups of people at social "margins," where their needs are persistently ignored or overlooked," surrounding health topics within the Deaf community (Gibson & Martin, 2019). This is partly due to the fact that many Deaf individuals read at lower levels, averaging at about or below a 6th grade level, and therefore have lower recognition rates of difficult health terminology. There is also a general misunderstanding on the part of hearing people, including hearing medical professionals, that Deaf individuals are inherently able to understand forms of communication such as lipreading or written English, though this is not the case. All of these factors culminate in the Deaf community having health illiteracy issues, which can and does include behavioral health. This health illiteracy is another problematic factor when studying the Deaf community's inclusion in, understanding of, and engagement with vital behavioral health services.

The Current Study

After reviewing much of the existing literature on these relevant topics, this information presents a case for an even greater urgency and need for research on the Deaf community's mental health services' quality and accessibility to be conducted. First, more research in general needs to be conducted on the Deaf community in order to provide both the general public and professionals like mental health service providers with an accurate picture of issues like mental disease and traumatic/victimizing experiences. It is difficult to analyze and improve the existing mental health services to better serve the Deaf community if we do not first know the most pressing issues present in this community nor how this group of people uniquely experiences these situations. In addition, the existing research and data seem to overwhelmingly depict an overrepresentation of mental disease and traumatic, victimizing experiences within the Deaf community. Thus, it should be regarded a pressing matter to more deeply investigate these issues and how professionals can better serve this community to lower the rates of all of these negative experiences in the Deaf community.

The current research surveyed a group of individuals who identify as Deaf/deaf/Hard of hearing, inquiring of their history of trauma as well as their opinion of access to and quality of mental health services. The existing literature highlights a history of Deaf attitudes towards and experiences with trauma, mental illness, and the services provided to treat these issues. However, a contemporary survey will have comparative value to previous research as well as fill in gaps of areas understudied in the Deaf population in relation to these topics. In addition, the importance cannot be overstated of ensuring that every human being, and especially members of overlooked minority groups, feel that they are seen and cared for by the system who claims this as their very mission. The current study will aid in educating, reforming, and updating the existing mental health services in the U.S. to be more inclusive and make an effort to better understand minority voices, or in this case, hands.

METHOD

Participants

Institutional Review Board approval was obtained before participant recruitment began. The sampling method used to obtain participants was initially a purposive sample, as the list of participants was obtained from an American Sign Language professor at Western Kentucky University and thus has connections to the Deaf community. From there, snowball sampling was used, as more contacts in the Deaf community were established and they were encouraged to share the survey with any other Deaf/Hard of Hearing people they thought may be interested in completing the survey.

Initially, 28 responses were collected. These 28 were screened, of which 9 responses were incomplete surveys or questions that were obviously clicked through, as evidenced by the open-ended questions which were filled out with random letters. After this, 19 of the responses were usable. Thus, the final N size for usable responses was 19. Participants ranged in age from 35-74, with most participants in the older (55+) age range, as can be seen in Table 1.

Gender was nearly even between participants. Seventeen participants filled out the demographic information. Out of the participants that chose to disclose their gender, there were eight males, eight females, and one self-identified “Demi-girl”. All participants self-identified as Caucasian. As is displayed in Table 2, most lived in a suburban area, with a few living in a rural area and one living in an urban environment. The N is again smaller due to only seventeen of participants filling out demographic information questions.

Twelve participants identified as d/Deaf and three were Hard of Hearing. Eleven respondents described their main mode of communication as ASL, four with a mixture of signing and voicing, and one with voicing.

Materials

The study used a self-report questionnaire presented online via Qualtrics to collect both qualitative and quantitative data measuring the Deaf individual's knowledge, perception, and attitude towards mental health services. The CAHPS Experience of Care and Health Outcomes (ECHO) Survey was modified and used as a base set of survey questions. The items on the ECHO Survey were reviewed for relevance in the current study, and questions were either edited to match the current study's objectives or eliminated from the question pool if pertaining to a topic that the current study was not pursuing. Additionally, a small set of questions was added to the ECHO Survey that dealt with eliciting information specific to the Deaf community's experience with mental health and trauma services. These questions were developed by the principle investigator and were based on concepts identified in the literature. Survey questions were a combination of formats, including multiple choice, Likert scale, and open-ended. These formats allowed for both comparability of respondents' answers of closed ended responses as well as unique qualitative data which showed the diversity of opinion within this community.

The CAHPS ECHO survey was chosen for use due to the plethora of research backing its validity as well as its utility in measuring the current research's topic of patient satisfaction with the behavioral healthcare system. CAHPS surveys are nationally hailed as "the standard" for objectively and systematically collecting information on patient experience and satisfaction (Price et al., 2014). Additionally, this instrument has been used and supported by numerous credible groups, including the National Committee for Quality Assurance, Centers for Medicare and Medicaid Services, state Medicaid programs, and the Department of Defense (Darby et al., 1976). These surveys measure a variety of aspects of healthcare, including but not limited to, dental services, cancer care, hospice, mental healthcare, surgical care, etc., measuring patients’ knowledge and satisfaction with the aspect of healthcare being studied (Agency for Healthcare Research and Quality, n.d.). This instrument’s goal is to inform organizations about their patients’ satisfaction in order to depict their internal strengths and weaknesses and highlight their shortcomings to ultimately show areas for improvement, which aligns with the current study’s goals and will be an aid to mental healthcare providers on how to better serve their Deaf and Hard of hearing clients.

Research on this instrument’s efficacy also demonstrates its benefit and utility in use with vulnerable and unique populations, including individuals with disabilities (Weinick et al., 2014). CAHPS surveys focus on issues that differentially impact these populations, such as health literacy, cultural competence, and interpreters, all of which are pertinent topics to the population in the current study. CAHPS surveys also have a reputation characteristic of “objective, specific, and actionable measurement, as well as the ability to assess specific reports of a patient’s experience beyond simply rating his or her overall satisfaction” (Weinick et al., 2014). This depth in level of assessment also gives CAHPS strong comparative utility, allowing for comparing responses across a variety of patients and health care service conditions (Price et al., 2014). Therefore, the CAHPS ECHO survey proved to be a strong choice for use in the current study’s research on a unique population’s satisfaction with the behavioral healthcare system, as it has historically demonstrated reliability, credibility, and widespread acceptability in these areas.

A self-report survey was the most feasible and beneficial data collection method to employ for several reasons. It is feasible, unlike long interviews in the midst of COVID, yet still provides the qualitative edge of real people as well as the descriptive nature of their opinions and perceptions of the topic at hand. Administering a written survey also eliminates the need to hire an ASL interpreter, collect responses in ASL, and later translate them into English. This avoids a further expansion of resources and the potential for translation error in responses. Since the participants all had the ability to comprehend written English, a written questionnaire was the simplest and most feasible way to collect information. In addition, the online format enabled the survey to remain anonymous to allow for the most honest answers and the highest level of comfort for participants. Overall, the use of this self-report questionnaire was the most practical and beneficial for collecting information on this unique community.

Procedures

Surveys were administered via sending each respondent a URL link to the survey in Qualtrics as well as a brief description of the survey's purpose. Respondents were given 4 months to take the survey; halfway through the time period as well as close to when the survey was about to close, a follow-up email was sent out that encouraged participants to take the survey if they wished to and had not done so already. Upon survey completion, participants were linked to a second non-connected survey where they were offered the chance to enter a raffle for one of four $25 Amazon gift cards as gratitude for completing the survey. The money for the gift cards was funded by a grant from the Western Kentucky University Diversity Equity and Inclusivity office. To review for patterns and correlation within the quantitative scale questions, a within subject t-test of a Repeated Measures ANOVA and between-subject Oneway ANOVAs were performed as well as a thematic qualitative analysis to identify common themes and patterns in respondents' answers to the open-ended and descriptive questions. The repeated measures ANOVA was used to study Therapist Preference in relation to the therapists' audiological status and included the covariates of "Confidence that a Hearing Clinician Would Act Respectfully Towards a Deaf Client" ("Respectful") and "Confidence that Clinicians are Knowledgeable of the Deaf Community and Deaf Culture" ("Knowledgeable"). Two Oneway ANOVAs were also conducted. The first examined the impact of Living Environment on "Current Knowledge of Available Trauma Recovery Services" ("Current Knowledge"). The second analysis examined the relationship between Education and "Knowledgeable."

RESULTS

Descriptive Data Analyses

The majority of respondents did not report receiving services in the last 12 months for feeling depressed, anxious, or stressed out; due to personal/family problems; or for needing help with drug or alcohol use. Only 21% cited that they had received services for any of the above reasons. However, when questioned about their experience with a list of selected traumatic events, 42% of respondents reported experiencing at least one of the traumatic events on the provided checklist, with the most common traumatic event being verbal abuse, as shown in Table 3.

In addition to respondents' experience with trauma, 58% also cited that they knew of a Deaf peer who had experienced at least one of the traumatic events. Knowledge of peers who received service was also substantial, with 63% of respondents reporting this. In relation to respondents' help-seeking behavior, sexual and verbal abuse were the traumatic events that the most participants received services for. Table 4 shows which traumatic events were followed by receiving services and the specific type of services received for each event.

The research also examined how influential participants felt that some of the commonly cited barriers in the literature were in their decision to not seek services following a traumatic event. Table 5 displays the barriers featured in the survey and how strongly participants felt each one was in prohibition of service acquisition, as it relates to each of the traumatic events.

For the respondents that did seek services, participants on average reported that their clinician would "usually" display positive, inclusive behaviors. Table 6 displays several potential positive aspects of an interaction with a clinician and how often participants felt these aspects were displayed to them. When asked about other aspects of their experience relating to involvement in and information about their ongoing services, participants overall responded that these qualities were occurring much less frequently than desired. Table 7 displays, based on a Likert scale of 1-4, with 1 being "Never" and 4 being "Always," how frequently these aspects of service occurred in their experience. Overall, participants rated the quality of their treatment/counseling as a 6.25 out of 10 and felt that they were helped "a little" (average response) on a scale from "Not at all" to "A lot" by the treatment.

In relation to interpreter security, 78% of participants were either unsure or not confident in their ability to easily obtain an interpreter if they chose to receive services from a hearing service provider. Next, the level of knowledge and information about mental health services was studied. Table 8 shows the most common way participants responded they were informed of services; respondents averaged a report of "Somewhat Confident" (2.53 on a scale from 1-5) in their knowledge about existing services.

To gain information about respondents' opinion and understanding of mental health and trauma, several survey question responses were examined. On average, participants felt "fairly confident" in their understanding of mental health (3.78 out of 5) as well as trauma (4.11 out of 5). Participants were subsequently asked what the first word or concept that comes to mind in relation to mental health is, as is displayed in Table 9, as well as an ASL sign that they would use to describe mental health, seen in Table 10.

Outreach efforts of clinicians towards the Deaf community were also examined. Only 22% of respondents reported ever previously experiencing outreach by mental health professionals. Inquiring about past experience with surveying the Deaf community on their opinion of existing mental health services provided similar responses, with 28% of participants responding they had been previously questioned. Surprisingly, when asked their opinion of stigma surrounding mental illness and therapy, only 44% of respondents felt that there was still significant stigma within the community. Additionally, only 39% of respondents indicated they were fearful that members of the Deaf community may gossip about or judge them if they sought mental health services.

Participants responded that they felt on average “slightly confident,” with a 2.28 rating on a scale from 1-5, that mental health clinicians were knowledgeable about the Deaf community and thus able to provide quality services. Respondents were overall more likely to seek help from professionals (56%) as opposed to family or friends. However, overall participants felt that there is still much improvement that needs to be made with the relationship between mental health services and the Deaf community. Sixty-seven percent of participants felt that either no improvements have been made over time or that some have been but there are still many additional aspects where improvements are needed in this relationship. Finally, participants were asked to provide a suggestion for mental health clinicians. Their responses can be viewed in Table 11.

Inferential Statistical Analyses

Due to the small sample size, several results are only reported as descriptive; however, three inferential analyses were conducted on particularly important aspects of the survey: a repeated measures ANOVA was used to study Therapist Preference in relation to the therapists’ audiological status and included the covariates of “Confidence that a Hearing Clinician Would Act Respectfully Towards a Deaf Client” (“Respectful”) and “Confidence that Clinicians are Knowledgeable of the Deaf Community and Deaf Culture” (“Knowledgeable”). As well as, two Oneway ANOVAs examining the impact of Living Environment on “Current Knowledge of Available Trauma Recovery Services” (“Current Knowledge”) and the relationship between Education and “Knowledgeable.”

The first Oneway ANOVA was conducted with Living Environment and “Current Knowledge” as the between-subjects variables. No significant main effect was found,

$F(2,15) = 1.63$, $p = .234$, *partial* $\eta^2 = 0.20$. Rural living environment (M= 3.50, SE= 0.65) was trending toward a higher confidence of knowledge than the suburban living environment (M=2.36, SE=0.43); however, this effect was not significant. A Oneway ANOVA was also conducted with Education and “Knowledgeable” as the between-subjects variables. No significant main effect was found, $F\ (3,16) = 1.47$, $\eta 2 = 0.\ 25$. These nonsignificant results may be due to the difficulty in obtaining a sufficient number of participants from a minority population resulting in a general lack of power.

A repeated measures ANOVA was also conducted with Therapist Preference as the within subjects independent variable and “Respectful” and “Knowledgeable” as covariates. A significant main effect was found for Therapist Preference, $F(2, 30) = 7.88$, $p = 0.002$, *partial* $\eta^2 = 0.34$. This main effect is qualified by an interaction between Therapist Preference and “Respectful”, $F(2, 30) = 3.80$, $p = 0.034$, *partial* $\eta^2 = 0.20$. Pair-wise comparisons for Therapist Preference accounting for the covariate of Respectful revealed participants were significantly less likely to visit a hearing therapist (M= 3.72, SE= 0.37) than a Deaf therapist (M= 5.89, SE= 0.41, $p < .001$, 95% CI [-3.24, -1.09]) and ASL competent therapists (M= 5.61, SE=0.39). Likelihood of seeing a Deaf therapist was not significantly ($p = .497$, 95% CI [-1.13, 0.57]) greater than likelihood of seeing a hearing therapist with ASL competence.

DISCUSSION

The current research studied the American Deaf community’s current knowledge and opinion of mental health services as well as Deaf experiences with traumatic events.

The literature depicts elevated rates of mental illness as well as traumatic experiences, both generalized and Deaf-specific, within the Deaf community. Yet, many Deaf individuals exhibit either a lack of overall knowledge of existing services or feel barriers towards service acquisition, representing the central problem of possessing an urgent need for but lack of quality mental health and trauma treatment services. To further study these concepts, a self-report survey was created and administered to a group of 28 Deaf/deaf/Hard of hearing individuals, which questioned participants about their mental health and trauma experiences as well as their opinion on existing mental health services and their inclusivity efforts. Overall, results seemed to somewhat mirror the existing literature's findings regarding barriers experienced towards service acquisition, though some trauma was reported in the current study's participants at differing rates.

Traumatic Experiences

Previous literature found elevated rates in traumatic experiences for Deaf individuals. The prevalence of traumatic events in the participant pool depicts the ongoing increased likelihood that Deaf individuals may experience trauma. Traumatic events' commonality was also seen in the higher percentage of respondents who stated they knew of a Deaf peer who had experienced trauma. It is especially interesting to note that the most common trauma was verbal abuse, as Deaf individuals may be more susceptible to things such as insults, name calling, etc. This may even fall in line with findings in the literature, which state that Deaf individuals are at a higher risk for experiencing interpersonal violence, if the verbal abuse occurred within an intimate or familial relationship. Additionally, the literature depicted sexual abuse as a trauma type which Deaf individuals may be more likely to experience. This finding was also supported by the current study, as seen in the respondents' commonality of sexual abuse. Surprisingly, only one respondent reported experiencing criminal victimization, though the literature would have predicted more participants to have experienced a crime. This may be explained by the participants' demographics, namely being older in age and White, and this group of people perhaps being less likely in general to experience crime. The prevalence of these specific trauma types provides overall support for the existing literature's claims and also aids in informing mental health clinicians where to tailor a majority of their services, in order to treat the trauma that is most heavily affecting the Deaf community. It also provides implications for better informing the Deaf community of these trauma types, such as how the trauma may present itself in the context of Deaf culture and where and how to seek treatment if an individual experiences one of these events.

Help-Seeking Behaviors and Service Acquisition

The literature also predicted that Deaf individuals would experiences barriers in relation to the process of seeking and receiving adequate treatment services following a traumatic event. The current study's results support this notion as well. Though the results indicate that trauma is somewhat common in the participant pool, help-seeking behavior even after traumatic events is not always as common. Not all participants who experienced trauma received services and treatment for it; there are significant discrepancies in the number of participants who reported experiencing a traumatic event versus the number of those who received treatment for it. For example, five participants experienced verbal abuse; however, only two received services for it. Four participants experienced sexual abuse, yet only half of them received services. Thus, there is an apparent disconnect between trauma and treatment, as is evidenced by a lack of treated trauma survivors. This may be due to a lack of knowledge of existing services due to a subpar level of outreach towards the Deaf community to inform them of services; it may also be due to one of the several commonly cited barriers Deaf individuals feel in relation to service acquisition, many of which center around a lack of linguistic and cultural competency from service providers and the behavioral healthcare system as a whole. For example, Deaf individuals appear to favor and desire Deaf or ASL-fluent therapists yet report a lack of security in ability to find a Deaf therapist. Furthermore, obtaining an interpreter was not considered a viable replacement, possibly due to the literature's cited challenges with interpreting, including confidentiality and concerns over miscommunication. Most participants also stated that they believe the relationship between the Deaf community and mental health services still needs numerous improvements. This may represent another reason for the hesitation in help-seeking behaviors, if the Deaf community feels a general lack of confidence in the behavioral healthcare system to begin with. As will be discussed below, this result presents a case for more research to be done, especially on Deaf opinion of mental health services, in order to identify some of the specific qualities about the behavioral healthcare system that Deaf individuals feel still need improvement, in order to correct them and create a more inclusive system.

The most barriers were felt towards receiving services for criminal victimization, a natural disaster, and verbal abuse. This finding supports the urgency in need for further research on these barriers and immediate solutions for them. Action should be motivated by the issue of a Deaf individual experiencing verbal abuse, for example, and not feeling empowered enough by the behavioral healthcare system to seek and receive services for it. This scenario is concerning and could be aided by addressing the barriers participants cited in relation to receiving services for these traumatic experiences. Several specific barriers discussed in the literature were also independently supported by this study's results. The barrier participants felt was most influential in their decision to not seek treatment was the inability to find a Deaf therapist or a therapist they felt comfortable with. The next most influential barrier was lacking a knowledge of available services followed by concerns over the clinician's ability to communicate with the client and concerns of securing an interpreter. Each of these most prevalent barriers from the current study were cited in the literature as common obstacles for the Deaf community's service acquisition. The fact that these specific obstacles are the barriers which seem to be most influential in the participants' decision to not seek treatment is important to note, especially because they largely center around a lack of linguistic and cultural competency from clinicians. Factors such as lacking the time or money to receive services rank below these other barriers. This finding is a good example of extra obstacles Deaf people must overcome to simply receive the same services as an English-speaking hearing individual who may not often, if ever, worry about being uncomfortable with most therapists or having communication difficulties with the provider.

Opinion on Services

For the participants who did receive services, opinion varied over quality and satisfaction for services. While the average overall rating for treatment was slightly above average, participants seemed to be lacking some positive qualities relating to treatment, including information about treatment types, ADA rights, and inclusion of family/friends in treatment. The most shocking element from this list is the ADA rights, as this is a legal requirement for Deaf people to be informed of. These qualities also show a lack of information being communicated with the patient, whether regarding treatment, patient rights, or peer involvement. Participants' opinion of service providers was also examined, specifically in relation to the type of hearing status respondents preferred in a therapist. Participants displayed a clear preference for therapists who were either Deaf or hearing but fluent in ASL. This holds importance for mental health practices particularly in areas with a high number of Deaf people; there is a clear need for these practices to hire at least one therapist who is fluent in ASL in order to better serve their Deaf clients. This preference may be due more so to the ease of communication with ASL-competent hearing therapists, considering that there was not a significantly greater preference for a Deaf therapist over a hearing but ASL fluent one. Respondents were also more likely to visit a hearing therapist if the clinician would treat them with respect, providing another suggestion for clinicians who wish to better reach their Deaf clients. The advice as to how to better reach Deaf clients as a hearing therapist seems to be: be respectful and/or learn ASL. Another suggestion for making service providers more accessible to the Deaf community is to provide more and better interpreters, especially ones who are specially certified for interpreting in mental health settings. This would help lessen the interpreter insecurity that respondents displayed, in their lack of confidence in ability to obtain an interpreter for services.

Professional Outreach Towards the Deaf Community

Another prominent literary theme was a lack of awareness of service avenues within the Deaf community. The current study's results corroborate this notion, with a noteworthy number of participants stating that they are not actively informed of mental health services. The current study examined a few potential reasons for this lack of information, including common information routes and lack of outreach. Most participants reported that they were most often informed about mental health services by friends and family or were not actively informed at all. This is problematic due to a lack of presence of mental health professionals in these Deaf individuals' common information routes, specifically that mental health professionals are not cited by respondents as being a common active source of information for the community. Thus, these results show the immediate need for more and better inclusivity efforts tailored by behavioral healthcare towards the Deaf community, especially in the form of outreach with the goal of informing the community of services. This can be achieved through having mental health professionals at Deaf community events, building rapport with community members, targeting advertising and informative programs to Deaf individuals, and presenting mental health materials in a way that is culturally appropriate to Deaf individuals (i.e., provide materials in ASL).

In addition to mental health services' need for improvement in outreach towards the Deaf community, the results also indicated a need for more research in general on this population and their experience with services, as is evidenced by the smaller percentage who reported that they had previously been questioned about this topic. This may be part of the issue of having services which are less effective with the Deaf community. If these individuals are not being regularly studied and polled on if services are meeting their needs, then it is logical that services may fall short in several areas without their target population's input. Thus, a simple tool such as a service satisfaction survey that Deaf patients have the option to complete after service cessation or inception would greatly aid in this lack of research and better include Deaf opinion on services.

Additionally, the relationship between Living Environment and Current Knowledge was examined, namely, to see if perhaps participants who lived in a more urban area had more knowledge of services than those living in a rural area that is underserved. Though this analysis did not reveal any significant main effects, it is interesting to note that the emerging trend was opposite of what one may logically predict about this relationship; results were trending towards participants who lived in a rural area being more informed of services. The lack of significant findings may be due to a lack of power from having a small N.

Opinion on Clinicians

While the literature more strongly described clinicians experience with the Deaf community in terms of areas where they are lacking, it is important to note that not all participants in the current study responded with hesitation, distrust, or even dislike towards mental healthcare professionals. On average, participants had a small confidence in clinicians' knowledge of the Deaf community and were more likely to seek help from professionals as opposed to friends and family. Analyses conducted on the relationship between Education and "Knowledgeable" did not reveal a significant main effect, however. Yet, this may have been due again to a lack of power due to the difficulty in obtaining a sufficient number of participants from a minority population.

While these results imply a more optimistic view of clinicians than literature may suggest, respondents also overwhelmingly felt that improvements still needed to be made between mental health services and the Deaf community. Analyzing participants' suggestions offered to clinicians again reveals a theme of a desire for clinicians and services that are culturally and linguistically meeting the needs of Deaf individuals. Responses included requests for a Deaf-friendly atmosphere (i.e., one where emphasis is placed on visual communication being easily able to occur), respecting their language and culture, becoming fluent in ASL, and having an attitude of acceptance. Truthfully, these are mostly very attainable, reasonable, and realistic expectations for clinicians to hear from language/cultural minority clients. One way clinicians can improve their efforts in these areas is through requiring pre-service training to inform professionals of basic ASL signs and Deaf cultural differences. Additionally, the practice of cultural humility must be taught and practically embraced by service providers, with special care and attention paid to clients who belong to minorities (language, cultural, or otherwise).

Overall, the results from the current research mostly align with those described in previous literature. Trauma's commonality was depicted in respondents, yet their help-seeking behavior was still shown to be inhibited by agreement with some of the literature's commonly cited barriers, particularly in relation to ASL disfluency or interpreter challenges and lack of awareness of services. The few results which seemed to openly contradict previous findings may be explained by additional outside factors, such as this particular population's decreased rates of criminal victimization. The results' utility includes aiding and supporting the limited existing research conducted on the Deaf community as well as being able to offer concrete and pragmatic suggestions based off of the new information given to service providers upon including Deaf opinion in their services.

Limitations

While the current research can certainly add to the body of knowledge about the Deaf community's experience with mental health services, there are also several limitations to the survey which must be acknowledged in the spirit of transparency and desire for accurate results. The first and most apparent one is the fact that the survey was written in English with an audience who is an English as a Second Language (ESL) population. Additionally, results may be confounded by the inclusion of hearing cultural norms in survey questions when participants are a part of a minority culture. This explains some respondents' attrition, especially those who opened the survey but did not complete it or who immediately exited the survey. It is also imperative to acknowledge this due to the fact that it is not guaranteed that respondents clearly understood each question on the survey and thus results, especially those that are dramatic or surprising, must be interpreted with caution. Ultimately, the decision was made not to translate the survey into ASL due to the limited financial and time restraints placed on this project's completion. Translation is often an expensive and time-consuming process; however, this has implications for translation in settings other than research (i.e., if it would have been costly and time consuming to translate a survey, what does this imply for translation in a doctor's office or therapy appointment?).

Another limitation also deals with potential for participant misunderstanding of the survey topic itself. As was discussed in the literature review, health illiteracy is a substantial problem in the general American public; yet, this issue is inflated in the Deaf community. This increased likelihood of health illiteracy in the Deaf community may have caused some confusion or lack of understanding on some of the survey topics and thus there is the possibility for inaccurate responses. There is also the issue of having a lack of data for a subpopulation, meaning that the respondents who completed the survey and were counted as a usable response may not be the population who needs services the most. Individuals that may have the most dire need for services may not have completed the survey due to a low English or health literacy.

Additionally, some limitations with the participant pool include a small sample size and a lack of diversity. The difficulty of conducting research on a small, tight-knit community like the Deaf community, especially being part of the outgroup, must be acknowledged. However, a prominent reason the Deaf community may be looked over in research is due to there being a low incidence of mental health issues compared to the hearing majority; yet, thought there are smaller numbers of cases due to there being a smaller number of Deaf individuals, this population should still be regarded as high need, as can be seen by the elevated *rates* of mental health needs in the Deaf community. Results may also not be generalizable to the Deaf community as a whole due to this study's use of convenience and snowball sampling. Additionally, respondents were older and completely homogenous in race (all white), which must be considered when attempting to generalize these results in relation to the very diverse Deaf community at large.

Future Research

In light of these limitations, one aspect of future research is certainly to have a larger and more diverse group of participants. Inclusion of racial minorities such as Black Deaf perspectives, LGBTQIA+ identities, etc. should be included in future research on

Deaf mental health to examine perhaps how these intersectional identities experience mental health and services differently. Research is needed on how those with perhaps two identities that have been historically marginalized, such as Black Deaf individuals, experience mental health and trauma as well as how comfortable they feel with services. Another aspect of diversity should account for language dysfluent Deaf individuals, exploring the implications of a lack of language access on mental health. Additionally, a survey which is more linguistically and culturally appropriate to the Deaf community should be used in future research. Ideally, a survey translated into ASL and/or disseminated by Deaf individuals may reveal more accurate results by eliminating confusing language or differing cultural norms from the present survey. Yet, another concern of future research may be how to study this community in a way that is cost effective yet culturally sensitive. As was previously mentioned, this survey was not translated due to the time and monetary costs of doing so. Yet, this is a service which is necessary to conduct the most accurate, fair research of this language minority. Closely related to the topic of translation is interpreting. Interpreter insecurity proved to be a substantial issue in the current study's population. Yet, interpreting is a service which is vital for Deaf individuals to be able to experience the same level of care in many settings including behavioral healthcare. Thus, future research should further investigate the reasoning behind this lack of availability and quality of interpreters, especially in behavioral healthcare settings. Once the root causes and reasoning behind this obstacle is identified, research should also examine a practical solution to help aid this issue and ensure more Deaf individuals are afforded equal access and health equity in relation to mental health services.

Another issue which deserves more research is the potential overpathologizing of behaviors which may present as mentally ill to an untrained hearing mental health clinician, but are actually indicative of a Deaf upbringing. Special emphasis should be placed on studying the aversive Deaf childhood experiences, such as communication isolation and delay, which may have both a severe impact on the Deaf individuals' cognitive and mental state well into adulthood as well as their current behaviors which may initially present as pathological but could more accurately be explained by these childhood experiences.

CONCLUSION

Overall, the results seem to generally support the existing literature's depiction of higher rates of trauma in the Deaf community, with some minor differences in frequencies of certain trauma types. Respondents still perceived and experienced many of the barriers described in the existing literature as well. Possibly due to these barriers, participants showed a substantial discrepancy between experiencing a traumatic event and subsequent help-seeking behaviors and service acquisition. Respondents who did receive services seemed to prefer clinicians who were either Deaf or ASL fluent, showing the great need for ASL competent mental health workers. Ultimately, respondents felt that improvements still need to be made between mental health services and the Deaf community, with many of their suggestions urging clinicians and behavioral healthcare to become more culturally and linguistically accessible to their community. Though the current research was limited, clinicians can glean useful information from research like the current study’s in order to better their practice’s inclusivity efforts towards the Deaf community. The door of research on the Deaf community and mental health services has only merely been cracked and promises to be a fruitful area for future research.

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APPENDIX

Table 1

Participant Demographics: Age Ranges

Age Range	Frequency
18-24	1
35-44	2
45-54	6
55-64	5
65-74	3

Table 2

Participant Demographics: Living Environment

Living Environment	Frequency
Suburban	12
Rural	4
Urban	1

Table 3

Traumatic Experience Prevalence

Trauma Type	**Number of Respondents**
Verbal Abuse	5
Transportation Accident	4
Sexual Abuse	4
Domestic Violence	2
Natural Disaster	2
Physical Abuse	2
Criminal Victimization	1

Table 4

Services Received for Traumatic Events

Trauma Type	# Received Treatment Services	Service Type Received
Domestic Violence	1	Group Therapy
Transportation Accident	0	N/A
Verbal Abuse	2	Individual Therapy
Criminal Victimization	0	N/A
Natural Disaster	0	N/A
Physical Abuse	1	Individual Therapy
Sexual Abuse	2	Crisis hotline; Individual Therapy

Table 5

Barriers to Service Acquisition for Traumatic Events

	Domestic Violence	**Transportation Accident**	**Verbal Abuse**	**Criminal Victimization**	**Natural Disaster**	**Physical Abuse**	**Sexual Abuse**	**Total**
Did not know of available services	N/A	5	7	7	7	N/A	6	**32**
Did not have money for service	N/A	3.25	5.33	7	6.5	N/A	5	**27.08**
Did not have time for service	N/A	4.75	4.33	7	5	N/A	5	**26.08**
Concern that clinician not able to effectively communicate	N/A	4.75	7	7	7	N/A	6	**31.75**

Concern of securing interpreter	N/A	4.5	7	7	7	N/A	6	**31.5**
Couldn't find Deaf therapist/therapist comfortable with	N/A	5.25	7	7	7	N/A	6	**32.25**
Didn't want community members to know about services	N/A	3	6.67	7	6.5	N/A	6	**29.17**
Total	**0**	**30.5**	**44.33**	**49**	**46**	**0**	**40**	

Table 6

Experience with Clinicians

Aspect of service	**Mean Rating**
Clinician listened carefully to you	1.75
Clinician explained in understandable way	2
Clinician respected your thoughts	2.25
Clinician spent enough time with you	2
Felt safe with clinician	2.25

Note. The mean ratings in the table are coded as 1-4 from a Likert scale ranging from "Never" (1) to "Always" (4).

Table 7

Treatment Inclusivity Rating

Aspect of Treatment	**Frequency of Occurrence**
Client involved in services as much as desired	2.5
Discussed with client involvement of family + friends in services	1.34
Client given information about types of treatment	1
Clinician shared private info with others	1.67
Client given information about patient/ADA rights	1.34

Table 8

Popular Information Routes for Mental Health Services Information

Information Route	**Frequency**
Not actively informed	5
Friends and Family	5
Community Events	3
Social Media	2
Advertisements	1
Mental Health Advisory Committee	1
Works in the mental health field	1

Table 9

Initial Word Describing Mental Health

Initial Concept Relating to Mental Health
Happy thought not negative thinking
Depression
Important
Mental health is an important component of overall health
Good state of mind
It depends
Healthy mind
Well being
Need help to stay mentally stable
Fluent in ASL?
Person in situation with view to their mental and emotional safety
Extremely important
Get me through this peacefully
Treatment

Table 10

ASL Sign to Describe Mental Health

ASL Sign to Represent Mental Health Services
ASL
Get help
One finger to head and use 2 hands down from the upper torso
Focus on our mind
Vital/important
I would sign mental health services in exact the same.
ASL help deaf to understand with picture
Finger spell MHS
Mind health
Communication access
Accessibility
Brainwash in ASL not SEE and few words that Deaf use ASL which hearing don't know.
Inadequate
Finger to the side of the head then then "health"

Table 11

Suggestions for Mental Health Clinicians

Suggestions for Mental Health clinicians
Communicate with therapists without help of interpreter
Deaf-friendly atmosphere
To improve on reacting the extreme emotions
Understand or respect the language & culture
If they will arrange to get interpreter, that's great!
Be aware of the help places
Direct services are better
Fluent in ASL
Professional Deaf with native ASL & culture
ASL fluency, Deaf Culture Competency, Attitude of Acceptance
To stay within their professions and not getting into or involve other professionals' work