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THE DEAF COMMUNITY AND THEIR PREFERENCES IN A CLINICAL PSYCHOLOGICAL SETTING

by

ALEXANDRA ALONSO

A thesis submitted in partial fulfillment of the requirements
for the Honors Undergraduate Thesis Program for Psychology
in the College of Sciences
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at the University of Central Florida
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Thesis Chair: Valerie Sims, Ph.D.

ABSTRACT

The focus of this study was to examine the Deaf community and their preferences for both a psychologist and the language utilized in a clinical psychological setting. The study gave each participant a mock profile for a psychologist and then asked participants to answer questions on their perceptions of the psychologist provided. A total of 22 participants who identified as Deaf, deaf, hard-of-hearing, or as an individual with hearing loss were surveyed. Results indicated that participants randomly assigned to the Deaf psychologist had higher rates of satisfaction and trust over participants who were assigned to other psychologists. The study also supported the concept that individuals who prefer using American Sign Language will similarly prefer a psychologist who knows and can communicate in American Sign Language.

ACKNOWLEDGEMENTS

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I would like to express my deepest gratitude to Dr. Valerie Sims, my thesis chair, for providing me with the opportunity to develop my research and guiding me throughout these past years as an undergraduate, both in the ACAT Lab and across Europe.

I would also like to thank Professor Bill Cooper, my committee member, whose class was the beginning of my love for American Sign Language. This thesis would not exist if I had never registered for your course, and three more courses after that!

Lastly, I would like to thank my family, friends, and cat for supporting me and being my team of personal cheerleaders, through all the stress, tears, and sleepless nights.

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Table of Contents

ABSTRACT ii

ACKNOWLEDGEMENTS iii

INTRODUCTION 1

METHODS 7

APPENDIX A- MOCK PSYCHOLOGIST PROFILE 20

APPENDIX B - MOCK PSYCHOLOGIST PROFILE QUESTIONNAIRE 23

APPENDIX C - DEAF IDENTITY QUESTIONNAIRE 25

APPENDIX E - DEMOGRAPHIC QUESTIONS 31

REFERENCES 36

INTRODUCTION

Across the world, 1.5 billion individuals have some level of hearing loss, ranging from mild to profound (World Health Organization, 2021). Additionally, it is estimated that there are at least 500,000 people who use American Sign Language as their primary or sole language (Mitchell, 2006). These individuals who have both hearing loss and use American Sign Language, or ASL, as their dominant language refer to themselves as being capital "D" Deaf. It is a sociocultural perspective on d/Deafness instead of the more pathological or medical view, also known as lowercase "d" deaf. The term Deaf is viewed as more of an identity, similar to ethnicity or gender identity. A Deaf person is a member of Deaf culture and a part of the Deaf community (Du Feu & Chovaz, 2014). While the world may label being d/Deaf as a disability or hindrance, many Deaf people do not share this view. They do not think being d/Deaf is something that needs to be fixed or changed, but rather a part of who they are (Jones, 2002). Many Deaf individuals reported that they felt stressed planning for and seeking out health care providers. Part of stress was said to come from the distrust of medical professions, who are thought of as wanting to "cure" Deaf patients. (Hoang et al., 2010)

The concept of Deafhood, a term coined by Dr. Paddy Ladd, focuses on the positive and cultural aspects of the Deaf experience, instead of on one's hearing loss. This strong sense of Deaf identity is believed to come from a long history of d/Deaf individuals being isolated from each other and many years of oralism in deaf education. Oralism concentrates on teaching deaf children how to lip read and speak, rather than sign, to help them better integrate into a hearing world. There is much debate on whether oralism is the right path to take, especially when a child

is profoundly deaf at a very young age. It is often hard for them to adapt to oralism (Watson & Knight, 1998). Many Deaf people who were introduced to signing later in life felt resentment over their delayed introduction to ASL. Typically, these individuals did not know of the existence of American Sign Language or they were taught that it was a primitive and crude language. They were frustrated that they had not only been separated from a community of people with similar life experiences and struggles, but denied access to a form of communication created by and for those with hearing loss (Ladd, 2003).

Perceptions of American Sign Language

For many years, society did not view American Sign Language as a true language. They perceived it to be a broken version of spoken English, only reserved for the uneducated or other undesirables, because it was primarily used by deaf individuals (Stokoe, 1980). Dr. William Stokoe, a linguist, knew very little about ASL until he became a professor and researcher for Gallaudet University, a university for the d/Deaf and hard of hearing. Through his lab at Gallaudet University, Stokoe argued that American Sign Language was just as genuine as any other language. It had its own unique components such as grammar, phonology, and abstractions. Many credit Stokoe's work, specifically the 1960's *Sign Language Structure* book, as the reason why the public perception of American Sign Language so rapidly changed. Though the use of ASL was accepted by some as a unified system for d/Deaf Americans to communicate, others looked to find what they thought to be solutions to d/Deafness (Glickman, 1993).

Perceptions of the d/Deaf

In recent years, there has been a rise in cochlear implant surgeries. The cochlear implant, also known as a CI, is an implant designed to restore hearing by emulating a working inner ear. They are typically used in moderately to profoundly deaf individuals. Studies have shown that three in four deaf infants, ranging from the ages zero to three, will receive a CI (Chapman & Dammeyer, 2017). The popularity of CIs is believed to stem from the high rate of deaf children born to hearing parents. Nine in ten deaf children are born into a hearing family. Additionally, a mere five percent of hearing parents are aware of ASL and have learned sign language to communicate with their children. Many claim that this is because hearing parents typically view deafness as something that needs to be cured, a pathological view, and are unaware of the cultural view or even the troubles that can occur with the cochlear implant (Mitchell & Karchmer 2004).

Even with the use of CIs from a young age, children with cochlear implants still report issues with social participation, a phenomenon known as social deafness. Social deafness is used to describe scenarios where, even with near perfect hearing correction, these d/Deaf individuals still encounter issues with hearing. These scenarios usually include group conversations or noisy environments. Many parents and teachers described children with the CIs as being social and outgoing in quieter environments but, when brought into louder environments, avoiding noisy areas and keeping to themselves or one other child. Many children reported not being friends with other deaf children, with or without CIs, because they did not know of any in their area, sometimes leading to feelings of isolation. Additionally, some reported frustration over challenges that would occur during periods of social deafness, upset over experiencing difficulty in expressing themselves or understanding others (Punch & Hyde, 2011). Many Deaf individuals

think that d/Deaf children, regardless if they use CIs or not, should be introduced to some form of signing in addition to spoken English. This bilingual system is thought to benefit the child by providing both an auditory and visual way to communicate, ideally to combat social deafness and help with overall communication in both a hearing and d/Deaf world (Lee, 2012).

Mental Health and the d/Deaf Community: Language Barriers

Most doctors aim to provide good care to their patients by centering the focus on the patient's needs and clear communication. These two factors are unfortunately not always in mind when providing healthcare services to d/Deaf patients (Hommes et al., 2018) Though interpreters are required to be provided by law, many healthcare providers rely on other informal methods of interpretation. These include writing notes back and forth between the healthcare provider and the patient, assuming the patient can lip read, and relying on family members to interpret. These methods often lead to miscommunication between the patient and provider (Shuler et al., 2013) It is reported that only twenty two percent of d/Deaf patients are provided with and use an ASL interpreter during medical appointments (Ebert & Heckerling, 1995).

When looking at d/Deaf experiences in a clinical psychological setting, the average length of a stay in a psychiatric hospital or inpatient unit for a d/Deaf patient is double the length of a stay for a hearing patient. Though many researchers previously thought this was because of a higher severity of mental illness, studies have supported the theory that this may not be accurate. If a d/Deaf patient is in a clinical environment where the therapists know how to sign and communicate using ASL, the patient's stay is then the same length as a hearing patient in the

same facility. This shows that the issue is more likely to be because of a language barrier (Di Baines et al., 2010).

Mental Health and the d/Deaf Community: Prevalence

Because of the lack of research, the exact prevalence of mental illness in the d/Deaf community is unknown. Currently, there are at least thirteen studies based in the United States focusing on the prevalence of mental illness in the d/Deaf community. Of the thirteen U.S.-based studies published, at least four were published in the last twenty years. A majority of these focused solely on the prevalence of only depression in the d/Deaf population, leaving the prevalence of many other disorders to be unknown (Kushalnagar et al., 2019). Additionally, many of the studies contradicted each other, meaning that the true prevalence of mental illness in this already underserved population is also unknown. Though there are many discrepancies, studies have consistently shown that impulse control disorders, pervasive developmental disorders, and intellectual disabilities are more prevalent among d/Deaf people than hearing people (Diaz et al., 2013) When analyzing a Deaf sample against a hearing control group, the rate of behavioral problems was twice as high. The study noted that the severity of the hearing loss had no significant effect on the prevalence of these behavioral problems (Fellinger et al., 2012).

Purpose of Study

The study provided participants mock profiles for a psychologist and ask about their comfort level in using that psychologist. There were four levels for the psychologist profile:

hearing with an on-site interpreter, hearing with a VRI interpreter, hearing and can sign, and Deaf and can sign. Additional demographics, such as age and gender, were also analyzed. Based on prior literature on the Deaf community and their experiences in a healthcare setting, the following hypotheses have been generated:

Hypothesis 1: Participants who identify as Deaf, deaf, hard-of-hearing, or as an individual with hearing loss will prefer a Deaf psychologist.

Hypothesis 2: Participants who primarily use ASL will prefer a psychologist who can sign.

METHODS

Participants

This study consisted of 22 participants: 6 participants were assigned to the Deaf psychologist profile, 5 participants were assigned to the hearing with an interpreter on-site psychologist, 5 participants were assigned to the hearing and can sign psychologist, and 6 participants were assigned to the hearing with an interpreter through VRI psychologist. Participants were surveyed through Qualtrics, an online survey software. This survey was then shared through Reddit and Facebook, social media platforms, and email. All the participants were eighteen years old or older and identified as deaf, Deaf, hard-of-hearing, or as an individual with hearing loss. The survey was voluntary and no identifiable information was collected from the participants.

Materials

Mock Psychologist Profile. Each participant was shown a mock psychologist profile. There were four levels a participant could be assigned to for the psychologist: hearing with an interpreter on-site, hearing with an interpreter through VRI, hearing and can sign, or Deaf and can sign. The mock psychologist profile is provided in Appendix A.

Mock Psychologist Profile Questionnaire. Following the mock psychologist profile, participants were asked about their comfort in using that psychologist on a 6-point scale ranging from 1 - *Strongly Agree* to 6 - *Strongly Disagree*. See Appendix B for the Mock Psychologist Profile Questionnaire.

Deaf Identity Questionnaire. Participants were asked about how strongly they feel about their Deaf identity and issues that may arise when using an interpreter during healthcare services. The Deaf Identity Questionnaire is shown in Appendix C.

Deaf Experience Questionnaire. Each participant was asked questions on their experience during healthcare appointments. These questions focus on the level of understanding for both the provider and the interpreter, if used. The Deaf Experience Questionnaire is shown in Appendix D.

Demographic Questions Participants were asked seven demographic questions: how they identify when it comes to their hearing loss, their level of comprehension for spoken languages, their preferred language, age, gender, ethnicity, and education level. See Appendix E for the Demographic Questions.

Procedures

After approval of the survey from the University of Central Florida's Institutional Review Board, participants were invited to participate in the survey. The survey was posted to social media platforms, Reddit and Facebook, and sent out through email. The message and image posted can be seen in Appendix F. After clicking the survey link, participants were shown an explanation of research and were told that participation was voluntary. After consenting to participation, participants were shown the Mock Psychologist Profile and were asked to answer the Mock Psychologist Profile Questionnaire based on the profile they were assigned to. Following this, participants were asked to complete the Deaf Identity Questionnaire, Deaf Experience Questionnaire, and then asked seven demographic questions.

RESULTS

This study utilized a within-subjects design where each of the 22 participants was randomly presented one of four mock psychologist profile. They were then asked questions about their comfort and confidence in using that specific psychologist on a 6-point scale ranging from 1 (Strongly Agree) to 6 (Strongly Disagree). For each of thirteen dependent variables, a one-way between-subjects ANOVA test was then conducted, with the type of psychologist shown in the mock profile for the independent variable.

Demographics

A total of 22 participants were surveyed, ranging from the ages of 18 to 50. The participants identified as hard-of-hearing (*n*=9), culturally Deaf (*n*=9), and deaf (*n*=4).

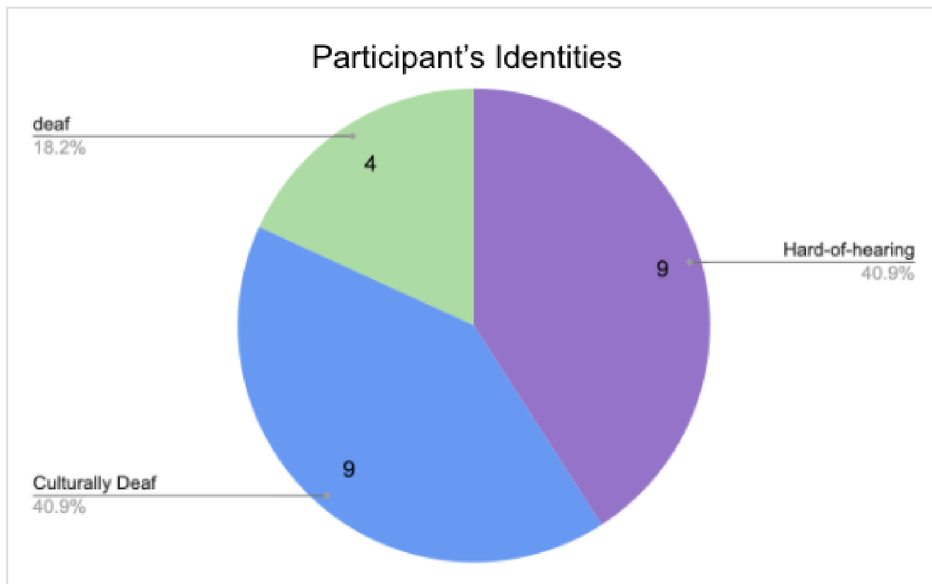

Figure 1: Participants' Identities

Most of the participants selected ASL (*n*=13) as their preferred language; others had selected English (*n*=6), PSE (Pidgin Signed English) (*n*=1), other sign language (*n*=1), or other spoken language (*n*=1).

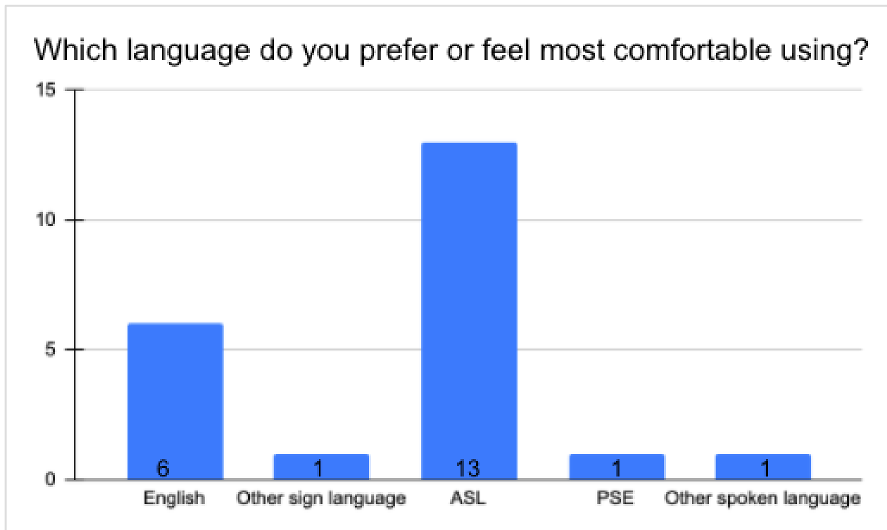

Figure 2: Participants' Preferred Language

The participants' highest education level varied from high school diploma (*n*=2), some college (*n*=6), associate's degree (*n*=2), bachelor's degree (*n*=8), master's degree (*n*=2), and doctorate degree (*n*=1). The majority of the participants identified as female (*n*=14), but also included male (*n*=7) and nonbinary (*n*=1) participants.

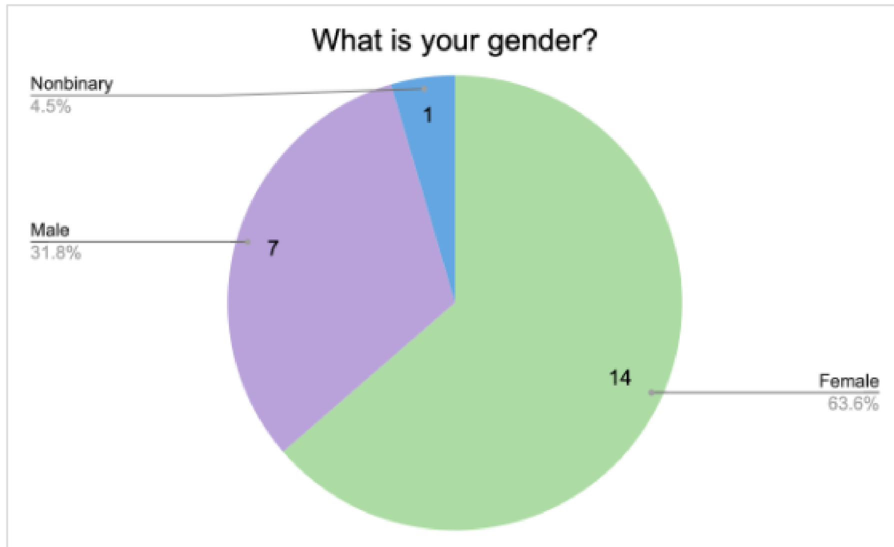

Figure 3: Participants' Gender

The participants' ethnicities ranged from White (*n*=14), Black or African American (*n*=3), Hispanic or Latino (*n*=3), and Asian and Pacific Islander (*n*=2).

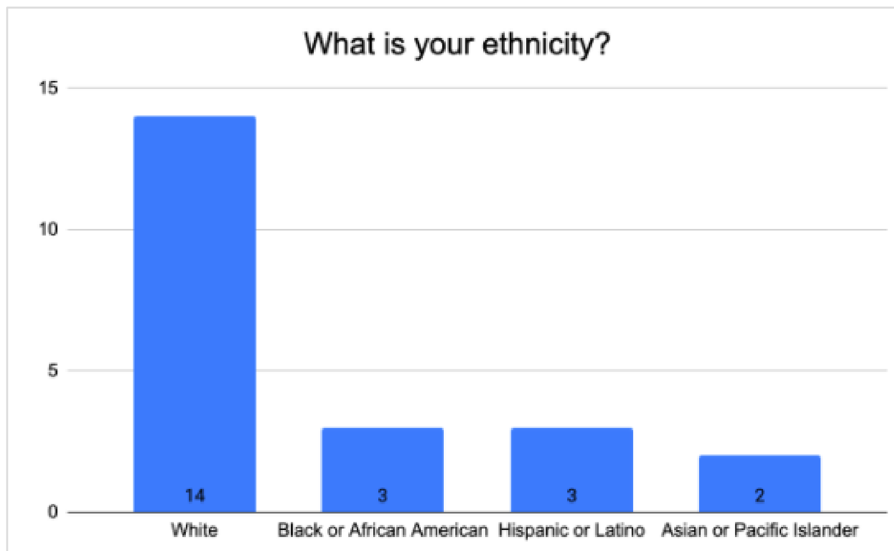

Figure 4: Participants' Ethnicities

Can Count on This Psychologist

The type of psychologist had a significant impact on whether or not participants thought they could count on the psychologist (F (3,18) =11.78, p<.001). The results indicated that participants assigned to the Deaf psychologist (M=1.83, SD= 0.75) reported higher levels of can trust over participants with the hearing and can sign psychologist (M= 2.20, SD= 0.45), hearing with an interpreter on-site psychologist (M=2.80, SD= 0.45), and hearing with an interpreter through VRI psychologist (M= 3.67, SD= 0.52).

Can Trust This Psychologist

When asked if the psychologist could be trusted, the type of psychologist again had a significant effect with participants viewing the Deaf psychologist (M=1.67, SD=0.52) as most trustworthy (F (3,18) =6.96, p=.003) over participants with the hearing and can sign psychologist (M=2.20, SD=0.45), hearing with an interpreter on-site psychologist (M=2.60, SD=0.55), and the hearing with an interpreter through VRI psychologist (M=3.17, SD=0.75).

Have a High Opinion of This Psychologist

Participants assigned to the Deaf psychologist (M=2.00, SD=0.63) (F (3,18) =10.70, p<.001) reported higher opinions of their assigned psychologist. This was followed by the participants assigned to the hearing and can sign psychologist (M=2.40, SD=0.55), hearing with an interpreter on-site psychologist (M=2.80, SD=0.84), and the hearing with an interpreter through VRI psychologist (M=4.17, SD=0.75).

Reliability of Psychologist

When assigned the Deaf psychologist (*M*=2.33, *SD*=0.52), participants scores were lower on average (F (3,18) =8.56, $p<.001$), showing the psychologist as being viewed as more reliable, than participants assigned the hearing and can sign psychologist (*M*=2.40, *SD*=0.55), hearing with an interpreter on-site psychologist (*M*=3.80, *SD*=0.84), and the hearing with an interpreter through VRI psychologist (*M*=3.83, *SD*=0.75).

Psychologist's Tendency to Avoid Deaf Issues

Participants provided with the hearing with an interpreter on-site psychologist (*M*=3.20, *SD*=0.84) had higher levels of reporting their assigned psychologist as being likely to avoid discussing issues involving being Deaf (F (3,18) =4.13, $p=.02$) followed by those provided with the hearing with an interpreter through VRI psychologist (*M*=3.67, *SD*=1.03), the hearing and can sign psychologist (*M*=4.40, *SD*=0.55), and the Deaf psychologist (*M*=4.67, *SD*=0.52).

Psychologist's Insensitivity Towards Deaf Community and Culture

The participants given the hearing with an interpreter on-site psychologist (*M*=3.60, *SD*=1.14) again reported higher levels of their assigned psychologist being viewed as likely to be insensitive towards the participants' discussion of Deaf culture (F (3,18) =4.64, $p=.014$). This was followed by participants assigned to the hearing with an interpreter through VRI psychologist (*M*=3.83, *SD*=0.41), the hearing and can sign psychologist (*M*=4.00, *SD*=0.71), and the Deaf psychologist (*M*=5.17, *SD*=0.75).

Psychologist's Perception of Oversensitivity on Deaf Issues

When asked if the psychologist provided would think that the participant was overly sensitive about issues concerning being Deaf, the type of psychologist was not significant ($F_{(3,18)} = 1.99$, $p = .152$).

Perception of the Psychologist's Stereotypes of the Deaf Community

Participants were asked if they thought the provided psychologist would have stereotypes about the Deaf community. The type of psychologist was again not significant ($F_{(3,18)} = 2.84$, $p = .067$).

Perception of the Psychologist Being Unaware of the Realities of Being Deaf

Participants provided with the hearing with an interpreter through VRI psychologist ($M = 3.17$, $SD = 0.75$) had an average higher score and view that their psychologist would be unaware of the realities of being Deaf ($F_{(3,18)} = 9.88$, $p < .001$). This was followed by the participants assigned the hearing with an interpreter on-site psychologist ($M = 3.20$, $SD = 1.30$), the hearing and can sign psychologist ($M = 4.80$, $SD = 0.45$), and the Deaf psychologist ($M = 5.17$, $SD = 0.41$).

Psychologist Not Grasping Concepts

When asked if they thought the psychologist presented would have difficulty grasping concepts they would try to convey, participants shown the hearing with an interpreter through VRI psychologist ($M = 2.83$, $SD = 1.17$) reported the highest levels of the psychologist being likely to not fully understand them ($F_{(3,18)} = 9.61$, $p < .001$) over the participants with the

hearing with an interpreter on-site psychologist (*M*= 3.20, *SD*= 0.84), the hearing and can sign psychologist (*M*= 4.20, *SD*= 0.45), and the Deaf psychologist (*M*=5.17, *SD*=0.41).

Deaf Pride

Participants were asked if they took a great deal of pride in being Deaf. This had no significant effect on the type of psychologist (*F* (3,18) =2.09, *p*=.137).

Connection to Deaf Community and Culture

Participants were asked if they do not feel connected to Deaf culture. This had no significant effect on the type of psychologist (*F* (3,18) =2.41, *p*=.100).

Involvement in Deaf Community and Culture

Participants who were shown the Deaf psychologist profile (*M*=1.83, *SD*=0.75) tended to report that being a part of the Deaf world and interacting with Deaf people was important to them (*F* (3,18) =2.41, *p*=.03) over participants assigned to hearing with an interpreter on-site psychologist (*M*=2.20, *SD*= 0.45), the hearing and can sign psychologist (*M*=2.60, *SD*= 0.55), and the hearing with an interpreter through VRI psychologist (*M*= 3.33, *SD*= 1.21).

DISCUSSION

The findings of this study support the two hypotheses stated earlier. The first hypothesis was that participants who identify as Deaf, deaf, hard-of-hearing, or as an individual with hearing loss will prefer a Deaf psychologist. Throughout the study, participants who were assigned the Deaf psychologist reported higher rates of trust and reliability over the other psychologists. A possible explanation for this finding could be that the participants were more likely to trust the Deaf psychologist over hearing psychologists because of the Deaf communities' strong connection to each other, as seen in previous research. Similarly with other minority groups when seeking a psychologist, it appears that the Deaf community prefers a psychologist who shares the same identity and culture. The Deaf individuals who have a preference for Deaf psychologists should have access to them. Something that should be noted is that areas with large Deaf communities, such as areas surrounding Deaf schools or colleges, typically have a greater prevalence of Deaf psychologists than other areas with smaller Deaf populations. This may have an impact on the accessibility of Deaf psychologists in an individual's location. Participants who were assigned the Deaf psychologist reported the highest scores on importance in involvement in the Deaf community and also showed a significant level of trust and perception of reliability for the Deaf psychologist (Jones, 2002).

The second hypothesis was that individuals who preferred using American Sign Language would prefer a psychologist who can sign. Though participants overall seemed to prefer a Deaf psychologist, the scores for Deaf psychologist and hearing and can sign psychologist were very close for several variables: reliability of psychologist, perceived tendency

to avoid Deaf issues, not being able to grasp concepts conveyed by the participant, and a perceived tendency of being unaware of the realities of being Deaf. Based on findings from previous research, one of the main issues of seeking psychological services is a lack of accessibility when it comes to communication. This lack of accessibility can be seen in the rates of unavailability of reliable interpreters and a shortage in psychologists and psychological staff who know and can communicate in American Sign Language (Di Baines et al., 2010). When treating Deaf patients, doctors should either use licensed and qualified interpreters, not family, friends, or any others who may have biases or may not be able to interpret correctly and efficiently. Doctors who wish to sign with their patients must also be competent in ASL and should preferably have a form of licensure from a reputable source such as the RID.

One of the limitations of this study was the small pool of participants. This small sample greatly affected the external validity of this study and would be difficult to apply these findings to the diverse Deaf community as a whole. Future research could be done on a wider and more diverse scale to better show the preferences of the Deaf community when it comes to their psychologist or other psychological services. Factors such as age, gender identity, ethnicity, and many others can also greatly affect the preference an individual has for their psychologist.

Other topics of interest for future research is the perceived reliability of Deaf interpreters. Participants assigned to psychologists using interpreting services were not told how their interpreters identify. There is a possibility that preferences in these psychologists may differ due to the interpreters present and their identities. Another aspect to consider is the participant's upbringing. Whether or not the individual was raised by into Deaf culture or became a part of the

Deaf community later in life may greatly affect preferences. Something else that researchers should consider for future variations of this or similar studies is having a video component for each of the questions, relaying them in ASL. This was something that was noted by two participants of the study.

CONCLUSION

The findings of this study support the concept that individuals who identify as Deaf, deaf, hard-of-hearing, or as an individual with hearing loss prefer Deaf psychologists. It also supports the concept that those who prefer to use ASL similarly prefer a psychologist who knows and can use American Sign Language in their practice. A focus on accessibility for all, including the Deaf population, in psychological settings must become the goal for the future of psychology. While the use of reliable and professional interpreting services must still become standard practice, the Deaf community should have access to providers who use American Sign Language. There must be easy access to not only Deaf psychologists or psychologists who know American Sign Language, but also for other health care providers who can communicate in the preferred language for the Deaf community.

APPENDIX A- MOCK PSYCHOLOGIST PROFILE

Mock Hearing and Interpreter On-Site Psychologist Profile

You are looking for a psychologist in your area. You find the following profile on a reputable website:

Dr. X Y

I have been a licensed psychologist for over 25 years. I provide services to the d/Deaf and hard-of-hearing. I am hearing and use an interpreter on-site. I am an experienced clinician with vast knowledge in many areas you may find yourself experiencing. I use a mindfulness approach in my therapy, along with cognitive behavioral therapy and dialectical behavioral therapy techniques. My primary focus is the d/Deaf and hard-of-hearing population. I myself am hearing and use an interpreter on-site and see mostly d/Deaf and hard-of-hearing patients.

Mock Hearing and Interpreter Through VRI Psychologist Profile

You are looking for a psychologist in your area. You find the following profile on a reputable website:

Dr. X Y

I have been a licensed psychologist for over 25 years. I provide services to the d/Deaf and hard-of-hearing. I am hearing and use an interpreter through VRI. I am an experienced clinician with vast knowledge in many areas you may find yourself experiencing. I use a mindfulness approach in my therapy, along with cognitive behavioral therapy and dialectical behavioral therapy techniques. My primary focus is the d/Deaf and hard-of-hearing population. I myself am hearing and use an interpreter through VRI and see mostly d/Deaf and hard-of-hearing patients.

Mock Hearing and Can Sign Psychologist Profile

You are looking for a psychologist in your area. You find the following profile on a reputable website:

Dr. X Y

I have been a licensed psychologist for over 25 years. I provide services to the d/Deaf and hard-of-hearing. I am hearing and can sign. I am an experienced clinician with vast knowledge in many areas you may find yourself experiencing. I use a mindfulness approach in my therapy, along with cognitive behavioral therapy and dialectical behavioral therapy techniques. My primary focus is the d/Deaf and hard-of-hearing population. I myself am hearing and can sign and see mostly d/Deaf and hard-of-hearing patients.

Mock Deaf Psychologist Profile

You are looking for a psychologist in your area. You find the following profile on a reputable website:

Dr. X Y

I have been a licensed psychologist for over 25 years. I provide services to the d/Deaf and hard-of-hearing. I am Deaf and can sign. I am an experienced clinician with vast knowledge in many areas you may find yourself experiencing. I use a mindfulness approach in my therapy, along with cognitive behavioral therapy and dialectical behavioral therapy techniques. My primary focus is the d/Deaf and hard-of-hearing population. I myself am Deaf and can sign and see mostly d/Deaf and hard-of-hearing patients.

APPENDIX B - MOCK PSYCHOLOGIST PROFILE QUESTIONNAIRE

Based on your thoughts of the psychologist's profile, please answer the following on a scale of 1-6, 1 being *Strongly Agree*, 6 being *Strongly Disagree*?

1. I can count on this psychologist.
2. I can trust this psychologist.
3. I have a high opinion of this psychologist.
4. I am sure this psychologist is reliable
5. I feel as if this psychologist would avoid discussing or addressing d/Deaf cultural issues in our session(s).
6. I think this psychologist would be insensitive about d/Deaf culture when trying to understand or treat my concerns or issues.
7. I think that this psychologist may think that at times that I am overly sensitive about issues about being d/Deaf.
8. This psychologist seems like they would have stereotypes about d/Deaf culture, even if they did not express them directly.
9. This psychologist seems unaware of the realities of being d/Deaf.
10. I feel as if the psychologist will have a hard time grasping the concepts I am trying to convey.

APPENDIX C - DEAF IDENTITY QUESTIONNAIRE

Please answer the following on a scale of 1-6, 1 being *Strongly Agree*, 6 being *Strongly Disagree*.

1. I take a great deal of pride in being d/Deaf.
2. I do not feel connected to d/Deaf culture.
3. Being involved in the deaf world (and with deaf people) is an important part of my life.
4. I struggle or get frustrated when I used VRI to contact my doctor, health insurance, or any medical service.
5. I feel having an on-site interpreter in the doctor's office will interfere with the disclosure of my health information with the doctor.
6. I feel having a VRI in the doctor's office will interfere with the disclosure of my health information with the doctor.

APPENDIX D - DEAF EXPERIENCE QUESTIONNAIRE

1. How do you communicate with your doctor, nurse, or health professional that you see the most?
    a. Signing
    b. Use of on-site interpreter
    c. Use of VRI
    d. other
2. If you used an interpreter, most of the time the interpreter was…
    a. On-site
    b. through VRI
    c. other
3. Have you used a video relay interpreter (VRI) to contact your doctor, health insurance, or any medical service?
    a. Yes
    b. No
4. If you had to choose one, how do you prefer to use an interpreter in health or clinical settings?
    a. On-site
    b. VRI
5. How would you rate the quality of VRI services you received in healthcare settings in the past 12 months?
    a. Excellent
    b. Very Good

   c. Good
   d. Fair
   e. Poor
6. Overall, how would you rate the quality of interpreting services you received on-site in healthcare settings in the past 12 months?
   a. Excellent
   b. Very Good
   c. Good
   d. Fair
   e. Poor
7. Overall, how well did you understand your ASL interpreters at your healthcare appointments in the past 12 months?
   a. Excellent
   b. Very Good
   c. Good
   d. Fair
   e. Poor
8. Overall, how well did the ASL interpreters at your healthcare appointments in the past 12 months understand you?
   a. Excellent
   b. Very Good
   c. Good

d. Fair

e. Poor

APPENDIX E - DEMOGRAPHIC QUESTIONS

1. What do you identify yourself as?
    a. Culturally Deaf
    b. deaf
    c. Hard-of-hearing
    d. Hearing
    e. Other
2. If a person speaks to you through a combination of listening and/or lip-reading in a quiet room, how much can you understand what the person says?
    a. Everything
    b. Almost Everything
    c. Some things
    d. Almost Nothing
    e. Nothing
3. Which language do you prefer or feel comfortable using?
    a. ASL
    b. English
    c. PSE
    d. Other sign language
    e. Other spoken language
4. What is your age?
5. What is your gender?
    a. Female

b. Male

c. Nonbinary

d. Other

6. What is your ethnicity?

    a. White

    b. Hispanic or Latino

    c. Black or African American

    d. Native American or American Indian

    e. Asian/Pacific Islander

    f. Other

7. What is the highest degree or level of school you have completed?

    a. Some high school

    b. High school diploma

    c. Associate’s degree

    d. Some college

    e. Bachelor’s degree

    f. Master’s degree

    g. Doctorate degree

APPENDIX F – RECRUITMENT MATERIALS

Hello. I am currently working on my undergraduate thesis on the preferences of the Deaf community in a clinical psychological setting. I made a survey for data collection, and I was hoping some of you could fill it out.

You will be asked to read a short mock psychologist profile, rate the psychologist, and answer some questions about your experience being d/Deaf. The study takes place online via Qualtrics and will take about 30 minutes to complete. You must be 18 years old or older to participate and identify as deaf, Deaf, hard-of-hearing, or as an individual with hearing loss. Thank you. Link follows below: https://ucf.qualtrics.com/jfe/form/SV_cZxXyL9mSelOdXE

Participants Needed

Study on the d/Deaf Community and their Preferences in a Clinical Psychological Setting

Looking for participants who are 18 years old or older and identify as deaf, Deaf, hard-of-hearing, or as an individual with hearing loss.
This study is being conducted by the ACAT Lab in the University of Central Florida. It is completely online.

Thank you!

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