

## BARRIERS TO WELLNESS IN A POPULATION OF DEAF INDIVIDUALS

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*In order to better understand the needs of Deaf people whose primary communication is American Sign Language; a nationwide sample of Deaf adults were surveyed. Previous research involving the Deaf community has been based on the opinions and experiences of professionals and providers, such as those of doctors, counselors, and American Sign Language interpreters. There is very little research based on the experiences of members of the Deaf population. Upon a review of existing literature, one of the prevalent themes is that the Deaf population, which makes up for 10% of society, is three times as likely to experience mental illness, addiction, and domestic violence (Bones, 2016). This study narrowed the scope of ways in which healthcare access and communication can be addressed directly, and not solely through the employment of professional interpreters (Phillips, 1996).*

When providing healthcare services to the Deaf population, a thorough understanding of the unique values of Deaf culture and the Deaf community is of major importance and needs to be taken into careful consideration. Unfortunately, there is an astonishing lack of research documenting the personal experiences of Deaf people within healthcare settings (DeVinney, 2002; Pollard, 1994). Documented information has been limited to that which has been provided by professionals who work with Deaf patients, such as American Sign Language (ASL) interpreters and healthcare providers. To best provide for the needs of the Deaf community, understanding Deaf culture, values, and barriers is also critical to preventing mistakes and in providing the best possible care to this underserved and marginalized population. The current study seeks to explore how Deaf people are accessing healthcare and what barriers they are experiencing.

### Literature Review

This literature review explores the difficulties experienced by members of the Deaf community concerning accessibility to healthcare and mental health services. Due to the differences noted in some of the author's works on which this review is based, it is important to include an explanation of the terms "Deaf," "deaf," and "Hard of Hearing," that are used in the scope of cultural background and social identity (Phillips, 1996). The term "Deaf" is used in a cultural context and describes an individual who identifies with a Deaf cultural community or the

cultural community itself. The term "deaf" is used in the context of the physiological condition of having severe to profound hearing loss and does not necessarily associate an individual with a cultural community. The term Hard of Hearing (HoH) can represent both an individual identity within the Deaf community and the physiological condition of having a degree of decibel hearing loss.

### Cultural Values

Misdiagnosis and misunderstandings are not uncommon due to medical professional's lack of knowledge of Deaf cultural norms and professional trainings. Trainings in disability competency represent only a small percentage of the overall training that professionals receive (Leigh et al., 1996). Many Deaf cultural values, such as storytelling, attention to detail, and differences in physical boundaries can be misinterpreted by non-deaf individuals as characteristics of neurodivergence or deviation of social norms. These types of misevaluations are, in part, a reason for Deaf individuals making a choice not to seek mental healthcare support altogether or choosing to not participate in continuing treatment after an initial diagnosis is made. This is often influenced by a culturally widespread mistrust of non-Deaf individuals, fear of misdiagnosis, or unnecessary treatment of their condition. (Bones, 2016). Though the use of interpreters and assistive devices may help to minimize errors in communication, they do not make up for a lack of cultural competency that can lead to under- or overdiagnosis of clients (Leigh et al., 1996).

### Commonly Faced Issues

There are several common experiences discussed throughout the available published research of the Deaf and HoH community. These experiences, though varying in impact and effect, all stem from difficulties with aspects of communication and culture that are not faced by people in the hearing population. It is estimated that between two-hundred-fifty thousand to one-million Deaf signers live in the United States (Mitchell as cited in Panzer et al., 2020). However, in respect to ASL preferences, the use of interpreters can only help to alleviate some of the difficulties in information exchange. Furthermore, the inclusion of an ASL interpreter is often not ideal in all situations, particularly those where mental health counseling is involved (Brunson, 2002; Kuenburg, 2016). For example, in the

therapeutic counseling setting, the relationship between patient and provider is one that is most effective when that relationship exhibits the qualities of trust and respect. “The trust/respect scale was significantly associated with patient willingness to share” (Crits-Christoph et al., 2019, p. 6). In a triadic, or three-person setting for therapy or intervention, the dynamic of having an interpreter present has the potential to change the patient’s willingness to share. There is also increased opportunity for error in translation when using an interpreter, as not all interpreters are trained to work within the complex field of medical interpreting. The English language, often being a second language to a patient’s primary ASL, can create a potential for lack of clarity and lead to misunderstanding and miscommunication between counselor and client (Meador et al., 2005). The effect of miscommunication may lower the beneficial results of counseling, or further the likelihood of the misdiagnosis of symptomatic behavior. Additionally, the presence of an ASL interpreter may unintentionally influence the mood of the session through nuance of body language, regardless of the interpreter’s training and ability to perform as an impartial language conduit (Brunson, 2002).

### ***Well-Being, Longevity, and Health Literacy***

While Deafness itself has not been shown to be an inherent cause for early mortality rates among the Deaf population, it is a factor for concern (Contrera et al, 2015). The average Deaf population tends to be at an increased risk of mortality than that of the non-deaf population. Of course, there are factors that increase this risk such as smoking and cardiovascular disease. This is often due to the resistance of seeking healthcare, lower health status, and lack of health literacy. As was concluded in a survey of the National Health index data between the years of 1990 and 1995, “adults with post lingual onset of deafness appear to have higher mortality than non-deaf adults, which may be attributable to their lower self-reported health status” (Barnett & Franks, 1999, p. 330). One limitation of the Barnett study that should be noted is that it was difficult to draw a conclusion in the differences between mortality in prelingual and post-lingual deafness.

People of the Deaf population may also experience what is described as limited access to information and inadequate health literacy due to lack of incidental exposure to what is otherwise considered to be general knowledge (Leigh et al., 1996). Another thing to be taken into consideration are accommodations for Deaf-friendly literature and health brochures. Care should be taken in the design and development of health-related literature to provide ease of readability for persons who may

have lower comprehension of the structure of the written English language (Meador & Zazove, 2005).

Poor health literacy among the Deaf population is further compounded because they are not exposed to information that many people who are not deaf are exposed to “in passing.” For example, they are unable to hear information in radio announcements made regarding health concerns, also it is typical that pharmaceutical and healthcare commercials are not available in closed caption. Due to this lack of health literacy, it is common culture that Deaf people are often more likely to turn to friends or family members for help or advice in times of need or crisis. To help to encourage health literacy and help-seeking, the inclusion of community outreach has been discussed to try and negate the lack of visibility for Deaf services (Anderson, 2017).

### ***Current Alternative Strategies***

*The Teach-Back Method.* The Teach-Back method, also known in healthcare as the “show me” method, is a method that asks the patient to teach back to the provider what instructions they have been given to ensure clear understanding of the instructions and allow the provider to assess patient understanding of the information. Though this method seems that it would be a logical way of ensuring understanding between patient and provider, eighty-one percent of ASL interpreters who were surveyed at the 2015 National Symposium on Healthcare Interpreting reported the Teach-Back method is a seldom used strategy (Hommes et al., 2018).

*Technology.* While there have been great strides in the creation and implementation of communication technology, it is not considered by Deaf people to be a reliable solution. Many users of these kinds of software programs and equipment experience problems with connectivity and individual access. (Hommes et al., 2018). The use of videophones, text messaging, and email also raise concerns about patient privacy and HIPPA policies (Panzer et al., 2020; Lesch, 2019).

### ***Professional Ethics, Diversity, and Cultural Awareness***

When surveyed about their education and experience, most professionals report having little training that is specific to working with people who have disabilities (Meador, 2005). This lack of experience can prove detrimental when the cultural values of a population are misunderstood or unknown. In the past, the Deaf population has been subject to manipulation and there still exists a distrust of hearing people, professionals, and researchers. This fear

extends as far as to cause hesitation towards signing medical documents such as insurance release forms and healthcare plans. Another concern is the still existing “deaf=dumb” phenomenon, which can adversely affect patient care should a person choose to not inquire further about something they do not understand for fear of appearing intellectually inferior. The competence of Deaf patients whose first language is ASL may not be reflected in written English and may cause misplaced concern and misguided efforts during provider-patient interaction. This is not to say that all Deaf, deaf, or Hard of Hearing people have the same communication needs, but to better serve the variety of subgroups within the Deaf community, providers have an obligation to educate themselves about the history and the culture of this population (Meador, 2005).

With fifteen percent of the overall U.S. population being deaf or HoH, the questions this study seeks to answer are as follows: Are communication and cultural barriers preventing or discouraging Deaf people from seeking the care they need? Also, how can services be improved upon to provide better information and access to wellness for this population?

## Methodology

### Participants

A total of eighty-one Deaf, deaf, or Hard of Hearing individuals participated in this study. Thirty-nine individuals who identify as culturally Deaf completed the survey. Of those thirty-nine respondents, nineteen (57.58%) report American Sign Language as being their preferred method of communication. Of the thirty-nine respondents, 38.46% overall, were between the ages of 35-44 at the time of completion of the survey. Seventy-six-point ninety-two percent received a diagnosis of hearing loss by the age of 5.

### Materials

The Barriers to Wellness in a Population of Deaf Individuals survey was adapted from an existing Barriers survey designed to study accessibility barriers to healthcare for people diagnosed with Parkinson’s disease (Dobkin et al., 2013). The adapted survey contained 31 items for which the options to response included yes/no, multiple-choice questions, Likert scale rating, and text fill box. The text fill box ensured that participants were given the opportunity to respond to the question of what they think can be done to help resolve the barriers they have experienced to healthcare, in their own words. The revised survey can be found in Appendix A.

### Procedure

An invitation link to the digital survey was shared via direct email and social media to Deaf Associations across the nation with additional Deaf clubs invited from cities with higher population density of Deaf people. The organizations were invited to share the link with others in their community. Seventy-two Deaf Associations were contacted in all. The survey was available to participants from May 31 to July 8, 2021.

## Results

Of the 57.58% of participants who use ASL, only 36.36% of them prefer to use interpreters for mental healthcare appointments and 39.39% prefer to use an interpreter for healthcare appointments. These numbers indicate that of the participants who use ASL as their primary language, a little over half of them prefer to use an interpreter (see Table 1). In response to question 21 regarding interpreter availability by request for healthcare appointments, 15.63% responded there are interpreters always available, 37.50% responded interpreters are sometimes available, and 31.25% responded that interpreters are never available (see Table 2 in Appendix B). Upon a qualitative analysis of questions 28 and 29, which ask about specific barriers, it was found that people have experienced barriers such as lack of interpreter services, insensitivity to cultural issues, time constraints, and difficulty scheduling appointments just under fifty percent of the time for both mental and physical healthcare settings.

Eighty-three-point seventy-eight percent of participants report having a primary healthcare provider and 68.42% also receive annual physical check-ups. However, 56.76% of people answered “yes” to feeling they have needed help managing mental health concerns such as depression, anxiety, and stress in the past. Currently, 13.51% attend weekly or monthly counseling appointments with a therapist or psychologist and 52.63% of individuals express awareness of resources in their community. Of thirty-six respondents, twenty-eight (77.78%) have private or commercial health insurance coverage. When asked if they have a primary care provider, 83.78% responded “yes.” Responses to question 30, “How familiar are you with the Teach-Back Method,” indicate that 75% of participants are not familiar at all with the method. Reporting for education for having earned a bachelor’s degree and above was a cumulative 76.32%, with only 2.63% having not completed high school, 7.89% having earned a high school diploma, and 13.16% having completed some college. For full text responses, see Appendix C.

## Discussion

Among those whose primary language is ASL and who identify as culturally Deaf, previous studies and the current study both demonstrate a strong consensus in favor of access to healthcare providers who can communicate directly in ASL and are knowledgeable in Deaf culture (Leigh et al., 1996). Despite availability of interpreter services, it is not widely preferred or used. Data reveals this is more so due to apprehensions about confidentiality and clear communication than it is interpreter availability (Crits-Christoph et al., 2019). There are also concerns about the close-knit nature of Deaf communities along with the value of sharing information (Boness, 2016). In general, the sample seems well informed and reported having high levels of access but concerns of interpreter service availability might be an artifact of the sample and not of the population (DeVinney, 2002).

The barriers reported by the participants are similar to those of prior research, apart from the difficulties in technology (Hommes et al., 2018; Lesch, 2019; Panzer et al., 2020). The results in this study imply that the difficulties are not necessarily due to access or internet connectivity, but rather a lack of the conversational aspects that one would similarly expect during an in-person appointment. Healthcare web portals are either not an effective platform for direct communication, or they are non-existent, and there are expressed concerns about patient confidentiality and HIPPA law. This technology barrier extends into the insurance aspects of healthcare as well when it is the responsibility of the client to negotiate interactions between their insurance companies and their providers.

Overall, the sample population receives annual physical check-ups, but has not often sought out professional services for mental health issues due to apprehension relating to a lack of confidence and mistrust of using interpreter services in small Deaf communities (Leigh et al., 1996). Lack of knowledge or employment of the Teach-Back method is consistent with previous studies and likely ties into the time allotted for each care appointment (Hommes et al., 2018). The major deficits in healthcare services as reported by the participants in this study reflect more concerns regarding legal confidentiality and linguistic differences than they do concerns of cultural understanding that has been explored in past studies (Meador, 2005). Past studies show that healthcare providers generally have minimal experience in providing adequate service to Deaf individuals (Meador, 2005). In this study, communication preferences and lack of access to professionals who are knowledgeable in Deaf culture and values seem to have more of an impact

on psychological treatment than physiological treatment. Though there are strong feelings of needing Deaf or ASL fluent providers for both mental and physical health care, participant responses reflect that the barriers are not as deterring in seeking physiological treatment.

Whether observed as cultural or non-cultural identities such as Deaf, deaf, or HoH, this study puts into perspective the importance of understanding people's individual needs and past experiences (Phillips, 1996). Furthermore, it highlights the need to utilize their input in the development of systems specifically designed to provide better care and to navigate, if not remove, communication barriers.

## Limitations

One of the major limitations to the study was that the sample may not have been representative of the population. The small sample size was likely a contributing factor to the absence of demographic diversity within the sample. Also, most of the respondents are well-educated and have a seemingly high literacy rate. According to a 2017 national survey conducted by the National Deaf Center on Postsecondary Outcomes, deaf people generally attain lower levels of education than those who are hearing, showing a fifteen percent gap in completion of a bachelor's degree. The education gap increases steadily from high school to graduate degree levels of education (Garberoglio et al., 2017).

Another limiting factor is there were no questions included in the survey to differentiate between individuals who are Deaf, deaf, or HoH which could have a substantial impact on the way that healthcare is delivered and received. Someone who is Deaf and uses ASL as a first language might prefer direct communication in ASL. Whereas someone who became deaf later in life, may prefer written communication.

There are questions remaining as to if the small sample size was due to the lack of trust of researchers as mentioned in the literature review (Boness, 2016). It is difficult to resolve the discrepancy in reporting for questions 21 and 22, as the type of appointment was not specified as regarding either mental health or physical health. More information is needed to determine if this discrepancy is due to healthcare institutions having full-time interpreters on staff, or otherwise.

Additional limitations to the study might include unexplored variables such as access to transportation, healthcare service availability, or interpreter availability in rural communities.

## Future Research

To increase the sample size and circumvent

concerns regarding literacy, future study would recommend that surveys be made available in delivery modes that would include American Sign Language in person or over prerecorded video. One particularly relevant question to include in future research may be to inquire if lack of trust in professionals continues to be a culturally widespread belief, as it might help to explain why there is minimal published research that involves members of the Deaf community. An interview-based qualitative design could prove useful in gaining a more granular understanding of participants thoughts and feelings and be a useful guide in addressing the specific needs of this highly diverse group (Sutton & Austin, 2015). It would allow for exploration into individually worded responses to expand on the importance of increasing the number of Deaf providers and people who are fluent in both medicine and ASL.

Appointment Type	Mental Health	Physical Health
Yes	36.36	39.39
Sometimes	21.21	30.30
No	42.42	30.30

**Table 1**  
*Interpreter Preference by Percent*

Appointment Type	Mental Health	Physical Health
All of the Time	18.75	15.63
Most of the Time	43.75	3.13
Half of the Time	15.63	12.50
Less Than Half of the Time	3.13	37.50
Services Not Available	18.75	31.25

**Table 2**  
*Interpreter Availability by Percent*

Type of Service	Mental Health	Physical Health
Lack of Interpreter Services	35.00	38.44
I Was Not Comfortable/ Had History With the Interpreter	46.56	43.31
Professionals Not Sensitive Enough to Cultural Issues	48.14	43.89
I Don't Trust Professionals	37.63	24.25
I Have Been Treated Unfairly/ Disrespected In the Past	25.88	40.31
I Was Not Actively Involved in How to Best Handle My Care	30.21	23.77
I Thought the Treatment Was Not Necessary	13.00	22.33
No Quality Options Were Available to Me	26.77	20.42
I Did Not Have Enough Time With My Provider/I Felt Rushed	41.44	55.43
Information Was Not Thoroughly Explained to Me	35.13	38.87
Difficulty Scheduling Appointments	38.08	38.50
Technological Barriers/ Lack of Access	45.13	28.06

**Table 3**  
*Barriers by Percent of Time*

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- Q2 Has your hearing loss been confirmed by an audiologist using a hearing test/audiology evaluation?"  
Yes  
No
- Q3 Do you culturally identify as Deaf or Hard of Hearing?  
Yes  
No
- Q4 What was your age when it was determined you had hearing loss?  
Birth - 1 year  
2 - 5 years  
6 - 11 years  
12 - 17 years  
18 - 24 years  
25 - 30 years  
31 - 36 years  
37 - 45 years  
46 - 51 years  
52 - 60 years  
Over 61, Please specify age
- Q5 Your Current Age:  
18 - 24 years  
25 - 34 years  
35 - 44 years  
45 - 54 years  
55 - 64 years  
65 - 74 years  
75 years or older
- Q6 Which state do you live in?  
▼ Alabama ... I do not reside in the United States
- Q7 Highest level of education:  
8th grade and below  
Some high school  
High school graduate  
Some college  
College graduate  
Some graduate school  
Graduate degree
- Q8 Work status (select all that apply):  
Full time  
Part time  
Not employed  
On disability  
Retired  
I work more than 1 job  
I am a student
- Q9 Health insurance  
Medicare only  
Medicare plus secondary insurance  
Medicaid  
Private or commercial insurance  
None
- Q10 Do you have a primary care provider?  
Yes

## Appendix A

### *Survey of Deaf Individuals Regarding Accessibility in Seeking Healthcare*

- Q1 Survey of Deaf Individuals Regarding Accessibility in Seeking Healthcare  
Yes, I agree to participate  
No, I do not agree to participate

- No
- Q11 Do you go to annual physical check-ups with a primary care provider?  
Yes  
No
- Q12 Do you go to weekly or monthly counseling with a therapist or a psychologist?  
Yes  
No
- Q13 In the past, have you felt that you have needed help managing depression, anxiety, or stress?  
Yes  
Sometimes  
No
- Q14 Are you aware of community resources for mental health and healthcare in your area?  
Yes  
Somewhat  
No
- Q15 Have you ever personally experienced addiction?  
Definitely yes  
Probably yes  
Unsure  
Probably not  
Definitely not
- Q16 If you answered yes to question 15, did you seek help?  
Yes  
No
- Q17 If you answered yes to question 16, where did you seek help?  
Friend or family  
Self-help literature  
Professional counseling/ treatment center  
Work/ School resources  
Community resources  
Other
- Q18 What is your preferred method of communication?  
American Sign Language  
Auditory/ Verbal  
Written  
Lip reading  
Assistive electronic devices  
Other (please specify)
- Q19 Do you prefer to use interpreter services when you attend mental health appointments?  
Yes  
Sometimes  
No
- Q20 Do you prefer to use interpreter services when you attend healthcare appointments?  
Yes  
Sometimes  
No
- Q21 When at a healthcare appointment, how often have you requested the use of an interpreter, but none was available?  
Always  
Most of the time  
About half the time  
Sometimes  
Never
- Q22 In the past, how often has there been an interpreter available for you at appointments?  
All of the time  
Most of the time  
Half of the time  
Less than half of the time  
Interpreter services not available
- Q23 Are mental healthcare appointments available to you when you need them?  
Always  
Most of the time  
About half the time  
Sometimes  
Never
- Q24 Are healthcare appointments available to you whenever you need them?  
Always  
Most of the time  
About half the time  
Sometimes  
Never
- Q25 Do you feel you are given clear instructions about procedures, medications, or follow-up appointments from medical professionals?  
Definitely yes  
Probably yes  
Sometimes  
Probably no  
Definitely no
- Q26 Do you feel like your provider understands your questions and concerns about your care?  
Definitely yes  
Probably yes  
Sometimes  
Probably no  
Definitely no
- Q27 How often do you feel you have experienced barriers to mental health care or healthcare services?  
Always  
Most of the time  
About half the time  
Sometimes  
Never
- Q28 Using the slide scales below, please rate how much each barrier has interfered with your access to mental health services. (Scale represents 0% to 100% of the time)  
0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100

## Appendix B

### *Barriers: Text Responses by Theme*

#### *Confidentiality*

“I don’t want to use interpreters as [I] use them for work so don’t want my information known.”

“Confidentiality.”

“I have never used an interpreter during my doctor appointments. I am a private person and most of the interpreters in my area are not well-versed in HIPPA. Many came from continuing education programs.”

“The challenge I experience is that I know almost all of the interpreters in my area due to my job. Having one of them in an appointment with me is quite uncomfortable as I don’t want my personal business shared. I am aware of the code of ethics and confidentiality, but it is still awkward.”

Frequency of Service Seeking

“I only have annual physical check-up at my primary care physician’s office.”

“New doctor and office. More accents and had [to] call supervisor, as they would not look at me when talking.”

#### *Communication Barriers*

“I refuse to use interpreters for mental health as I have seen too many communication misunderstandings. As for doctor offices, it is fine as I am able to help clear things up if I catch it. There are no direct mental health folks using ASL or knowledge of deaf culture in my state.”

“During Covid, I had to visit the emergency room, but there was a door phone to screen for symptoms. I felt absolutely awful and was in pain when I basically had to guess what they were saying before I was let in.”

#### *Lack of providers/interpreters*

“For dental appointments, the dental office wants me to provide my own interpreter. They won’t do it.”

#### *Provider inadequacy*

“Not having enough service providers who are familiar with hearing loss and the challenges, barriers, etc. it provides daily... how to function in a hearing world as a person who isn’t hearing.”

“Some doctors are good, others [that are] not used to deaf people are harder to work with. Some doctors do not listen well, despite my requests for some things when a process isn’t helping at all, so it depends on the type [of

Lack of interpreter services,  
I was not comfortable with the interpreter/ I had prior history with them,  
Mental health professionals are not sensitive enough to cultural issues,  
I don’t trust mental health professionals,  
I have been treated unfairly or disrespected by mental health professionals in the past,  
I was not actively involved in the decision as to how to best handle my care,  
I thought the treatment was not necessary,  
No quality options were available to me,  
I did not have enough time with my provider/ I felt rushed,  
Information was not thoroughly explained to me,  
Difficulty scheduling appointments,  
Technological barriers/ lack of access,  
Other (please explain),

Q29 Using the slide scales below, please rate how much each barrier has interfered with your access to healthcare services. (Scale represents 0% to 100% of the time)

0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100

Lack of interpreter services,  
I was not comfortable with the interpreter/ I had prior history with them,  
Healthcare professionals are not sensitive enough to cultural issues,  
I don’t trust healthcare professionals,  
I have been treated unfairly or disrespected by healthcare professionals in the past,  
I was not actively involved in the decision as to how to best handle my care,  
I thought the treatment was not necessary,  
No quality options were available to me,  
I did not have enough time with my provider/ I felt rushed,  
Information was not thoroughly explained to me,  
Difficulty scheduling appointments,  
Technological barriers/ lack of access,  
Other (please explain)

Q30 How familiar are you with the “Teach-Back” method?

Extremely familiar  
Very familiar  
Moderately familiar  
Slightly familiar  
Not familiar at all

Q31 What changes do you think would be helpful in improving mental health and healthcare accessibility for Deaf people?

Please enter text response here

I decline to respond to this question



appointment] and who the doctor is, as it is a mixed bag.”

### **Technology**

“Zoom.”

## **Appendix C**

### **Suggestions for Improvement by Theme: Text Response**

#### **Culture**

“Accessibility through OUR language and OUR culture. I refuse to go to someone who is hearing because they just don’t get it. They don’t understand us and it’s challenging.”

“More awareness of the issue from the practitioners.”

#### **Communication**

“For physical health – more time. I need doctors/nurses to repeat themselves often, as I lipread, and half the time their back is to me while they’re on the computer. This takes time and I feel rushed, and I never get all of my questions answered.”

“Healthcare is more flexible in terms of communication, but more awareness would be helpful as many do not realize how dependent we are with our eyes, hands, etc. Especially when it hurts to use it. For example, a pinched nerve is enough to impact functionality. Same can be said for sleep doctors as that was one of the more challenging things to deal with due to no interpreters repeatedly and bad care.”

“Better access hearing assistance as well as interpreters.”

“People should be more aware of Deaf people’s needs and also be more flexible.”

#### **Direct Providers**

“More Deaf, deaf, Hoh, DB [(deafblind)] in the field.”

“Have more mental health professionals that know sign language. Also, healthcare professionals that know how to interact with patients through interpreters.”

“[Censored expletive] interpreters. We need direct services, deaf doctors, deaf nurses, ASL fluent doctors, ASL fluent nurses, etc. Not limited to on-site, but also available via telehealth.”

#### **Ethical considerations**

“Revise code of ethics to reflect linguistic minorities.”

“Confidence in interpreter confidentiality.”

“Workshop on understanding HIPPA law.”

### **Incentives**

“Increase number of deaf/ASL speaking mental health professionals via scholarships and grants.”

“More incentives for more direct language services, primarily [for] mental health.”

### **Technology**

“Expand remote based therapy.”

“Online access and more insurance options for nationwide deaf resources/mental health/therapy/counseling.”

“More text-based or low-cost accessible options, education about interpreting access and confidentiality.”

“There has to be some way to contact healthcare that involves a chat-like conversation. Since phone is not an option to me, I need to use our web portal to ask questions or book appointments. In most cases, I have been given poor or incorrect information or support just because there is no way to reply to messages. If the healthcare provider misunderstands something or needs more information, they cannot ask for it in the web portal, and instead provide generic answers that don’t fit my specific condition or request.”

“More online/virtual options for scheduling and contacting insurance/providers, having insurance/providers communicate with each other rather than me being a middleman and having to find a way to communicate with both.”