Stigma and Mental Health among Deaf and Hard of Hearing Adults: The Moderating Role of Social Support

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Abstract

Deaf and hard of hearing (DHH) individuals constitute 4.5% of the total population in Turkey. They experience challenges in integrating into society, along with stigma and discrimination. Studies document that they have limited access to healthcare services and are at higher risk of mental health problems such as anxiety and depression. The current study focuses on that vulnerable group and examines the association between stigma, perceived social support, and mental health outcomes. Data were collected through social network platforms, DHH associations, and word of mouth. The study was conducted with Turkish adults (18-65 years old) who had either total or partial hearing loss and/or used hearing assistance devices or Turkish Sign Language (TSL). Participants were provided with three online study participation options including survey written in Turkish, written in simplified Turkish (parallel with TSL), or videotaped TSL with subtitles. The final sample included 97 participants (68% female; 51% DHH since birth; Mean_{age}= 32.75; SD_{age}= 9.86). Multiple linear regression analysis revealed that higher levels of experienced stigma was associated with increased levels of self-reported anxiety, but not depression. Internalized stigma and age were robust predictors of anxiety symptoms, suggesting that DHH individuals who were younger and self-stigmatized reported more anxiety symptoms. Furthermore, perceived social support and internalized stigma were independently linked to depressive symptoms, but did not interact with one another. Findings suggest the need to focus on internalized stigma as a risk factor for DHH individuals’ mental health.

Keywords: Anxiety, Deafness, Depression, Hard-of-hearing, Social support, Stigma

Özet

Sağır veya işitme güçlüğü olan bireyler, Türkiye'deki toplam nüfusun %4,5'ini oluşturmaktadır. Bu kişiler, damgalama ve ayrımcılığın yanı sıra toplumla bütünleşmede de zorluklar yaşamaktadırlar. Çalışmalar, sağlık hizmetlerine sınırlı erişime sahip olduklarını ve anksiyete ve depresyon gibi ruh sağlığı sorunları açısından daha yüksek risk altında olduklarını göstermektedir. Mevcut çalışma, bu savunmasız gruba odaklanmakta ve damgalanma, algılanan sosyal destek ve ruh sağlığı sonuçları arasındaki ilişkileri incelemektedir. Bu çalışmada kullanılan veriler sosyal platformlar, sağır ve işitme güçlüğü odaklı dernekler ve ağızdan ağza pazarlama yoluyla toplanmıştır. Çalışma, total veya kısmi işitme kaybı olan ve/veya işitme cihazı veya Türk İşaret Dili (TİD) kullanan, 18—65 yaş arasındaki Türk yetişkinler ile yürütülmüştür. Katılımcılara Türkçe yazılı, sadeleştirilmiş Türkçe yazılı (TİD'e paralel) ve videolu TİD versiyon (altyazılı) olmak üzere üç çevrimiçi anket seçeneği sunulmuştur. Nihai örneklem 97 katılımcıyı içermektedir (%68 kadın; %51 doğuştan sağır veya işitme güçlüğü olan; Ortalama= 32.75; SDyaş= 9.86). Çoklu doğrusal regresyon analizine göre, damgalanma ve algılanan sosyal desteğin sağır veya işitme güçlüğü olan bireyler arasında depresyon ve kaygı ile farklı bağlantıları olduğu bulunmuştur. Spesifik olarak, deneyimlenen damgalanmanın yüksek olmasının, daha yüksek kaygı düzeyiyle (öz-bildirim) ilişkiliydi olduğu, ancak depresyonla ilişkili olmadığı bulunmuştur. İçselleştirilmiş damgalanma ve yaşın, kaygı belirtilerinin güçlü yordayıcıları olduğu, daha genç ve damgalanmayı içselleştiren sağır veya işitme güçlüğü olan bireylerin daha fazla kaygı belirtisi bildirdiği bulunmuştur. Ayrıca, algılanan sosyal destek ve içselleştirilmiş damgalanmanın, birbirlerinden bağımsız olarak depresif semptomlarla bağlantılı oldukları ve birbirleriyle etkileşime girmedikleri saptanmıştır. Bulgular, sağır veya işitme güçlüğü olan bireylerin ruh sağlığı için bir risk faktörü olarak içselleştirilmiş damgalamaya odaklanma ihtiyacını ortaya koymaktadır.

Anahtar Kelimeler: Anksiyete, Sağırlık, Depresyon, İşitme Güçlüğü, Sosyal Destek, Damgalama

CHAPTER 1

INTRODUCTION

Among the disabilities present at birth, deafness is the most common one (Brody, 2000). World Health Organization (WHO, 2021a; 2021b) estimates that there are over 1.5 billion deaf and hard of hearing (DHH) individuals worldwide and it is projected to increase to 2.5 billion by 2050. Although the number of DHH individuals varies by regions and countries, the majority of them are in low and middle income countries (WHO, 2021b). According to the Turkish Statistical Institute Health Survey (TURKSTAT, 2018), the percentage of individuals who have problems with hearing[1] in Turkey constitutes 4.5% of the total population. However, those estimates may be conservative and not capture the diversity of the DHH community. Individuals differ regarding their degree of hearing impairment (i.e., mild vs. total hearing loss), time of occurrence (pre-linguistic vs. post-linguistic), and anatomy of the hearing loss (Tüfekçioğlu, 2003; İpek Timur, 2016). Preferred communication method, language use and assistance devices vary depending on the level of hearing loss of the DHH individuals (İpek Timur, 2016).

In the current study, we focus on DHH individuals who either have total hearing loss or need hearing assistance devices and methods to comprehend speech and communicate. DHH individuals are an invisible and a marginalized population around the world, including Turkey (Aydoğdu & Yüksel, 2020). According to the Turkish Statistical Institute (2002, 2010), 36.3% of individuals with disability (orthopedically, seeing, hearing, speaking and mentally disabled) are

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[1] Turkish Statistical Institute Health Survey (2016) conceptualized 'hearing disabled person' as those who are completely deaf or have partial hearing in one or both ears. Of note, individuals who use 'hearing apparatus' are also included in this data.

illiterate, 52.5% of them do not have a social security registration and 73.2% of DHH are unemployed. Those experiences clearly indicate that DHH individuals are a disadvantaged population who experience social exclusion and deprivation due to ablism and stigma.

In his seminal work, Goffman (1963) defines stigma in a broad sense and refers to it as 'attributes that is deeply discrediting', which he categorized as a) tribal stigmas (i.e., race, nation, religion); b) blemishes of individual character (i.e., weak will, domineering or unnatural passions, treacherous and rigid beliefs, dishonesty); and c) abominations of body-physical deformities, including deafness (p. 11, 13). According to Goffman (1963), stigma is 'the situation of the individual who is disqualified from full social acceptance' (p. 11). Stigma represents prejudice, discrimination, labeling, stereotyping and negatively biased attitudes and behaviors toward the individual or the group that is stigmatized (Corrigan, 2000; Link & Phelan, 2001; Mak et al., 2007). Turan and his colleagues (2017a) noted that stigmatization and its consequences are 'pervasive social processes', in which stigmatized individuals' social value is perceived as lower than the others who do not possess socially undesirable attributes or identities (p. 863), and experiences of prejudice and discrimination are the outcomes of stigma. In line with those operational definitions of stigma, DHH individuals constitute a stigmatized population who are labeled, rejected and marginalized from the hearing world because of their unique communication styles and needs. Often, DHH individuals are perceived as "the other" by the hearing individuals (Aydoğdu & Yüksel, 2020; Mousley & Chaudoir, 2018).

Stigma has many negative effects on well-being of DHH individuals, including mental health issues (i.e., depression, anxiety), defensiveness, hostility, self-derogation and self-hate (Mousley & Chaudoir, 2018; Fellinger et al., 2012). Although it is known that DHH individuals have more mental health problems compared to the general population (Clausen, 2003), DHH studies are relatively new to the field of clinical psychology, especially in Turkey. In addition, while there is an accumulation of research with a deficit and psychopathology-oriented perspective, little is known about the stigma experiences of DHH adults and their mental health with regard to protective factors such as social support and resilience. Therefore, the current study addresses the relationship between stigma and mental health in DHH adults with a focus on social support.

DHH Stigma

In order to comprehend the stigma of DHH, social representations of this specific population, specifically stereotypes about DHH should be addressed. Stereotypes are generalized beliefs formed by others to categorize a particular group of people based on their characteristics (Cardwell, 2014; Kiger, 1997). DHH individuals experience many difficulties due to these stereotypes, particularly the risk of assimilating them into their self-image (Cambra, 1996). For instance, Kiger (1997) found that DHH individuals are mostly described as ‘happy, alone, angry and friendly’. Such stereotypes seem mostly ‘positive’ at first sight, indicating that DHH individuals are not perceived as dangerous or a threat to the hearing participants. However, those stereotypes hint a sense of physical weakness or a vulnerability attached to the image of being a DHH individual (Kiger, 1997).

According to Lane (1993), although individuals do not exhibit hostile behaviors and attitudes towards the DHH, they may behave in a more patronizing and paternalistic way. Several examples of negative stereotypes around individuals with DHH include attributes such as ‘immature’, ‘emotional’, ‘aggressive’, and ‘argumentative’ as compared to hearing individuals (Coryell et al., 1992). Additional stereotypes included the depiction of DHH individuals as less communicative and segregated as a group (Coryell et al., 1992). These stereotypes are parallel to the communicational and attitudinal barriers DHH individuals experience in areas such as higher education, the workplace, and leisure activities (Ladd, 2005; Olsson et al., 2021). These communication barriers stem from a lack of DHH awareness and perpetuate the social exclusion of DHH individuals in a circular manner (Hoang et al., 2011; Olsson et al., 2021). The more DHH individuals experience language and communication barriers (e.g., lack of sign language translator, inability to communicate in TSL), the less they build relationships with others (Olsson et al., 2021), and the more unfriendly they might be perceived. That perceived unfriendliness, an outcome of a stereotype, may inadvertently fulfill these stereotypes and make DHH individuals socially excluded from the hearing world. All limited knowledge considered, negative stereotypes and pathologizing views towards DHH constitutes a major obstacle in their social integration within the hearing world (Munoz et al., 2000; Olsson et al., 2021).

Regarding DHH stigma and its consequences, studies have shown that DHH individuals feel compelled to prove their abilities and try to fit to the social norm when they are around hearing individuals (Powell-Williams, 2017; O’Connell, 2016). Specifically, DHH individuals modify their behavior, appearance and communication preferences and even try to imitate hearing individuals’ interactions to feel accepted and prevent potential discrimination (O’Connell, 2016; Powell-Williams, 2017). Furthermore, DHH individuals may try to cover the markers of their "deafness" (e.g., avoid using hearing aids or concealing it, avoid using or abandoning sign language), minimize its effects, or nullify the difficulties they experience in communication (O’Connell, 2016; Powell-Williams, 2017; WHO, 2021b). Studies document that DHH individuals may get ‘tired of trying to fit in’ and feel frustrated with the hearing world (Aydoğdu & Yüksel, 2020; Meadow-Orlans & Erting, 2022; WHO, 2021b). As a reaction, DHH individuals might give up – they may refuse to interact with the hearing people, isolate themselves, but also develop a sense of anger against the hearing world who focuses on their lack of hearing, perceives them as ‘disabled and handicapped’ (Aydoğdu & Yüksel, 2020; Meadow-Orlans & Erting, 2022; WHO, 2021b).

In particular, DHH individuals experience stigma, prejudice, and discrimination in employment, housing, healthcare, and education. With regard to employment, they frequently face underemployment and pay inequality (Garberoglio et al., 2019). In addition, DHH individuals experience significant problems related to communication with hearing colleagues in the workplace setting in addition to the physical obstacles and negative attitudes that interfere with their work (Punch et al., 2004). Those barriers negatively influence their job performance (Rosengreen & Saladin, 2010). Moreover, regarding housing, DHH individuals struggle with communicating with the landlords and in obtaining information about available units. Turner and colleagues (2005) found that housing providers gave less information about rental application processes and provided fewer follow-up calls to DHH individuals as compared to hearing customers (Turner et al., 2005). In healthcare settings, DHH individuals struggle to communicate their needs to the healthcare providers (Kuenburg et al., 2015) and lack adequate access to health-related information due to the unavailability of materials in sign language (Fellinger et al., 2012; Pollard et al., 2009). In a study examining physicians’ knowledge and beliefs about DHH patients (Ebert & Heckerling, 1995), it was reported that although most of the participants knew that sign language interpreters should be utilized as needed, only a minority of physicians used interpreters in their practice. Instead, they utilized methods such as writing notes and lip reading. DHH patients who experience communication barriers with healthcare professionals struggle to comprehend diagnosis, treatment, medication use, and side effects (Ubido et al., 2002). DHH individuals reported feeling fear, mistrust, and frustration in healthcare settings (Steinberg et al., 2006). As a result of such difficulties, many DHH patients are reluctant to seek physical health care and are at higher risk of chronic health conditions (Emond et al., 2015).

In addition, DHH individuals may be also stigmatized within the deaf community (Aydoğdu & Yüksel, 2020; Powell-Williams, 2017). DHH adults who are trying to adapt to the hearing world and assimilate with hearing people are often viewed as "inauthentic" by the DHH communities, and they may be stigmatized for not adapting to the DHH culture and identity (Powell-Williams, 2017). Although DHH stigma is mostly generated from strangers, DHH individuals also face stigma from significant others such as family and close friends who do not adapt to their communication needs (Hauser et al., 2010). Relatives with negative attitudes toward being DHH significantly reduces DHH individuals' motivation to seek care for their hearing (Meyer et al., 2014). DHH individuals often describe their interactions with hearing others as stressful (Zaidman-Zait & Dotan 2017). These experiences operate as a vicious cycle as they reinforce the view that deafness is stigmatized and should be hidden. Therefore, DHH stigma is a factor that limits the opportunities and potential of DHH individuals and causes further social stress (Atcherson, 2002; Wallhagen, 2010).

DHH Stigma and Mental Health

Studies document that DHH individuals report earlier onset of mood disorders (Kvam et al., 2007; Kushalnagar et al., 2019), impulse control disorders, learning disabilities and pervasive developmental disorders (Landsberger & Diaz, 2010) than the general population. In addition, DHH individuals have increased rates of mental health problems such as anxiety, depression, somatization, and paranoid ideation symptoms (Fellinger et al., 2005; Bridgman et al., 2000). Despite such high rates of mental health issues, DHH continues to experience difficulties in accessing quality mental health care (Vernon & Leigh, 2007). In a study with undergraduate and graduate students in behavioral health, most participants reported feeling unsure about their level of competency about serving DHH population and had little knowledge about the needs of this population (Tarmey, 2007). In addition, Bartlett (2017) found that mental health professionals, including psychologists, psychiatrists, and psychological counselors had limited knowledge of DHH culture and low awareness of DHH individuals.

Not surprisingly, stigma has direct and indirect effects on the mental health of DHH individuals. Neal (2015) found that perceived discrimination was significantly associated with depression. In another study with people with concealable stigmatized identities, it was found that anticipated stigma leads to greater levels of psychological distress in terms of depression and anxiety (Quinn & Chaudoir, 2015). Moreover, in a qualitative study by Wallhagen (2010), researchers conducted interviews with DHH adults and found that deaf stigma lead to alterations in DHH individuals' self-perception. The results were deduced from discussions of DHH individuals about the influence of the meaning of hearing loss, hearing aids, how they perceived themselves and their partners, as well as their expectations about the perspectives of the others.

Regarding experienced stigma[2] (past experiences of prejudiced and discriminative behaviors encountered by the stigmatized individual; Pescosolido & Martin, 2015), it was found that such experiences predicted greater levels of depressive symptoms, anxiety, and lower quality of life (Chapman & Dammeyer, 2017; Mousley & Chaudoir, 2018; Quinn & Chaudoir, 2015). On the other hand, research is limited on DHH adults that focus on anticipated stigma and its effects on their mental health. Two studies are exceptions (Chaudoir & Quinn, 2016; Quinn &

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[2] Of note, the terms "enacted" and "experienced" stigma are used interchangeably in the literature. In the current study, we will use the term "experienced stigma."

Chaudoir, 2015) and revealed that anticipated stigma is linked to greater depressive symptoms and anxiety among people with concealable stigmatized identities.

The literature on internalized stigma among DHH individuals is mixed. Internalized stigma (or self-stigma) refers to endorsing, believing, and assimilating the perceived negative stereotypes, discriminative behaviors and prejudice held by the others on the part of the stigmatized individual (Pescosolido, 2015). Some studies suggested that internalized stigma among DHH individuals is rare. That is, DHH individuals experience stigma and anticipate further stigma, but do not necessarily internalize them (Pescosolido, 2015; Mousley & Chaudoir, 2018). One potential explanation is that DHH individuals who identify with DHH communities are proud to belong to that culture and society (hence, the term Deaf with capital "D" refers to the individuals who identify themselves with the Deaf community, Powell-Williams, 2017). Therefore it is possible for them to internalize DHH stigma at lower rates or they have developed a sense of belonging that protects them against internalized stigma (Bauman & Murray, 2014; Mousley & Chaudoir, 2018). Contrary to these findings, Admire and Ramirez (2021) found that DHH individuals reported internalized stigma when they experienced institutional and interpersonal violence because they viewed themselves as "devalued persons" who are less worthy than the hearing individuals. Such contrary findings indicate that social isolation and rejection may be quite influential in aggregating internalized stigma, while community belonging and social support may be beneficial (Admire & Ramirez, 2021).

Stigma, Social Support, and Mental Health

Social support refers to being cared for, loved, esteemed and valued as well as belonging to a supportive network of individuals for communication and mutual obligation (Cobb, 1976). In addition to being a significant predictor of the quality of life of DHH individuals, social support is positively associated with mental health (Lovretic et al., 2016). Nevertheless, the majority of research that examines the link between social support, stigma and mental health focuses on marginalized and vulnerable minority groups such as HIV patients and LGBTQ+ minorities, and there is not any study focusing on the DHH adults through including all of these variables. For instance, Turan and his colleagues (2016) reported that lower rates of social support and higher rates of loneliness may embitter depressive symptoms in individuals having HIV, and according to the findings, depression mediated the relationship between internalized stigma and treatment adherence. Similarly, in a study with the LGBTQ+ community as another marginalized group, a relationship was found between social support, depression, and anxiety levels of the participants. Namely, people with higher levels of social support have been found to have lower levels of depression and anxiety (Budge et al., 2014).

When DHH individuals experience abuse, violence, and negative treatment in various settings, they may internalize these experiences and perceive themselves as devalued individuals (Admire & Ramirez, 2021). Those experiences, in turn, may have negative effects on their mental health (Admire & Ramirez, 2021; West, 2017). Moreover, DHH individuals with severe self-rated hearing problems (who become hard of hearing due to aging) demonstrated higher levels of depressive symptoms when they had less social support, and higher levels of social support were linked to lower levels of depressive symptoms (West, 2017). Although these findings did not demonstrate a buffering effect of social support on the relationship between hearing impairment and mental health, it was suggested that social support interacted with mental health outcomes and had a moderator role in this relationship. In this context, providing social support and an inclusive social environment is crucial to make DHH individuals feel socially included (Olsson et al., 2021).

The Current Study

The current study examined the relationship between experienced stigma, internalized stigma and mental health symptoms among DHH individuals as well as their interaction with the perceived social support. The hypothesized model 1 and 2 are presented in Figure 1. Consistent with the literature (Mak et al., 2007; Lee et al., 2002), it was expected that there would be a positive and significant correlation between stigma and mental health symptoms. The stress-process paradigm suggests that social support can change the relationship between the stressor and depression, where social support can act as a protective factor through interacting with the stressor (Cohen & Wills, 1985). Building on that model, we hypothesized that perceived social support would interact with the stigma experiences of DHH individuals. In this context, stressors in the model were experienced stigma and internalized stigma, independently. Specific hypotheses were as follows:

Model 1: Depressive symptoms

$H_{1.1}$: Experienced stigma is positively associated with depressive symptoms.

$H_{2.1}$: Internalized stigma is positively associated with depressive symptoms.

$H_{3.1}$: Perceived social support is negatively associated with depressive symptoms.

$H_{4.1}$: Perceived social support moderates the relationship between experienced stigma and depressive symptoms such that it decreases the effects of stigma on depressive symptoms.

$H_{5.1}$: Perceived social support moderates the relationship between internalized stigma and depressive symptoms such that it decreases the effects of stigma on depressive symptoms.

Model 2: Anxiety symptoms

$H_{1.2}$: Experienced stigma is positively associated with anxiety symptoms.

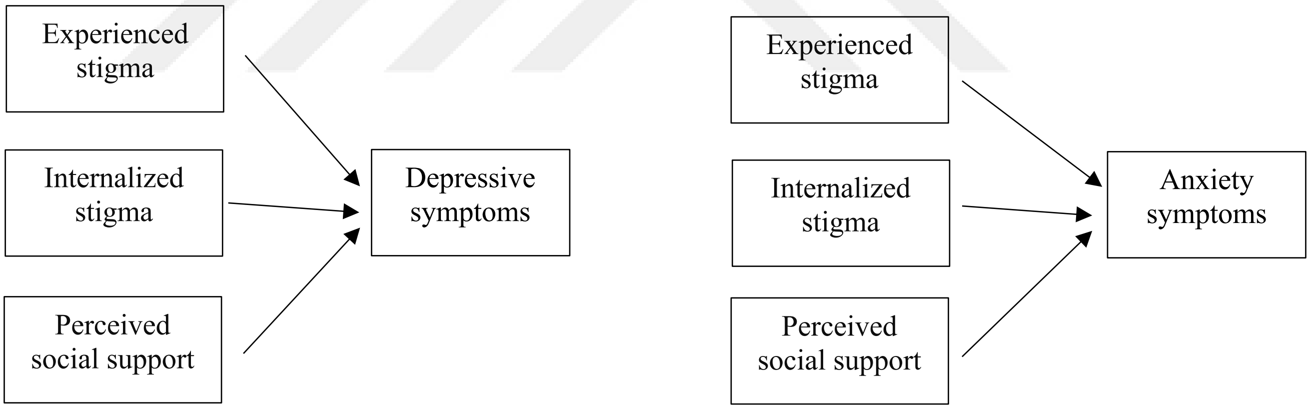
$H_{2.2}$: Internalized stigma is positively associated with anxiety symptoms.

$H_{3.2}$: Perceived social support is negatively associated with anxiety symptoms.

$H_{4.2}$: Perceived social support moderates the relationship between experienced stigma and anxiety symptoms such that it decreases the effects of stigma on anxiety.

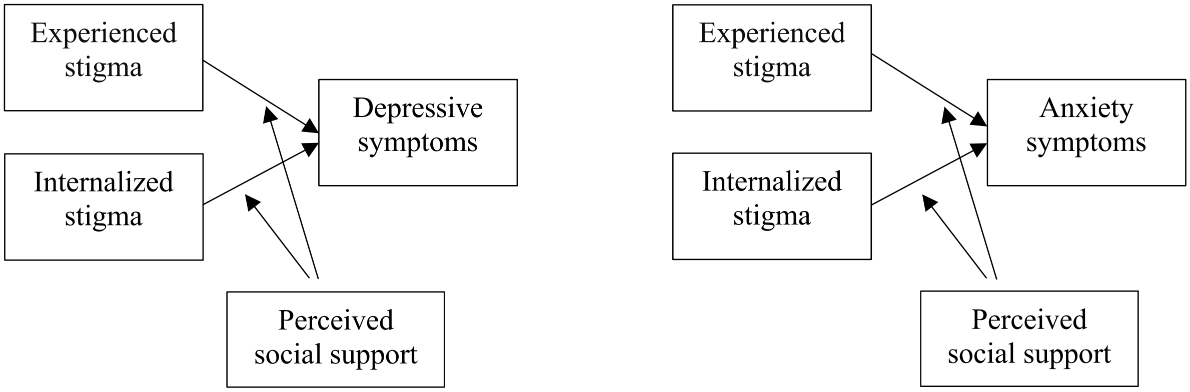
$H_{5.2}$: Perceived social support moderates the relationship between internalized stigma and anxiety symptoms such that it will decrease the effects of stigma on anxiety.

Figure 1. *Hypothesized models*



Model 1a: Predictors of depressive symptoms

Model 2a: Predictors of anxiety symptoms



Model 1b: Predictors of depressive symptoms

Model 2b: Predictors of anxiety symptoms

CHAPTER 2

METHOD

Procedure

To be eligible for the study, participants needed to be between 18 to 65 years old, and either had total hearing loss or had partial hearing but used hearing assistance devices or methods to communicate (e.g., sign language, hearing aid, cochlear implant, lip reading). Consistent with current inclusive definitions of Deafness and being hard of hearing (National Association of the Deaf, 2021; WHO, 2021; Aydoğdu, 2017), we operationally defined DHH individuals in a broad sense so that timing of the hearing loss (at birth vs. lifespan or pre-linguistic vs. post-linguistic) or the degree of hearing loss (i.e., mild vs. total hearing loss) were not accounted for in the participant selection. Participants who were completely illiterate (those who could not read either Turkish, or simplified Turkish, or understand Turkish Sign Language; TSL) were excluded from the study. We recruited participants via social network platforms (i.e., Instagram, Facebook, Twitter), deaf and hard of hearing associations (i.e., *DEM Derneği*), and word of mouth (i.e., TSL translators, TSL instructors, CODAs). Individuals who were eligible to participate in the study continued with the consent form and completed the survey study in Qualtrics.

The consent form and the survey were available in three different formats to accommodate the diverse needs of participants: 1) written materials in Turkish, 2) a simplified Turkish version in parallel with TSL, 3) a videotaped version in TSL and supported with Turkish subtitles. Two TSL translators translated, revised, and finalized the study materials. One of the translators was a CODA (a child of a deaf adult), therefore, was bilingual. The other translator was a hearing translator whose first language was Turkish. This survey translation process was preferred because DHH individuals vary in their literacy rates, and there are grammatical differences between Turkish and TSL. Therefore, offering several options for survey format ensured the accessibility and feasibility of our study while also increasing the validity of our study measures.

All survey options (written Turkish, simplified written Turkish (parallel to TSL), and videotaped TSL with Turkish subtitles) followed the same order of questions. The survey started with a demographics form, followed by the scales. The completion of the study varied across versions: it took around 34 minutes to complete for written in Turkish version (due to the possible slowness of reading rates of DHH participants), 30 minutes for the simplified written version, and 60 minutes for the videotaped TSL version. After the data collection was complete, 50 participants randomly drawn from the total sample were given 100 TL gift card to a supermarket (A101) to compensate for their time to participate in the study. All study procedures were approved by the Koç University College of Social Sciences Ethics Review Board (Protocol no: 2021.421.IRB3.196).

Participants

Data were collected from November 2022 to February 2023. Prior to the data collection, we used G*Power program to determine the sample size. In order to achieve .80 power with seven predictors at alpha = 0.05, the required sample size was 103 participants. The study was conducted with a hard-to-reach population; therefore, we were able to recruit 97 participants in total. Although the study was underpowered, we decided this sample size was adequate to test the main study hypothesis.

Of the 97 participants, 31 (32%) were male, and 66 (68%) were female. Participants were 32.75 years old on average (*SD* = 9.86). Approximately half of the sample (51%, *n* = 49) indicated that they were DHH from birth and the latter group (49%, *n* = 47) became DHH later on their lives. Among the participants who became DHH later, the mean age of hearing loss was 10.96 years (*SD* = 11.17). Regarding marital and relationship status, more than one-third of the sample was single and not in a relationship (39.2%, *n* = 38) and married (36.1%, *n* = 35). The rest of the sample reported being single and in a relationship (16.5%, *n* = 16), divorced (6.2%, *n* = 6), and widowed (2.1%, *n* = 2). In addition, more than half of our participants had a university degree (58.8, *n* = 57), followed by those with a high school diploma (29.9%, *n* =29), a graduate degree (7.2%; *n* = 7) and primary school 83.1%, *n* = 3). Lastly, one participant reported being literate but not having a diploma. There were no participants who were middle school graduates. Regarding employment status, mostly our participants were full-time employed (68.8%, *n* = 66). The rest of them were students (10.4%, *n* = 10), not employed (8.3%, *n* = 8), part-time employed (6.3%, *n* = 6), and retired (6.3%, *n* = 6).

When communication preferences were investigated (where the DHH individuals could select more than one option), 53.6% (*n* = 52) of the participants selected lip reading, 46.4% (*n* = 45) selected sign language and 45.4% (*n* = 44) selected speech (verbal) as their communication preference. Moreover, 40.2% (*n* = 39) of our participants stated that they utilize hearing aids and 35.1% (*n* = 34) of them cochlear implant. Notably, the vast majority of our participants (79.4%, *n* = 77) reported that they have other DHH individuals (i.e., relatives) around.

Table 1. Demographic characteristics of the sample *(N= 97)*

Age (years)	*Mean (SD)*	32.75 *(9.86)*
Gender		
Male	*n (%)*	31 *(32.0%)*
Female	*n (%)*	66 *(68.0%)*
Hearing loss period		
Inborn	*n (%)*	49 *(51.0%)*
Later	*n (%)*	47 (49.0%)
Hearing loss age (if later is chosen)	*Mean (SD)*	10.97 *(11.17)*
Relationship status		
Single and not in a relationship	*n (%)*	38 *(39.2%)*
Single and in a relationship	*n (%)*	16 (16.5%)
Married	*n (%)*	35 (36.1%)
Divorced	*n (%)*	6 (6.2%)
Widowed	*n (%)*	2 (2.1%)
Education level		
No diploma, literate	*n (%)*	1 *(1.0%)*
Primary school	*n (%)*	3 *(3.1%)*
Middle school	*n (%)*	0 (0.0%)
High school	*n (%)*	29 (29.9%)
University	*n (%)*	57 *(58.8%)*
Masters	*n (%)*	7 *(7.2%)*

Employment Status		
Student	*n (%)*	10 *(10.4%)*
Part time employed	*n (%)*	6 *(6.3%)*
Full time employed	*n (%)*	66 *(68.8%)*
Not employed	*n (%)*	8 *(8.3%)*
Retired	*n (%)*	6 *(6.3%)*
Communication Preference*		
Sign language	*n (%)*	45 *(46.4%)*
Speech (Verbal)	*n (%)*	44 *(45.4%)*
Hearing aid	*n (%)*	39 *(40.2%)*
Cochlear implant	*n (%)*	34 *(35.1%)*
Lip reading	*n (%)*	52 *(53.6%)*
Having other DHH individuals around		
Yes	*n (%)*	77 *(79.4%)*
No	*n (%)*	20 *(20.6%)*

**Note:* Respondent could pick more than one option in this question. Therefore, total percentage exceeds 100%.

Measures

Demographic form. The survey included a demographic form that assessed age, gender, the onset of deafness or hardship of hearing, relationship status, education level, employment status, preferred methods or assistance devices to communicate, and whether they have DHH relatives or not.

Access to health care services. We also utilized 14-item access to health services scale to assess barriers DHH individuals experience when seeking health care. The scale was constructed based on questions used in studies on vulnerable populations such as refugees (Fuhr et al., 2020; Sijbrandij et al., 2017), but the original study did not report the psychometric properties of the measure. Of 14 items, 12 items inquired about the utilization of physical health, mental health, TSL translation services and other issues related to the health care system (sample item: 'Have you ever had a 30-minute or longer counseling or therapy session with any professional?). All items were dichotomized with two categories (yes / no). One additional dichotomous item inquired perception on the access to health care ('How would you evaluate deaf and hard of hearing individuals' access to the health care services and health-related information?') and was rated as sufficient / insufficient. Also, one item was a checklist where participants could indicate potential stigma experiences and discrimination. Options included; negative attitude of health personnel, denial of their rights, absence of a health institution where they live, refusing to provide them treatment or health care services and other stigma or discrimination experiences. The checklist was also coded in a dichotomous format (yes/no).

Experienced Stigma Scale. Mousley and Chaudoir (2018) adapted the Experienced Stigma Scale (a 26-item scale, Cronbach alpha = .85 in the original study). In this scale, participants were asked whether they had experienced the situations presented in the items. Examples of the items are “Not get hired for a job” or “Getting poorer service than others do at restaurants or stores.” Response categories were “Yes, this has actually happened to me (1)” or “No, this has never happened to me (0).” Of note, the "Roommates wanting to move out of the apartment or dorm room" item on this scale were omitted in the current study as it was not applicable to our target population. Cronbach alpha of the scale was .87 in the current sample.

Internalized Stigma of Mental Illness Scale (ISMI). We used an adapted version of ISMI to examine internalized stigma levels of DHH adults. ISMI was originally developed by Ritsher et al. (2003) to measure the subjective experience of stigma. It has 29 items and five subscales; alienation (6 items), stereotype endorsement (7 items), perceived discrimination (5 items), social withdrawal (6 items) and stigma resistance (5 items). Items of the stigma resistance subscale were reverse-coded prior to the analysis so that higher scores in the scale indicated higher internalized stigma. The original English version of ISMI demonstrated internal validity coefficient as .90 and its' test-retest reliability coefficient was $r = .92$. The internal consistency of the subscales ranged from .58 to .80 and test-retest coefficients ranged from .68 to .94. Ersoy and Varan (2007) adapted the ISMI to Turkish and they reported that it is a reliable and valid tool. Cronbach's alpha of the Turkish version of ISMI was .93 for the entire scale, ranging from .63 to .87 for the subscales. For the current study, we used the Turkish version of ISMI and replaced the items related to mental health with DHH to measure the internalized stigma of DHH. Sample items were "I cannot contribute anything to society because I have a hearing disability" and "I feel inferior to others who are not DHH.") Items were rated from 1 ("strongly disagree") to 4 ("strongly agree"). We used the total score of the scale which demonstrated adequate reliability (α =.89).

The Center for Epidemiologic Studies Depression Scale (CES-D). The scale was initially designed to measure depressive symptoms with an emphasis on its' affective components (Raddolff, 1977). It is a self-report instrument in which participants are asked to rate how often during the past week they have felt as stated in the items. It consists of 20 items rated on a 0 ("never-rarely") to 3 ("mostly-usually") scale. Items 4, 8, 12 and 16 were reverse-coded before the statistical analysis. Examples of the items are "I was bothered by things that usually do not bother me" or "I had crying spells". The total score on the CES-D range from 0 to 60, with higher scores indicating greater depressive symptoms. Internal consistency of the scale was high in both the general population (healthy) and clinical sample, α was .85 and .90, respectively (Raddolff, 1977). It has shown adequate test-retest reliability (.45 to .70; Raddolff, 1977). For the current study, Turkish version of CES-D was used (Tatar & Saltukoğlu, 2010). It has been found to demonstrate good psychometric properties for internal consistency (α range from .75 to .90), the Guttman split-half coefficient (.89), and the test-retest reliability (two weeks; .69) with Turkish samples. In our study, the Cronbach alpha of the scale was .89.

Brief Symptom Inventory (BSE). The scale was initially developed by Derogatis (1992) to assess the psychological symptom status of participants. It is a 53 item self-report symptom inventory in which each item is rated on a 5-point scale (0 = not at all, 4 = extremely). In the original study (Derogatis, 1992), the scale had a nine factor solution with the subscales including somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism, with internal consistency coefficients ranging from .71 (psychoticism) to .85 (depression). In addition, the test-retest reliability (by two weeks) ranged from .68 (somatization) to .91 (phobic anxiety). BSI was adapted to Turkish by Şahin and Durak (1994) and has shown high internal consistency with a Cronbach's alpha ranging from .95 to .96 (Savaşır & Şahin, 1997). In the Turkish adaptation study, BSI was found to have five factors including anxiety, depression, negative self concept, somatization and hostility. In the current study, 13 item anxiety subscale was utilized to measure anxiety symptoms of DHH adults and higher scores indicated high levels of anxiety symptoms. Cronbach alpha of the anxiety subscale was .88.

Multidimensional Scale of Perceived Social Support (MSPSS). The scale was initially developed by Zimet et al. (1988) to assess perceived social support. It is a self-report scale consisting of 12 items in which participants rate perceived social support using 7-point Likert type scale ranging from 1 ("very strongly disagree") to 7 ("very strongly agree"). MSPSS has three subscales that address different sources of social support: significant other, family and friends. The original scale has good internal reliability, factorial validity, and adequate construct validity (Zimet et al., 1988). Cronbach's alpha was reported as .88 and it was .91, .87 and .85 for each subscale, respectively. For the current study, Turkish version of MPSSS (Eker et al., 2001) was used which demonstrated good internal reliability with Turkish samples (αs range from .80 to .95). In the current study, we used the total score of the scale and internal reliability was .89.

Data Analysis

First, preliminary analyses were conducted to investigate the demographic characteristics of the sample and participants' experiences about access to health care services. In addition, the distribution of variables were examined in terms of means, standard deviations, frequencies, skewness and kurtosis. The correlations between age, access to health care and main variables (experienced stigma, internalized stigma, perceived social support, depressive symptoms and anxiety symptoms) were analyzed through Pearson correlation analysis. In addition, independent samples t-test analyses were conducted to examine gender differences and differences by hearing loss in dependent and independent variables.

For the main analyses, two separate multiple linear regression analyses were performed for depression and anxiety. The models were built using enter method and missing data were handled by listwise deletion. In the first step, experienced stigma, internalized stigma, and perceived social support were added as the predictors and age was included as a control variable in both models. In the second step, three interaction terms (experienced stigma * perceived social support; internalized stigma * perceived social support; and experienced stigma * internalized stigma * perceived social support) were added to the models. Explained variance of each dependent variable was assessed via R Squared and model fit indicators were reported via F tests at $p < .001$.

CHAPTER 3

RESULTS

Preliminary Analyses

Test of normality assumption. First, we investigated whether the distribution of scales confirmed the assumptions of normality. As it can be seen in Table 2, there was no violation of normality assumption since all scales' kurtosis and skewness were in an acceptable range (+1.96 and -1.96). Therefore, it was concluded that the data were normally distributed and could be used for multiple linear regression analysis.

Table 2. Descriptives of independent and dependent variables

	N	Mean	SD	Skewness		Kurtosis	
Variables				Statistic	Std. Error	Statistic	Std. Error
Age	95	32.75	9.86	1.24	.25	1.75	.49
Access to health care services	97	5.75	2.23	.31	.25	.14	.49
Experienced stigma	97	9.37	5.62	.21	.25	-.60	.49
Internalized stigma	97	58.84	14.14	.27	.25	-.56	.49
Perceived social support	97	60.24	19.27	-1.08	.25	1.31	.49
Depressive symptoms	97	20.14	11.36	.64	.25	.11	.49
Anxiety symptoms	97	.88	.67	1.14	.25	1.82	.49

Access to health care and discrimination experiences. In addition, we investigated DHH individuals' reports of the availability of and access to physical and mental healthcare services (Table 3). The majority of our participants reported that they had health insurance (83.5%, *n* = 81), there was a healthcare institution available in their residential area (90.7%, *n* = 88), and they knew where to go and which doctor to see if they had any health problems (85.6%, *n* = 83). The majority of DHH individuals (73.7%; *n* = 70) perceived their access to available healthcare services and information as insufficient. Similarly, 74.7% (*n* = 71) of participants did not receive sign language translation or support when they went to the hospital and 70.8% (*n* = 68) of the sample have never been briefed on mental health issues, nor they have ever received any mental health care such as counseling or therapy (75%, *n* = 72). Additionally, 64.2% (*n* = 61) of the individuals who participated in this study have never been briefed on any topic about physical health or physical illness. For 53.1% (*n* = 51) of the participants, it was financially challenging to meet health care services and among them, 43.1% (*n* = 22) have postponed their health checks due to economic difficulties. Almost half of the participants (52.6%, *n* = 50) felt stigmatized or discriminated against while receiving health care services due to their DHH status and listed several experiences of discrimination. The most common experience was the negative attitudes of the health personnel (40.2%; *n* = 39), followed by denial of rights (23.7%; *n* = 23) and being rejected to be provided with treatment or health care services (7.2%; *n* = 7). Further details on the challenges to access to healthcare services are presented in Table 3.

Table 3. Participants' access to healthcare

	Yes *n (f%)*	No *n (f%)*
Do you have health insurance?	81 (83.5%)	16 (16.5%)
Is there an institution in your area where you can get healthcare services?	88 (90.7%)	9 (9.3%)
Do you know where to go and which doctors to see if you have any health problems?	83 (85.6%)	14 (14.4%)
When you go to the hospital, do you think that the healthcare professionals inform you enough about the treatment options?	41 (42.7%)	55 (57.3%)
Would you evaluate DHH individuals' access to available healthcare services and healthcare information as sufficient?	25 (26.3%)	70 (73.7%)
Were you able to get sign language translation-support when you went to the hospital for any reason, or do you think you can get it if you request it?	24 (25.3%)	71 (74.7%)
Have you ever been briefed on any topic about mental health or mental illness issues? (For example: depression, anxiety disorders, therapy options…)	28 (29.2)	68 (70.8%)
Have you ever had a 30-minute or longer counseling or therapy session with any professional?	24 (25.0%)	72 (75.0%)
(If yes) Were you satisfied with the service you received?	18 (75.0%)	6 (25.0%)

Have you ever been briefed on any topic about physical health or physical illness? (For example: diabetes, cancer, drugs…)	34 (35.8)	61 (64.2%)
When you receive health care services, is it financially challenging for you to meet these services?	51 (53.1%)	45 (46.9%)
In the last 12 months, have you postponed your health checks due to economic difficulties?	22 (43.1%)	29 (56.9%)
Have you ever felt stigmatized or discriminated against while receiving health care services because you are DHH?	59 (52.6%)	45 (47.4%)
In which of the following issues have you experienced stigma or discrimination?*		
Negative attitudes of health personnel	39 (40.2%)	
Denial of my rights	23 (23.7%)	
There is no health institution where I live	2 (2.1%)	
Refusing to provide me with treatment or health care services	7 (7.2%)	
Other	10 (10.3%)	

Note: *Respondent could pick more than one option in this question. Therefore, total percentage exceeds 100%.

"Other" category was formatted as open-ended question. Therefore, the answers consisted of the stigma or discrimation experiences written by the participants (e.g., “Health care personnel don't understand my problem and they treat me as if I don't deserve to be treated as people who are not DHH”.

Correlational analysis. Pearson correlation coefficients were computed between independent and dependent variables (Table 4). Access to healthcare services (count variable) was significantly and negatively correlated with experienced stigma ($r = -.36$, $p < .001$), but was not associated with any other variables in the model (internalized stigma, mental health outcomes, and perceived social support, $p > .05$). Given the overlap between experienced stigma and access to healthcare services, we decided to include experienced stigma in the main analysis as a more broad assessment of stigma experiences and dropped access to healthcare services variable.

Significant correlations between independent and dependent variables ranged from $r = -.21$ to $r = .74$ and were low to high in magnitude. Results revealed that experienced stigma was significantly and positively associated with internalized stigma ($r = .32$, $p < .001$), depressive symptoms ($r = .33$, $p < .001$) and anxiety symptoms ($r = .29$, $p < .001$) and was negatively correlated with perceived social support ($r = -.29$, $p < .001$). In addition, internalized stigma was significantly and positively associated with depressive symptoms ($r = .53$, $p < .001$) and anxiety symptoms ($r = .48$, $p < .001$) and it was negatively correlated with perceived social support ($r = -.30$, $p < .001$). Moreover, perceived social support was significantly and negatively correlated with both depressive symptoms ($r = -.42$, $p < .001$) and anxiety symptoms ($r = -.28$, $p < .001$). Age was associated with all study variables except for access to health care services. Finally, a strong correlation was found between depressive symptoms and anxiety symptoms ($r = .74$, $p <$

.001; Table 4). Given those findings, we decided to run a separate regression analysis for depression and anxiety. Bivariate correlations between independent variables (stigma variables and perceived social support) were in an acceptable range and indicated no issues with multicollinearity; therefore, we maintained the original model. Age was added to the model due to its relevance to all selected variables.

Table 4. Pearson correlation coefficients between independent and dependent variables

	1	**2**	**3**	**4**	**5**	**6**	**7**
1. Age	1						
2. Access to health care services	.02	1					
3. Experienced stigma	-.21*	-.36***	1				
4. Internalized stigma	-.22*	-.17	.32***	1			
5. Perceived social support	.32***	.04	-.29***	-.30***	1		
6. Depressive symptoms	-.23*	-.14	.33***	.53***	-.42***	1	
7. Anxiety symptoms	-.32***	.03	.29***	.48***	-.28***	.74***	1

*$p < .05$, ***$p < .001$

Group comparisons. All study variables were compared by hearing loss timing (birth vs. later). Independent samples t-test analysis showed that there was no significant difference between participants who are inherently DHH and those who became DHH later on. Namely, there were no statistical difference between two groups for experienced stigma, [t (94) = 1.43, p = .16], internalized stigma, [t (94) = .06, p = .96], perceived social support [t (94) = .06, p = .95], depressive symptoms [*t* (94) = -.85, *p* = .40], and [anxiety symptoms, *t* (94) = -.77, *p* = .45]. Given those findings, we analyzed data using the full sample and did not control for hearing loss timing in the final regression model (Table not shown).

All study variables were also compared by gender (men vs. women). According to the results of the independent samples t-test, women reported significantly higher depressive symptoms, [*t* (95) = 1.96, *p* = .05] and anxiety symptoms [*t* (95) = 2.40, *p* = .02], than men. There were no gender differences in reports of experienced stigma [*t* (95) = .212, *p* = .83], internalized stigma [*t* (95) = -.79, *p* = .43], and perceived social support, [*t* (95) = -.57, *p* = .57]. Since the sample size was small and the results were marginally significant at $p < .05$, gender was not included in the final model as a variable.

Main Analysis: Multiple Linear Regression

For the main analysis, we conducted multiple linear regression analyses separately for depressive symptoms (Model 1) and anxiety symptoms (Model 2) in two steps. In the first step, the model included age, stigma variables, and social support (Model 1a for depressive symptoms and Model 2a for anxiety). In the second step, we added interaction terms between stigma and social support to the full model (Model 1b and 2b for depression and anxiety, respectively; Table 5).

In Model 1a, internalized stigma was positively (β = .43**,** $p < .001$) and perceived social support was negatively (β = -.27**,** *p* = .004) associated with depressive symptoms. On the other hand, age (β = -.02, *p* = .82) and experienced stigma (β = .11, *p* = .21) were not related to depressive symptoms. The model 1a accounted for 39% of the variance and demonstrated a good fit to the data [*F*(4, 90) = 14.63, $p < .001$]. After adding the two and three-way interactions to the model (Model 1b), associations of internalized stigma (β = .32, *p* = .19) and perceived social support ($\beta = -.13$, $p = .70$) with depressive symptoms became nonsignificant. In model 1b, experienced stigma was still nonsignificant but there was a trend ($\beta = .52$, $p = .07$). In addition, all interactions' effects were nonsignificant. Contrary to our hypothesis, perceived social support did not moderate the relationship between internalized stigma, experienced stigma, and depression. The Model 1b accounted for 42% of the variance.

In Model 2a, internalized stigma was the only significant predictor of anxiety ($\beta = .38$, $p < .001$) and age was marginally nonsignificant, indicating a trend ($\beta = -.01$, $p = .06$). On the other hand, experienced stigma ($\beta = .10$, $p = .30$) and perceived social support ($\beta = -.08$, $p = .41$) did not significantly predict anxiety. The final model explained 30% of the variance in anxiety symptoms. Model fit was significant at $F(4, 90) = 9.22$ ($p < .001$). The model with interaction terms (Model 2b) yielded different results; age ($\beta = -.19$, $p = .04$) and experienced stigma ($\beta = .68$, $p = .03$) became significantly associated with anxiety symptoms. Additionally, the relationship between anxiety symptoms and internalized stigma remained significant ($\beta = .57$, $p = .03$) after adding the interaction variables. Similar to Model 1b, all interaction terms were nonsignificant in Model 2b (Table 5). The final model accounted for 33% of the variance in anxiety symptoms.

Table 5. Multiple linear regression analysis findings

	Model 1: Depressive symptoms				**Model 2: Anxiety symptoms**			
	Model 1a		*Model 1b*		*Model 2a*		*Model 2b*	
	β	*p value*	β	*p value*	β	*p value*	β	*p value*
Variable								
Age	-.02	.82	-.04	.65	-.18	.06	-.19	.04
Experienced stigma (ES)	.11	.21	.52	.07	.10	.30	.68	.03
Internalized stigma (IS)	.43	<.001	.32	.19	.38	<.001	.57	.03
Perceived social support (PSS)	-.27	.004	-.13	.70	-.08	.41	.37	.30
ES x PSS			-.69	.11			-.47	.30
IS x PSS			.08	.83			-.16	.69
ES x IS X PSS			.29	.55			-.15	.77
Model indices								
F test and *p* value	14.63	<.001	8.92	<.001	9.22	<.001	6.09	<.001
R squared	.39		.42		.29		.33	
Adjusted R squared	.37		.37		.26		.28	

CHAPTER 4:

DISCUSSION

In the current study targeting DHH adults, we investigated the barriers to access to health care as well as the relationship between experienced stigma, internalized stigma, and mental health symptoms (depression and anxiety) and the potential role of perceived social support for mental health. Overall, our study demonstrated that stigma and perceived social support have different links to depression and anxiety among DHH individuals. Specifically, higher levels of experienced stigma was associated with increased levels of self-reported anxiety, but not depression. Internalized stigma and age appear as robust predictors of anxiety symptoms, suggesting that DHH individuals who are younger and self-stigmatize report more anxiety symptoms. On the other hand, perceived social support and internalized stigma were independently linked to depressive symptoms, but did not interact with one another in the current study.

Internalized stigma played a partial role in the increase in depressive symptoms and a more robust role in the alleviation of anxiety symptoms. In the current study, internalized stigma (self-stigma), defined as the stigmatized individual’s acceptance, belief, and assimilation of the perceived negative stereotypes, discriminatory behaviors, and prejudice held by the others (Pescosolido, 2015), played a more key role than experienced stigma. It appears that the endorsement of the negative beliefs and assimilation of negative stereotypes attributed to DHH population may make DHH individuals more vulnerable for developing mental health issues (Mousley et al., 2018).

DHH individuals, as well as other stigmatized populations, may develop anxiety and depression in addition to other mental health problems regardless of their discrimination experiences (Fellinger et al., 2005; Fellinger et al., 2012; Kushalnagar et al., 2019; Kvam et al., 2007). Limited research in the literature focuses on the relationship between internalized stigma and mental health problems among DHH individuals. Contrary to our findings, the only study in the literature focusing on DHH adults, stigma and mental health found a significant and negative relationship between experienced stigma, depression and anxiety, and a non-significant role of internalized stigma on DHH individuals' mental health (Mousley & Chaudoir, 2018). All limited research focusing on mental health, stigma and DHH individuals considered, our findings regarding internalized stigma can be interpreted through considering the literature on the internalized stigma experiences of the DHH adults and the negative effects of internalized stigma on mental health in other stigmatized identities (Hatzenbuehler et al., 2013; Hinshaw & Stier, 2008; Meyer, 2013).

With regard to internalized stigma and its negative effects on mental health, Turan and his colleagues (2017b) investigated the relationship between community stigma and mental health outcomes and found a mediator role of internalized stigma, which negatively effected self-esteem, depressive symptoms, avoidance coping and self-blame among individuals living with HIV. Moreover, similar to our findings, internalized stigma was linked to increased depression, anxiety, and suicidal ideation among sexual minorities (Cronin et al., 2021). In addition, in a meta-analysis on stigma and mental health across other stigmatized identities, it was reported that stigma increased psychological distress and had negative effects on adjustment and growth. In a study conducted by Whitehead and his colleagues (2016) with LGBT individuals as one of the other stigmatized identities, a significant and negative relationship between internalized stigma and self-esteem was found and potential participation in negative health behaviors was emphasized as the outcome of this relationship. Similarly, in a study conducted with DHH and visually impaired individuals, internalized stigma was higher for DHH individuals and it mediated the relationship between perceived personal discrimination and self-esteem (Pérez-Garín et al., 2021). If evaluated by adapting to the internalized stigma of being deaf or hard of hearing, these results are also in line with the self-stigma of mental illness model in which self-esteem decrement is considered as the final outcome of internalized stigma (Link, 1987; Link & Phelan, 2001). Based on these findings, it can be suggested that impairments in self-esteem may be another outcome of internalized stigma in addition to the increase in depression and anxiety symptoms. In this context, studies document that low self-esteem resulted in a vicious cycle with early onset and worst prognosis of psychiatric disorders, and its' negative effects on mental health endured even after the remission of disorders (Pérez-Garín et al., 2021; Silverstone & Salsali, 2003). Moreover, in accordance with our findings, minority stress model describes stigma as one of the main factors that lead to poorer mental health outcomes (i.e., anxiety; Dohrenwend, 2000; Meyer & Northridge, 2007; Meyer, 2013).

Additionally, internalization of the stigma experienced by DHH individuals may lead to alterations in their self-perception and formation of a devalued image in their self-worth, which is also referred as "the most destructive form of violence" and it may reinforce the notion that DHH individuals are inferior (Admire & Ramirez, 2021; Sobsey & Doe, 1991; Wallhagen, 2010). In addition, the process in which DHH individuals internalize the stigma that they experience and view themselves as devalued individuals (Admire & Ramirez, 2021), may have been contributed to their depressive symptoms, as Beck (1979) suggested in his cognitive triad model which he proposed a vicious cycle that negative views about oneself leads to negative views about the world and the future. Therefore, by changing the self-image in a negative way, internalization of the stigma may appear as a risk factor for depressive symptoms. In sum, it could be suggested that internalization of the stigma is a significant risk factor that may put individuals at higher risk for developing psychopathologies such as depression and anxiety.

Contrary to our hypotheses, experienced stigma was related to an increase in anxiety symptoms, but not depression. Even though the accumulating evidence suggests a positive and significant relationship between stigma experiences and depression levels in different hearing and DHH populations (Chapman & Dammeyer, 2017; Hatzenbuehler et al., 2013; Heredia Montesinos, 2012; Li et al., 2021; Mousley & Chaudoir, 2018; Marti-Pastor et al., 2020), our results only suggested a partial link between the two variables. It can be suggested that although stigma is related to serious problems for mental health, it may bring out the urge to develop new and more effective coping methods, a sense of purpose, and closer relationships with the stigmatized group that the one belongs to (Frost, 2011). Literature on stigma and depression emphasizes that the internalization of the stigma experienced by individuals as a significant factor that might be effectful on depression (Amini-Tehrani et al., 2021; Li et al., 2020; Li et al., 2021; Lo Hog Tian, 2021). Therefore, it could be argued that the the experienced stigma by itself might not be an influential factor in explaining changes in the depression level. In other words, individuals' perceptions about their stigma experiences and the level that they internalize this stigma might have hindered the effect of experienced stigma on depression.

Additionally, perceived social support was a protective factor for depression, but not for anxiety. However, social support did not interact with stigma and functioned as an independent factor for the alleviation of depression. Similar to our findings, in a study with DHH individuals (with poor vs excellent hearing), high levels of social support reduced depressive symptoms of DHH individuals with poor self-rated hearing and social support was associated with alleviation of the depressive symptoms (West, 2017). One possible explanation for the non-significant relationship between anxiety and perceived social support and its lack of interaction with stigma types might be made through intergroup anxiety, originally defined by Stephan and Stephan (1985). Major tenets of intergroup anxiety suggest that it increases and causes discomfort for both interactants (able and disabled individuals) when they communicate. Accordingly, DHH individuals may make assumptions regarding the possibility of their interactions with hearing individuals as the outgroup members to be negative and that they will experience rejection and discrimination (Stephan & Stephan, 1985). In addition, they may internalize this anticipated stigma and self-doubt about their ability to communicate with outgroup members, which eventually increase their anxiety (Stephan & Stephan, 1985). As the other interactant part, outgroup members' anxiety levels may also increase due to the uncertainty and lack of knowledge about the appropriate behaviors they should engage in these interactions (Stephan & Stephan, 1985). Therefore, the lack of a protective role of social support in alleviating the anxiety levels of DHH individuals and the lack of interaction between social support and stigma types may be due to DHH individuals' perception of social support resources as a factor that may trigger stigmatization and increase their anxiety. In sum, our findings suggest that DHH individuals who seek and receive social support from significant others have benefits in alleviating their depressive symptoms, but the effect of other protective factors for their anxiety levels and psychological well-being might be in question.

We expected that when individuals with DHH experience stigma or internalize the stigma that they experience, perceived social support of significant others would act as a protective factor for their mental health. Contrary to our hypotheses and premises of the stress-process paradigm (Cohen & Wills, 1985), social support did not moderate the relationship between stigma and mental health. That is, DHH individuals' perception of the social support did not change the relationship between internalized stigma, experienced stigma, and depression and anxiety levels. Regarding the overall non-significant moderating effects of perceived social support (for both experienced and internalized stigma), this contradictory finding could be explained in several ways. One possibility is that, receiving visible social support might be interpreted as 'neediness' which may perpetuate the stereotype that they are vulnerable, in need of help, and hierarchically lower than the provider of the support who is superior then themselves (Zee & Bolger, 2019). Moreover, DHH individuals may feel so isolated that their perceived social support may be too low to detect any protective role against stigma, indicating a floor effect. Indeed, this feeling of isolation may cause feelings of being left out even among their significant others who need to be the primary source of social support (Sheppard, 2014). DHH individuals' isolation within family environments which was referred as "dinner table syndrome" (Lee et al., 2022), eventually may rule out their significant others' (i.e. family) role as a resource of social support and protective role against stigma. In a study focused on DHH individuals and their mental health, it has been reported that DHH individuals feel stigmatized about their problems even within their own community and were concerned about confidentiality which may lead them not to share their problems and seek social support when it is needed (Cabral et al., 2013). Specifically, as individuals existing both in the hearing and the DHH worlds, being in a position in which they seek social support for another issue may bring the possibility of a "double stigma" against them (Cabral et al., 2013). In this context, DHH individuals may not have seen social support as a protective factor, but as another factor that may cause stigmatization. Therefore, they may not utilize social support as a coping mechanism in order to avoid an extra resource of stigma.

Another potential explanation pertains to other potential protective factors (other than social support) that are helpful in enduring the challenges of stigma. For instance, in the current study social support was assessed as supportive interactions with friends, partners or significant others – that is our operational definition of social support was restricted to significant others. However, support of DHH community, belonging, and identification with the DHH culture may be important factors to help DHH individuals persist despite the negative effects of stigma. Indeed, sense of belonging is regarded as one of our basic human needs and it is crucial for survival (Baumeister & Leary, 1995). In that sense, embracing the DHH identity and belonging to DHH community may be a potential protective factor for DHH individuals' well-being while coping with the adverse effects of stigma (Chapman & Dammeyer, 2017; Crabtree, 2010; Powell-Williams, 2017). In sum, perceived social support benefits DHH individuals in dealing with depressive symptoms, but offers no protective value in dealing with stigma and its negative consequences for mental health.

Of note, findings pertaining to age are noteworthy. Our study demonstrated that as age decreased, DHH individuals' anxiety levels were more prone to increase. This finding is in line with previous research that showed a negative relationship between age and anxiety (Carden et al., 2022; Gould & Edelstein, 2010). Our results regarding younger DHH individuals experiencing more anxiety may be explained through Socioemotional Selectivity Theory (Carstensen, 1992). According to the Socioemotional Selectivity Theory (Carstensen, 1992), individuals' ability to regulate their emotions and utilize positive experiences increases as they age, enabling them to cope with discriminatory experiences more quickly and easily and internalize the stigma at a lower level. Similarly, Carden and his colleagues (2022) found that there is a decrease in perceived discrimination among younger individuals. As our findings suggested, experienced stigma and internalized stigma is related to an increase in anxiety. Therefore, young DHH individuals might be exposed to higher levels of stigma which might eventually increase their anxiety levels. On the other hand, age was not a significant predictor of depression scores of DHH individuals either before or after adding the interaction variables. Previous findings on the relationship between age and depression is mixed. While some studies reported a significant and positive relationship (Stordal et al., 2003), others reported no significant correlation between age and depression (Jorm, 2000). The researchers suggested that the discrepancy between these findings may be explained through other variables and risk factors (e.g., gender, race, social support) that may influence the results (Stordal et al., 2003). Although the relationship between age and depression and the variables which may effect this relationship might be in question, our results supported the studies which reveal a nonsignificant role of age on depression.

Limitations and Strenghts

There are several limitations of the current study. First of all, most of our participants were women and more than half of the participants were university graduates, suggesting a bias in the sample towards a relatively less advantaged and educated subpopulation of DHH individuals. Secondly, the study was designed as cross-sectional. Since the research was not designed as experimental, no causal inferences can be made from our results. We can not provide any finding regarding the direction of the relationships. In other words, our hypotheses' directions may be reversed. Namely, participants may have internalized the stigma and found themselves in a more depressive or anxious mental state, or they may have a tendency to internalize stigmatizing attitudes from the others due to ongoing depression or anxiety issues. Similarly, we can not draw any conclusions regarding whether participants' experiences of stigma have caused their anxiety or they were exposed to stigmatizing behaviors from their surroundings as a result of their anxious nature. Of note, we also acknowledge that we did not assess other potential stigma factors such as associative stigma (stigmatizing attitudes of family members, their experiences of stigma and their self-stigma) and disclosure. DHH individuals may refrain from disclosing their status, yet we did not have information on concealment efforts and its potential role in internalized and experienced stigma. Finally, we acknowledge that our study sample was relatively small and the study may lack enough power to detect potential significant associations between stigma and mental health.

Besides limitations due to the nature of the research design, there were also some limitations stemming from the characteristics of the sample group of our study. One of the major issues in the current study was related to recruitment difficulties during data collection. The DHH participants lacked the motivation to participate in our study. This issue can be actually attributed to the overall recruitment and engagement issues with vulnerable groups (Flaskerud et al., 1998; Sutton et al., 2003). Similarly, we observed that DHH adults were cautious, critical, and guarded about participation, possibly due to the worries about confidentiality and being stigmatized. Such issues may have biased our results because DHH individuals who feel the most stigmatized, isolated and discriminated may have refused to participate the study. It may be also the contrary claim; we may have recruited participants with the most strong relationship with DHH organizations, hence, they have relatively low mental health issues or high social support to deal with stigma.

Although there were several limitations as mentioned above, the current study has contributed to the literature. Our study is one of the few empirical research with Turkish DHH individuals that offers a detailed and comprehensive picture of DHH adults’ stigma experiences and the level in which they internalize the stigma that they experience. Additionally, our findings contributed to the literature by examining the roles of stigma types (i.e., experienced stigma, internalized stigma) and the effect of perceived social support on depression and anxiety symptoms of DHH individuals. Our study expands the research on stigma literature investigating one of the minority populations in Turkey. It is known that stigma has many negative effects on mental health (Admire & Ramirez, 2021; Clair, 2018; Fellinger et al., 2012; Sheppard & Badger, 2010; West, 2017). In addition, populations that are likely to be stigmatized, such as DHH adults, are known to experience the detrimental effects of stigma on their mental health. However, there was a gap in the literature regarding the lack of studies investigating these factors together and focusing on DHH adults. Our findings highlighted the critical role of internalized stigma in terms of depression and anxiety symptoms of DHH adults. In this context, our study shed light on the importance of stigma for DHH adults' mental health and might contribute to the understanding for future studies in terms of factors related to the psychosocial processes, such as perceived social support.

In addition, the current study might contribute to the visibility of DHH adults living in Turkey and raise awareness about their unmet needs in the healthcare system, especially in the mental health area. In our study, 70% of our participants evaluated their access to healthcare services and healthcare-related information as insufficient. Their experience with mental health services was even more remarkable. 68% of our participants have never been briefed on any topic about mental health or mental illness issues and 72% of them never had a counseling or therapy session with any professional. Therefore, it is crucial to add on improvements in the prevention and intervention studies for DHH community health care. In this context, we hope that our findings will contribute to the awareness of professionals working in the field of mental health.

Most importantly, our study is an example for future studies on DHH population in terms of its data collection method. The fact that DHH individuals use various methods for communication makes it impossible to collect data with a single type of material. In our study, we prepared the online survey in three formats (Turkish written version, simplified Turkish written version, and TSL videotaped version with subtitles) to address the diverse communication needs of DHH individuals. Such an approach underscores the heterogeneous nature of the DHH community. We hope that the presentation of research materials through this highly inclusive method, which ensures that the entire DHH population is able to comprehend the data collection materials, will serve as an example for future studies and could hopefully inspire the researchers in our field to focus on DHH and mental health topics by highlighting the gap in the literature.

Implications for Future Research

The experiences of DHH adults with regard to stigma and its impact on their mental health would be better understood by a longitudinal design because it would enable us to gain information on how experienced and internalized stigma may change over time or how their association may interact with the onset and prognoses of depression and anxiety. In addition, although our findings suggested a relationship between internalized stigma, depression and anxiety, future studies might focus on experienced stigma through considering other stigma types in different models. Specifically, investigating the mediator role of internalized stigma on the relationship between experienced stigma and mental health through a study with a higher sample size might be beneficial to understand the dynamics between various types of stigma (i.e., perceived, anticipated) and its' effects on the mental health of DHH adults.

In addition, although there are many unanswered research questions in the clinical psychology literature in terms of studies focusing on DHH adults, it is essential to turn the focal point from the psychopathology oriented approach to the protective factors and resilience of DHH adults in future studies. In the current study, perceived social support was investigated as one of the factors that may contribute to the psychological well-being of DHH adults. Contrary to our expectations, its' lack of significant relationships with the other variables suggests many research questions and variables that can be considered such as community belonging, identification, and self-esteem (Bat-Chava,1993; Munoz, 2000; Olsson, 2021). In addition, although social support is considered as a protective source for the individuals coping with difficult situations, studies document that it can have negative effects when it is done directly and recognizably and perceived as "help" by the recipient of social support (Zee and Bolger, 2019). Future research could explore these variables with more complex models to better understand the differences or similarities between visible vs invisible social support on the relationship between experienced or internalized stigma and the psychological well-being of DHH adults.

Lastly, our participants' moderate scores on experienced and internalized stigma might raise the question of whether this situation is related to other variables that were not investigated such as, group identification. Chapman and Dammeyer (2017) found that although feeling discriminated against explains psychological well-being, individuals who identify as deaf, hearing or bicultural had higher levels of psychological well-being compared to the participants who identify as neither deaf nor hearing. Investigation of such protective factors in future studies could be beneficial in terms of intervention and prevention studies in the field of application.

Suggestions for Clinical Practice

This study has emphasized the key role of internalized stigma in DHH individuals' mental health. Our findings demonstrated the need for identifying and treating self-stigma tendencies among DHH individuals when dealing with experiences related to prejudice, discrimination, labeling, stereotyping and negatively biased attitudes. Cognitive Behavioral Therapy (CBT; Roe et al., 2014) and other therapeutic modalities or techniques that aim to alleviate the negative effects of internalized stigma, such as focusing on training in self-compassion for internalized stigma (Edwards, 2022), may assist individuals in managing adverse effects of stigma on their psychological well-being.

DHH individuals might utilize a different language (i.e., TSL) or have inadequate literacy to comprehend written therapy materials (O'Hearn & Pollard, 2008). Therapies that rely on written materials or processes and include frequent use of metaphors or acquire familiarity with culture-related issues might be challenging for this unique population (O'Hearn & Pollard, 2008). Although there are few studies focused on the adaptation of therapy modalities for the utilization with DHH individuals (e.g., dialectical behavior therapy, solution-focused therapy, constructionist therapy, and CBT), many of the modalities and methods remain unavailable to DHH clients due to extensive reliance on written materials, and other culturally specific qualities (Estrada & Beyebach, 2007; Fellinger et al., 2012; Munro et al., 2008; O'Hearn & Pollard, 2008). Additionally, clinicians need to be aware that DHH individuals might lack the proper understanding of or motivation to access and employ mental health care services (Glickman, 2008). In terms of being culturally prepared, they might not have the prior knowledge to work with mental health professionals as hearing individuals do, which might also be an issue for mental health professionals in their clinical practice (Glickman, 2008). Therefore, clinicians should be aware of these difficulties that might be faced in therapeutic environments, improve their familiarity with DHH culture, and modify the methods according to the unique needs of this specific population.

Lastly, as the findings of the current study and previous studies demonstrated, although a variety of mental health problems are prevalent among DHH individuals (Fellinger et al., 2005; Bridgman et al., 2000; Kvam et al., 2007; Kushalnagar et al., 2019), their access to health services, especially mental health services is quite limited (Mousley & Chaudoir, 2018; Fellinger et al., 2012). Due to communication barriers, DHH individuals are mostly unable to comprehend the information related to the diagnosis and treatment (Sheppard, 2014). By offering specialized services with clinical practitioners educated to directly communicate with DHH individuals or with sign-language interpreters, it is possible to increase and improve their access to health and mental health care services (Fellinger et al., 2012).

Conclusion

In conclusion, the findings of this study emphasized the importance of internalized stigma for DHH adults' mental health, the partial importance of social support for depression, and the importance of internalized and experienced stigma for anxiety. This study is among the first known research that provide quantitative evaluation and empirical support regarding the relationship between stigma, perceived social support and mental health among Turkish DHH adults. Our findings added to the existing literature on stigma and addressed much-needed research on DHH individuals and their mental health.

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APPENDIX A: Version Selection

1) Anketi aşağıdaki versiyonların hangisinde görüntülemek istiyorsunuz?

( ) Türkçe

( ) Sadeleştirilmiş Türkçe

( ) Türk İşaret Dili videolu versiyon (Türkçe alt yazılı ve ses destekli)

APPENDIX B: Participation Criteria

1) Sağır veya işitme engelli misiniz?

   ( ) Evet

   ( ) Hayır

2) 18-65 yaş aralığında mısınız?

   ( ) Evet

   ( ) Hayır

3) İletişim kurmak için işaret dili, işitme cihazı, koklear implant ve dudak okuma gibi yöntemlerden/araçlardan birini veya birden fazlasını kullanıyor musunuz?

   ( ) Evet

   ( ) Hayır

APPENDIX C: Demographics Form

1) Kaç yaşındasınız? Lütfen aşağıya yazınız.

____

2) Cinsiyetiniz nedir?
   ( ) Kadın
   ( ) Erkek
   ( ) Diğer

3) Sağırlık veya işitme engellilik durumunuz:
   ( ) Doğuştan itibaren var
   ( ) Sonradan gelişti

4) Sağırlık/işitme engellilik durumunuz kaç yaşında gelişti? Lütfen aşağıya yazınız.

____

5) İlişki durumunuzu aşağıdaki seçeneklerden hangisi tanımlar?
   ( ) Bekarım ve ilişkim yok
   ( ) Bekarım ve ilişkim var
   ( ) Evliyim
   ( ) Boşandım
   ( ) Dulum (eşim vefat etti)

6) Devam eden bir ilişkiniz var mı?
   ( ) Evet
   ( ) Hayır

7) Eğitim durumunuz nedir? (Lütfen en son mezun olduğunuz dereceyi işaretleyiniz.)

( ) Eğitim almadım, yalnızca okuma yazma biliyorum

( ) İlkokul

( ) Ortaokul

( ) Lise

( ) Üniversite

( ) Yüksek lisans

( ) Doktora

8) Çalışma durumunuzu tanımlayan seçeneği işaretleyiniz.

( ) Öğrenciyim

( ) Yarı zamanlı (part time) çalışıyorum

( ) Tam zamanlı çalışıyorum

( ) Çalışmıyorum

( ) Emekliyim

9) İletişim kurmak için aşağıdaki seçeneklerin hangisinden/hangilerinden faydalanıyorsunuz?

( ) İşaret dili

( ) Konuşma (sesli)

( ) İşitme cihazı

( ) Koklear implant

( ) Dudak okuma

10) Çevrenizde sizden başka sağır/işitme engelli var mı?

( ) Evet

( ) Hayır

APPENDIX D: Access to Healthcare Services Form

Bu bölümde, sağlık hizmetlerine erişiminiz konusunda sorular sorulacaktır. Lütfen herhangi bir nedenle sağlık kurumuna gittiğinizde yaşadıklarınızı düşünerek sorulara cevap veriniz.

1) Sağlık sigortanız var mı?

   ( ) Evet

   ( ) Hayır

2) Oturduğunuz bölgede sağlık hizmeti alabileceğiniz bir kurum var mı?

   ( ) Evet

   ( ) Hayır

3) Herhangi bir sağlık probleminiz olduğunda, nereye gideceğinizi ve hangi doktorlarla görüşebileceğinizi biliyor musunuz?

   ( ) Evet

   ( ) Hayır

4) Hastaneye gittiğinizde sağlık çalışanlarının tedavi seçenekleri konusunda sizi yeterince bilgilendirdiğini düşünüyor musunuz?

   ( ) Evet

   ( ) Hayır

5) Sağır ve işitme engellilerin, mevcut sağlık hizmetlerine ve sağlığa yönelik bilgilere erişim imkanlarını nasıl değerlendirirsiniz?

   ( ) Yeterli

   ( ) Yetersiz

6) Herhangi bir nedenle hastanaye gittiğinizde işaret dili desteği alabildiniz mi veya talep ederseniz alabileceğinizi düşünüyor musunuz?

   ( ) Evet

( ) Hayır

7) Akıl sağlığı veya akıl hastalığı sorunları hakkında herhangi bir konuda bilgilendirildiniz mi? (Örneğin: depresyon, kaygı bozuklukları, terapi seçenekleri…)

( ) Evet

( ) Hayır

8) Hayatınızda hiç herhangi bir profesyonelle 30 dakika veya daha uzun süren bir psikolojik danışma veya terapi seansınız oldu mu?

( ) Evet

( ) Hayır

9) Aldığınız hizmetten memnun kaldınız mı?

( ) Evet

( ) Hayır

10) Fiziksel sağlık veya fiziksel hastalıklar hakkında herhangi bir konuda bilgilendirildiniz mi? (Örneğin: diyabet, kanser, ilaçlar…)

( ) Evet

( ) Hayır

11) Sağır veya işitme engelli olduğunuz için sağlık hizmeti alırken kendinizi damgalanmış veya ayrımcılığa uğramış hissettiğiniz oldu mu?

( ) Evet

( ) Hayır

12) Aşağıdaki konulardan hangilerine bağlı bir damgalanma veya ayrımcılık deneyimlediniz? Geçerli olanların hepsini işaretleyin.

( ) Sağlık personelinin tutumu

( ) Haklarımın reddi

( ) Yaşadığım yerde sağlık kurumu olmaması

( ) Bana tedavi sağlamayı veya sağlık hizmeti vermeyi reddetme

( ) Diğer
Belirtiniz: ……………………

13) Sağlık hizmeti aldığınız zamanlarda, bu hizmetleri karşılamak sizin için maddi olarak zorlayıcı oluyor mu?

( ) Evet

( ) Hayır

14) Son 12 ay içinde, ekonomik güçlükler sebebi ile sağlık kontrollerinizi ertelediğiniz oldu mu?

( ) Evet

( ) Hayır

APPENDIX E: Experienced Stigma Scale

Deneyimlenen Damgalanma Ölçeği

Geçmişte aşağıdakilerden hangisi **sağır/işitme engelli olmanız nedeniyle gerçekten başınıza geldi?** İfadeleri okuduktan sonra, uygun olan seçeneği işaretleyiniz.

1) Bir işe alınmamak
   ( ) Evet, bu gerçekten başıma geldi
   ( ) Hayır, bu hiç başıma gelmedi

2) İş terfisi verilmemesi
   ( ) Evet, bu gerçekten başıma geldi
   ( ) Hayır, bu hiç başıma gelmedi

3) Bir işten kovulmak
   ( ) Evet, bu gerçekten başıma geldi
   ( ) Hayır, bu hiç başıma gelmedi

4) Bir öğretmen tarafından, eğitiminize devam etmeniz konusunda cesaretinizin kırılması
   ( ) Evet, bu gerçekten başıma geldi
   ( ) Hayır, bu hiç başıma gelmedi

5) Eğitiminize devam etmeniz için burs almayı istemeniz, fakat reddedilmeniz
   ( ) Evet, bu gerçekten başıma geldi
   ( ) Hayır, bu hiç başıma gelmedi

6) Ev kiralamanızın veya satın almanızın engellenmesi

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

7) Banka kredisi talebinizin reddedilmesi

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

8) Komşular tarafından yaşadığınız mahalleden gitmeye zorlanmak

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

9) Size tıbbi bakım verilmesinin reddedilmesi (veya daha aşağı düzeyde verilmesi)

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

10) Size hizmet vermenin reddedilmesi (veya daha aşağı düzeyde verilmesi) (Örneğin su tesisatçısı, tamirci vb. tarafından)

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

11) Polis tarafından güçlük çıkarılması

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

12) İnsanların, sizin onlar kadar iyi olmadığınızı düşünüyormuş gibi davranması

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

13) İnsanların, sizin zeki olmadığınızı düşünüyormuş gibi davranması

( ) Evet, bu gerçekten başıma geldi
( ) Hayır, bu hiç başıma gelmedi

14) Size, diğer insanlara davranıldığından daha az saygıyla davranılması
( ) Evet, bu gerçekten başıma geldi
( ) Hayır, bu hiç başıma gelmedi

15) Size, diğer insanlara davranıldığından daha az kibar davranılması
( ) Evet, bu gerçekten başıma geldi
( ) Hayır, bu hiç başıma gelmedi

16) İnsanların sizden korkuyorlarmış gibi davranması
( ) Evet, bu gerçekten başıma geldi
( ) Hayır, bu hiç başıma gelmedi

17) Restorantlarda veya mağazalarda diğer insanlardan daha kötü hizmet almak
( ) Evet, bu gerçekten başıma geldi
( ) Hayır, bu hiç başıma gelmedi

18) İnsanların size güvenilmezmiş gibi davranması
( ) Evet, bu gerçekten başıma geldi
( ) Hayır, bu hiç başıma gelmedi

19) İnsanların size takma isimlerle seslenmesi veya hakaret etmesi
( ) Evet, bu gerçekten başıma geldi
( ) Hayır, bu hiç başıma gelmedi

20) İnsanların sizi tehdit etmesi veya taciz etmesi
( ) Evet, bu gerçekten başıma geldi
( ) Hayır, bu hiç başıma gelmedi

21) Arkadaşlarınızın sizinle vakit geçirmeyi bırakması

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

22) Arkadaşlarınızın sizden kaçınması

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

23) İnsanların, sizi daha yakından tanımak istememeleri

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

24) İnsanların, sizinle flört randevusuna çıkmak istememeleri

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

25) İnsanların, sizinle yakın bir ilişki içine girmek istememeleri

( ) Evet, bu gerçekten başıma geldi

( ) Hayır, bu hiç başıma gelmedi

APPENDIX F: Internalized Stigma of Mental Illness Scale (ISMI; Adapted Version)

Ruhsal Hastalıkların İçselleştirilmiş Damgalanması Ölçeği (RHİDÖ; Adapte Edilmiş Versiyonu)

Bu testte sık sık geçen "sağır/işitme engelli" terimi, en geniş anlamda kullanılmıştır. Her bir cümleyi dikkatle okuduktan sonra, okuduğunuz cümleye ne ölçüde katıldığınızı ya da katılmadığınızı belirtiniz. Her cümle için seçeneklerden sadece bir tanesini işaretleyiniz.

1) Sağır/işitme engelli olduğum için kendimi bu dünyada bir yabancı gibi hissediyorum.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

2) Sağır/işitme engelli olan kişiler saldırgan olmaya eğilimlidirler.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

3) Sağır/işitme engelli olduğum için insanlar bana farklı davranıyorlar.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim
( ) Aynı fikirdeyim
( ) Kesinlikle aynı fikirdeyim

4) Reddedilmemek için, sağır/işitme engelli olmayan kişilere yaklaşmaktan kaçınıyorum.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim
( ) Aynı fikirdeyim
( ) Kesinlikle aynı fikirdeyim

5) Sağır/işitme engelli olmaktan utanıyorum.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim
( ) Aynı fikirdeyim
( ) Kesinlikle aynı fikirdeyim

6) Sağır/işitme engelli olan kişiler evlenmemelidir.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim
( ) Aynı fikirdeyim
( ) Kesinlikle aynı fikirdeyim

7) Sağır/işitme engelli olan kişiler topluma önemli katkılarda bulunurlar.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

8) Kendimi sağır/işitme engelli olmayan kişilerden daha aşağı hissediyorum.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

9) Sağır/işitme engelli olmam benim “garip” görünmeme ya da davranmama neden olabileceğinden dolayı pek sosyal biri değilim.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

10) Sağır/işitme engelli olan kişiler iyi ve doyum verici bir hayat yaşayamazlar.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

11) İnsanları sağır/işitme engelli olmamla ilgili problemlerle sıkmak istemediğimden dolayı, kendimle ilgili fazla konuşmam.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

12) Halk arasındaki sağırlık/işitme engellilik ile ilgili olumsuz düşünceler, benim “normal” yaşamın dışında kalmama neden oluyor.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

13) Sağır/işitme engelli olmayan kişilerle birlikteyken, kendimi sanki o ortama ait değilmiş ve yetersizmişim gibi hissediyorum.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

14) Sağırlığı/işitme engelliliği açıkça anlaşılan biriyle toplum içinde birlikte görülmek beni rahatsız etmez.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

15) Sırf sağır/işitme engelli olduğum için insanlar bana sık sık ne yapmam gerektiğini söyleyip, sanki çocukmuşum gibi davranırlar.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

16) Sağır/işitme engelli olduğum için kendimden memnun değilim.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

17) Sağır/işitme engelli olmam hayatımı berbat etti.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

18) İnsanlar görünüşümden sağır/işitme engelli olduğumu anlayabilirler.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

19) Sağır/işitme engelli olduğum için benimle ilgili çoğu kararı başkalarının vermesine ihtiyaç duyarım.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

20) Ailemi ve arkadaşlarımı utandırmamak için sosyal ortamlardan uzak dururum.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

21) Sağır/işitme engelli olmayanların beni anlamaları mümkün değildir.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim
( ) Aynı fikirdeyim
( ) Kesinlikle aynı fikirdeyim

22) Sırf sağır/işitme engelli olduğum için insanlar beni göz ardı eder ya da pek ciddiye almazlar.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim
( ) Aynı fikirdeyim
( ) Kesinlikle aynı fikirdeyim

23) Sağır/işitme engelli olduğum için topluma hiçbir katkım olamaz.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim
( ) Aynı fikirdeyim
( ) Kesinlikle aynı fikirdeyim

24) Sağırlıkla/işitme engellilikle yaşamak beni mücadeleci bir insan yaptı.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim
( ) Aynı fikirdeyim
( ) Kesinlikle aynı fikirdeyim

25) Sağır/işitme engelli olduğum için kimse bana yakınlaşmak istemez.

( ) Kesinlikle aynı fikirde değilim
( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

26) Genel olarak, hayatımı istediğim şekilde yaşayabiliyorum.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

27) Sağır/işitme engelli olmama rağmen, iyi ve dolu dolu bir hayatım var.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

28) İnsanlar sağır/işitme engelli olduğum için hayatta fazla başarılı olamayacağımı düşünüyorlar.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

29) Sağır/işitme engellilerle ilgili olumsuz yaygın inanışlar benim durumum dikkate alındığında hiç de yanlış sayılmaz.

( ) Kesinlikle aynı fikirde değilim

( ) Aynı fikirde değilim

( ) Aynı fikirdeyim

( ) Kesinlikle aynı fikirdeyim

APPENDIX G: Center for Epidemiological Studies Depression Scale (CESD)

Aşağıda duygu ve davranışlarınızla ilgili ifadeler yer almaktadır. Lütfen **geçen hafta boyunca** aşağıdakileri ne sıklıkla hissettiğinizi veya yaşadığınızı belirtin.

1) Genellikle canımı sıkmayan şeyler canımı sıktı.
   ( ) Hiçbir zaman – nadiren (1 günden daha az)
   ( ) Birazcık – Birkaç Kez (1-2 gün)
   ( ) Arada sırada – Bazen (3-4 gün)
   ( ) Çokça – Çoğu zaman (5-7 gün)

2) Açlık hissetmedim, iştahım yerinde değildi.
   ( ) Hiçbir zaman – nadiren (1 günden daha az)
   ( ) Birazcık – Birkaç Kez (1-2 gün)
   ( ) Arada sırada – Bazen (3-4 gün)
   ( ) Çokça – Çoğu zaman (5-7 gün)

3) Arkadaşlarım veya ailemin yardımına rağmen kötü ruh halinden kurtulamadım.
( ) Hiçbir zaman – nadiren (1 günden daha az)
( ) Birazcık – Birkaç Kez (1-2 gün)
( ) Arada sırada – Bazen (3-4 gün)
( ) Çokça – Çoğu zaman (5-7 gün)

4) Ruh halimin diğer insanlar kadar iyi olduğunu hissettim.
( ) Hiçbir zaman – nadiren (1 günden daha az)
( ) Birazcık – Birkaç Kez (1-2 gün)
( ) Arada sırada – Bazen (3-4 gün)
( ) Çokça – Çoğu zaman (5-7 gün)

5) Yaptığım işe odaklanmakta zorlandım.
( ) Hiçbir zaman – nadiren (1 günden daha az)
( ) Birazcık – Birkaç Kez (1-2 gün)
( ) Arada sırada – Bazen (3-4 gün)
( ) Çokça – Çoğu zaman (5-7 gün)

6) Kendimi depresyonda hissettim.
( ) Hiçbir zaman – nadiren (1 günden daha az)
( ) Birazcık – Birkaç Kez (1-2 gün)
( ) Arada sırada – Bazen (3-4 gün)
( ) Çokça – Çoğu zaman (5-7 gün)

7) Her şeye çaba harcamam gerektiğini hissettim.
( ) Hiçbir zaman – nadiren (1 günden daha az)
( ) Birazcık – Birkaç Kez (1-2 gün)
( ) Arada sırada – Bazen (3-4 gün)
( ) Çokça – Çoğu zaman (5-7 gün)

8) Gelecek için umutlu hissettim.

( ) Hiçbir zaman – nadiren (1 günden daha az)

( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

9) Hayatımın bir başarısızlık olduğunu düşündüm.

( ) Hiçbir zaman – nadiren (1 günden daha az)

( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

10) Korktuğumu hissettim.

( ) Hiçbir zaman – nadiren (1 günden daha az)

( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

11) Huzursuz uyudum.

( ) Hiçbir zaman – nadiren (1 günden daha az)

( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

12) Mutluydum.

( ) Hiçbir zaman – nadiren (1 günden daha az)

( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

13) Her zamankinden az konuştum.
   ( ) Hiçbir zaman – nadiren (1 günden daha az)
   ( ) Birazcık – Birkaç Kez (1-2 gün)
   ( ) Arada sırada – Bazen (3-4 gün)
   ( ) Çokça – Çoğu zaman (5-7 gün)

14) Kendimi yalnız hissettim.
   ( ) Hiçbir zaman – nadiren (1 günden daha az)
   ( ) Birazcık – Birkaç Kez (1-2 gün)
   ( ) Arada sırada – Bazen (3-4 gün)
   ( ) Çokça – Çoğu zaman (5-7 gün)

15) İnsanlar arkadaş canlısı değildi.
   ( ) Hiçbir zaman – nadiren (1 günden daha az)
   ( ) Birazcık – Birkaç Kez (1-2 gün)
   ( ) Arada sırada – Bazen (3-4 gün)
   ( ) Çokça – Çoğu zaman (5-7 gün)

16) Yaşamdan zevk aldım.
   ( ) Hiçbir zaman – nadiren (1 günden daha az)
   ( ) Birazcık – Birkaç Kez (1-2 gün)
   ( ) Arada sırada – Bazen (3-4 gün)
   ( ) Çokça – Çoğu zaman (5-7 gün)

17) Ağlama nöbetleri geçirdim.
   ( ) Hiçbir zaman – nadiren (1 günden daha az)
   ( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

18) Kendimi üzgün hissettim.

( ) Hiçbir zaman – nadiren (1 günden daha az)

( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

19) İnsanların benden hoşlanmadığını hissettim.

( ) Hiçbir zaman – nadiren (1 günden daha az)

( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

20) İşler yolunda gitmedi.

( ) Hiçbir zaman – nadiren (1 günden daha az)

( ) Birazcık – Birkaç Kez (1-2 gün)

( ) Arada sırada – Bazen (3-4 gün)

( ) Çokça – Çoğu zaman (5-7 gün)

APPENDIX H: Brief Symptom Inventory (BSE) – Anxiety Subscale

Kısa Semptom Envanteri – Kaygı Alt Ölçeği

Aşağıda insanların bazen yaşadıkları belirtilerin ve yakınmaların bir listesi verilmiştir. Listedeki her maddeyi lütfen dikkatle okuyun ve SİZDE BUGÜN DAHİL, SON BİR HAFTADIR NE KADAR VAROLDUĞUNU aşağıdaki seçeneklerden işaretleyin.

Hiç yok (1), Biraz var (2), Orta derecede var (3), Epey var (4), Çok fazla var (5)

1) Hiç bir nedeni olmayan ani korkular
    - ( ) Hiç yok
    - ( ) Biraz var
    - ( ) Orta dereced e var
    - ( ) Epey var
    - ( ) Çok fazla var

2) Kontrol edemediğiniz duygu patlamaları
    - ( ) Hiç yok

( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

3) Otobüs,tren,metro gibi umumi vasıtalarla seyahatlerden korkmak
( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

4) Sizi korkuttuğu için bazı eşya, yer ya da etkinliklerden uzak kalmaya çalışmak
( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

5) Kafanızın bomboş kalması
( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

6) Konsantrasyonda (dikkati bir şey üzerinde toplama) güçlük/zorlanmak
( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

7) Kendini gergin ve tedirgin hissetmek

( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

8) Diğerlerinin yanındayken yanlış bir şeyler yapmamaya çalışmak
( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

9) Kalabalıklarda rahatsızlık duymak
( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

10) Dehşet ve panik nöbetleri
( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

11) Sık sık tartışmaya girmek
( ) Hiç yok
( ) Biraz var
( ) Orta derecede var
( ) Epey var
( ) Çok fazla var

12) Yalnız bırakıldığında / kaldığında yalnızlık hissetmek

( ) Hiç yok

( ) Biraz var

( ) Orta derecede var

( ) Epey var

( ) Çok fazla var

13) Yerinde duramayacak kadar tedirgin hissetmek

( ) Hiç yok

( ) Biraz var

( ) Orta derecede var

( ) Epey var

( ) Çok fazla var

APPENDIX I: Multidimensional Scale of Perceived Social Support

Aşağıda 12 cümle ve her bir cümle altında da cevaplarınızı işaretlemeniz için 1'den 7'ye kadar rakamlar verilmiştir. Her cümlede söylenenin sizin için ne kadar çok doğru olduğunu veya olmadığını belirtmek için o cümle altındaki rakamlardan yalnız bir tanesini işaretleyiniz. Bu şekilde 12 cümlenin her birine bir işaret koyarak cevaplarınızı veriniz. Lütfen hiçbir cümleyi cevapsız bırakmayınız. Sizce doğruya en yakın olan rakamı işaretleyiniz.

1) Ailem ve arkadaşlarım dışında ihtiyacım olduğunda yanımda olan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.

(1) Kesinlikle hayır

(2)

(3)

(4)

(5)

(6)

(7) Kesinlikle evet

2) Ailem ve arkadaşlarım dışında sevinç ve kederlerimi paylaşabileceğim bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.

(1) Kesinlikle hayır

(2)

(3)

(4)

(5)

(6)

(7) Kesinlikle evet

3) Ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana gerçekten yardımcı olmaya çalışır.

(1) Kesinlikle hayır

(2)

(3)

(4)

(5)

(6)

(7) Kesinlikle evet

4) İhtiyacım olan duygusal desteği ailemden (örneğin, annemden, babamdan, eşimden, çocuklarımdan, kardeşlerimden) alırım.

(1) Kesinlikle hayır

(2)

(3)

(4)

(5)

(6)

(7) Kesinlikle evet

5) Ailem ve arkadaşlarım dışında beni gerçekten rahatlatan bir insan (örneğin, flört, nişanlı, sözlü, akraba, komşu, doktor) var.

(1) Kesinlikle hayır
(2)
(3)
(4)
(5)
(6)
(7) Kesinlikle evet

6) Arkadaşlarım bana gerçekten yardımcı olmaya çalışırlar.
    (1) Kesinlikle hayır
    (2)
    (3)
    (4)
    (5)
    (6)
    (7) Kesinlikle evet

7) İşler kötü gittiğinde arkadaşlarıma güvenebilirim.
    (1) Kesinlikle hayır
    (2)
    (3)
    (4)
    (5)
    (6)
    (7) Kesinlikle evet

8) Sorunlarımı ailemle (örneğin, annemle, babamla, eşimle, çocuklarımla, kardeşlerimle) konuşabilirim.
    (1) Kesinlikle hayır
    (2)
    (3)
    (4)
    (5)
    (6)

(7) Kesinlikle evet

9) Sevinç ve kederlerimi paylaşabileceğim arkadaşlarım var.
   (1) Kesinlikle hayır
   (2)
   (3)
   (4)
   (5)
   (6)
   (7) Kesinlikle evet

10) Ailem ve arkadaşlarım dışında duygularıma önem veren bir insan (örneğin, flört, akraba, komşu, doktor) var.
   (1) Kesinlikle hayır
   (2)
   (3)
   (4)
   (5)
   (6)
   (7) Kesinlikle evet

11) Kararlarımı vermede ailem (örneğin, annem, babam, eşim, çocuklarım, kardeşlerim) bana yardımcı olmaya isteklidir.
   (1) Kesinlikle hayır
   (2)
   (3)
   (4)
   (5)
   (6)
   (7) Kesinlikle evet

12) Sorunlarımı arkadaşlarımla konuşabilirim.
   (1) Kesinlikle hayır

(2)
(3)
(4)
(5)
(6)
(7) Kesinlikle evet

APPENDIX J:

Bu çalışmaya katılan kişiler arasında yapılacak çekilişle 50 kişiye verilecek olan 100 TL değerinde market çekini iletebilmemiz için telefon ve adres bilgilerinizi yazar mısınız? Bilgileriniz, market çekleri iletildikten sonra silinecek ve farklı hiçbir amaç için kullanılmayacaktır.

Telefon:
Adres:

Araştırmamıza katıldığınız için teşekkür ederiz.