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The National Child
Traumatic Stress Network



Facts on Trauma and Deaf Children

**National Child Traumatic Stress Network
Adapted Trauma Treatment Standards Work Group
Subgroup on the Deaf and Hard of Hearing**

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From the

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Facts on Trauma and Deaf Children

Definitions and Descriptions

General Definitions

The Deaf and hard-of-hearing community is very diverse. Its members vary widely as to the cause and degree of hearing loss and its age of onset. They come from a variety of educational backgrounds and utilize different communication methods. They also vary as to how they feel about their hearing loss. How people identify themselves in terms of their hearing loss is a very personal matter and may reflect identification with the Deaf community or merely how their hearing loss affects their ability to communicate. They can either be deaf, Deaf, hard of hearing, or have acquired deafness. (More information is available at www.nad.org.)

- *Acquired deafness* refers to hearing loss that begins in late childhood, adolescence, or adulthood. Typically, people with acquired deafness communicate with the use of assistive technology, including hearing aids and real-time captioning.
- *Children of deaf adults (CODAS)* are hearing children born to deaf parents and, though functionally hearing, usually identify culturally with the Deaf community.
- *Deaf* with a capital *D* is used when referring to a particular group of people who share a common language (American Sign Language in the United States), heritage, social affiliation, educational background, experience of oppression, and culture. Persons who are deaf from an early age share a bond created by their experiences as individuals who know and interact with the world primarily through vision and as members of a group that is frequently misunderstood and oppressed (Meadow, 1972). These common experiences have been identified as Deaf culture (Padden & Humphries, 1988). An understanding of Deaf culture recognizes that members of the Deaf community often emphasize the role or presence of vision in their lives rather than the lack or absence of hearing. Hearing people may emphasize the sense that deaf people lack by labeling them as handicapped, disabled, or impaired. By contrast, deaf people emphasize and are proud of their capabilities and positive qualities as visual human beings (Meadow-Orlans & Erting, 2000).
- *Deafness* generally refers to the inability to hear speech without a hearing aid.
- *Hard of hearing* refers to a hearing loss, whether permanent or fluctuating, that may adversely affect a child's educational performance but which allows the child access to some degree of communication with or without amplification. (Easterbooks, 1997; "Individuals with Disabilities Education Act (IDEA)," 1990). Hard-of-hearing individuals generally have a mild to moderate hearing loss, and they may feel reasonably comfortable in using their hearing for communication in some settings.

- *Hearing impaired* is a stigmatizing, generic term describing reduced hearing acuity, which pathologizes hearing loss. The term is much resented by many deaf and hard-of-hearing people, because it implies a deficiency that is not culturally affirming.
- *Hearing loss* is a generic term describing reduced hearing acuity irrespective of severity.

Descriptive Statistics

Two million Americans are profoundly deaf (7.5 per 1,000). During the 2001–02 school year, 42,361 students were identified as having a hearing loss.

- Approximately 50% rely on communication methods other than spoken English.
- Approximately 40% are identified as having additional conditions.
- 92.6% of their mothers are hearing.
- 86.4% of their fathers are hearing.
- 12.7% of them have a deaf or hard-of-hearing sibling.
- 71.7% of their family members do not sign regularly.
- The racial/ethnic backgrounds of these children nationwide are:
 - 52.6% white
 - 15.9% black/African American
 - 22.8% Hispanic/Latino
 - 0.8% American Indian
 - 4.2% Asian/Pacific Islander
 - 1.7% other
 - 2.0% multi-ethnic background

Source: Gallaudet Research Institute. (January, 2003). Regional and National Summary Report of Data from the 2001-2002 Annual Survey of Deaf and Hard of Hearing Children & Youth. Washington, DC: GRI, Gallaudet University.

Statistical Information Regarding the Incidence of Trauma for this Population

- Deaf children are more vulnerable to neglect, emotional, physical, and sexual abuse than children in the general population. (Sullivan, Vernon, & Scanlan, 1987)
- 50% of deaf girls have been sexually abused as compared to 25% of hearing girls. (Sullivan et al., 1987)
- 54% of Deaf boys have been sexually abused as compared to 10% of hearing boys. (Sullivan et al., 1987)

- Individuals with disabilities are over four times as likely to be victims of crime as the non-disabled population. (Sobsey, 1996)
- Children with communication disorders are more likely to be physically and sexually abused than children without these disorders. (Sullivan & Knutson, 1998)
- Maltreatment of children with disabilities is 1.5-to-10 times higher than of children without disabilities (Baladerian, 1991; Sosey & Doe, 1991; Sobsey & Vamhagen, 1989; Sullivan & Knutson, 2000).
- Immediate family members perpetrate the majority of neglect, physical abuse, and emotional abuse. Extrafamilial perpetrators account for the majority of sexual abuse. (Sullivan & Knutson, 2000)
- Sexual abuse incidents are almost four times as common in institutional settings as in the community. (Blatt & Brown, 1986)

Deaf children are at increased risk for traumatization. The ongoing communication barriers that often exist within the family and in other key settings can cause

- increased frustration by adults and children;
- difficulty in teaching deaf children about safety;
- a paucity of useful educational resources such as safety curricula and sexual abuse/kidnapping prevention programs;
- assumptions by perpetrators that deaf children are less able to disclose information about abuse;
- difficulties in teaching/learning skill building and socialization;
- decreased opportunities for incidental learning;
- decreased opportunities for trusting, open relationships;
- less disclosure of abuse to caregivers; and
- less understanding of the parameters of healthy/safe touching.

Deaf people may also experience

- additional communication barriers, misunderstanding, and fear during the disclosure or investigation of a traumatic event, and
- exacerbated feelings of isolation and difference after a traumatic event.

In addition, the effect of trauma is increased for the deaf due to

- possible difficulties in social understanding;
- misattribution of the causes and effects of their own and others' behaviors;
- an impoverished vocabulary of emotional language;
- a higher incidence of sensory, behavioral, emotional, or cognitive difficulties that sometimes accompany the etiological factor that caused the deafness (Hindley & Kroll, 1998); and
- a paucity of trained professionals who sign and are knowledgeable about deafness to help them in processing traumatic incidents

Suggestions for Mainstream Clinicians on Modifying Treatment to Meet the Needs of this Population

Preparation for therapy

- Find a certified interpreter that can commit to working with you and the deaf client.
 - Only 6 to 30% of speech can be read on the lips.
 - "Lipreading, even under the best circumstances, is challenging. It requires close attention, concentration, memory, and an ability to guess at a whole from a fragment. . . . If your patient is experiencing acute anxiety, agitation, or other mental problems, his/her lipreading ability will be reduced." (UCSF Center on Deafness at www.uccd.org)
 - Writing back and forth is not a reliable or comfortable way for anyone to express him/herself.
 - Reading skills vary with the average grade equivalent for a deaf adult falling between a fourth and sixth grade level.
 - Ethical guidelines for mental health treatment state that therapy must be offered in the client's native language.
- Get details about a client's history of hearing loss and social emotional development.
- Assess history of language use and ability to communicate in multiple settings.
- Ask about educational background and school settings.
- Find out about the availability of culturally relevant supports.
- Be aware of the oppression, stigmatization, and isolation that deaf people often face.
- Consult with specialized providers about bringing a culturally affirming view of deafness into your work.
- Find out about the family's past experiences with therapy and interpreters.

Working effectively with an interpreter

- Prepare the interpreter for traumatic content before the sessions in order to minimize his/her emotionality.
- Debrief with the interpreter after each session.
- Arrange physical placement to maximize your direct eye contact with client.
- Look and speak directly to the deaf individual, not the interpreter.
- Work with the interpreter to repeat or rephrase as necessary to ensure the client's understanding. Remember that the interpreter has an ethical obligation to interpret all that is said in the room.
- Be aware that the interpreter's own history could affect his/her ability to interpret accurately and/or that personal issues could lead to a violation of boundaries or a dual relationship between the client and interpreter.

Adapting individual child sessions

- Modify relaxation techniques to focus on visual and tactile aspects.
- A trauma narrative may need to be done with a more visual medium than writing.
- The therapist and interpreter together may need to teach the child and family appropriate signs and words for what has happened to them.
- The therapist may need to put more emphasis on increasing socialization skills and safety.

Adapting parent sessions

- Support the parent in communicating and emphasizing consistent rules and consequences.
- The therapist may need to focus longer on decreasing parental guilt and grief with parents of deaf children, as they sometimes are still struggling to understand their child's deafness.
- Support the parent in decreasing overprotectiveness, while helping to increase the deaf child's knowledge of self-protection.
- Encourage and facilitate the family's use of signing/deaf supports in the community.
- It may be important to spend significant time on the historical lack of communication and the cultural gap within the family

Adapting joint parent-child sessions

- Ensure that everyone in the family can follow the communication and can fully participate.
- Ensure that the child is using his/her preferred language even if parents prefer another.
- Work to increase family communication both in session and at home.

Important Policy and Research Issues

- In order to meet the needs of the higher numbers of traumatized children that exist within the Deaf community, systems of care need to find ways of facilitating access to quality mental health services.
- Although the ideal best practice for serving the Deaf community involves specialized service interventions that are staffed by sign-fluent and/or Deaf clinicians, the current reality in many communities is that these types of programs are often unavailable.
- Therefore, it will be essential to create a collaborative approach with the Deaf community and specialized providers to establish strategies for mainstream clinicians to provide effective treatment to deaf children and/or families experiencing traumatic stress.
- One such approach would involve creating a culturally appropriate adaptation of an evidence-based treatment such as Trauma-focused CBT, which would be provided by a mainstream clinician and interpreter, in consultation with a specialized (signing or Deaf) provider.
- Funding sources for such services would need to provide reimbursement for the work of clinicians, interpreters, and consultants.
- Efficacy and effectiveness research on such a model would be important.

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