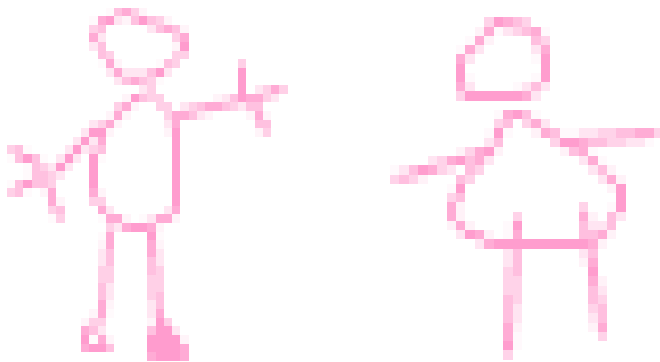**NCTSN** The National Child
Traumatic Stress Network

Addressing the Trauma Treatment Needs of Children Who Are Deaf or Hard of Hearing and the Hearing Children of Deaf Parents, revised

White Paper from the National Child Traumatic Stress Network
Adapted Trauma and Treatment Standards Work Group on
Children with Disabilities,
Subgroup on the Deaf and Hard of Hearing

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FAST FACTS ON TRAUMA AND DEAFNESS

Deaf children are more vulnerable than hearing children to neglect and emotional, physical, and sexual abuse (Patricia M. Sullivan, Vernon, & Scanlan, 1987).

50% percent of deaf girls have been sexually abused as compared to 25% of hearing girls (Patricia M. Sullivan, Vernon, & Scanlan, 1987).

54% of deaf boys have been sexually abused as compared to 10% of hearing boys (Patricia M. Sullivan, Vernon, & Scanlan, 1987).

28 million Americans have a hearing loss (National Institute on Deafness and Other Communication Disorders, 2005).

2 million Americans are considered profoundly deaf (National Institute on Deafness and Other Communication Disorders, 2005).

Severe hearing loss or deafness affects approximately 22 out of every 1,000 people in the United States. (Gallaudet Research Institute, 2005).

Approximately two to three out of every 1,000 children are born deaf or hard of hearing. (National Institute on Deafness and Other Communication Disorders, 2005).

90% of deaf children are born into families with hearing parents (Padden & Humphries, 1988).

There are approximately 250,000 to 500,000 American Sign Language users in the United States and Canada (Baker & Cokely, 1980).

Deaf children face tremendous difficulties learning to read, write, and communicate in the hearing world around them. The average deaf adult reads between fourth and sixth grade levels (Traxler, 2000).

Approximately 140 out of every 1,000 people in the United States report some type of hearing loss (Gallaudet Research Institute, 2005).

3.78% of children ages 8 to 17 have some type of hearing loss (Gallaudet Research Institute, 2005).

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I. BACKGROUND AND PURPOSE OF THIS PAPER

A. The Need

Deaf children experience trauma more frequently than their hearing peers. A seminal study on sexual abuse conducted in the mid-1980s found that deaf and hard of hearing children appear to be abused at rates significantly higher than hearing children, and that this abuse often happens in homes, buses or residential school settings (Patricia M. Sullivan, Vernon, & Scanlan, 1987). In subsequent research, deaf adults reported that as children they had experienced more frequent sexual abuse by a larger number of perpetrators (Hester, 2002) and overall childhood maltreatment rates at significantly higher levels (Embry, 2000) than their hearing counterparts. Another study indicates that the incidence of child maltreatment among deaf children is one-and-one-half times greater than it is among their hearing peers (Skinner, 1991).

Like others who have experienced abuse and other types of trauma, deaf and hard of hearing children often need trauma-specific mental health services to ensure their safety and to equip them with the skills they need to cope with their traumatic experiences. Ideally, treatment for these children involves specialized interventions provided by sign-fluent and/or deaf clinicians. However, most children do not have access to these specialized services:

The incidence of child maltreatment among deaf children is one-and-one-half times greater than it is among their hearing peers.

> There is a serious, nationwide shortage of mental health professionals who have the training and experience to work with consumers who are deaf. This shortage extends to qualified sign language interpreters, especially those with specialized training in mental health settings (Critchfield, 2002, 19).

Experts in the field estimate that only 2-15% of deaf persons in need of mental health services are able to obtain them (Heller, Langholtz, & Acree, 1986; Steinberg, 1991). Given the overall shortage of treatment resources for persons who are deaf, it is likely that trauma-specific mental health services for deaf and hard of hearing children are in even more limited supply.

B. Incidence of Hearing Loss in the General Population

The National Institute on Deafness and Other Communication Disorders estimates that about 28 million Americans have some type of hearing loss (National Institute on Deafness and Other Communication Disorders, 2005). Of these, two million are considered profoundly deaf (i.e., cannot hear or understand speech at a conversational level). About two to three out of every 1,000 children in the United States are born deaf or hard of hearing. Hearing loss affects approximately 17 in 1,000 children under age 18 (National Institute on Deafness and Other Communication Disorders, 2005). Each day, 33 babies are born with permanent hearing loss, making it the nation's most frequently occurring birth defect (White, 1997). About two to four of every 1,000 babies have permanent, congenital hearing loss, and in about one of these 1,000 births, this loss is judged to be profound.

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C. Purpose

The intent of this paper is to enhance opportunities for deaf and hard of hearing children who experience traumatic stress to receive treatment tailored to their individual, cultural, and communicative needs. Although it can be argued that the ideal best practice in treating deaf and hard of hearing children involves specialized service interventions delivered by deaf, hard of hearing, and/or sign-fluent clinicians, the reality is that providers with these skills are often unavailable.

The assumption behind this document is that not all deaf children and families needing trauma-specific mental health services will have access to specialized interventions. This means that mainstream clinicians—those who are nonsigning and who may be just developing their knowledge of Deaf cultural issues—are likely to be the primary providers of trauma-informed treatment for deaf children and their families. Therefore, we believe that it is essential to create collaborative efforts involving the Deaf community, specialized providers, and mainstream clinicians to facilitate the delivery of effective treatment to deaf children and/or families experiencing traumatic stress.

> *Mainstream clinicians—those who are nonsigning and who may be just developing their knowledge of Deaf cultural issues—are likely to be the primary providers of trauma-informed treatment for deaf children and their families.*

The guidelines in this paper are designed to begin this collaborative process. They offer information on ways nonspecialized mainstream providers can use consultative, culturally affirming strategies to adapt their existing trauma treatment models and enhance their competence in working with deaf clients. Best practice interventions within mental health place a clear value on client-centered and strengths-based services for all consumers (Rapp, 1993; Rapp & Wintersteen, 1989; Ronnau & Poertner, 1993; Dennis Saleebey, 1992; D. Saleebey, 2006; Walrath, Mandell, Holden, & Santiago, 2004). This document offers a tool for mainstream clinicians in maintaining that value in their treatment of deaf clients.

D. Approach

Our approach starts with and affirms the needs of a broad spectrum of persons with deafness and their families, including:

- culturally deaf persons,
- oral deaf persons,
- hard of hearing persons,
- persons with acquired deafness, and
- children of deaf adults.

This array of terms is one indication of the Deaf community's diversity. Clinicians must understand this diversity as it relates to deaf children and their families. In particular, they need to recognize the impact of two different ways of looking at deafness described by Baker and Cokely (1980)—the *medical-pathological model* and the *cultural model*. The medical-

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pathological model represents the common view of the dominant hearing community that deafness is a terrible tragedy and deaf people are to be pitied. The cultural model represents a more progressive view. It defines the Deaf community as a group of persons who share a common language and culture, social affiliation, and educational background, along with the experience of oppression. (For more information on this issue, please refer to Section II.A on page 10 and to Appendix B on page 55).

Because healthy beliefs about their deafness are so important to the psychological wellbeing of deaf children, wherever possible, this guide will emphasize the cultural model of deafness. In their work on counseling the culturally diverse, Sue and Sue (2003a) state that culturally competent mental health professionals must be aware of their own assumptions, values, and biases. Because a medical-pathologic view of deafness is pervasive in the dominant hearing culture, therapists working with deaf and hard of hearing children who have experienced trauma must understand the effects of the medical model on these children and their families:

> Culturally affirmative therapists strive to extend the relevancy and usefulness of psychotherapy to culturally different people. They think about social structure, culture, power, and oppression and seek to intervene in ways that (a) are relevant and sensible to the client, (b) empower the clients and the clients' community, (c) make connections between personal and collective experience, and (d) balance cultural and clinical considerations (N. S. Glickman, 1996, 7).

For treatment to be successful, practitioners working with families with deaf members must employ a multicultural therapeutic approach defined as "both a helping role and process that

- uses modalities and defines goals consistent with the life experiences and cultural values of clients,
- recognizes client identities to include individual, group, and universal dimensions,
- advocates the use of universal and culture-specific strategies and roles in the healing process, and
- balances the importance of individualism and collectivism in the assessment, diagnosis and treatment of client and client systems." (Sue & Sue, 2003b, 16)

The information and guidance contained in this guide is intended to equip clinicians to successfully deliver effective, culturally competent interventions for deaf and hard of hearing children and their families, particularly those who have experienced trauma.

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II. CHARACTERISTICS OF DEAF OR HARD OF HEARING CHILDREN AND THE HEARING CHILDREN OF DEAF PARENTS

A. Deafness–A Culture, Not a Pathology

1. Two Dominant Beliefs about Deafness

As identified in the previous section, there are two dominant perspectives on deafness. The first view is a cultural belief. The second is a medical or pathological belief. Our belief systems influence how we see ourselves and others. Deaf persons, family members and clinicians need to understand their own beliefs about deafness, because they influence deaf persons' identity development, self-esteem, and interactions with both hearing persons and others who are deaf.

The *cultural model* sees the deaf person as a part of a community with its own cultural norms and values. The Deaf community shares a common language and a common culture. Deaf people socialize with other Deaf people and feel they belong to the Deaf community. Deaf individuals learn American Sign Language to communicate. They are taught to believe that their future options are endless and there is nothing wrong with them. This value is best expressed by Dr. I. King Jordan, the first Deaf president of Gallaudet University, who said, "I can do anything, except hear."

The *medical belief* views deafness as a problem that needs to be fixed. Based on this belief, parents and other caregivers of children with a hearing loss often seek out support from medical professionals for solutions to their loved ones' deafness. Deaf individuals are fitted for hearing aids or undergo a cochlear implant in attempts to make them "hearing." They may attend thousands of hours of speech therapy to learn how to lip read and speak. They often view themselves as handicapped or disabled and therefore different from hearing people.

> The cultural model sees the deaf person as a part of a community with its own cultural norms and values. The medical belief views deafness as a problem that needs to be fixed.

2. Three Types of Cultural Identities

Deaf persons typically identify with one of three cultural identities: hearing, Deaf or bicultural. Figure One below illustrates the key cultural norms associated with each of these identities.

Children whose hearing loss is present at birth and those who lose their hearing at an early age, especially those with profound hearing loss, are more likely to identify with the Deaf community and Deaf culture. Their hearing loss affects their ability to communicate with persons who are hearing, so they often have difficulty identifying with the hearing culture. From the beginning, they are more comfortable with their Deaf peers, and thus are more likely to adopt this culture.

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Figure One: Cultural Norms for Three Types of Deaf Identities

Biculturalism

Knowledge or awareness of both medical & social models of deafness

Clear cultural pride as a Deaf person

Recognizes that both Deaf and hearing people have strengths and weaknesses

Comfortable in both hearing and deaf settings (though may have a preference for one)

Appreciation and respect for English and ASL as distinct languages

Depends on both visual and auditory cues to the extent possible

Ability to recognize and oppose hearing paternalism and other forms of Deaf oppression while maintaining alliances with hearing people who are trustworthy allies

A deep and personal sense of what it means to be Deaf

Hearing Cultural Norms

Expects deaf person to be hearing in attitude, behavior and communication style

Assumes hearing people are more healthy and capable than deaf people

Stereotypes deaf people as socially awkward, lonely, and less intelligent

Understands deafness solely as a medical condition/pathology

Seeks medicine/technology to help deaf people become full members of hearing society

Relies primarily on spoken language, residual hearing, speech training, and lipreading

Deaf person strives to overcome barriers imposed by deafness; feels successful only if fully functional

Deaf Cultural Norms

Deafness seen as a social or cultural difference

Socialization primarily with Deaf

Primarily uses American Sign Language for communication

American Sign Language seen as superior to English

Some anger directed at hearing people

In contrast, late-deafened adolescents or adults and hard of hearing adults typically tend to initially adopt a medical/pathological belief about their deafness. They have been a part of the hearing world, and their social and family environments are in this world. Because people who lose their hearing later in life identify themselves as hearing, they may have to reestablish their new identity as late-deafened. This can trigger a grieving process. Some eventually resolve these issues by adopting a middle course, becoming part of both the hearing world and the Deaf community.

Persons who are comfortable with both the hearing and the Deaf communities are said to be bicultural. They do not try to hide their deafness and are able to function effectively in both worlds. They are comfortable communicating with others who are deaf as well as with those who are hearing. Although many hearing children with deaf parents initially feel caught between the Deaf and hearing cultures, most eventually adopt a bicultural identity as well. More detailed information about identity development in deaf and hard of hearing children, as well as hearing children with deaf parents, is included in Section II.D on page 26.

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B. Operational Definitions

Deaf persons form unique identities that may reflect their relationship with the Deaf community or merely how their hearing loss affects their ability to communicate. They may define themselves as "deaf," "Deaf," "hard of hearing" or having "acquired deafness." In order for clinicians to understand and address these unique identity issues when working with deaf clients and their families, it is helpful to have an understanding of the following terms:

1. Deafness

This term generally refers to the inability to hear speech without a hearing aid. More detailed information about this term will be found throughout this document.

2. Hearing Loss

This is a generic term describing reduced hearing acuity irrespective of severity. The degree of deafness can range from mild to profound. Table Three on page 18 provides further information about the various degrees of hearing loss.

3. Deaf

This term is defined differently depending on whether it is capitalized or written in lowercase. When capitalized, the term *Deaf* is used to refer to a particular group of people who share a common language (American Sign Language in the United States), heritage 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 (K. P. Meadow, 1972).

> **When capitalized, the term *Deaf* is used to refer to a particular group of people who share a common language, heritage and culture. These common experiences have been identified as Deaf culture.**

These common experiences have been identified as Deaf culture (Padden & Humphries, 1988). Members of this Deaf community 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 are proud of their capabilities and positive qualities as primarily visually-oriented human beings (K. Meadow-Orlans & Erting, 2000).

In contrast, the lowercase noun or adjective *deaf* is generally used to refer to people with extensive hearing loss. Functionally, a deaf child primarily depends on vision for communication and is unable to understand words spoken at a conversational level. Rather than emphasizing the deaf person's strengths, the federal definition of the word *deaf* for children in educational settings is deficit-based. It states that *deaf* means a hearing loss that adversely affects educational performance and is so severe that the child or adult is impaired in processing linguistic information through hearing, with or without amplification (hearing aids) (Easterbooks, 1997).

4. Hard of Hearing

This term generally refers to persons who have mild to moderate hearing loss. Functionally, hard of hearing children depend primarily on speech and listening for communication, augmented with visual cues. They feel reasonably comfortable in using their hearing for communication in

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most settings. Like the definition of *deaf*, the federal definition of *hard of hearing* is deficit-based. It refers to a permanent or fluctuating hearing loss that adversely affects a child's educational performance but which allows the child access to some degree of communication with or without amplification (Easterbooks, 1997).

5. Hearing Impaired

This is a stigmatizing, generic term that describes reduced hearing acuity. It is not well received by nearly all Deaf and hard of hearing people because it implies that hearing loss is pathological. Clinicians who work with deaf and hard of hearing children and their families should avoid using this term because of its pejorative nature.

6. Congenital Hearing Loss

This is a hearing loss that is present at birth. It includes hereditary hearing loss as well as hearing loss due to factors that are present in utero (prenatal) or that occur at the time of birth. The most common causes of congenital hearing loss are described in Section II.C.3 on page 14.

7. Prelingual and Postlingual Deafness

These terms define those who have lost their hearing either before (prelingual) or after (postlingual) they have acquired any spoken language, e.g. English or Spanish.

8. Acquired Deafness or Late-Deafened

This refers to individuals whose hearing loss begins in late childhood, adolescence, or adulthood, after they have developed language skills. Typically, people with acquired deafness communicate using assistive technology, including hearing aids and captioning provided in real-time.

9. Hearing Children of Deaf Parents

Hearing children of deaf parents, sometimes referred to as children of deaf adults, or CODAS, are functionally hearing and typically use spoken language to communicate with hearing persons. However, these children usually identify culturally with the Deaf community and may be fluent in the sign language used in their home. Trauma-focused therapeutic interventions with hearing children of deaf parents must be adapted to address the linguistic and cultural needs of both the child and the parents.

C. Diversity within the Deaf Population

The Deaf and hard of hearing community is very diverse, and hearing loss has a different impact on each child. Individuals in the Deaf community differ greatly in the cause of their hearing loss, age of onset, educational background, and the methods they use to communicate. The effects of their hearing loss depend on many factors, including its severity, how they feel about the loss, when it was first identified, the availability of early intervention services, parental involvement and attitudes, and the history of amplification use. Clinicians should be prepared to consider these and other factors contributing to the diversity of deaf children when assessing the child and/or implementing a therapeutic intervention. They include the following:

1. Age of Onset of Hearing Loss

The age at which a child loses his/her hearing is strongly related to the way he/she learns to communicate. Children who have congenital hearing loss and those who experience hearing

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loss before they acquire spoken language (prelingually deafened) are almost always delayed in developing oral language skills. As a result, they are more likely to communicate visually. Postlingual deaf children are less likely to be delayed in oral language skills. They may combine spoken language with visual methods for communication. Adolescents and adults who become deaf after having experienced hearing as well as spoken speech and language development are referred to as late-deafened.

Age can also impact the children's beliefs about their deafness. Prelingually deafened children are more likely to identify with the Deaf community and Deaf culture. Children whose hearing loss occurs later spent a significant amount of time as members of the hearing community, and are therefore more likely to identify with this group.

2. Severity of Hearing Loss

Like age of onset, severity of hearing loss generally impacts both communicative functioning and cultural identity and belief systems. Children with severe and profound degrees of deafness are more likely to learn American Sign Language for communication and education. They generally see themselves as members of the Deaf community. Children with mild and moderate deafness often use oral communication methods. Thus, they are more likely to be exposed to, and often espouse, medical-pathological beliefs about deafness. Table One identifies how the severity of deafness may influence communicative functioning.

3. Causes (Etiologies) of Deafness

Congenital and early-onset permanent hearing loss can be attributed to a variety of causes (etiologies), including genetic factors (heredity), various disease processes, and birth-related complications (Gallaudet Research Institute, 2003a, 2003b; Harrington, May 2002; Joint Committee on Infant Hearing, 2000; Pollack, 1997; Pollack, Goldberg, & Caleffe-Schenck, 1997).

Genetic factors are thought to cause more than 50% of congenital hearing loss in children (National Institute on Deafness and Other Communication Disorders, 1989). Approximately 70% of these genetic cases can be attributed to recessive genes. The remaining 30% appear to be split evenly between a dominant gene and all other forms of inheritance patterns. These genetic factors may be the following:

- *Autosomal dominant*—one parent typically has a hearing loss and carries the dominant gene for hearing loss.
- *Autosomal recessive*—both parents, who typically have normal hearing, carry a recessive gene (approximately 80% of inherited hearing loss).
- *X-linked*—hearing loss is inherited from mutations of genes on the X chromosome. Most X-linked hearing loss genes are recessive, most commonly affecting males (i.e., a mother carries the recessive trait for hearing loss and passes it on to her son but not her daughter). This cause accounts for about 1% to 3% of hereditary hearing losses.

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Table One
Influence of the Severity of Hearing Loss
on Communicative Functioning

Degree of Deafness	Possible Effects on Communicative Functioning
Mild	The child may have difficulty hearing faint speech at a distance, may miss up to 10% of speech signal when speaker is at a distance greater than three feet or if the environment is noisy, and is likely to experience some difficulty in group education settings.
Moderate	The child can understand conversational speech at a distance of three-to-five feet in quiet settings. A hearing aid may help the child hear most speech sounds. Without a hearing aid, 50% to 100% of speech signal may be missed.
Moderate to Severe	If hearing loss occurs before spoken language is learned, the child's spoken language development and speech may be severely delayed unless early intervention has occurred. With an adequate hearing aid, the child should be able to detect the sounds of speech and identify environmental sounds. Without amplification, the child is aware of loud voices about one foot from the ear and is likely to rely on vision for communication. Use of a sign language or a signed system can promote and enhance language development.
Profound	The child will primarily rely on vision rather than hearing for communication and learning. Speech and oral language will not develop spontaneously without early intervention and extensive training. Use of a sign language or a signed system should promote language development, but speech intelligibility is often greatly compromised. A hearing aid can be useful for alerting the child to environmental sounds.

In 30% of children who have a congenital hearing loss because of genetic factors, other clinically identifiable factors also may be present. These constitute more than 400 forms of syndromic deafness. In the remaining 70%, deafness is not associated with other clinical findings that form a recognized syndrome (Genetic Evaluation of Congenital Hearing Loss Expert Panel, 2002).

About half the cases of permanent congenital hearing loss are not attributed to heredity. Prenatal, perinatal, and postnatal medical problems cause hearing loss in these children (Marschark, 1993a). Demographic reports (Gallaudet University Center for Assessment and Demographic Studies, 1998; Schildroth & Hotto, 1993) have revealed that perhaps as many as four out of 10 children with permanent hearing loss have additional disabilities that may have concomitant effects on their communication and related areas of development (Joint Committee on Infant Hearing, 2000).

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The different causes of congenital and early-onset permanent hearing loss can result in "diversity in their developmental consequences" (Marschark, 1993b, 14). Many causal factors also impair neurological processes and sensory systems other than hearing (Konigsmark, 1972; Rodda, Cumming, & Fewer, 1993). Children whose hearing losses stem from these causes can have varying degrees of permanent hearing loss, as well as co-occurring developmental delays, learning difficulties, and/or behavioral and emotional problems (D. E. Bond, 1979, , 1984; Hindley & Kroll, 1998; Mauk & Mauk, 1992, 1998; Murphy, 1997; B. J. Pollack, 1997; D. Pollack, Goldberg, & Caleffe-Schenck, 1997; Ratner, 1988; Vernon, 1982; Zwierki, Stansberg, Porter, & Hayes, 1976). In fact, the interaction of congenital or early-onset permanent hearing loss and other cause-related problems "results in unique and qualitatively different behavior patterns than would otherwise be attributed to a single or even multiplicative effect" (Flathouse, 1979, 561). This can create a complex array of secondary consequences, especially in the interrelated areas of "social, language, and cognitive development over the first months and years of life" (Marschark, 1993a, 9).

Demographic reports have revealed that perhaps as many as four out of 10 children with permanent hearing loss have additional disabilities that may have concomitant effects on their communication and related areas of development.

It is important to remember, however that children whose hearing loss is caused by conditions that increase their risk for additional difficulties can have this risk mitigated by other "conditions that can improve resistance to risk factors and contribute to successful outcomes, adaptation, and child resiliency" (Landy & Tam, October 1998, 3). Section III.C on page 33 discusses these issues in detail.

The particular cause of a child's permanent hearing loss is unalterable and irreversible. However, information about the cause of the hearing loss, any associated risks and difficulties, and relevant protective factors can help professionals understand how these factors may have impacted a particular child's overall development and, consequently, affect his or her reaction to trauma and responsiveness to potential treatment/intervention.

Table Two contains a brief delineation of several causes of permanent hearing loss during childhood (e.g., genetic factors, prenatal, perinatal, and postnatal medical conditions) and possible associated physical problems and developmental/psychological difficulties.

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Some Causes of Childhood Permanent Hearing Loss,

Possible Physical Problems, and Developmental/Psychological Difficulties

Cause	Possible Co-Occurring Difficulties	References
Genetic Factors (Heredity)	• Children whose hearing loss is genetically based are the least likely of all major etiological groups to have multiple disabilities. • However, approximately 1/3 of genetic hearing loss is associated with another trait recognizable as a syndrome (e.g., Down Syndrome, Usher Syndrome, Fetal Alcohol Syndrome) that can negatively affect physical and psychological well being.	(Brookhouser, Worthington, & Kelly, 1994; Grundfast, 1992; Grundfast, Atwood, & Chuong, 1999; Karchmer, 1985; Vernon, 1969a, 1969b, 1976, 1982)
Complication of Rh Factor	• Cerebral palsy • Aphasia • Developmental delay/mental retardation • Multiple disabilities	(D. F. Moores, 1987; Vernon, 1982)
Meningitis	• High incidence of physical and cognitive disabilities (e.g., aphasia, developmental delay/mental retardation, learning disabilities, behavioral/emotional problems). • Children may suffer severe physical and neuropsychological sequelae and have difficulty in educational programs.	(Dodge, 1992; Karchmer, 1985; D. F. Moores, 1987; Schuyler & Rushmere, 1987; Vernon, 1967)
Maternal Rubella	• Physical difficulties may include hearing, vision, urogenital, and endocrine disorders • Major, frequently late-occurring neuropsychological sequelae (such as developmental delay/mental retardation, autism, abnormal behavior patterns, impulsivity, hyperactivity, rigidity and specific learning disabilities).	(Cunningham, 1992; Hutchinson & Sandall, 1995; D. F. Moores, 1987; Sison & Sever, 1993)
Prematurity	• Infants under 3.5 pounds who experience anoxia or intracranial bleeding are at risk for later developmental problems. • Infants with a hearing loss who are born prematurely often have physical and psychological sequelae (e.g., developmental delay/mental retardation, cerebral palsy, and learning and emotional disabilities).	(American Academy of Pediatrics, 1995; Bergman et al., 1985; Duara, Suter, Bressard, & Gutberlet, 1986; Hille et al., 1994; McCormick, 1997; McCormick, Brooks, Workman-Daniels, Turner, & Peckham, 1992; D. F. Moores, 1987; Vernon, 1969b, 1982)
Syphilis Bacterial Infection	• May be asymptomatic at birth, but may later manifest signs of intellectual delay, visual disability and sensorineural hearing loss.	(American Academy of Pediatrics, 1995; Blackman, 1997)
Herpes Simplex Virus Infection	• Approximately two-thirds of all herpes simplex virus infections are body-system pervasive. • More than half of all survivors have permanent neurological impairments (e.g., learning disabilities) and accompanying visual system disturbances and hearing loss.	(Hutchinson & Sandall, 1995; McCollister, 1988; Sison & Sever, 1993; Stagno & Whitley, 1985)
Cytomegalo-virus (CMV) Infection	• CMV is a common cause of congenital hearing loss. • One out of 100 infants born with CMV is asymptomatic. • 10% to 15% of affected infants will likely develop central nervous system damage (i.e., hearing loss, developmental and intellectual delays, psychomotor difficulties). • CMV-related learning problems may go unidentified until formal schooling begins. • Schildroth (1994, 31) noted that "CMV has pernicious educational consequences" for children who are deaf or hard of hearing.	(Bale, Blackman, Murph, & Andersen, 1986; Barbi et al., 2003; Blackman, 1997; D. F. Moores, 1987; Pappas, 1985; Schildroth, 1994; Schuyler & Rushmere, 1987; Sison & Sever, 1993; Stagno, Pass, Dworsky, & Alford, 1982)

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4. Co-Occurring Disorders

During the 2003–04 school year, 38,744 students in the United States were identified as having a hearing loss. Forty percent of these students were identified as having other conditions that could affect their educational progress (Gallaudet Research Institute, 2005). Table Two lists common co-occurring disorders associated with various causes of hearing loss.

Deaf children born to hearing parents are more likely to have traumatic causes of their deafness than deaf children born to deaf parents. Many traumatic causes and genetic anomalies that cause deafness may also cause mental, behavioral and/or emotional disabilities. A study by Vernon (1969a) indicated that deaf children with multiple disabilities showed much higher levels of emotional and behavioral problems than other groups of deaf children. A complete assessment, including a developmental history, is essential in implementing a best practice approach to trauma treatment. In addition, information collected from schools, physicians, and parents is important in treatment planning.

5. Language and Communication Methods

Deaf and hard of hearing children use many ways to communicate. A 2001–02 survey reports that more than 50% of deaf students in our nation's schools use a communication method other than the English language (Gallaudet Research Institute, 2003a). The most common methods are visual, including sign languages and speech-reading. In some cases, communication combines a variety of techniques, including visual, gesturing, and oral/spoken language. When a clinician requests an interpreter for assessment and treatment, it is critical to know the deaf/hard of hearing child's preferred communication method, as well as the preferred communication method of other involved family members. The clinician should not assume that family members sign as well as the child.

Deaf children and their families may use any of the following strategies for communication:

- *American Sign Language (ASL)*—ASL is the identified language of the Deaf community and is used primarily in the United States and Canada. It is a visual-gestural-spatial method, in which placement, movement, and expression of the hands, face and body are actually a part of the language. ASL has its own grammatical structure and syntax distinct from English.

- *Other Sign-Based Communication Methods*

  - *Manually Coded English Systems*—There are a number of sign systems that have been developed in an attempt to represent the translation of spoken English (or other spoken languages) word-by-word with signs. These systems are not a natural language. They borrow from the vocabulary of ASL but add, subtract, and alter many elements to mimic English syntactic and grammatical characteristics in an attempt to represent them visually. They have been developed by educators in an attempt to teach deaf children the structure of English more readily. Examples of these manually coded English systems include Conceptually Accurate Sign Language (CASE), Pidgin Signed English (PSE), Signed English (SEE-I), and Signing Exact English (SEE-II).
  - *Signing in Languages Other Than American Sign Language*—Like spoken languages, sign languages around the world are not universal. For example, the

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sign language used in England is structurally different than the ASL used in the United States and Canada.

- *Finger Spelling*—Finger spelling refers to the use of one hand to make 26 shapes representing the English alphabet. Words are finger spelled by making one hand shape after another until each letter of the word has been presented. It is typically used in conjunction with ASL or one of the systems for manually coded English, and is quite useful for representing proper names or words for which there is no commonly agreed upon sign.

- *Cued Speech*—This manual system of visual cues is used conjointly with spoken English and designed to help deaf children discriminate lip movements to improve their capacity to learn English. The cueing system consists of eight different hand shapes held in four different positions close to the speaker's mouth.

- *Home Signs*—Deaf children and their families who are not exposed to other Deaf people often do not have an opportunity to learn formal sign language. In this case, the deaf person and his or her associates often develop a manual system for communicating that is unique to this individual and others in the family or small community.

- *Speech-reading* (also referred to as lip-reading)—This receptive modality depends on visual information, including body language, mouth and lip movements, and facial expressions, to understand what is being spoken. Because of the highly transient nature of these visual cues, even the most proficient speech-readers only understand 5 to 20 percent of what is being said (Vernon, 1981).

- *Oral Methods*

  - *Auditory-Oral*—This method is designed to promote oral language development by encouraging the deaf child to use hearing in conjunction with speech-reading for receptive communication and to use speech for expressive communication. Intensive speech training is combined with a hearing aid or a cochlear implant to promote use of any residual hearing (Ling & Ling, 1978).

  - *Auditory-Verbal Therapy*—A specialized type of therapy designed to teach the deaf child to use the hearing provided by a hearing aid or a cochlear implant for understanding speech and learning to talk. The child is taught to develop hearing as an active sense with limited use of visual cues (D. Pollack, Goldberg, & Caleffe-Schenck, 1997).

- *Combination Methods*

  - *Simultaneous Communication*—Sign language and spoken English are used together, typically combining spoken communication with a Manually Coded English modality. Sometimes referred to as "Sim-Comm."

  - *Total Communication*—An educational philosophy that involves using a combination of speech, sign language, auditory training (Durity, 1982), speech-reading, finger spelling, reading and writing to promote language acquisition.

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- *Minimal Language Skills, Minimal Language Competency, or High Visual Orientation*—These are terms used interchangeably to refer to individuals who have no language skills in ASL, spoken English, or any other language. This sometimes occurs because an individual has been educationally or socially deprived and never had an opportunity to develop language skills. Typically, an individual who is linguistically deprived is also socially deprived because she or he has never had an opportunity to learn societal norms, cultural values, or appropriate ways of interacting with others.

6. *Hearing Technology and Its Usefulness in Understanding Speech*

Deaf and hard of hearing children may also use a variety of amplification devices to improve their understanding of spoken language. The longest-used and most common of these devices is the *hearing aid*. Hearing aids are electronic devices worn at ear-level or on the body that amplify sound. They collect sound from the environment, amplify

> **Hearing aids help some deaf and hard of hearing children to understand speech. However they do not correct or restore hearing.**

it, and direct the amplified signal into the user's ear. They can be useful for some deaf and hard of hearing children to help them understand speech. However, they do not correct or restore hearing. To maximize effectiveness, hearing aids should be custom fit to the child's individual hearing loss and needs.

The *cochlear implant* is an electronic device designed to provide enhanced sound detection and the potential for greater speech understanding in children with severe to profound hearing loss who obtain negligible benefit from traditional hearing aids. Cochlear implants require electrodes to be surgically placed into the part of the inner ear known as the cochlea. They pass sound as electrical impulses directly to the auditory nerve and bypass the damaged parts of the ear. The electronic signals are relayed by the auditory nerve to the part of the brain responsible for hearing. Cochlear implants have been approved for use in children since 1990 and currently about 7,000 children in the U.S. have been implanted (A.G. Bell Association, 2001).

There has been significant discord between the Deaf community and the medical community regarding cochlear implants in deaf children. This discord stems from the differences between the cultural view of deafness and the pathological view (See Section II.A on 10). Culturally identified Deaf persons express significant concern that cochlear implants represent attempts by the medical community to "fix" deafness, which could lead to the eventual demise of Deaf culture and language. The Deaf community is concerned that hearing parents of deaf children may be misled by medical professionals who falsely represent

> **Culturally identified Deaf persons express significant concern that cochlear implants represent attempts by the medical community to "fix" deafness, which could lead to the eventual demise of Deaf culture and language. The National Association of the Deaf affirms the rights of families to reach their own decision about implantation but asserts that family members be fully apprised of the facts before an implantation is made.**

that implantation will make their child "hearing" (National Association of the Deaf, 2001a). In a recent position statement, the National Association of the Deaf affirms the rights of families and

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individual to reach their own decision regarding implantation but asserts that family members be fully and accurately apprised of the facts (National Association of the Deaf, 2001b). Before an implantation decision is made, the NAD strongly advises parents of deaf children to talk with members of the Deaf community, and not just with medical experts (National Association of the Deaf, 2001a).

Assistive listening devices or *FM systems* are used by deaf and hard of hearing children in classroom and group situations to help reduce background noise. An FM device is much like having a small, personal radio transmit sound directly to the ears through a portable microphone carried by the primary speaker. FM systems can be an important way to supplement hearing aids and cochlear implants by reducing the negative effects of distance, background noise, and reverberations. If the deaf child relies on hearing for communication, assistive listening devices may be particularly useful in group therapy settings or family therapy.

7.   *Language Proficiency*

Deaf children may be exposed to a variety of communication methods, generally determined by the hearing status of their parents and the communication philosophies of the early intervention and educational programs they attend. These early experiences will affect their proficiencies in spoken languages such as English or in a signed modality such as ASL or manually coded English. For trauma treatment to be effective, it is important for the therapist to have an understanding of the individual deaf child's communicative proficiency or proficiencies and to use them as the primary modality for intervention.

During infancy and the preschool years, the majority of deaf children with hearing parents do not have access to the visual communication and linguistic environment they need to progress developmentally at typical rates achieved by hearing children. Thus, most of these children do not arrive at school ready to learn at grade level. And for children of Deaf parents who are bilingual in ASL and English, "most schools and teachers are not well-prepared to provide them with the kind of education that builds on their visual strengths and the bilingual foundation they have acquired at home" (Signs of Literacy Project, 2003, para. 1).

Therefore, it is not surprising that in a large national study of academic achievement of deaf and hard of hearing school-aged students (ages 8 to 18) conducted by the Gallaudet Research Institute (2003), the median reading comprehension subtest scores on the Stanford Achievement Test (Traxler, 2000) for 17- and 18-year-old deaf students corresponded to about a 4.0 grade level for hearing students. This means that half of the deaf and hard of hearing students in that age group scored above the typical hearing student at the beginning of fourth grade, and half scored below.

The difficulties that deaf children experience in reading performance are also readily apparent in their writing. Marschark (1997, 149) states that "relative deficits in vocabulary, syntax, and relational discourse processing result in deaf children's written productions appearing concrete, repetitive, and structurally simplistic relative to both the written productions of hearing peers and

> **Any assessment and treatment approaches that depend on reading and writing frequently require adaptation. . . . Psychological test findings must be cautiously interpreted based on a thorough comprehension of the limitations of the test instruments used.**

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to their own signed productions." Many deaf individuals see writing as a laborious, sentence-by-sentence task rather than an attempt at verbal communication.

The implications for the therapist are that any assessment and treatment approaches that depend on reading and writing frequently require adaptation for the deaf child. It is important to emphasize that deaf children's reading levels and written language may not reflect either their intelligence or their overall language and communication skills. It is also important to note that few psychological tests provide adequate reliability and validity as assessment measures for deaf children. Even non verbal tests may still tap into "skills and knowledge that are typically learned through language" (Marschark, 1997, 165–166). Therefore, psychological test findings for deaf children must be cautiously interpreted based on a thorough comprehension of the limitations of the test instruments used (Steinberg, 1991). Section IV.F on page 45 discusses these issues in detail.

8. Educational Methods and Learning Environments

Although deaf education falls under special education services, there are some unique issues in placing deaf students appropriately. Federal regulations pertinent to education for deaf students are the Individuals with Disabilities Education Act (IDEA) of 2004 and Section 504 of the Vocational Rehabilitation Act of 1973. IDEA mandates that children with disabilities be

> A deaf student's communication needs, linguistic needs, and social-emotional needs must be primary factors in considering the least restrictive educational environment. The concept of inclusion, which may work well for many students with disabilities is not always appropriate for deaf students.

educated in the least restrictive environment. Section 504 of the Vocational Rehabilitation Act of 1973 requires provision of a free, appropriate public education. This requirement is applicable to local educational agencies serving children who are deaf. According to the U.S. Department of Education Deaf Students Education Services Notice of Policy Guidance (1992), a deaf student's communication needs, linguistic needs, and social-emotional needs must be primary factors in considering the least restrictive environment. This means that the concept of inclusion, which may work well for many students with disabilities, is not always appropriate for deaf students.

Some states have enacted further legislation in order to promote full access to a free and appropriate public education in the least restrictive setting that takes into account the deaf student's communication, linguistic, and social-emotional needs. For example, in Colorado, educational program options for deaf students have been strengthened and preserved through the Deaf Child Bill of Rights, a state law passed in 1996. This law requires each child's Individualized Education Plan (IEP) to include a communication plan. This plan, which is created by the IEP team (including parents), contains an action plan addressing specific areas of a student's social and emotional development. Colorado's Deaf Child Bill of Rights can be accessed at www.handsandvoices.org.

There are several different educational environments available to deaf children. Throughout the course of their education, they may attend one or any combination of programs. These include:

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- *Early Intervention/Preschool Programs*—These provide educational preparation for children from birth to four years. They emphasize language development, parent-child communication, and social skills.

- *Mainstreaming/Inclusion* Programs—These are designed to involve deaf children in all aspects of the public education environment by having them attend regular classes with their hearing peers. They have the right to support services such as interpreters and note takers and may also participate in some special education classes to augment their studies.

- *Residential Schools for the Deaf*—These are campus-based schools where children live in dormitories throughout the school year and attend classes during the day. Depending on their philosophy, these schools use a variety of educational approaches and communication systems.

- *Bilingual-Bicultural (Bi-Bi)*—These teach the use of ASL as the primary language of communication. Students learn English through reading and writing. Children receive educational, social, and emotional support from both the hearing and Deaf communities.

- *Oral Day School/Sign Day School*—These schools represent a compromise between residential school and mainstreaming. Children remain at home and attend school at a day school for the deaf which may use an oral, sign or total communication approach.

- *Self-Contained Classroom*—These are classrooms in hearing public schools that contain only deaf or hard of hearing children. The mode of communication in these classrooms can vary from an oral approach to a signed mode of communication.

9.   Family Constellation

Deaf Children in Hearing Families

According to the 2003–04 annual survey of deaf and hard of hearing children and youth enrolled in schools in the United States (Gallaudet Research Institute, 2005), 92.3% of these students had hearing mothers and 86.3% had hearing fathers. In addition, only 13.3% of these children had a deaf or hard of hearing sibling. The vast majority of hearing parents of deaf children have had no experience interacting with deaf individuals and no first-hand knowledge of deafness. At the time the child's

> **Parents serve as role models for language acquisition in hearing children. For deaf children with hearing parents, the roles may be reversed. The child frequently becomes the role model for parental acquisition of sign language.**

hearing loss is identified, hearing parents often enter a protracted period of grieving and adjustment that must be renegotiated at developmental stages such as when their child enters school, begins adolescence, and transitions into adulthood (Donald F. Moores, 2001; Sloman, Springer, & Vachon, 1993).

Parents who are unable to work through the trauma of having a deaf child to arrive at a level of acceptance, may engage in activities such as pursuing a "cure for deafness" where none is available, becoming fixated on having their child learn "normal speech," and ignoring opportunities for the child to develop language and social skills. The parents' "mature acceptance of deafness . . . is a prerequisite for adequate psychological and social

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development. Without such acceptance, parents will fail to develop healthy mechanisms to cope with the outer reality of bringing up a child with a hearing loss and the inner reality of desiring a normal child" (Donald F. Moores, 2001, 49).

The extent to which parents accept their child's deafness can affect how the child learns to communicate. For example, deaf children may not be encouraged or even allowed to sign in their homes. The vast majority of hearing parents know and use only very basic signs. Most parents who do develop conversational signing skills are mothers, with a very low proportion of hearing fathers becoming proficient in sign skills. Parents serve as role models for language acquisition in hearing children. For deaf children with hearing parents, the roles may be reversed. The child frequently becomes the role model for parental acquisition of sign language.

Deaf Children with Deaf Parents

A significant body of research conducted in the 1960s and 1970s found that deaf children with deaf parents demonstrated significant advantages over deaf children with hearing parents in social-emotional adjustment, academic achievement and English-language abilities (Brasel, 1975; K. Meadow, 1968; Donald F. Moores, 1976, 1979; Stuckless & Birch, 1966; Vernon & Koh, 1970). Many deaf parents express a preference for having deaf children. However, when a deaf child is born to these parents, they may experience feelings of shock, helplessness, and guilt similar to those of hearing parents. Because of their own frustrations in dealing with the hearing world, deaf parents may express their wishes for a better life for their deaf children (R. A. Thompson, Thompson, & Murphy, 1979).

Hearing Children with Deaf Parents

In the United States, 90% of the children born to deaf adults are hearing. Hearing children with deaf parents often use different languages and have different cultural experiences than most other hearing children. Most are bilingual, using both spoken English and American Sign Language (ASL). Within the family and Deaf community, hearing children of deaf parents do not consider their parents to be "handicapped" (Hoffmeister, 1985).

Following are some common issues that these children face:

- *Adjustment to the Hearing Community*—Hearing children often notice their deaf parents' differences during early childhood years through other hearing family members, media or public events. Their first years of school tend to be a major adjustment since it is often their first experience in a setting where all or most other people around them are hearing.

- *Speech Impairment/Language Delays*—Because their parents often have different speech and language methods and patterns, they may find it difficult to help their children communicate in the hearing community. As a result, many of these children are misdiagnosed as speech impaired or language delayed (Schiff & Ventry, 1976).

- *Balancing Both Worlds*—When these children enter school, they are straddling two worlds with two languages, spoken English and ASL. Dealing with the communication issues and barriers within these worlds may cause stress, but most eventually learn to balance them.

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- *Interpreting for Their Parents*—Hearing children are often put in an awkward position when asked to interpret for their deaf parents (Mallory, Schein, & Zingle, 1992). This can cause role reversal with the parent being dependent on the child for assistance in communicating.

10. Ethnic and Racial Diversity

Within the Deaf community, there is great diversity in racial, ethnic, and cultural backgrounds. According to the 2003-04 annual survey of deaf and hard of hearing children and youth enrolled in schools in the United States (Gallaudet Research Institute, 2005), the students' racial/ethnic backgrounds were distributed as follows: white, 51.5%; Black/African American, 15.4%; Hispanic/ Latino, 24.2%; American Indian, 0.9%; Asian/Pacific Islander, 4.1%; other, 1.8%; and multiethnic background, 2.1%. This data indicates that minority children represent at least 48.5% of the deaf and hard of hearing school-aged population. This is a significant increase from ten years ago, when minority children made up 40% of the population (Gallaudet Research Institute, 1995).

In general, persons with disabilities who are also members of minority groups face double discrimination and a double disadvantage. They are more likely to have fewer opportunities than other members of the population, and be poor and undereducated (National Council on Disability, 1993). For the purposes of this discussion, deaf persons from racial and ethnic minority communities are identified as "multicultural deaf." People in this group face discrimination from multiple sources, similar to those identified for multiracial persons (D.W. Sue & Sue, 2003b). For example, African-American deaf people may experience discrimination by the majority White culture, discrimination within the African American community based on assumptions about deafness and discrimination from the Deaf community influenced by racism in the larger society (G. B. Anderson & Grace, 1991; Corbett, 2002). Thus, even within the Deaf community, they may experience marginalization, oppression, and racism.

As reported by the U.S. Surgeon General, minority children are less likely to receive the mental health care they need than are non-minority children (Isaacs-Shockley, Cross, Bazron, Dennis, & Benjamin, 1996; U.S. Department of Health and Human Services, 1999, 2001). This disparity is significantly compounded for multicultural deaf children. Minority providers of mental health services with expertise in deafness are scarce. However, nonspecialized clinicians with expertise in providing culturally competent trauma-informed services can play an important role in providing treatment services for deaf and hard of hearing children from minority communities. To address the dual identity concerns that may arise, the mainstream therapist may want to rely on support from a Deaf community "culture broker." These culture brokers are community leaders with first-hand knowledge and awareness of important resources available in both the Deaf and hearing communities. As described by Wax (1996), they can serve as important links between mental health providers and the Deaf community.

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11. Deaf Immigrant Status

Although data are not readily available on the numbers of deaf immigrants to the United States, deaf educators and service providers observe that recent immigration from Latin America, Southeast Asia, Africa, and Eastern Europe has contributed to greater racial, ethnic, cultural, and linguistic diversity among deaf and hard of hearing children. Immigrant families may have distinct sociocultural views about disability that influence how they respond to and support their deaf children. For a more complete understanding of how sociocultural variables influence how children with disabilities are viewed in developing nations, see Woods (1993). Therapists working with these families should be prepared to explore how parental attitudes and beliefs about their deaf children and their role in the family will influence their expectations about therapeutic outcomes. In addition, communication issues in these families can be compounded because deaf children are often taught in English or ASL within the American school system, rather than their caregivers' native language. Finally, meeting both the foreign caregivers' and the deaf child's language needs in treatment may require inclusion of more than one interpreter or an interpreter and a bilingual therapist.

D. Identity Development in Deaf or Hard of Hearing Children and Hearing Children with Deaf Parents

1. The Process of Identity Development in Ethnic and Cultural Minority Groups

Many theorists have observed that members of ethnic and cultural minority groups, including deaf and hard of hearing persons, adjust to cultural oppression in similar ways that profoundly influence their identity development. Sue and Sue (2003a) provide a five-stage conceptual framework designed to help therapists understand their clients' culture-based attitudes and behaviors. The five stages in Sues' Cultural and Racial Identity model are

1. conformity,
2. dissonance,
3. resistance and immersion,
4. introspection, and
5. integrative awareness.

Helms (1990) proposed a similar four-stage model of identity development. Both models chart the stages of development that oppressed people experience as they struggle to understand themselves and their relationship to their own and the dominant culture. The stages move from ignorance about and denial of cultural differences (conformity stage) to (1) the discovery of or encounter with oppression, (2) immersion within the minority community and complete rejection of the larger society, (3) pulling back and searching for a more personal and integrated identity, and (4) final stage of biculturalism (integrative awareness).

Multicultural experts have also identified models that describe the cultural identity development of persons from the majority culture, which can be useful in examining a clinician's stage of cultural identity development (Hardiman, 1982; J. E. Helms, 1995). These cultural identity models can help clinicians from the majority culture determine whether and in which circumstances they should provide therapy with a client from a minority culture based on the

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client's stage of identity development. In addition, the clinician's stage of identity development can be a factor in deciding whether she or he can provide culturally affirmative therapy.

2. *The Process of Identity Development in Deaf Children*

While children from ethno-cultural minority groups typically acquire language, cultural knowledge, and a sense of identity from their parents, only a small proportion of deaf children (those born to deaf parents) follow a similar developmental course. For the majority of deaf children, transmission of the language and culture from one generation to the next occurs with exposure to a critical mass of deaf peers either in school or social settings (Meadow-Orlans & Erting, 2000).

> **For the majority of deaf children, transmission of the language and culture from one generation to the next occurs with exposure to a critical mass of deaf peers in school or social settings.**

Glickman (1996) describes how the psychological processes underlying cultural identity development in deaf persons are similar to those for other minority groups. Table three illustrates Glickman's theory of identity development. First, deaf individuals experience a state of alienation from their own deaf (minority) community, identifying instead with the majority hearing community (the culturally hearing stage). This alienation is interrupted by his or her discovery of oppression (culturally marginal). Then, the deaf individual becomes immersed in the minority community, embracing everything pertaining to it and becoming angry with the larger society (immersion in Deaf world). Next, the person becomes reflective, enlarging his or her vision of what it means to belong to the minority community. At this point, the individual enters a stage of biculturalism, which can include a commitment to political action.

Table Three
Glickman's Theory of Deaf Identity Development (1996, 145)

Stage	Reference Group	View of Deafness	View of Deaf Community	Emotional Theme
Hearing	Hearing	Pathology	Uninformed & stereotyped	Despair, Depression
Marginal	Switches	Pathology	Shifts from good to bad	Confusion & conflict
Immersion	Deaf	Cultural	Positive, non reflective	Anger/"In love with Deafness"
Bicultural	Deaf	Cultural	Positive, personal, integrated	Self-acceptance & group pride

Hearing parents' capacity to respond to and support their deaf child's identity development depends in large part on the degree to which they identify and are able to work through the feelings of grief they experience in having a deaf child. As described by Harvey (2003), parents' acceptance of the deaf identity of their child may begin prior to the diagnosis of deafness, as they begin to suspect that there is something different in the child's responses. This acceptance process often continues well into the child's adulthood. The critical developmental junctures that retrigger questions about the parents' acceptance can include the selection of the school(s) and the communication method for the child, selection of postsecondary placement, and reactions to whom the child selects to marry as well as the birth and hearing status of grandchildren.

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3. The Process of Identity Development in Hard of Hearing Children

For hard of hearing children, identity development begins at the time their hearing loss is first identified, often when hearing health professionals distinguish them from children with more severe hearing loss. Upon entering school, hard of hearing children may initially recognize that they are different than their hearing peers but may be praised for their ability to appear "hearing" (Harvey, 2003). As a result, these children may see their hearing loss as an unacceptable part of themselves that must be hidden. These children can frequently feel that they do not fully fit within their hearing families, school, or social settings. They find themselves trying to function between both worlds. The hearing world praises them for not appearing to have a disability, while the Deaf world rejects them for not being sufficiently deaf.

By adolescence, issues of affiliation with other hearing, hard of hearing, or deaf peers become more prominent. Hard of hearing youth may not have a peer group with which to identify, and they often feel alienated from any group. While communication may be relatively easy with hearing persons in one-to-one situations, it is typically more difficult if not impossible with groups of hearing peers. Similarly, the hard of hearing adolescent will not find it easy to engage with deaf peers because she or he does not share a common language and tends not to want to identify with a group seen to be more obviously "disabled." It is not unusual for hard of hearing adolescents to feel anger and rage about their hearing loss and to project this anger onto hearing peers and family.

When selecting an educational setting after high school, hard of hearing young adults typically choose a mainstream or hearing program where they will use assistive technology in the classroom. Career choices typically focus on jobs with low demand for spoken communication. Unlike their deaf peers, the majority of hard of hearing persons marry hearing spouses.

4. The Process of Identity Development in Hearing Children with Deaf Parents

Hearing children who have deaf parents may be caught between two identities. Because of their family environment, their early identification is generally with the Deaf culture. Their later school and social experiences expose them to the hearing community and its medical/pathological views on deafness. Preston (1995) conducted an ethnographic study of adult hearing children of deaf parents in the United States. It focused on their cultural identity and affiliation, and the paradox of being culturally Deaf and yet functionally hearing. Preston found that hearing children of deaf parents have inherited dual, often polarized interpretations of the meaning of deafness. From hearing people, they understand deafness as brokenness, stigma, and disability. From their parents, they experience deafness as a viable, normal cultural community.

For the hearing child of deaf parents, separation and individuation involves the challenge of mediation between two worlds with differing values. The transition from home to school will generally have a level of complexity similar to that of children from immigrant families. When they make the transition from adolescence to adulthood, they may experience confusion or other mixed feelings about where they belong. For some, this new independence can mean giving up a whole community and way of life that is significantly different from the hearing world in which they will spend most of their time. Healthy adjustment for these children means acknowledging the experience of a dual or alternating identity and being aware that their difference from their family of origin includes possibilities for stress, growth, and strength.

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5. Dual-Identity Development in Multicultural Deaf Children

Multicultural deaf persons often have a multicultural or "dual identity" rather than a primary ethnic or primary deaf identity, as described by Aramburo (1989) with African-American deaf persons, Page (1993) with Hispanic deaf persons, Eldredge and Carrigan (1992) with American-Indian deaf persons and

> **The multicultural deaf child may struggle with conflicts and feelings about this dual identity depending on the degree of exposure to other dual-identify role models.**

Plue (1997) with Asian deaf persons. Multicultural deaf persons have their own cultural family life, social customs, cultural artwork, social roles and attitudes. However, depending on the degree of exposure to other dual-identity role models, the multicultural deaf child or adolescent may struggle with conflicts and feelings about this dual identity. This struggle can contribute to a sense of social marginalization, guilt, and internal disharmony. Minority deaf community leaders are increasingly advocating for:

- greater awareness of the multilingual and multicultural dimensions of the Deaf community,
- more effective ways to address the educational and social needs of minority deaf children, and
- strategies for increasing parental involvement (see Christensen, 2000; O. P. Cohen, 1993).

This struggle for healthy resolution of dual identity may complicate the after-effects of exposure to trauma for multicultural deaf children (Burke, Gutman, & Dobosh, 2002). Therapists working with dual0identity children should be aware that healthy resolution of this marginality may follow different paths, similar to the model proposed by Root (1990) for healthy resolution of marginality in multiracial persons. Root's model supports a more fluid, nonlinear understanding of identity development, which recognizes that there are many types of healthy adjustments to dual identity.

6. Assessing Deaf Cultural Identity

Based on the deaf identity model described above, Glickman has developed the Deaf Identity Development Scale (DIDS) (Glickman & Carey, 1993), which was later revised and validated by Fischer (Fischer & McWhirter, 2001). The 60-item scale was first developed in English, then translated into American Sign Language and videotaped. Results from the factor analysis of the revised instrument support the existence of four relatively independent deaf identities. Another instrument, the Deaf Identity Scale, assesses whether the individual identifies with the deaf world, hearing world, or both (Sterritt, Weinberg, & Knoblock, 1983).

7. Other Influences on Cultural Identity in Deaf Children

All of the characteristics and factors described in Section II.C beginning on page 13 (e.g., communication method, family attitudes) may also serve as significant influences on each deaf child's unique identity and on his or her self-esteem. Figure two illustrates these important contributors to Deaf identity. Clinicians need to be aware of these different influences and take into consideration the impact they may have on the deaf or hard of hearing client.

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Figure Two: Influences on Deaf Identity Development

Parents' Hearing Status, Attitudes Toward Deafness and Communication Methods

Communication Mode and Language Proficiency

Use of Hearing Aid or Cochlear Implant and Usefulness for Processing Language

Cultural/ Religious Values and Beliefs about Disability

Deaf Identity Development

Age of Onset, Cause and Severity of Deafness

Presence of Deaf Peers in Educational Environment

Exposure to Deaf Role Models and Cultural Activities

Causes of Deafness and Co-Occurring Disorders

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III. Trauma Issues in Deaf and Hard of Hearing Children

A. Incidence of Trauma in Deaf and Hard of Hearing Children

1. Abuse and Neglect

In their pioneering work, Sullivan, Vernon and Scanlan (1987) reported on the scope, nature, and incidence of abuse of deaf children based on four studies conducted between 1983 and 1987. Two studies conducted with more than 150 residential school students found that 50% of the students reported being sexually abused. In a third investigation, students at a post-secondary educational institution for the deaf completed a retrospective child abuse survey, revealing that 28% had experienced physical or sexual abuse. A fourth study, of 100 victims of sexual abuse, discovered that 49% were abused at school, 31% at home, and 20% at both home and school.

Skinner (1991) conducted a national survey of 53 mental health therapists who reported that 69% of their adult deaf clients reported childhood maltreatment and abuse. Using the Trauma Symptom Inventory (Briere, 1995) with 81 deaf and hard of hearing adult subjects drawn from clinical, internet and college environments, Dobosh (1999) found that 59% of the 48 respondents indicated a history of sexual trauma. Embry (2000) surveyed 770 deaf adults to determine childhood maltreatment prevalence rates and found that 49% reported some type of abuse. Of these, 19% had been abused by a caregiver, 30% had experienced abuse by residential staff, 18% had been sexually abused, and 9% had experienced physical neglect. Hester (2002) compared prevalence rates of child sexual abuse reported by a total of 104 hearing and deaf adults. She found no difference in rates of sexual abuse between hearing and deaf subjects, but the deaf victims reported more severe forms of abuse and were abused more frequently than hearing victims.

Methodological differences among these investigations limit the conclusions that can be drawn regarding the incidence of maltreatment in the general population of deaf and hard of hearing children. In general terms, there appears to be some agreement on the following:

- The incidence of sexual abuse for deaf children is higher than for their hearing peers.
- Deaf boys are more likely to report abuse than deaf girls, whereas with hearing children, girls are more likely to report abuse.
- The abuse tended to occur in vans or buses when children are being transported to and from school, or in their bathrooms and beds.
- Approximately 20 to 25% of deaf children were abused both at school and home.

2. Communicative Isolation

In addition to the types of traumatic events that their hearing peers may experience, many deaf children experience trauma due to communicative isolation within their families. Evidence for this can be drawn from the clinical experience of Harvey (1996), who observes that his adult deaf clients report childhood-based post-trauma responses triggered by more recent communication situations. Following a particularly difficult communicative interaction, deaf

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clients may report a number of common trauma responses identified in the Diagnostic and Statistical Manual IV (American Psychiatric Association, 1994). During communication situations with hearing people in adulthood, deaf individuals will re-experience:

- the feelings of isolation and being misunderstood they had as children within their hearing families;
- thoughts of being socially isolated or actually withdrawing from contact with hearing persons in order to avoid stimuli associated with the trauma of communicative isolation within their families; and
- hyperarousal and hypervigilance as they become aware of the inadequacy of their communication, resulting in reactions that may be overly assertive or resigned and passive.

Harvey (1996) raises the question as to whether sustained communicative isolation can be considered traumatic for a deaf child. He points to the three criteria that McCann and Pearlman (1990) have identified for determining if an event is traumatic:

1. it falls outside the range of ordinary human experience,
2. it exceeds the individual's perceived coping abilities and
3. it significantly disrupts the individual's psychological functioning.

Because language-based communication with family members fulfills a universal human need, Harvey (1996, 157) identifies that its absence for the deaf child is "extraordinary," satisfying criterion 1. He also reports that criteria 2 and 3 are demonstrated throughout the deafness literature (H. Lane, 1984; Mindel & Vernon, 1987; Donald F. Moores, 1982, 2001; Schlesinger & Meadow, 1972), which shows that "inadequate communication with significant others during one's developmental years severely impedes all facets of psycho-social development" (Harvey, 1996, 158). Harvey concludes "that the quintessential trauma for many of the deaf clients we see in psychotherapy is 'conversational isolation'" (Harvey, 1996). Discussions on how this unique experience of trauma may impact psychotherapy with deaf children are outlined in Section IV.J on page 51.

B. Lack of Prevention Programs with Demonstrated Effectiveness

While deaf children have been shown to be more vulnerable to neglect and emotional, physical, and sexual abuse (Patricia M. Sullivan, Vernon, & Scanlan, 1987), there is little research on the effectiveness of the small number of prevention/intervention programs developed to assist deaf children with issues of avoiding or dealing with sexual abuse. Examples of these programs include the following:

- *Safe and Okay* (Trevelyn, 1988)—this program, also known as "NO-GO-TELL" (Krents & Brenner, 1991), offers self-protection training to deaf children up to sixth grade.
- *Keep Deaf Children Safe Program* (Kennedy, 1989)—this program was developed and disseminated in Britain.

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- *PACES: Preventing Abuse of Children through Education for Sexuality*—this program developed at Gallaudet University (Achtzehn, 1987).
- *Children's Self-Help Project Manual*— this program was developed at the University of California Center on Deafness (Moser & Burke, 1989/1990).
- A program developed by Anderson (1987) and used throughout Canada uses a standard vocabulary to discuss specific maltreatment issues, recommends various types of instructional media and allows additional time for processing information (Patricia. M. Sullivan, Brookhouser, & Scanlan, 2000).

More general prevention programs designed to increase overall social and emotional competence may also help deaf children deal with trauma. A consortium sponsored by the W.T. Grant Foundation (1992) developed a list of social competencies that are addressed in the most effective school-based programs. These core competencies are described in Section IV.H on page 49. Again, however, these programs have not been tested with deaf populations.

Finally, while all the prevention programs described above focus at the level of the child, Sullivan, Brookhouser, and Scanlan (2000) caution that the issue of maltreatment of deaf and hard of hearing children must also be addressed at the system level. Some school programs for deaf or hard of hearing students do provide abuse prevention information, but it is not systematically integrated into the curriculum. In addition, hearing parents of deaf children may lack the communication skills to discuss sensitive, emotion-laden subjects related to sexual and physical abuse. The Center for Abuse Prevention and Education–Deaf and Hard of Hearing (CAPE-d/hh) offers education and training programs to increase awareness and promote prevention of abuse. (See Appendix A, page 53 for contact information).

> Some school programs for deaf or hard of hearing students do provide abuse prevention information, but it is not systematically integrated into the curriculum.

C. Risk and Protective Factors, Resilience, and Developmental Assets

Thompson and Rudolph (1992) contend that many adults like to think children and adolescents are immune to the difficulties and complexities of the world. They assert that it comforts adults to believe that youth are not sensitive to the stress produced by the rapid changes occurring in the adult world. However, the reality is that all youth face many stressors in their lives that require them to cope in one way or another. Risk and protective factors in the lives of children and adolescents predict increased or decreased probability of developing mental health problems and other developmental or behavioral difficulties (Howell, 1995).

A *risk factor* is something that increases the likelihood of a negative developmental outcome. Drawing from the work edited by Howell (1995), some examples of various risk factors include:

School and individual/peer group risk factors

- delayed identification of and intervention for physical and other problems
- changes in friendships or peer groups
- academic failure, lack of commitment to school, and/or problem behaviors

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Family risk factors

- lack of knowledge of child/adolescent development and behavior management practices
- parental attitudes and involvement in problem behavior
- stressors such as physical illness, divorce, unemployment or poor parental mental health

Community risk factors

- transitions and mobility
- low neighborhood attachment/social capital
- community violence
- poor communication and coordination of school-family-community resources

Although children with disabilities have many risk factors similar to those children without disabilities, some factors specific to a child's disability may increase the probability of negative physical and psychosocial outcomes. For example, some investigators postulate that families of children with disabilities experience greater stress, which places the child at higher risk for maltreatment (Ammerman, Van Hasselt, & Hersen, 1988). Others report that the greatest risk for maltreatment occurs in disability services settings (Sobsey & Doe, 1991), such as a residential school for the deaf (Patricia M. Sullivan, Vernon, & Scanlan, 1987). Finally, some professionals suggest that the risk of maltreatment for deaf or hard of hearing children is related to the impact of the communication method and communication quality on parent-child attachment (M. Greenberg, 1980; Mather & Mitchell, 1993). In a survey of 770 adult deaf respondents, Embry (2000) examined family communication method, family communication quality, and attendance at residential school for the deaf as risk factors for maltreatment of deaf children. He found that lower quality family communication and attendance at residential school increased risk for childhood maltreatment.

As a group, deaf children and adolescents may be at risk for a number of adverse outcomes (M. T. Greenberg & Kusché, 1989; Marschark, 1993b). These include

- lower academic achievement,
- delays in some cognitive and social-cognitive processes,
- greater impulsivity and poorer emotional regulation,
- higher rates of social maladaptation and psychological distress and disorder (externalizing and internalizing problems), and
- poor peer relations.

However, not all deaf children develop adjustment problems (M. T. Greenberg, 2000). *Protective factors* can mitigate the effects of risk factors (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002), helping the youth "achieve adaptive developmental outcomes despite adversity" (Yates, Egeland, & Sroufe, 2003, 243). Children and adolescents who rise above their circumstances or overcome their adversity are said to demonstrate *resilience*. Masten, Best, & Garmezy (1990)

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defined resilience as "the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances" (426). Protective factors such as the following can mediate and moderate the impact of deafness and can foster resilience in youth:

- early detection of hearing loss and timely intervention;
- caring, supportive and positive family, peer and community environments;
- social bonding with significant others;
- parental adaptation to deafness;
- family coping;
- the nature of school and community resources; and
- the child's own individual attributes such as social competence, self-esteem, and self-control.

Peter Benson and the Search Institute (www.search-institute.org) have set forth a model of 40 internal and external *developmental assets* (Benson, 1997; Benson & Leffert, 2001). These assets prepare youths "to respond to adversity with effective, healthy strategies and coping mechanisms" (Browne, Gafni, Roberts, Byrne, & Majumdar, 2004, 1368). According to Benson, *internal assets* are internalized qualities and dispositions that guide choices, create a sense of centeredness, purpose, and focus, and encourage wise, responsible, and compassionate judgments. These can include commitment to learning, positive values, social competencies, and positive identity. *External assets* are positive experiences that children and adolescents receive from the people and institutions in their lives. Examples include support, empowerment, boundaries and expectations, and constructive use of time.

Collectively, Benson's 40 developmental assets offer a set of benchmarks for positive child development and health. They show the important roles that families, neighborhoods, schools and community institutions and agencies play in shaping young people's lives (Benson, 1997; Benson & Leffert, 2001; Scales, 1999). Also, the developmental assets framework seems to blend well with a strengths-based approach to mental health practice (Rapp, 1993; Rapp & Wintersteen, 1989; Ronnau & Poertner, 1993; Dennis Saleebey, 1992; Walrath, Mandell, Holden, & Santiago, 2004).

D. Family Issues

1. Deaf Children of Hearing Parents

More than 90% of deaf children are born to hearing parents who do not expect to be the parents of a deaf child and who have little if any knowledge of the Deaf community and sign language. Thus, most deaf people share the experience of being different from their parents and siblings (K. Meadow-Orlans & Erting, 2000). Initially, and perhaps for several years, hearing parents typically have a difficult time accepting that their child is deaf. They may experience grief reactions that include denial, anger, guilt, and depression. A parent's grief reactions can subsequently be retriggered when the deaf child approaches certain developmental transitions including entering school, the onset of adolescence, and the start of dating. Parents' reactions related to the child's disability can also be triggered when the child has experienced a traumatic

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event. Hearing parents may also feel frustration in trying to communicate with a child who cannot hear or speak (K. Meadow-Orlans & Erting, 2000).

While there have been a few studies looking at the patterns of attachment in deaf children, there currently is no empirical evidence indicating that deaf children are less likely to be securely attached to their mothers than hearing children. However, a study comparing the interactional styles of hearing mothers of deaf children to deaf mothers of deaf children indicates that hearing mothers are more likely to demonstrate directiveness (Spencer & Gutfreund, 1990). Summarizing two other studies, Marschark reports that "relative to mothers in either hearing or deaf dyads, hearing mothers of deaf children are more likely to be intrusive, tense and directing in their verbal and nonverbal interactions" (Marschark, 1993b, 45) as compared to a more reciprocal mother-child communication process, which has been shown to promote a more secure attachment bond in hearing children.

> **Studies of the interactional styles of hearing mothers of deaf children indicate that they are more likely to demonstrate directiveness as compared to a more reciprocal interactional style demonstrated by deaf mothers of deaf children and hearing mothers of hearing children.**

Other studies have shown that compromised communication between a deaf child and mother may affect their relationship (Schilling & DeJesus, 1993), decrease the amount of time spent with the mother (Lederberg & Mobley, 1990), and lead to parents becoming more protective (K. P. Meadow-Orlans, 1990). Further review of the available studies on mother-child attachment for deaf children leads Marshark (1993b) to point to the importance of early diagnosis, early intervention programs and communication training to promote and support the attachment bond, especially for hearing parents with a deaf child. As identified by Harvey (1996) and outlined in Section III.A.2 on p. 31, communication difficulties with family members may pose additional risk factors for trauma in some deaf children specifically related to their communicative isolation. Furthermore, many hearing parents of deaf children cannot communicate effectively enough with their children to discuss sensitive subjects such as physical and sexual abuse. Conversely, a supportive family environment can be a protective factor and promote resilience.

Raising a deaf child can have a profound impact on a family and elicits very real problems of communication, understanding, and acceptance. However, since studies show that the majority of deaf persons achieve a level of healthy functioning by the time they reach adulthood, deaf children and their families must apparently be making the necessary adjustments (Moores, 2001). It seems that, at some point, most hearing parents relinquish their expectations for a "cure" and learn to accept the implications of deafness for their child.

2. *Deaf and Hearing Children of Deaf Parents*

Regardless of the hearing status of the child, families with deaf parents have been shown to provide a rich early learning environment for infants using voice, manual communication, and physical contact. They are typically able to lay a strong foundation for the development of effective communication with other family members whether or not the child has a hearing loss. Thus, deaf and hearing children of deaf parents do not have the experience of early communicative isolation that deaf children of hearing parents experience.

Because the incidence of abuse and neglect is reportedly greater for deaf children when compared to their normally hearing peers, deaf parents as a group are more likely to have

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experienced abuse in childhood than hearing parents. The extent to which they have dealt with the issues of their own abuse may determine how they will respond in the event that their deaf or hearing child experiences abuse. In this case, work with the family may involve trauma-specific work for the deaf parent.

As described in Section II.C.11 on page 24, hearing children of deaf parents experience a unique set of dynamics by being both culturally Deaf and biologically hearing. Myers, Myers, and Marcus (1999) outline two overarching themes that define the experience of hearing children of deaf parents: (1) mediation between deaf and hearing world views and (2) identity issues as a result of the mediator role. Many hearing children of deaf parents begin at an early age to take on interpretation responsibilities. This can involve complex brokering between the deaf and hearing cultures as well as the need to make on-the-spot decisions about what information is shared and what information is not. Retrospectively as adults, hearing children of deaf parents report that this "parentified" role can be both an honor and a burden. Some experiences as a mediator are developmentally inappropriate for a young child, such as being called upon to interpret in a family crisis or medical emergency or interpreting in a difficult negotiation and/or conflict between the parent and a hearing stranger.

Hearing children of deaf parents report a strong sense of responsibility as protector and/or advocate for the family. Some learn at an early age that they should be alert to environmental sounds that could threaten family safety, including sounds of violence in the neighborhood. Even into adulthood when they no longer are living in a deaf environment, adult children of deaf adults report feelings of hyper vigilance with regard to sounds and safety (Myers, Myers, & Marcus, 1999).

> **Hearing children of deaf parents report a strong sense of responsibility as protector and/or advocate for the family.**

In some families where the grandparents are hearing and the parents are deaf, the boundaries between parents and children can routinely be usurped by the hearing grandparents. Harvey (2003) refers to this clinically prevalent situation as an "inverted power hierarchy." In this situation, the hearing children may be expected to obey their hearing grandparents and essentially ignore their deaf parents. For some children, this may result in minimal verbal communication with their parents and limited ability to communicate in sign language. Harvey (2003) sees this intergenerational dysfunction as being rooted in the interactional patterns first established between the hearing grandparents and their young deaf child. "What these deaf parents did not linguistically get from their hearing parents, they may find difficult to give to their hearing children" (Harvey, 2003, 156).

3. *Hard of Hearing Children in Hearing Families*

While learning that their child is hard of hearing can be devastating for parents, they typically are reassured by health professionals that the child is not profoundly deaf and that he or she will be able to use residual hearing to develop speech and English language skills. In many cases, this reassurance allows parents of hard of hearing children to deny the implications of the hearing loss (Harvey, 2003). However, once they enter school, hard of hearing children become painfully aware of the barrier between them and their peers, while concurrently receiving positive reinforcement from their teachers and parents for their success in being able to function similar to "normal" hearing children. Reinforcement for functioning like a "hearing

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child" can lead the child to develop compensatory mechanisms to hide their hearing loss, such as pretending to understand when they do not, talking all the time rather than listening and avoiding difficult group communication situations such as family gatherings. Because validation from their parents is important, hard of hearing children can find it difficult to disclose the degree of difficulty they are having in school, social, or family settings.

In most communicative situations, hard of hearing children expend a significant amount of energy focusing on the lips and facial expressions of the speaker to maximize participation in conversations. This can result in profound physical and mental exhaustion. Hearing parents and family members may also find it cumbersome, demanding, and tiring to communicate with their hard of hearing relatives. Some admit that there are times when they avoid communication with the hard of hearing family member because it can be tiring.

E. Other Characteristics of Deaf and Hard of Hearing Children that Increase Vulnerability to Abuse

1. Limited Benefit from Incidental Leaning

Deaf children may be at greater risk for vulnerability to trauma because they cannot benefit from learning the types of protective messages hearing children learn incidentally without being intentionally taught. For deaf children to be included in communication, the communication must be directed specifically to them and they must pay close visual attention. In hearing children, incidental learning occurs aurally, often when they overhear private conversations among adults, their siblings, or their peers or from the television or radio in the background. Frequently these overheard conversations include specific information about values and attitudes. For example, a hearing sibling may tell friends about an uncomfortable encounter with a neighbor which made him or her feel "weird" or "creeped out." Deaf children have less frequent access to this type of information. Therefore, parents and clinicians need to be more deliberate in educating the deaf child about potential threats and safety skills.

2. Factors that May Work Together to Increase Vulnerability

Critchfield (1983) postulates a number of factors that may work together to increase deaf children's vulnerability to abuse. Abusers may perceive these children as particularly "ideal" victims because they may naively suppose them to be unable to report abuse. For some deaf children, a general lack of social knowledge contributes to a lack of understanding about what behaviors are acceptable and unacceptable in others. Further, limited communication between hearing parents and deaf children may increase the children's need for inappropriate intimacy to fill their communication needs.

Deaf immigrants are particularly susceptible to exploitation and abuse, as evidenced by the 1997 case of 44 Mexican deaf immigrants (10 of whom were children) who were smuggled into the United States, held captive in a New York City apartment, and required to participate in a brutal slavery ring selling trinkets in streets and subways. Related rings have been uncovered in Philadelphia, Chicago, Boston, Baltimore, and Washington, DC (Sexton, 1997).

Finally, as discussed earlier, deaf children have a substantially higher incidence of co-occurring disabilities, learning difficulties, and mental handicaps than hearing children (D. Bond, 2000). These co-occurring disabilities may contribute to deaf children's increased risk for abuse and neglect (National Child Traumatic Stress Network, 2004).

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IV. WHAT THERAPISTS NEED TO KNOW

A. Legal and Ethical Issues

In treating deaf children and children of deaf adults, practitioners need to be aware of the Americans with Disabilities Act (ADA) guidelines, which require them to provide accessible services to these populations. The act states that places of public accommodation, including treatment agencies, must ensure that their communications with children and parents who are deaf are as effective as communications with hearing people. In order to provide equal access, these agencies are required to obtain and cover the costs for auxiliary aids and services that promote effective communication. Examples include qualified interpreters, captioning, TTYs, and computer software. Because it is estimated that the best lip reader is able to understand only about 25% of what is being said, the ADA guidelines state that lip reading should not be used in lieu of an interpreter. It is also not considered satisfactory to use writing as a primary method of communicating with a deaf person in treatment. See Critchfield (2002) for a broader discussion of the legal and ethical issues regarding access to mental health care for the deaf.

B. Communicating with Your Deaf or Hard of Hearing Client

Before any assessment or treatment begins, it is critical to establish the preferred mode of communication for each deaf client and his or her family (see section II-C-5 on page 18 for a discussion of common communication methods). Other communication recommendations include the following:

- Always face your client, leaving no physical barriers between the two of you.
- Provide a well-lit, quiet environment without distractions.
- Keep in mind that it will take longer to do your assessment due to the translation time.
- When using an interpreter, speak directly to the client, not the interpreter, and speak in normal tones and speech rate.
- Try not to seat the client facing a window because the glare can interfere with vision.
- Be sure to explain the role of each person in the room (e.g., interpreters, clinicians, etc.) and highlight that the professionals are bound to maintain confidentiality.
- Allow more time for communication.
- Use the same interpreter throughout the course of treatment.

In group therapy settings that include a deaf or hard of hearing child, care must be taken to ensure that the child is given ample opportunity to participate and to process concepts. Misunderstandings are common. The clinician should clarify what is being said by asking the child and other group members to rephrase their comments. This will help the child become an active member of the group. In all types of therapeutic settings, clinicians should also remember that children who rely on hearing aids or oral communication may become tired more quickly and easily than hearing clients. They are using much of their energy to concentrate on communication.

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C. Using Sign Language Interpreters

1. Overview

In many therapeutic situations with deaf or hard of hearing clients, the most effective method of communication is through sign language interpreting. Interpreting is taking something expressed in one language and expressing its meaning in another language (Moxham, 1996). Effective sign interpretation can be critical to successful trauma treatment for deaf children. Depending on the interpreter's skill, interpretation can be the most helpful or most detrimental part of providing mental health services (Critchfield, 2002).

> **Interpretation can be the most helpful or most detrimental part of providing mental health services.**

Family members, friends, and a deaf child's classroom interpreter are inappropriate to use as interpreters in treatment regardless of their communication abilities. They have a dual relationship with the child, are likely to be emotionally involved, and are often not equipped to remain neutral in the trauma treatment process. Family members may not be able to maintain confidentiality, posing serious threats to the child's willingness to participate in therapy and to treatment effectiveness. Even if trauma therapy is provided in a school-based setting, the educational interpreter should not be used. He or she is not likely to have the necessary mental health interpretation skills and may make the child feel uncomfortable because they have a relationship outside the therapy sessions.

Despite the fact that certified interpreters have a strict code of ethics that mandates confidentiality, the client may have concerns about how truly private the communication will be. This is particularly true in smaller communities where there are fewer trained interpreters, or when a deaf client anticipates future contact with the interpreter. When this occurs, the therapist should be prepared to reassure the client of the role and responsibilities of the interpreter but also be prepared to look for alternative interpreting resources (Steinberg, 1991).

The following parts of this section provide a brief discussion of the most important issues in using sign language interpretation in trauma treatment. More detailed information about the effective use of sign language interpreters in mental health settings can be found through the Registry of Interpreters for the Deaf (2000; 2002), and the University of California Center on Deafness (2003) or as described by Turner, Klein & Kitson (2000).

2. Finding a Qualified Sign Language Interpreter

Professional sign language interpreters are fluent in both English and ASL, and are competent in reframing from one language to another. A professional interpreter is bound by a code of ethics (which includes confidentiality) and trained for accuracy. Professional interpreters trained in mental health issues will ensure the highest quality communication and protect client confidentiality. In trauma treatment, it may also be important to consider the gender, ethnicity/ culture and personality match between the deaf child and the interpreter.

Some states have interpreter certification or credentialing requirements. Therapists should check their state's commission for the deaf to find out what these legal requirements are. Where there are no state-level requirements, therapists can find nationally certified interpreters through the National Registry of Interpreters for the Deaf (www.rid.org). In some situations, it

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may be necessary to use a Certified Deaf Interpreter (CDI) who is deaf or hard of hearing in addition to the ASL interpreter in order to translate the clinician's language and concepts to a level that the deaf child will understand. In particular, a CDI should be used when the deaf child's communication mode is so unique that it cannot be adequately accessed and expressed by interpreters who are hearing (Registry of Interpreters for the Deaf, 1997).

Even certified sign language interpreters may lack the specific knowledge and skills necessary for effective mental health assessment and treatment (Glickman, 1996). For example, "certified sign language interpreters are not trained to recognize and distinguish between variations in ASL use and psychotic distortions in deaf people's responses to test items" (Brauer, Braden, Pollard, & Hardy-Braz, 1998, 304). For this reason, clinicians should use only professional, certified sign language interpreters who are familiar with and trained in mental health terminology and issues.

3. *Working with Interpreters in Therapy Sessions*

When introducing an interpreter, the clinician should give the interpreter and child time to warm up to each other. During this time, the child will have an opportunity to develop trust in the interpreter and the interpreter will be able to assess the child's language needs. The same interpreter should be used throughout the treatment process in order to maintain trust and rapport. Depending on their age and type of educational placement, deaf children may have limited experience in using an interpreter. Therefore, the interpreter needs to be flexible enough to accommodate the child's developmental issues, vocabulary and educational level.

In addition to enabling communication between the clinician and the deaf child, an interpreter may contribute to the therapeutic process by acting as a cross-cultural mediator. He or she consults on language and culture, commenting to one or both parties on the communication process itself (N. S. Glickman, 1996). For example, the child may use home signs, word jumbles, or other inconsistent communication modes. The cross-cultural mediator can explain to the clinician the use of this language, the child's language level, and the cultural implications of this type of communication.

In family therapy sessions, having an interpreter in the room can be useful in assessing, supporting, and altering specific communication dynamics within the family. Families who may not have used an interpreter before may initially question why the interpreter is necessary and/or try to control what the interpreter is allowed to interpret to their child. In general, the interpreter will interpret everything that is said. At the outset of each session, the therapist should review the ground rules for communication and use of the interpreter in that session, with the expectation that these rules may need to be reviewed more than once during the session.

> **In family therapy sessions, having an interpreter in the room can be useful in assessing, supporting, and altering specific communication dynamics within the family.**

4. *Issues with Interpretation in Trauma Treatment*

Even when an interpreter is trained in mental health terminology and interpreting techniques, there are many issues that must be addressed when interpretation is used in the therapeutic process. First and foremost, it is important for the therapist and the interpreter to be aware how interpretation may be impacting the therapeutic process. While the clinician's goal is to

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establish rapport with the child, the child's communication link is with the interpreter. Thus, it is likely that the child will establish rapport with the interpreter before the clinician.

In the therapeutic session, the interpreter can also become the object of transference or experience countertransference. In the case of transference, the presence of the interpreter may trigger a strong emotional response from the child or other family member. The therapist will need to be aware of how any possible transference is impacting the therapy and manage it appropriately. Similarly, the therapist may need to identify and address any countertransference issues that may arise for the interpreter and either address them in the session or after the session as appropriate.

> **The therapist will need to be aware of how the presence of the interpreter may create transference and countertransference issues that impact the therapy.**

In the case of child who has been abused, the clinician may need to be sure that the interpreter understands how the child's experience can impact his or her behaviors regarding attachment and boundaries. In most situations it is preferable for the interpreter to have no contact with the child when the therapist is not present. This will ensure that clinical material is not discussed between the interpreter and the client.

D. Understanding the Psychosocial Dynamics of Deafness and Deaf Culture

Sue and Sue (1990) identify three characteristics that the culturally skilled counselor must work toward in order to provide culturally competent interventions and effective interventions for persons with disabilities. These characteristics are particularly applicable to those working with the deaf and hard of hearing persons. The culturally skilled counselor:

- Becomes aware of his/her own assumptions about human behavior, values, biases, preconceived notions, personal limitations, etc. Culturally skilled therapists form hypotheses rather than making premature conclusions about the status of culturally different clients, develop creative ways to test hypotheses and act on the basis of acquired data.

- Attempts to understand the world view of his or her culturally different client including attempting to understand the client's values and assumptions about human behavior. The culturally skilled therapist has specific knowledge of the cultural groups with which he or she works and understands sociopolitical influences on that group.

- Actively develops and practices appropriate, relevant, and sensitive intervention strategies for working with the culturally different client. The culturally skilled therapist knows when to generalize and be inclusive and when to individualize and be exclusive.

Therapists working with Deaf/deaf and hard of hearing children, those with acquired hearing loss and children with Deaf parents need to be aware of and well-informed regarding cultural diversity issues among persons who are deaf (Critchfield, 2002). Knowledge of the deaf culture itself is also essential. Finally, therapists working with these children need to be aware that they may be struggling with their own identity formation across at least two cultures (hearing and deaf).

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E. Using a Consultative Model

1. Overview

The relatively high prevalence rates of trauma exposure for deaf and hard of hearing children and youth are compounded by a shortage of therapists with specialized expertise in deafness. As a result, alternative models need to be considered to ensure access to culturally affirmative treatment. Models being explored to address multiculturalism within mainstream clinical settings include:

- training clinicians in generic approaches to cultural competence (Minas, 2001; Sue & Sue, 2003a),
- using culture brokers or community health advisors (Rosado & Elias, 1993; Wax, 1996), described in Section II.C.12 on page 25, and
- use of the consultation-liaison model.

A consultation-liaison model can allow nonspecialized clinicians in mainstream settings to provide trauma-informed therapy to deaf and hard of hearing children. Support for this approach can be found in the "Cultural Competence Standards in Managed Mental Health Care Services." These standards include guidelines for delivery of mental health care to underserved racial/ethnic groups, specifying that a racial/ethnic mental health specialist should be involved in care planning "directly or via consultation" (Center for Mental Health Services, 2001, 37–38, 42).

A consultation-liaison model can allow nonspecialized clinicians in mainstream settings to provide trauma-informed therapy to deaf and hard of hearing children.

2. Cultural Consultation

"Cultural consultation" is a type of consultation currently being developed in Montreal to improve the delivery of mental health services in mainstream settings for ethnocultural minority groups (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003). A cultural consultation is a comprehensive assessment of the social and cultural factors influencing diagnostic, prognostic, and treatment issues of patients with mental health problems. The Montreal approach to cultural consultation establishes guidelines for cultural assessment and formulation that elaborate on those outlined in the DSM-IV (American Psychiatric Association, 1994). A cultural formulation addresses the social, cultural, and political context for patient behaviors in order to guide diagnostic assessment, treatment planning, and service delivery. Cultural consultation is designed to provide specific cultural information, formal culturally based assessments, recommendations for treatment, and links to culturally affirming community resources.

The Montreal approach consists of three types of available consultation, similar to those first described by Caplan (1963; 1995):

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1. In *client-centered* case consultation, consultants with relevant cultural expertise directly assess an ethnocultural minority client referred by the mainstream clinician. The consultants provide recommendations to the referring clinician by phone, in a case conference, and/or in a written report.
2. In *consultee-centered* case consultation, the cultural consultants discuss the case with the referring mainstream clinician either by phone or in a case conference.
3. In *program-centered* case consultation, a group of individuals from a community provider organization receives cultural consultation focused on concerns they have in meeting the needs of a particular cultural community.

Once the cultural assessment/formulation is complete, the consulting team convenes and invites the consultee to attend a clinical case conference where they discuss, formulate, and propose specific recommendations on the case (Cultural Consultation Service, 2005).

In Montreal, cultural consultation has been shown to be useful in cases where there are difficulties in understanding, diagnosing and treating patients due to cultural differences between clinician and patient. Consultees report benefits from this approach that include increased knowledge of social and cultural aspects of their cases, improved empathy and therapeutic alliance, and increased confidence in diagnosis and the treatment approach. Following consultation, clinicians report increased understanding of the complexity of the case and less frustration in providing therapeutic interventions. Cultural consultation also resulted in increased demand for interpreting services.

The use of cultural consultation in Montreal has also brought to light some constraints, including

- how the consultant service will be reimbursed,
- concerns about how long the consultant can be available to the consultee through the course of treatment,
- the need for the consultant and the consultee to have a shared understanding about the consultant's role,
- the need for clinicians to have training in the effective use of interpreting and for interpreters to have specific expertise in mental health interpreting, and
- the need to develop the role of culture brokers for use in mental health settings.

Specialized mental health providers with expertise in deafness have traditionally provided a less structured approach to cultural consultation with nonspecialized providers in the mental health system. For example, clinical staff with the Mental Health Center of Denver's Deaf Counseling Services program (www.mhcd.org/MeetingtheNeeds/AdultOutpatient/DeafCounseling.htm) routinely provide cultural consultation for deaf and hard of hearing consumers in mainstream crisis/emergency, residential, and substance abuse treatment settings. Deaf Counseling Services clinicians may also consult with mental health providers in other areas of Colorado when deaf and hard of hearing persons request services. In most circumstances, they provide consultee-centered and program-centered consultation, addressing issues of communication,

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access/use of interpreters, available community resources, cultural assessment, considerations in evaluation and diagnosis, and treatment considerations.

There is a strong need to further explore the apparent utility of the cultural consultant approach to ensure culturally affirmative access to care for deaf and hard of hearing persons. There remains a need to identify the most effective way to structure this approach and to train specialized consultants. The applicability of telemedicine technology to broaden the use of the model should also be explored. Consideration should be given to integrating this approach with the use of culture brokers from the Deaf community (Wax, 1996); training clinicians in the effective use of interpreters (Turner, Klein, & Kitson, 2000); general training for clinicians in cultural competence; and specific training for interpreters in mental health interpreting.

Therefore, the following three principles should be followed in implementing a cultural consultation approach:

- The therapist/consultee should be well versed in the importance of cultural competency in working with diverse populations and recognize that the Deaf population has its own culture.
- The consultant must be familiar with providing consultation on Deaf culture in a mental health setting and thus be aware of typical mental health and general issues common with this population.
- The interpreter needs to be familiar with providing services in a mental health environment.

Use of the cultural consultation approach will assist the mainstream therapist in dealing with the special treatment considerations described in the following sections.

F. Assessment Issues

1. Using Assessment Instruments

As described throughout this document, there are a significant number of factors that contribute to the differences among deaf and hard of hearing children. Appropriate assessment of these children depends not only on a thorough knowledge of testing measures and techniques but also on an understanding of how linguistic and experiential differences will influence the results.

From surveys conducted over the past 20 years, Blennerhasset (2000) has compiled a list of 33 psychological tests most frequently used with deaf people to measure intelligence/cognitive functioning, social-emotional functioning/personality, achievement, and adaptive behavior. Of these, only seven were standardized for use with deaf people. As a result, the majority of these tests require significant modifications in administration, scoring, and interpretation because of inappropriate items and over reliance on verbal language. Even when practitioners use only performance-based or nonverbal sections to eliminate verbal bias, many measures require extensive English instructions. This may make it difficult for a deaf

Even when practitioners use only performance-based or non-verbal sections to eliminate verbal bias, tests must be used with careful adaptation and cautious interpretation

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client with limited receptive language to understand the task (Spragins, Blennerhassett, & Mullen, 1993). Tests must be used with careful adaptation and cautious interpretation, and a clinician reviewing a deaf client's test results should inquire about and consider whether the testing situation was adequate to yield useful and valid results.

2. *Special Considerations during the Assessment Process*

Psychologists at the University of California (Orr, DeMatteo, Heller, Lee, & Nguyen, 1987) advise that testing be conducted by competent practitioners with an extensive knowledge of deafness, taking the following into consideration:

- *language competence* of the deaf child in English, ASL, or other visual communication system;
- *culture differences* between deaf and hearing people, including styles of relating, common experiences, and customs as they impact the findings;
- *use of an interpreter* and how it will impact the testing situation;
- *language competence of the examiner* and his or her ability to meet the deaf child's language needs;
- *provision of instructions* clearly and simply, in the appropriate communication mode to ensure that the child understands; and
- *previous test experience of the child*, in which he or she may have experienced a sense of failure or been informed of their deficiencies.

Because of the complexity inherent in the psychological assessment of deaf children, it is highly recommended that the skilled but deaf-inexperienced practitioner seek consultation from a psychologist with deafness-specific expertise about the appropriate selection, adaptation, interpretation, and reporting of psychological testing.

3. *Using Test Results*

It is important to note that even with consultation, it may not be appropriate to compare the test results of one deaf child with those of other deaf or hearing children. When directions or test items are signed rather than read, standardization of the test items is lost, as various interpreters may sign the same question differently. Also, because of the range of communication styles and levels among deaf children, the same questions could be understood differently by different children even if signed identically by the same interpreter.

> **It may not be appropriate to compare the test results of one deaf child with those of other deaf or hearing children.**

Finally, because most tests have no deaf-specific normative groups against which to compare results, clinical cutoffs should not be used as definitive diagnostic tools. Therefore, symptom checklists such as the Trauma Symptom Checklist for Children (TSCC) (Briere, 1995) and the UCLA Index for PTSD (Rodriguez, Steinberg, & Pynoos, 1998) can best be used to inform treatment effectiveness and/or functioning over time for a specific deaf child. For example, a clinician can compare a deaf child's TSCC score before beginning treatment with his or her score six months later to determine whether symptoms are decreasing. However, the clinician should avoid using an individual score to determine the child's diagnosis at either time.

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G. Family Interactions

One important protective factor in a child's recovery from trauma is a strong and positive attachment with a parent (Freidrich, 2002). However, experts estimate that only 15 percent of parents develop sign language communication skills at levels enabling them to carry on meaningful conversations with their deaf children (Critchfield, 2002). Therapists working with traumatized deaf children should therefore consider using therapeutic techniques that build attachment and communication between parents and their children. These techniques should recognize that hearing parents may not be able to communicate effectively and may need to learn some specific signs or other ways to support their children during the therapy process and beyond. Some strategies include the following:

- Get both the parents' perspective and the child's view of the child's deafness, communication needs, effectiveness of communication, involvement with other deaf persons and Deaf culture, and resources needed for child and parents. Differing perspectives may indicate underlying issues.

- Provide parents with information on the child's current and future developmental tasks, including how these tasks are impacted by both the child's deafness and the trauma he or she has experienced.

- Hearing parents of abused deaf and hard of hearing children may have unique needs for support related to their child's abuse, because they may feel guilty about not being able to protect or meet the emotional needs of their child. Family therapy may need to be structured around the parental grief process and how it impacts their parenting.

- Provide ideas for parents to facilitate the child's developmental achievements. These should specifically address the potential risk that parents will become overprotective due to unresolved grief and guilt issues both before and after the trauma incident.

- Teach all members of the family about relaxation and visualization techniques that have been shown to be effective for use with deaf children in therapy.

- Hearing children of deaf parents may not always be fluent enough in sign language to communicate their feelings during the family session. Family therapy utilizing an interpreter is an opportunity for the deaf parents and hearing child to communicate at a deeper level.

- Parents of deaf and hard of hearing children should be encouraged to help improve their child's safety skills. While some hearing parents may lack the sign language fluency to provide this support, any efforts at developing communication skills should be encouraged and reinforced.

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H. Social-Emotional Development in Deaf Children

1. Studies of Deaf Children's Development and Concerns about These Studies

The social-emotional development process is complex and is navigated via a combination of verbal and nonverbal elements. In hearing children, emotional understanding, social development, and intellectual growth have been shown to be closely linked (Nowicki & Duke, 1992). Beginning in the 1950s, some reports have indicated that prelingually deaf children raised in a spoken language environment may have difficulty with social-emotional development (Gray, Hosie, Russell, & Ormel, 2001). There is a significant body of research comparing performance on various elements of social-emotional development in deaf and hard of hearing children with that of hearing children. However, there are major concerns about the design of these studies, including test administration, language, scoring, content, norms, and subject groups (Moores, 1982, 2001). Just as research with ethnocultural groups has come under fire for pathologizing cultural differences, similar issues have been raised with the lack of methodological rigor in studies of deaf children's development. These studies are seen as supporting the stereotypes that exist in the dominant hearing culture (Lane, 1988). Some researchers account for differences in social-emotional development as due to conversational deprivation common among the majority of deaf children raised in hearing households (Gray, Hosie, Russell, & Ormel, 2001; Marschark, 1993a; Marschark, 2001; Peterson & Siegal, 1999). Others believe that language may not account for all these differences (Kusché & Greenberg, 1983; Woolfe, Want, & Siegal, 2002).

> Just as research with ethnocultural groups has come under fire for pathologizing cultural differences, similar issues have been raised with the lack of methodological rigor in studies of deaf children's development.

There have been few controlled studies of deaf children's emotional development, so the real nature of their differences remains unclear. However, there are some recurring themes in the literature indicating that deaf children reportedly differ in social maturity (Mindel & Vernon, 1987; Schlesinger & Meadow, 1972); understanding of affective vocabulary words (Blanton & Nunnally, 1964); role-taking ability and empathy development (Bachara, Raphael, & Phelan, 1980; Odum, Blanton, & Laukhut, 1973), particularly when language is required (Kusché & Greenberg, 1983); egocentrism (Levine, 1981); ability to interpret emotions reflected in facial expressions (Gray, Hosie, Russell, & Ormel, 2001; Odum, Blanton, & Laukhut, 1973); social problem solving (Coady, 1984); use of rules governing displays of emotion (Hosie et al., 2000); predicting emotionally based behavior in others (theory of mind) (Marschark, Green, Hindmarsh, & Walker, 2000; Peterson & Siegal, 1997; Scott, Russell, Gray, Hosie, & Hunter, 1999); external locus of control (Blanton & Nunnally, 1964; Dowaliby, Burke, & McKee, 1983); impulsivity (Harris, 1978); and moral development (DeCaro & Emerton, 1978).

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2. Approaches for Mainstream Clinicians

Mainstream clinicians who provide trauma-focused therapy with deaf and hard of hearing children should be both aware and skeptical of the stereotypes described above. At the same time, they should be observant about the social-emotional developmental characteristics of the individual deaf children they are treating. They should keep in mind that the variation in social-emotional development *among* deaf children overall is greater than the differences between this group and the hearing population. Thus, a good rule-of-thumb is to be aware of the possible ways that deaf and hard of hearing children may differ from hearing children, while keeping in mind that these differences may or may not be present in every deaf child.

> **Mainstream clinicians should be aware of the possible ways that deaf and hard of hearing children may differ from hearing children, while keeping in mind that these differences may or may not be present in every deaf child**

The reported differences outlined above suggest that a clinician working with a deaf child may need to consider adapting his/her approach based on an assessment of the client's level of social-emotional development. Many mainstream clinicians are experienced in working with developmental delays in hearing children from impoverished backgrounds. Similarly, clinicians may want to take into account a deaf child's opportunities (or lack of opportunities) for acquiring skills such as self-control, emotional awareness, and interpersonal problem solving. Consultation with a specialized therapist familiar with deaf and hard of hearing children may also be useful in identifying and addressing social-emotional developmental differences.

Assessing the individual deaf child's social-emotional functioning will help identify his or her unique strengths and needs as they relate to age-appropriate expectations. A consortium of professionals supported by the W.T. Grant Foundation (1992) has developed a list of core social-emotional competencies, which could be useful in conducting such an assessment. It includes the following:

Emotional

- identifying and labeling feelings,
- expressing feelings,
- assessing the intensity of feelings,
- managing feelings, and
- delaying gratification.

Cognitive

- using self-talk—conducting an "inner dialogue" as a way to cope with a topic or challenge or reinforce one's own behavior;
- reading and interpreting social cues—for example, recognizing social influences on behavior and seeing oneself in the perspective of the larger community;
- using steps for problem solving and decision making—for instance, controlling impulses, setting goals, identifying alternative actions, and anticipating consequences;
- understanding the perspectives of others;
- understanding behavioral norms (what is and is not acceptable behavior);

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- having a positive attitude toward life; and
- developing self-awareness—for example, developing realistic expectations about oneself

Behavioral
- using nonverbal skills—communicating through eye contact, facial expressiveness, tone of voice, gestures, etc.; and
- using verbal skills—making clear requests, responding effectively to criticism, resisting negative influences, listening to others, helping others, and participating in positive peer groups.

To facilitate the development of these and other important social-emotional competencies, Greenberg and Kusché (1993) have developed the PATHS (Promoting Alternative Thinking Strategies) Curriculum for elementary school-aged deaf students. The curriculum has four goals. First, it teaches children to "stop and calm down," thus facilitating the development and use of internal verbal thought. Second, children receive enriched linguistic experiences to help them mediate understanding between themselves and others. Third, emotional regulation is modeled and encouraged through the use of self-control strategies. Fourth, children learn to integrate emotional understanding with cognitive and linguistic skills in order to analyze and solve problems and improve their daily behavior (M. T. Greenberg & Kusché, 1993, 68).

I. Adapting Cognitive Behavioral Techniques

Nearly any treatment modality can be adapted and used with deaf children. However, cognitive behavioral techniques have the largest amount of empirical support for treating child trauma (Putnam, 2003). Mainstream therapists working with deaf and hard of hearing children should take into account the following considerations in adapting trauma-informed treatment:

- Assess the child's affective and general vocabulary, regardless of age. How developed is the child's sign language skills/linguistic competence? Consider that he/she may be unable to recognize the written English or finger spelled word for a specific emotion, but that he/she may know the ASL sign for the emotion.
- Be aware that, in assessing a deaf child's affect, facial expression and body language are very important. Both are elements used in sign language just as intonation is used in spoken language to convey emotion. When explaining something in sign language, the child's affect may reflect his or her emotions at the time of the event, not the current emotional state. The therapist should also be aware of his or her own facial expression and body language and what it conveys to the deaf child.
- Use role-play in conjunction with pictures and drawings to teach various emotions relevant to the child's age. Dolls can be used to role play with younger children.
- Differentiate emotional "feeling" from physical "feeling" using the "Color my Life" technique described by Cohen, Mannarino, and Deblinger (2000). Visual techniques and artwork can be helpful in explaining the relationships between situations, thoughts, and feelings.

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- Use words and behavioral descriptions that children can understand to describe concepts of cognitions. With younger children, the concept of cognitions can be visually represented by drawing cartoon-like figures representing various types of thoughts in a "thought balloon" above the figure's head.
- Use balloons to teach visualization. The therapist can have the interpreter interpret guided imagery instructions while the child watches and follows along.
- Adapt written exercises to the child's reading and writing ability when necessary. Pictures and drawings can be substituted for the written material.
- Use metaphors like cooked vs. uncooked spaghetti to help the child understand relaxation vs. tension in the body.
- Include learning the correct vocabulary for sexual anatomy and sexual terms, as well as identifying trusted people the child can talk to about abuse for safety-skills training.

J.   Management of Countertransference and Use of Transference

As described in Section III.A.2 on page 31, many deaf children will have experienced trauma due to sustained communicative isolation within their families. The psychotherapist must be prepared to identify and address any reactions related to this isolation along with the reactions to other traumatic events the child may have experienced. Therapists experienced in trauma-focused work may see this as similar to the modifications they make when a child has experienced previous chronic stress or trauma. For example, having experienced a previous traumatic event increases the risk of more severe PTSD symptoms when a new traumatic event occurs (Krupnick et al., 2004; Neuner et al., 2005). In their study of Asian-American veterans of the Vietnam conflict Loo et al. (2001) have shown that exposure to race-related stressors can be a potent risk factor for PTSD where an additional 19-20 % of the variance in PTSD is accounted for by adding race-related stressors. Harvey's conceptualization of communicative isolation can be likened to a chronic race-related stressor (or in this case, culturally related), as it is the result of discrimination/oppression of members of one minority group (deaf children) by members of the majority (hearing parents and siblings) who hold more power both individually (parents over their children) and as a group in society (hearing over deaf).

> **The psychotherapist must be prepared to identify and address any reactions related to [communicative] isolation along with the reactions to other traumatic events the child may have experienced.**

Treating posttrauma reactions of deaf/hard of hearing children and adolescents requires unique therapeutic considerations. These include the following:

- Psychotherapists who routinely work with deaf clients need to deal with their vicarious trauma reactions to the clients' experience of sustained communicative isolation. Harvey (1996) warns that these can manifest as desensitized, discounting, or nonempathic reactions by the therapist. As a result, the therapist may pathologize the child's

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experience of being an outsider in a hearing world and devalue his or her sense of identity with other deaf persons.

- When an older deaf child or adolescent has been traumatized by hearing persons, the hearing therapist should be aware that the client may likely reexperience that trauma with the therapist, i.e., the phenomena of traumatic transference and traumatic reenactment (Harvey, 1996). Traumatic transference and reenactment may be expressed in various forms, including idealizing the hearing therapist or devaluing the hearing therapist. In this circumstance, the therapist must be prepared to deal with typical countertransference reactions, which include seeking validation from the client.

- With older deaf children and adolescents, the culturally competent hearing therapist should be prepared to utilize traumatic transference and reenactment to assist the child in working through traumatic responses to sustained communicative isolation (Harvey, 1996).

K. Working with the System of Care

Mainstream service delivery systems for children are typically not fully accessible for deaf and hard of hearing children. This means that the mental health provider, as the person most knowledgeable about the deaf child's needs, may frequently feel pressure to serve in an advocacy or educational role for his or her clients and their families. This leads to a dual role for the practitioner. Therefore, the clinician should make every attempt to access community resources, however limited, to create additional support through wraparound services. The practitioner needs to be aware of how to access resources specific to deaf children and families. Therapists are advised to work with their state's deaf center, state coordinator of deaf services, commission for the deaf, and/or schools for the deaf to identify and access resources that may be available for the Deaf population.

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APPENDIX A. HELPFUL WEBSITES

General Information on Deafness	
Deaf Linx	www.deaflinx.com
What You Need to Know about Deafness	www.deafness.about.com/mbody.htm
Hearing Exchange	www.hearingexchange.com/?source=Sprinks
Procuring and Using an Interpreter	
Deaf and Hard of Hearing Interpreting Services	www.dhisnyc.com/useinterpreter.cfm
Deaf Linx	www.deaflinx.com/useterp.html
UCSF Center on Deafness	uccd.org/products.html
Registry of Interpreters for the Deaf	www.rid.org
ASL Info	www.aslinfo.com/interpreting.cfm
General Tips for Communication	
Deaf and Hard of Hearing Interpreting Services	www.dhisnyc.com/commtips.cfm
Children of Deaf Adults	
Children of Deaf Adults International	www.coda-internationa.org
Kids of Deaf Adults	www.koda-info.org/
Deaf Linx	www.deaflinx.com/coda.html
Multicultural Issues in Deafness	
Laurent Clerc National Deaf Education Center	clerccenter.gallaudet.edu/InfoToGo/409.html
Silent Blessings Deaf Ministries	www.silentblessings.org/index.asp
National Black Deaf Advocates	www.nbda.org/
Intertribal Deaf Council	www.deafnative.com
Rainbow Alliance of the Deaf	www.rad.org
National Asian Deaf Congress	www.nadc-usa.org
Readings and Resources on Multicultural Issues and Deaf Students	http://clerccenter.gallaudet.edu/InfoToGo/409.pdf
Deaf Aztlan: Deaf Latino/a Network	www.deafvision.net/aztlan/welcome.html
Jewish Deaf Congress	www.jdcc.org
Deaf Women United	www.dwu.org
Deaf and Hard of Hearing Children	
American Society for Deaf Children	www.deafchildren.org/home/home.html
Hands & Voices-Deaf Child Bill of Rights	www.handsandvoices.org/resource/resourceguide
Organizations of and for the Deaf and Hard of Hearing	
Deaf America	www.deafamerica.com/DeafOrganizations.htm
National Association of the Deaf	www.nad.org/index.html
Self Help for the Hard of Hearing (SHHH)	www.hearingloss.org
Alexander Graham Bell Association for the Deaf and Hard of Hearing	www.agbell.org

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Prevention Resources	
Center for Abuse Prevention and Education– Deaf and Hard of Hearing	www.uncg.edu/ses/cape/index.html
Legal Issues	
National Association of the Deaf Information Center	www.nad.org/infocenter/infotogo/legal/ada3qa.html
Cultural Consultation in Mental Health	
Cultural Consultation Service of the Jewish General Hospital	www.mcgill.ca/ccs/about/
Hearing Technology	
Alexander Graham Bell Association for the Deaf and Hard of Hearing	www.agbell.org/DesktopDefault.aspx?p=Hearing_Technology
Standards of Care	
National Technical Assistance Center for State Mental Health Planning	www.nasmhpd.org/ntac/reports/Deaf.pdf
Sign Language Resources	
ASL Access ASL Info ASL in Motion	www.aslaccess.org www.aslinfo.com/index.cfm www.learnsignlanguagedvd.com/index.htm
Deaf Culture	
National Theater of the Deaf Big River; The Adventures of Huckleberry Finn Deaf West Theatre Hands On ASL Info	www.ntd.org www.handson.org/bigriver.htm www.deafwest.org/home.html www.handson.org/index.html www.aslinfo.com/deafculture.cfm
Training and Technical Assistance	
Safe Place Disability Services	http://www.austin-safeplace.org/programs/disability/default.htm
Resources for Parents of Deaf and Hard of Hearing Children	
Colorado Hands and Voices	www.handsandvoices.org

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APPENDIX B. CULTURAL VS. PATHOLOGICAL VIEWS OF DEAFNESS

Two Views of Deafness	
Outline by Chris Wixtrom from: *The Deaf American*, winter 1988 *(Wixtrom, 1988)* Reprinted with permission.	
Deafness as Pathology	**Deafness as a Difference**
With this perspective, a person might:	**With this perspective, a person might:**
Define deafness as a *pathological condition* (a defect or handicap) that distinguishes *abnormal* deaf persons from normal hearing persons.	Define deafness as merely a *difference* or a *characteristic* that distinguishes normal deaf persons from normal hearing persons. Recognize that deaf people are a linguistic/cultural minority.
Deny, downplay or hide evidence of deafness.	Openly acknowledge deafness.
Seek a "cure" for deafness: focus on ameliorating the effects of the "auditory disability" or "impairment."	Emphasize the abilities of deaf persons.
Give much attention to the use of hearing aids and other devices that enhance auditory perception and/or focus on speech, e.g., amplifiers, tactile and computer-aided speech devices, cue systems.	Give much attention to issues of communication access for deaf persons through visual devices and services, e.g., telecommunication devices, light signal devices, captioning devices, interpreters.
Place much emphasis on speech and speech reading ("oral skills"); avoid sign and other communication methods which are deemed "inferior."	Encourage the development of all communication modes, including but not limited to speech.
Promote the use of auditory-based communication modes; frown upon the use of modes that are primarily visual.	Strongly emphasize the use of vision as a positive, efficient alternative to the auditory channel.
Describe sign language as inferior to spoken language.	View sign language as equal to spoken language.
View spoken language as the most natural language for all persons, including the deaf.	View sign language as the most natural language for the deaf.
Make mastery of spoken language a central educational aim.	In education, focus on subject matter rather than methods of communication. Work to expand all communication skills.
Support socialization of deaf persons with hearing persons. Frown upon deaf/deaf interaction and deaf/deaf marriages.	Support socialization within the deaf community as well as within the larger community.
Regard "the normal hearing person" as the best role model.	Regard successful deaf adults as positive role models for deaf children.
Regard professional involvement with the deaf as "helping the deaf" to "overcome their handicap" and to "live in the hearing world."	Regard professional involvement as "working with the deaf" to "provide access to the same rights and privileges that hearing people enjoy."
Neither accept nor support a separate "Deaf culture."	Respect, value and support the language and culture of deaf people.

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APPENDIX C. CONTACT INFORMATION

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