

November 2019

Childhood Trauma: Considering Diagnostic and Culturally Sensitive Treatment Approaches for Deaf Clients

Tomina Schwenke
Georgia State University

Follow this and additional works at: <https://repository.wcsu.edu/jadara>

Recommended Citation

Schwenke, T. (2019). Childhood Trauma: Considering Diagnostic and Culturally Sensitive Treatment Approaches for Deaf Clients. *JADARA*, 45(1). Retrieved from <https://repository.wcsu.edu/jadara/vol45/iss1/3>

Tomina Schwenke

Georgia State University

Abstract

As the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV-TR, 1994) is under revision, the complexity of diagnosing and treating childhood trauma with the current trauma-related diagnoses, including Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) is being debated (van der Kolk, 2005). Regarding deaf individuals, significant differences in symptom presentation (e.g., avoidance/numbing, hyperarousal, and re-experiencing symptoms) suggest that caution is needed when using the current criterion for the diagnosis of PTSD within this population (Schild & Dalenberg, 2011). Despite diagnostic uncertainties, it is generally accepted that regardless of hearing status, early childhood is a critical period for the development of relationships and attachment styles which profoundly affect the later development of interpersonal relationships (Bowlby, 1988; Ainsworth, Bell, & Stayton, 1971).

The existing research acknowledges that in comparison to hearing individuals, deaf children are exposed to interpersonal traumas (e.g., neglect, physical abuse, sexual abuse and emotional abuse) at greater rates of prevalence (Sullivan & Knutson, 1998). Furthermore, significant behavioral and emotional problems have been associated with the experience of abuse for deaf and hard-of-hearing children, including increased symptoms of PTSD, anxiety and depression (Sullivan & Knutson, 1998). It is well documented that over ninety percent of deaf children are born to hearing parents, a factor thought to contribute to impaired communication in the home, creating an environment in which a deaf child is uniquely vulnerable to abuse (LaBarre, 1998). Indeed, Ridgeway (1993) contends that due to the high rate of childhood abuse within the deaf community, some children may view the abuse as part of being deaf. Given the prevalence of childhood trauma, the invasive effects of childhood maltreatment, the potential for subsequent behavioral and emotional problems there is clearly a need for intervention. Within this context play therapy is one treatment modality that is considered in this paper as potentially effective in treating deaf children who have experienced trauma.

Keywords: trauma, play therapy, deaf

Eth and Pynoos (1985) state that a psychological trauma occurs "when an individual is exposed to an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety, and instinctual arousal" (p. 38). Special interest has been devoted to treating victims of childhood trauma (e.g. Terr, Herman, James, van der Kolk, Webb), and the literature has provided insight regarding case conceptualization, intervention options, as well as developmental and cognitive implications. Furthermore, childhood trauma has received recent attention as diagnostic categories are currently being debated and treatment modalities explored (van der Kolk, 2009).

Regarding deaf¹ individuals, there remain considerable barriers to identifying, diagnosing and treating victims of trauma (Schild, 2011; Swartz, 1995). Complicating matters, there are limited clinicians prepared to provide services and deaf children represent an underserved population (Ridgeway, 1993). Thus, there is a call for culturally competent clinicians and researchers as well as documentation of treatment approaches that meet the needs of deaf trauma survivors. It is suggested that therapy with children who are deaf and hard-of-hearing require a strong sense of creativity, as existing therapeutic interventions frequently require modification, so they are less auditory and more visual (LaBarre, 1998). Related to this suggestion, it is thought that expressive arts and play therapy may provide promise for effective treatment outcomes and healing for deaf and hard-of-hearing children.

Trauma, Symptoms and Diagnosis

Recent empirical findings, suggest a strong association between childhood trauma (e.g. maltreatment) and social, emotional, behavioral and cognitive adaptational failure and psychopathology (Glaser, 2000). Given the sensitive period for brain growth and maturation it is suggested that childhood neglect and failure of environmental stimulation in early life (0-2 years) may produce permanent deficits in cognitive abilities (Glaser, 2000). For many abused children, hypervigilance and hyperactivity are common and sensitive stress responses symptomatically resemble behaviors associated with ADHD; however these behaviors are likely a manifestation of post-traumatic arousal (Glaser, 2000). The literature also suggests associations between early experiences of abuse and aggressive responses, dissociative reactions, difficulties with aspects of executive functions, and educational underachievement (Glaser, 2000). Empirical support indicates a strong association between functional, structural, and chemical changes in the brain, and a child's history of early trauma, such as abuse and neglect (Glaser, 2000). Finally, psychobiological attachment theory suggests vulnerabilities (e.g., developing brain, neural development, social interactions and information processing throughout the lifetime) in the absence of early secure attachments; however, posits that the presence of securely attached relationships with caregivers can provide a kind of buffer to physical and mental wellness (Glaser, 2000).

¹ The term "deaf" is to be interpreted to include individuals who are hard of hearing, late deafened, and deaf-blind.

Following the publication of the *Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III)* (American Psychiatric Association, 1980) research on traumatized children began in earnest and seemed to flourish (Fletcher, 1996; Ogawa, 2004). Today the American Psychiatric Association, publishers of the *Diagnostic and Statistical Manuals*, is actively revising the fourth edition in anticipation of the final publication expected in May 2013. Regarding the limitations of the manuals (e.g., DSM-IV-TR, 1994), van der Kolk and his colleagues (1996) suggest that children who are chronically abused and neglected are pervasively effected, develop complex reactions to stress, and are not easily diagnosed by current diagnostic criteria. Symptoms of children with trauma histories vary; however, often include increased fear, worry, sadness, anger, feeling alone and apart from others, and difficulties trusting others, as well as, heightened aggression, out-of-place sexual behavior, and self-harming behaviors (Department of Veteran Affairs PTSD website, 2011).

In a study conducted by Black and Glickman (2006) in which the hospital records of 64 deaf psychiatric patients were reviewed, 29.7% of the sample had a diagnosis of PTSD. These rates were greater than hearing counterpart (6.6%), raising questions regarding the validity and reliability of diagnosing disorders in deaf individuals (Black & Glickman, 2006). This reality, is further complicated by the complexity of identifying, diagnosing, and treating children who have experienced a trauma (van der Kolk, 2009). Overall, it is suggested that the heterogeneity of deaf individuals, the dearth of appropriately validated measures, and a shortage of culturally and linguistically competent mental health professionals are factors that complicate the diagnosis and treatment process (Schild & Dalenberg, 2011). Furthermore, when working with the pediatric population factors including developmental level and communication abilities are important considerations.

Communication

It has been noted that deaf children can experience communication isolation within their families, which can be a form of trauma (Harvey, 1996). Several studies have looked at the compromised communication patterns developed between a deaf child and mother and have seen the effects of this relationship problem on development (Schilling & DeJesus, 1993) and the amount of time that the pair spends together (Lederberg & Mobley, 1990). Research suggests that approximately 81% of hearing

parents are not able to effectively communicate with their deaf children inhibiting open communication, a critical factor regarding the identification of abuse (Phoenix, 1988).

The literature about children who are prelingually deaf suggests that a lack of significant early exposure to language and the consequences of his deprivation are profound (Ridgeway, 1993). Researchers agree that early language deprivation has serious consequences on deaf children, as deficits are inversely related to emotional well being and self-esteem (Ridgeway, 1993). Specifically, children who have not acquired a primary language will be disadvantaged in academic and social domains as they try to learn and develop interpersonal relationships (Quittner, Leibach, Marciel, 2004) and are particularly vulnerable to interpersonal abuse (Ridgeway, 1993).

Regarding deaf individuals, access to communication and traumatization go hand and hand. It is well documented that deaf children are at a disadvantage related to accessing information regarding safety and abuse (Ridgeway, 1993). Furthermore, Schild and Dalenberg (2011) found an emerging theme when analyzing their data from a sample of deaf individuals exposed to traumatic events in which there was a prevalence of *Information Deprivation Trauma (IDT)*. IDT, is defined as an event that is traumatic which becomes more traumatic due to the limited access to information or knowledge regarding the event (Schild & Dalenberg, 2011). This lack of information resulted in an exacerbation of factors related to traumatization such as suddenness, unpredictability and uncontrollability (Carlson & Dalenberg, 2000; Schild & Dalenberg, 2011). In addition, it is suggested that early language deprivation coupled with social isolation may increase a deaf individual's vulnerability for a symptom of PTSD, disassociation (Schild & Dalenberg, 2011). Given the complexity of the problem it is essential to assess the scope and severity of the issues within the general population in order to consider issues salient within the deaf population.

General Demographics

Epidemiological research has indicated gender differences regarding trauma. Whereas the initial population studied when establishing the PTSD diagnostic criteria were usually males who had been traumatized (e.g., in accidents, war, and assaults) it is known that women report childhood abuse as the most frequent cause of traumatization (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Of particular import are statistics indicating that

between 17% and 33% of women in the general population report histories of sexual and/or physical abuse (Finkelhor, Hotaling, Lewis, & Smith, 1990; Kessler et al. 1995) and within the mental health settings these rates increase to 35% to 50% (Cloitre, Cohen, Han, & Edelman, 2001). Although 10% of the general population reports experiencing rape in adulthood, twice as many women report experiencing childhood sexual abuse.

Research conducted on children adds additional quantitative data, which can help guide client conceptualization, clarify assessment and diagnostic issues, and assist with the intervention process. Research by the National Child Traumatic Stress Network (NCTSN) utilized a complex trauma survey to collect information from 1,699 children across 25 network sites (Spinazzola, Ford, van der Kolk, Brymer, Garner, Silva, S., et al., 2003). The survey was designed to assess for complex trauma exposure, outcomes and treatment approaches received by children and families during a particular time period in 2002. The findings showed that a majority of the children (78%) were exposed to multiple and/or prolonged trauma. Furthermore, the initial exposure to trauma typically occurs early as the results indicated that the average age of onset was 5 years old. Specifically, 98% of clinicians reported that on average trauma onset happened prior to age 11 and 93% of clinicians reported an average onset of age 8. One-half of the children surveyed reported that they had experienced psychological maltreatment (Child Emotional Abuse or CEA; i.e. verbal abuse, emotional abuse or emotional neglect); traumatic loss; dependence on an impaired caregiver (i.e., parental mental illness or substance abuse); and domestic violence. Similarly prevalent were reported cases of sexual maltreatment/assault (Child Sexual Abuse or CSA), and neglect (i.e., physical, medical or educational neglect), which were observed in at least one in three children (Complex Trauma in Children and Adolescents, National Child Traumatic Stress Network, 2002). Regarding treatment, one consistent finding regarding intervention and treatment was that weekly individual therapy and family therapy were rated to be effective modalities for working with this population; however, there was not a consensus on the effectiveness of play therapy, expressive therapies, or group therapy.

Case Studies

There are several case studies of children that have experienced interpersonal traumas; however, published case studies of children who are deaf are limited and tend to focus on educational or linguistic implications

related to isolation and impaired. The published cases of “Doris” (Bodenheimer, 1974) and “Chelsea” (Cutiss, 1989) provide some insight into some of the complexity within the assessment and treatment processes. Both of these cases provide evidence of systemic barriers and professional ethical standards that are involved in treating children who are deaf. In Aron Bodenheimer’s book, “Doris: The Story of a Disfigured Deaf Child,” the author provides an account of the treatment of a deaf child who lived in a residential school for the deaf in Zurich. The observations and interventions took place in 1968, when Doris was 13 years old. The author writes in the book’s preface that Doris’s drawings were used to explore her psychological issues. While these drawings were primarily used for assessment purposes they speak to the power of expressive arts as a clinical tool used with a deaf child. Bodenheimer suggests that “it might seem peculiar that in our discussion so far we have not once hinted at any special technique” or “methodology” for coming to an understanding with deaf children...A good understanding of how deaf people speak and understand and how one talks with them is naturally indispensable for conversing with them...Anything beyond this kind of competence would probably be not only superfluous but actually obstructive for the psychotherapist” (Bodenheimer, p. 116). In this statement the author identifies the essential nature and ethical obligation to communicate in a language accessible to the client.

The case of “Chelsea” (Curtiss, 1989) has been compared to the well-documented case of “Genie” (Curtiss, 1977) as an example of critical periods for language learning. In the case of Chelsea, although she was born deaf, she mistakenly diagnosed as mentally retarded or emotionally disturbed. Based on this diagnosis she was reportedly never exposed to sign language or speech training. Chelsea was referred to a neurologist when she was 31 years old, and it was learned that she was neurologically within normal limits, but was deaf. She was then provided with hearing aids and intensive rehabilitation. Despite the remediation Chelsea’s language acquisition was impaired, and although she learned several of the rudimentary aspects of grammar and developed a sizable vocabulary, she was never fluent in sign or spoken language. This case, exemplifies the devastating effects of limited access to language and is a reminder of the trauma inherent in negligent treatment.

Scholars such as Harlan Lane (1984, 1992) have documented the history of patronizing and harmful practices by professionals working with deaf individuals. These accounts provide the backdrop for the current dilemma

faced by individuals who are deaf or who have children who are deaf. Documented cases of misdiagnosis and ethical violations contribute to the apprehensions amongst the deaf community about seeking professional assistance and treatment (National Association of the Deaf, 2008). This is an unfortunate legacy as trauma survivors may be hesitant to engage in activities that could be beneficial.

Demographics Related to Deafness

Deafness is considered a low-incidence disability; however, these data provide a clearer picture of the population, culture, and potential risks. Evidence suggests that compared to non-disabled women, women with disabilities are abused by a greater number of perpetrators and are abused for longer periods of time (Young, Nosek, Howland, Chapog, & Rintala, 1997). It is estimated that 28 million Americans have a hearing loss (National Institute on Deafness and Other Communication Disorders, 2005); 3.78 % of children ages 8 to 17 have some type of hearing loss (Gallaudet Research Institute, 2005) and in the state of Alabama, for example, there are approximately 20,000 deaf and hard of hearing children and adolescents (Hamerdinger & Smith, 2005). It has been documented that approximately 90% of deaf children are born into families with hearing parents (Padden and Humphries, 1988), and therefore, most parents are not fluent in sign language. Deaf children are more vulnerable than hearing children to neglect and emotional, physical, and sexual abuse (Sullivan, Vernon, & Scanian, 1987). Of particular concern are the findings that 50% of deaf girls have been sexually abused as compared to 25% of hearing girls (Sullivan, 1987) and 54% of deaf boys have been sexually abused as compared to 10% of hearing boys (Sullivan, et al., 1987). Overall, a deaf child is estimated to be two to three times more likely to be sexually abused than their hearing peers (Hamerdinger & Smith, 2005; Kvam, 2004; Willis & Vernon, 2002). Given the statistics, deaf children, adolescents and adults are at an elevated risk of experiencing symptoms of trauma, and children may be particularly vulnerable based on environmental factors, such as the ability to participate in communication at home and access to resources at school or in the community.

Deaf Children

The National Association of the Deaf (NAD) Law and Advocacy Center has issued a position statement on Mental Health Services for Deaf Children (2008). In particular the authors emphasize the influences of language

barriers, which are more highly correlated, with higher rates of aggression, low self-esteem and impaired abilities to develop meaningful bonds with peers and adults (Kennedy, 1989; Marschark, 1993; Sarti, 1993). Additionally, the authors note that 22% of deaf children have additional disabilities, many of which result in cognitive impairments. Overall, the position statement focuses on many of the failures in the current service delivery system with the status of mental health services for deaf and hard of hearing people in the United States characterized as “sorely inadequate,” with profound barriers to services, such as the dearth of mental health professionals who are trained to work with deaf individuals and the potential risk for misdiagnosis (Morgan & Vernon, 1994; Hindley, 1999). Furthermore, the ethical implications of using inappropriate assessment tools and evidence-based practices that have been generally untested on deaf children, are explored in greater depth (NAD, 2008). Recommendations are made for increasing the number of trained clinicians who are fluent in American Sign Language (ASL) and are trained in the use culturally affirmative interventions (Hamerdinger & Hill, 2005; Glickman & Harvey, 1996; Willis & Vernon, 2002; Mason & Braxton, 2004).

Childhood Trauma and Deaf Children

The results of a 1994 National Center on Child Abuse and Neglect (NCCAN) found that whereas primary caretakers of children with disabilities were involved in the reported maltreatment in only 14% of the reported cases, for children without disabilities the primary caretakers were involved in 24% of the cases. In related research, Sullivan, Vernon and Scanian (1987) looked at the experience of deaf children living in residential settings. The researchers conducted four studies between the years of 1983 and 1987. In the initial two studies the researchers learned that of those students that were living in the residential school, 50% reported being sexually abused. In the subsequent study of deaf college students, 28% of those surveyed reported experiences of physical or sexual abuse. In the fourth study Sullivan, Vernon and Scanian (1987) found that 49% of the victims of sexual abuse reported that the abuse happened at school, while 31% took place at home, and 20% incidents both at home and school. These findings indicate that deaf children may experience different kinds of risks for interpersonal abuse and maltreatment. Schild and Dalenberg (2011) reported findings consistent with Sullivan, et al. (1987). Specifically, in a quantitative study of trauma exposure within the deaf population, of the sample of 79 deaf adults, 44.1% of men and 53.3% of women reported

sexual abuse and 73.5% of men and 71.1% of women reported physical assault (Schild & Dalenberg, 2011).

Research suggests an association between early childhood trauma and clinical implications including behavioral problems and devaluing of the self. Specifically, Sullivan and Knutson (1998) administered the Total Problems, Externalizing, and Internalizing Scales of the Child Behavior Checklist (CBC) and while deaf children who were not abused attained scores within normal limits; those children that were abused indicated distress. Those who had been abused reported clinically elevated symptoms in the area of Internalizing behaviors and Total behavior problems, indicating higher incidents of depression and anxiety symptomology (Sullivan & Knutson, 1998). Furthermore, as Ridgeway (1993) argues, deaf children who are abused are offered little support and over time develop negative self-concept and low self-esteem.

Play Therapy

Play can have healing properties in difficult situations (Brown & Webb, 2005), and play therapy has been well documented as an intervention for traumatized children (van der Kolk, Silva, Cloitre, Webb, Chard). The use of play in child therapy has origins in the 1920s when Anna Freud (1992/1946, as cited in Landreth, 2002) utilized games and toys to build relationships with her patients. Additionally, Melanie Klein (1932), made interpretations of the child based on an assessment of his or her play. David Levy (1938) used a structured play format as a means of assisting children to reenact traumatic events, an intervention known as Release Play Therapy. Gove Hambidge (1955) extended Levy's work and through the structured play format, "Structured Play Therapy," he used a more directive approach. From a strengths-based approach regarding children and their potential for growth, change play therapists such as Hesse Taft (1933), Frederick Allen (1942), Claude Moustakas (1959), and Virginia Axline (1947) attended to the power of the therapeutic relationship (Webb, 2007; Landreth, 2002). Regarding play, Bettelheim (1987) reported that "play is the royal road to the child's conscious and unconscious inner world; if we want to understand his inner world and help him with it, we must learn to walk his road" (Brown & Webb, p. 35). Similarly, Axline's conceptualization of play therapy included a belief that play is a child's natural medium for self-expression (Brown & Webb; Axline, 1947). Landreth stated that "The goal of my work

in play therapy has been to help make the world a safer place for children” (University of North Texas website, 2010).

Play therapy has been defined as “a helping interaction between a trained adult therapist and a child for the purpose of relieving the child’s emotional distress by using the symbolic communication of play” (Webb, 2007, p. 46). Working through the metaphor of play accomplishes two goals; not only are the presenting symptoms of distress reduced, efforts are simultaneously being directed towards the removal of impediments for the child’s future growth and development (Webb). It is not the exclusive use of play that provides symptom relief but it is believed that the therapeutic relationship is an essential component of the healing process (Chethik, 2000; Landreth, 2002). Some of the curative factors of using play therapy with traumatized children include experiencing a sense of security, sense of control, and freedom of expression (Ogawa, 2004). Play therapy consists of both verbal and play interactions and is typically used when working with children up to late elementary school age; however, there are additional uses for play therapy and expressive arts beyond this age parameter. Therapists working with clients throughout the lifespan often utilize art techniques, commonly used in play therapy.

Play therapy has been used in a variety of settings with a number of clinical presentations and special populations. Crisis Intervention Play Therapy (CIPT), is a specialized model of treatment used with children who are symptomatic following exposure to a crisis or traumatic event. CIPT uses standard play therapy methods and techniques, and has the “specific goal of helping the child attain mastery over his or her anxiety associated with the experience” (Webb, 2007, p. 49). CIPT is a treatment method that is typically directive and short-term in nature. CIPT can be used to treat what Terr (1991) distinguishes between Type I and Type II traumas. Specifically, CIPT is a recommended treatment for children who have experienced a single event (Type I) trauma as well as an initial intervention used with children who have experienced multiple (Type II) traumas.

Consistent with directive and non-directive approaches to play therapy communication is essential between clinician and client. Most approaches rely on language in order to track a child’s play, to set limits, to convey encouragement and to show empathy (e.g. Landreth, Kottman). Given the importance of language accessibility, mode of communication and possible modifications are important considerations to meet the needs of the deaf

client. A therapeutic intervention such as play therapy holds the promise of strengthening communication between the deaf child and a caring adult and is worth further exploration, regardless of the inherent complexities.

Play therapy is believed to be an effective intervention for assisting children with self expression (Axline, 1947; Bratton & Ray, 2000; Landreth, 2002) and when used with deaf and hard of hearing individuals has been recognized as facilitating the development of more mature behavior patterns (Landreth, 2004). Landreth has suggested that play is an “innate and universal” means by which children express themselves regardless of developmental or special needs. It has been stated by Burke, Gutman and Dobosh (1999) through their work with deaf clients that “a patient, creative therapist who is willing to be flexible in approach can help a client with the healing process despite the absence of extensive language skills” (p. 297). The authors report that “drawings, collages, and related techniques can constitute a dialogue between client and therapist within which change can occur and be recorded” (Burke, Gutman & Dobosh, 1999, p. 297).

Culturally Affirming Play Therapy

Minimal research has explored the validity of play therapy as a clinical approach to working with deaf clients; however, Garry Landreth’s pioneering work may provide some direction. As a clinician and researcher, Landreth has developed a non-directed play therapy approach that has been applied to a variety of special populations. In one study of pre-school students who were deaf and hard of hearing, Smith and Landreth (2004) explored the effectiveness of a form of play therapy, filial therapy. In this study teachers were trained in basic play therapy and filial therapy skills and then selected students with special emotional and behavioral needs were assessed over a period of time. Teachers were observed regarding issues of empathic responsiveness; communication of acceptance; and allowance of self-direction. Students were observed with a focus on possible reductions in overall behavior problems; internalizing behaviors; and externalizing behavior problems. Results indicated that students were identified as having fewer overall behavior problems, including being withdrawn and showing internalizing behaviors, at the post-test evaluation.

Beyond obtaining skills in mental health and sign language fluency, clinicians and researchers working with deaf individuals should acquire

knowledge in developmental, biological, social, vocational, educational, legal, and cultural facets of deafness (Pollard, 1996). Glickman and Gulati (2003) emphasize that a clinician working within a culturally affirming framework uniquely should be culturally competent and have relevant self-awareness, in addition to special knowledge and skills (Sue, Arredonondo, & McDavis, 1992).

When considering culturally affirming approaches for working with children who have experienced a traumatic event(s) and are also deaf there are many conceivable barriers to receiving quality treatment; however, Burke, Gutman and Dobosh (1999) and Landreth (2002) look at possible solutions that involve the use of play therapy. Considering the heterogeneous nature of the deaf community and the trauma community each clinical arrangement will require individualized planning and treatment negotiations. Thus, further effort is needed in the area of research and clinical practice to consider culturally affirming interventions, such as play therapy, that may be appropriate when working with trauma survivors within this linguistically and culturally marginalized group.

Contact Information

Tomina Schwenke, MA, MA, CI/CT
Emory University
Dept. of Psychiatry and Behavioral Sciences
Grady Health System
80 Jesse Hill Jr. Drive NE
Atlanta, GA 30303
(404) 616-2890
tomina.schwenke@mac.com

References

- Ainsworth, M. D. S., Bell, S. M., & Stayton, D. J. (1971). Individual differences in Strange Situation behavior of one-year-olds. In H. R. Schaffer (Ed.), *The origins of human social relations* (pp. 17-57). London: Academic Press.
- Axline, V. (1947). *Play Therapy*. Churchill Livingstone. London: Elsevier Science Limited.
- Black, P. A. & Glickman, N. S. (2006). Demographics, psychiatric diagnoses, and other characteristics of north American deaf and hard-of-hearing inpatients. *The Journal of Deaf Studies and Deaf Education*, 11 (4), 303-321. doi: 10.1093/deafed/enj042
- Bodenheimer, A. (1974). *Doris: The story of a disfigured deaf child*. Detroit, MI: Wayne State University Press.
- Bowlby, J. (1988). *A secure base. Parent-child attachment and healthy human development*, New York: Basic Books.
- Briere, J. & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage Publications.
- Burk, F., Gutman, V., & Dobosh, P. (1999). Treatment of deaf survivors of sexual abuse: A process of healing. In Leigh, I. (Eds.) *Psychotherapy with deaf clients from diverse groups*, (pp. 279-305). Washington D.C.: Gallaudet University Press.
- Carlson, E. B., & Dalenberg, C. J. (2000). A conceptual framework for the impact of traumatic experiences. *Trauma, Violence, & Abuse*, 1, 4-28.
- Cook, A., Blaustein, M., Spinazzola, J., van der Kolk, B. (2002). *Complex trauma in children and adolescents*, The National Child Traumatic Stress Network (Eds.), www.NCTSNet.org.
- Courtois, C. & Ford, J. (2009). *Treating Complex traumatic stress disorders: An evidence-based guide*. New York: The Guilford Press.

- Eth, S., & Pynoos, R.S. (Eds.). (1985). *Post-traumatic stress disorder in children*. Washington, DC: American Psychiatric Press.
- Figueras, B., Edwards, L., & Langdon, D.W. (2008). Executive function and language in hearing impaired children. *Journal of Deaf Studies and Deaf Education*, 13, 362-377.
- Fletcher, K. E. (1996). Childhood posttraumatic stress disorder. In E. j. Mash, & R. A. Barkley (Eds.). *Child psychopathology* (pp. 242-276). New York: The Guilford Press.
- Glaser, D. (2000). Child abuse and neglect and the brain – A review. *Journal of Psychological Psychiatry*, 4, 97-116.
- Gleitman, L. R. & Newport, E. L. (1995). The invention of language by children: Environmental and biological influences on the acquisition of language. In L.R. Gleitman and M. Liberman (Eds.), *An invitation to cognitive science, vol. 1: Language* (pp. 1-24). Cambridge, MA: Massachusetts Institute of Technology.
- Hamerdinger, S., & Hill, E. (2005). Serving severely emotionally disturbed deaf youth: A statewide program model. *JADARA*, 38 (3), 40-59.
- Kottman, T. (2003). *Partners in Play: An Adlerian Approach to Play Therapy* (2nd edition). Alexandria, VA: American Counseling Association.
- Kraemer, G. (1992). A psychobiological theory of attachment. *Behavioral and Brain Sciences*, 15, 493-541.
- LaBarre, A. (1998). Treatment of sexually abused children who are deaf. *Sexuality and Disability*, 16, 321, 321-324.
- Landreth, G. (2002) *Play therapy: The art of the relationship* (2nd edition). New York, NY: Rutledge.
- National Center of Child Abuse and Neglect. (1993). *Understanding child abuse and neglect*. Washington, DC: National Center of Child Abuse and Neglect.

- Obinna, J., Krueger, S., Osterbaan, C., Sadusky, J., & DeVore, W. (2005). Understanding the needs of the victims of sexual assault in the deaf community. Council on Crime and Justice. U.S. Department of Justice.
- Phoenix, S. (1988). *A study of the deaf population in Northern Ireland*. Belfast: Queen's University Press.
- Pollard, R. (1996). Professional psychology and deaf people: the emergence of a discipline. *American Psychologist*, 51, 389-396.
- Quittner, A. L., Leibach, P. L., & Marciel, K. (2004). The impact of cochlear implants on young, deaf children: New methods to assess cognitive and behavioral development. *Archives of Otolaryngology, Head and Neck surgery* 130, 547-554.
- Ridgeway, S. M. (1993). Abuse and deaf children: Some factors to consider. *Child Abuse Review*, 2, 166-173. doi: 10.1002/car.2380020306
- Schild, S. & Dalenberg, C. J. (2011). Trauma exposure and traumatic symptoms in deaf adults. *Psychological Trauma: Theory, Research, Practice, and Policy*, Advance online publication, 1-11. doi:10.1037/a0021578.
- Smith, D.M., & Landreth G. (2004). Filial therapy with teachers of deaf and hard of hearing preschool children. *International Journal of Play Therapy*, 13,13-33.
- Spencer, E. (1996). Association between language and symbolic play at two years: Evidence from deaf toddlers, *Child Development*, 67, 867-876.
- Spinazzola, J., Blaustein, M., & van der Kolk, B. (2005). Posttraumatic stress disorder treatment outcome research. *Journal of Traumatic Stress*, 18, 425-436.
- Spinazzola, J., Ford, J., van der Kolk, B., Brymer, M. Garner, L., Silva, S. (2003, November). *Complex trauma in the National Child Traumatic Stress Network*. Paper presented at the 19th Annual Meeting of

the International Society for Traumatic Stress Studies, Chicago, IL.
<http://www.nctsnct.org>.

- Sullivan, P. M., & Knutson, J. F. (1998). Maltreatment and behavioral characteristics of youth who are deaf and hard-of-hearing. *Sexuality & Disability*, 16, 295-225. doi: 10.1023/A:1023019912548
- Terr, L. (2003). Childhood Traumas: An outline and overview. *American Journal of Psychiatry*, 1, 322-333.
- van der Kolk, B. A. (2005). Development trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35, 401-408.
- Wang, C. T., & Daro, D. (1997). *Current trends in child abuse reporting and fatalities: The results of the 1997 annual fifty state survey*. Chicago: National Committee to Prevent Child Abuse.
- Webb, N.B. (2007). *Play therapy with children in crisis: Individual, group, and family treatment* (3rd edition). New York: The Guilford Press.