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Trauma and the use of formal and informal resources in the deaf population: perspectives from mental health service providers

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Introduction

Deaf[1] individuals, on average, experience traumatic events and/or are diagnosed with trauma at a much higher rate than hearing individuals. Causes of traumatic events can be attributed to cultural, educational, and/or language developmental contexts such as family, school and community (Anderson & Leigh, 2011; Black & Glickman, 2006; Kvam, 2004). Investigation into this disproportionate prevalence reveals a complex picture when considering the relationships between developmental contexts. Mental health providers and researchers unfamiliar with the nuances inherent in deaf culture and American Sign Language (ASL) often fail to account for such complexities when treating deaf individuals for trauma and post-traumatic stress disorder (PTSD). As a result of this lack of cultural and linguistic competency, therapists and providers can confuse symptoms and potentially diagnose erroneously (Black & Glickman, 2006; Schild & Dalenberg, 2012). In addition to developmental contexts and cultural competency issues, a lack of resources available for deaf individuals has been reported, and has been linked to lack of funding, negative attitudes, and a dearth of culturally affirmative mental health services and providers.

In working with clients from diverse backgrounds, counselors and therapists often acknowledge limitations in their capacity to effectively serve deaf clients, and are aware of resources available to supplement therapy and treatment (Crimando & Riggar, 1996). Formal and informal resources are often utilized to assist in the treatment of mental disorders and general counseling discourse. Formal resources could include 12-step programs, therapy groups, or even governmental assistance programs. Informal resources could include the client's own personal network of family, friends and advocates (Black & Glickman, 2006; Thompson & Peebles-Wilkins, 1992). Although evidence reveals the protective benefits of familial, peer, and formal supports aiding in the treatment of trauma within the general hearing population, it is not known how these resources supplement and benefit the deaf population. This study focused on obtaining the perspectives of therapists specializing in working with deaf individuals, and what informal and formal resources they had identified as relevant and beneficial to the treatment of trauma. Using grounded theory analysis, communication access emerged as the most salient theme among participants. Formal support, informal networks, and lack of resources emerged as additional themes.

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[1] Numerous terminologies for deaf or hard of hearing are used in research literature including "Deaf," (Padden & Humphries, 1988), "individuals with a hearing loss," "hearing-impaired," "deaf," and "hard of hearing." In this paper, deaf individuals are referred to broadly, and the term "deaf" includes all variations in identification and language use.

Prevalence of Trauma in the Deaf Population

Deaf individuals, on average, experience maltreatment, sexual and non-sexual abuse, and other types of traumatic events, and are diagnosed with PTSD at a greater rate than hearing individuals (Black & Glickman, 2006; Pollard, Sutter, & Cerulli, 2014; Schenkel et al., 2014). Data collected over a five-year period from 64 inpatients at a deaf psychiatric inpatient unit revealed that 52% of the patients had reported some type of abuse prior to their stay, and 29.7% of these patients were diagnosed with PTSD, whereas for the hearing patients who had received treatment from the same hospital (*n*=180), 48.8% had a history of trauma, yet only 6.7% were diagnosed with PTSD (Black & Glickman, 2006). This reflects a psychiatric sample of patients within a unit that serves acute and chronic psychiatric problems among deaf people.

In a study of 100 undergraduate women at a university for deaf students, researchers discovered that the women were on average twice more likely to experience some form of physical assault, psychological aggression, or sexual coercion in a year compared to hearing women (Anderson & Leigh, 2011). Similarly, investigating intimate partner violence (IPV) in the deaf community, found that both women and men who were deaf were three to four times more likely to experience physical and sexual abuse than hearing individuals (Pollard, Sutter & Cerulli, 2014). Abused Deaf Women Advocacy Services (ADWAS), a national advocacy organization, reported that 25% of deaf women experience interpersonal violence (ADWAS, 1997). In Schenkel et al. (2014), a survey of 147 deaf and hard of hearing college students found that deaf and hard of hearing students reported significantly more instances of child maltreatment compared to hearing controls on a childhood trauma questionnaire (CTQ) in all domains, with rates of physical and sexual abuse reportedly at least double of the hearing control.

Causes of Trauma in the Deaf Population

Although the evidence shows an alarmingly high prevalence of abuse that leads to trauma in the deaf population, it is difficult to ascertain that the abuse and trauma are a direct result of hearing loss. What is known is that factors contributing to traumatic events for deaf individuals are unlike the factors contributing to trauma in the hearing population. Exploration of trauma in the deaf community reveals a complex interplay of developmental, educational, and cultural contexts (Fellinger, Holzinger, & Pollard, 2012; Schild, 2007; Williams & Abeles, 2004).

Deaf individuals are members of a cultural and linguistic minority, of which there are an estimated 500,000 members (Mitchell et al., 2006). Approximately 90% of deaf individuals are born to hearing parents, yet fewer than 10% of hearing parents learn sign language or other language modality, resulting in inadequate parent-child communication, which then leads to frustration, stress and strain in the parent-child relationship (Gulati, 2003; Schenkel et al., 2014). This often leads parents to physically discipline their deaf children excessively (Fellinger et al., 2012; Greenwald, Bank, Reid, & Knutson, 1997; Schild, 2007). Hearing loss also has been found to result in the failed development of key coping skills, social skills, and effective decision-making, due to the child's inability to hear and comprehend surrounding communications. Much of what hearing children learn in relation to social skills and understanding about the world comes from incidental learning opportunities and through "unplanned learning opportunities" (Schild, 2007, p. 20) that take place typically by observing others' behaviors and overhearing conversations.

At residential schools for deaf students, high rates of victimization among youth have been attributed to the lack of information available to students about the prevalence and nature of abuse, perceived threats of abandonment, and feelings of guilt, along with residential staff denying events of abuse or victimization under their watch — all of which contribute to the child being less likely to report instances of abuse or maltreatment (Schenkel et al., 2014). Educational placement in a rural mainstream program has also been identified as a contributing factor to trauma. By nature of its geographical location and the sparse availability of qualified interpreters and other accommodation providers can make it difficult to maintain effective facilitation of communication and education for the deaf child (Checker, Remine, & Brown, 2009). In these types of environments, youth and adolescents are often at risk for being singled out and bullied due to perceived differences (wearing hearing aids, cochlear implants, signing, and/or having speech difficulties) (Critchfield, 2002), and lacking in social competence and prosocial behaviors (Schenkel et al., 2014).

As a cultural minority, deaf individuals commonly experience oppression, discrimination, substance abuse, unemployment, isolation and segregation, and a general distrust of the mainstream society (Glickman, 2009). Much of the deaf cultural beliefs, values and behaviors evident today are responsive to these experiences. In particular, Information Deprivation Trauma, (IDT) (See Schild, 2012, p. 123 for discussion), results from not being able to access much - needed information, or when information is perceived as purposely withheld. In addition, a mistrust of the mainstream society is characterized by deaf individuals'

perception of institutions and service providers as "authoritarian, restrictive, and prejudiced" (Steinberg, Sullivan, & Loew, 1998, p. 983).

As is typical with marginalized communities, an increased sense of collectivism and vigilance have emerged as traits, as well as a deeper sense of community (Fantasia, 1988). For example, the LGBT community has provided support to its members, support that is particularly important when individuals may feel rejected by their own families (Shilo, Antebi & Mor, 2015). This shift in acculturation from the family unit to the community unit is critical in understanding the similar social support provided in the LGBT and deaf communities. Because the majority of deaf people are born to hearing parents, transmission of the deaf community's beliefs and values are typically conducted from community member to another, rather than from parents. Consequently, the social ties among members of the deaf community are much closer, and individuals are more closely networked (Ladd, 2003; Lane, 1992).

On the other hand, while the connected nature of the deaf community provides a protective resilience for many, it also has its downsides. Concerns with confidentiality may be a barrier to mental health treatment, for fear of personal information being shared with others in the community (Cabral, Muhr, & Savageau, 2013; Gutman, 2005). In response to this, counselors and therapists who work with deaf individuals often find themselves needing to be vigilant for situations that may compromise their clients' confidentiality (Williams & Abeles, 2004).

In considering the relationships and the complex factors that contribute to trauma, it becomes apparent that one needs to be mindful of the many factors affecting mental health services for deaf individuals, and that there cannot be a one-size-fits-all approach to treating trauma. In light of these realities, mental health providers often turn to utilizing resources to supplement the benefits that therapy may afford.

Trauma Treatment Resources for the Deaf Population

Numerous organizations and service centers have been established to meet the need for culturally affirmative support services across the United States. However, there continues to be pockets of cities and areas where no such services are available, or there is a lack of culturally competent, ASL-fluent clinicians (Diaz, Landsberger, Povlinski, Sheward, & Sculley, 2013; Pollard, 1994). Among these support organizations, services range from mental health services to dedicated federal and educational programs for deaf people (Part III Supportive

and Rehabilitation Programs and Services, 1981). The deaf community historically has experienced limited or no access to the mainstreamed media, and have had little to no access to outreach programs and information, especially in relation to domestic violence (ADWAS, 1997).

In a study of deaf adults in Florida, 90% surveyed indicated that there was an insufficient amount of mental health services available (Feldman & Gum, 2007). This finding is mirrored in a study in the United Kingdom where the perspectives of community mental health teams were explored. A large disparity in mental health services for deaf people in the United Kingdom was revealed. At the same time, the sample in that study consisted of mental health providers who, despite having had experience in working with Deaf individuals, lacked sufficient communication and cultural capabilities, and were not clearly identified as being either deaf or hearing. The study did, however, reveal that these participants highlighted communication difficulties, limited knowledge and access to resources for Deaf people, and geographical locations as barriers (Thomas, Cromwell, & Miller, 2006).

Steinberg, Sullivan & Loew (1998) found that 72% of the participants they surveyed expressed a preference for working with a therapist who was deaf or hard of hearing, and 81% of study participants expressed a preference for group support consisting of deaf and hard of hearing individuals. This highlights a clear need for working with individuals who are at least competent in deaf culture and are able to provide culturally affirmative services.

The benefits of utilizing formal and informal resources and networks on psychological distress and well-being have been well-documented. Kogstad, Mönness, & Sörensen (2013) investigated the relationship between respondents' experiences with their social networks and the use of professional mental health services, and found a positive relationship. In a study of adolescent black mothers, Thompson & Peebles-Wilkins (1992) found that support from a male partner, a caseworker, or support groups had a positive effect on the mothers' psychological well-being. However, support from friends had the opposite effect: it increased the mothers' psychological distress. Minority groups, such as the LGBT community, appear to benefit immensely from the availability of resources. Colleges and universities, in response to reports of violence perpetuated upon LGBT individuals, have created "safe places" and resource programs, along with the implementation of policies and procedures designed to accommodate individuals who identify as LGBT (Rankin, 2005).

Although limited research has shown the benefits of utilizing network resources, yet there has been little investigation into how resources are utilized in mental health treatment in the deaf population, and in what ways.

Methods

Data was gathered through qualitative interviews as part of a larger study of trauma manifestation in deaf individuals (Schoffstall, 2016). Nineteen mental health counselors working primarily with the deaf population were interviewed on their perspectives of the resources, either formal or informal, that support the treatment of trauma for deaf individuals.

Instrument Development

This study involved the creation of two instruments: a 29-item demographic questionnaire to assess each participant's background and a set of 17 interview questions designed to answer a range of research question. The interview questions were tested during pilot interviews with two practicing hearing clinicians in the field of deaf mental health. The interview questions revolved around the identification, assessment, and treatment of trauma for deaf individuals in the primary study.

Recruitment Procedures and Participant Demographics

Potential interviewees were recruited through a national organization listing mental health therapists and counselors who worked with deaf individuals and had a variety of experiences and areas of expertise (e.g., school counseling, community counseling, university mental health services, and counseling training programs). Several other participants were recruited via email based on recommendations from others, which represented a snowball sampling technique. Informed consent was obtained from all study participants.

Demographic information (see Table 1) was collected using the pre-interview survey. Eight participants identified themselves as deaf, and 11 identified themselves as hearing. All held current licenses to practice as mental health providers. The majority was Caucasian (18 of 19; 94.7%) and female (17 of 19; 89.5%), which is representative of the field. Participants were located in 11 states throughout the United States. All were reported to have at least one professional degree. Six had a degree in clinical social work (31.6%), four had a degree in clinical psychology (21.1%), two in school psychology (10.5%), two in professional counseling, one in psychiatry (5.2%), one in mental health

counseling, one in alcohol and drug abuse counseling, and one in marital family therapy. Four (21.1%) reported "other" credentialing.

Table 1
Participant Demographics

Characteristic	n	%
Hearing Status		
Culturally Deaf	8	42
Hearing	10	52
Late Deafened	1	5.2
Gender		
Male	2	10.5
Female	17	89.5
Race		
Caucasian	18	94
Multi-racial	1	5.2
Degree		
Social Work	6	31.6
Clinical psych	4	21.1
School Psych	2	10.5
Professional Counseling	2	10.5
Psychiatry	1	5.2
Mental health counseling	1	5.2
Alcohol & drug counseling	1	5.2
Marital family therapy	1	5.2
Other	4	21.1
Current Professional Setting		
Secondary Educational	5	26.3
College or University	5	26.3
Hospital	1	5.2
Residential Setting	1	5.2
Outpatient Setting	8	42.1
Private Practice	4	21.1

Eight participants (7 hearing, 1 deaf; 42.1%) reported having over 20 years of professional experience in the field of mental health. Equal numbers of deaf and hearing participants (3 hearing, 3 deaf; 31.6%) reported having between 10 and 19 years of professional experience. The remaining five participants (4 deaf, 1 hearing; 26.3%) reported between 5 and 10 years of professional

experience. Participant roles included university assistants, adjunct professors, directors of counseling and psychological services, prevention education specialists, clinical directors of mental or behavioral health agencies, certified professional counselor supervisors, child case managers, behavioral health task force members, and coordinators or administrators of state divisions for deaf behavioral or mental health services (see Table 2).

Table 2 *Years of experience as a percentage of the sample*

	Deaf		Hearing	
	n	%	n	%
20+	1	5.2	7	37.0
10-19	3	15.8	3	15.8
5-10	4	21.1	1	5.2

Interview Procedures

Participants were interviewed individually in person or via videoconference. Each interview took approximately one hour to complete. Every effort was made to match the preferred communication modalities of the participant (e.g., speech-using interviewer with a speech-using interviewee; signing interviewer with a signing interviewee). Prior to the interview, all participants were asked to indicate their preferred communication modality, and a trained research assistant was assigned to match the participant's modality. Three research assistants (two deaf native ASL users and one hearing native English user) underwent a two-hour training to administer the semi-structured interview.

If a video interview was conducted in ASL, a native ASL user transcribed the video into written English. Another interviewer fluent in ASL for accuracy then reviewed each transcript. The finished transcripts were distributed to the study participants to double-check content and to provide additional clarity for their responses. Member checking of the transcripts and coding with experienced professionals within the field was utilized to provide an additional check for researcher bias.

Data Preparation and Analysis

This study utilized a grounded theory technique (Strauss & Corbin, 1994), and involved the following steps: open coding, axial coding and selective coding.

Open coding. The researchers utilized open coding in that the interview transcripts were first analyzed line by line to break the data into identified concepts, ultimately standing as blocks of raw data (Strauss & Corbin, 1994). This process links codes to segments of the original text, such as field notes. Open-coding themes and labels are often at a low level of abstraction and are derived from the language of the people being studied, the literature, or new ideas that occur as the study progresses (Strauss & Corbin, 1994).

Axial coding. The open codes were then examined for repetition, similarity, patterns, relationships, and disparities. Codes with repeated or shared commonalities were condensed according to their similar properties, thereafter referred to as *themes*. The themes for formal or informal resources supporting trauma treatment were as follows: accessibility, formal supports, informal networks, events, general awareness/stigma/attitudes, gap in resources, and any other theme worthy of mention. Five themes were also drawn from the interviews and applied toward a separate study revolving around resiliency as a factor in the treatment of trauma (Johnson, 2016). The remaining themes focusing on the identification and treatment of trauma were applied toward the lead researcher's dissertation (Schoffstall, 2016).

Selective coding. With the five themes drawn from the axial coding process, the coding was then scrutinized for further derivation of these themes for each transcript (Table 3). The first theme, *accessibility*, pervaded the transcripts and counselors alluded to or explicitly mentioned communication in descriptions of challenges and adaptations. Two themes — formal supports and informal networks — were direct descendants of the original research question. General awareness/knowledge/stigma/attitudes was a broad theme capturing either the presence of or lack of resourceful knowledge, presence or lack of stigma and attitudes in either the public or among mental health providers. Gap in resources highlights any discussion around the lack of, or gap, in resources available to accompany or supplement the treatment of trauma in deaf individuals. Lastly, study participants mentioned other resources that were identified as important enough to include in the study findings.

All verbatim responses were recorded onto a spreadsheet, and each response was coded as a meaning unit. The authors looked for common, emergent themes throughout each response that might be either explicit or implicit, and determined whether there was a presence of or lack of resources. The emergent themes identified were: accessibility, formal supports, informal networks, general awareness/stigma/attitudes, gaps in resources, and any other themes that may be worthy of mention (see Table 3).

Table 3 *Themes and participant quotes*

Theme	Sample Quote
Accessibility	*Resources for psychical health care because sometimes people are very afraid to go for medical care and we still have difficulty getting language access at basic medical appointments, so physicians who are willing to be fully accessible for people who are deaf and hard of hearing who will be that medical home and provide that support throughout.*
Formal supports	*I definitely encourage clients to go to AA. I think there are a couple interpreted meetings. There is Safe Place, they have some great resources. They have survivor groups.*
Informal networks	*[…] informal is friends, church, teachers, family, people who are able to tolerate and know that the person needs a listening ear and that it's real and believes them that's something's happened or that there's a history here that needs attention.*
General awareness/stigma/attitudes	*Well, I'm thinking now specifically of even the type of trauma that involves people ending up in the hospital. Any kind of domestic violence, intimate partner violence, sexual assaults just having the communication access, people sensitive and prepared culturally and linguistically on the front lines of having centers that are really deaf and hard of hearing focused and deaf-blind. Really need to be sensitive to that. Having hospitals that are informed for the early front line. Informal resource, (I guess thinking, I mean I'm in a university setting) so even having like the wellness center, they have psychoeducational presentations, informational Take Back The Night various kinds of advocacy. That's a little bit more formal but they're people around more informed and then having people aware of the need for providing safe places and supportive people who are not in roles specifically that that's their job, maybe faculty, friends, or people working in the dorms, having some training or sensitivity.*
Gaps in resources	*Many people we work with are SSI, SSDI, and they don't have the money to get healthy food, they don't have the money or don't have the ability to cook. I*

	think we need more wellness programs, more of just teaching people about coping skills and giving them opportunities for yoga, exercise, or healthy eating.
Other themes *External resources*	*Yes, there are two organizations: VOA (Volunteers of America) where they have their DHH mental health where they have counselors that come to our school and we have an office here for them to use.*
Concerns with privacy & confidentiality	*Therapy groups are really hard for us to get going. I think because of the confidentiality in the deaf community.*

Results

The coding revealed several themes that reflect struggles with language access, available resource types available, and attitudes and stigmas among service providers.

Accessibility

Accessibility appeared to be a pervasive and ubiquitous theme woven throughout the interview responses. Participants recognized that the issue of accessibility meant (1) when a particular resource is available, it must also be able to provide accommodations for clients. When a resource is accessible, this generally means that communication flows effortlessly in the client's preferred language modality either by direct contact with a resource provider who can meet the client's communication modality, or through a qualified and preferably a certified interpreter; (2) advocating on behalf of the client to ensure that the client benefits from accessible communication when in contact with an employer or a resource.

Extending from the language access issue, accessibility also means that service providers are cognizant of the cultural underpinnings of deaf culture. One counselor (MH) spoke to this point: "Just having the communication access, people sensitive and prepared culturally and linguistically on the front lines of having centers that are really deaf and hard of hearing focused and deaf-blind. Really need to be sensitive to that."

The counselors also acknowledged a dearth of accessible resources and accommodations, which often means less privacy and confidentiality for deaf individuals utilizing the same resources. JA said, "And I will ask them, 'Are you interested in joining? But understand, there's one other deaf person there.' And

we will set up an interpreter. Maybe you'll meet others who have the same experience as you." This may appear benign for hearing individuals, but for deaf individuals, the closeness of the community makes the need for privacy and confidentiality much more paramount (Gutman, 2005).

Formal Supports

For this study, formal supports were defined as those facilitated by professionals such as social workers, psychologists, 12-step programs and therapy groups facilitated by organizations and institutions. Such professionally operated groups are often found in institutional settings, including hospitals, drug treatment centers and correctional facilities. These types of support group may run for a specified period of time, and an attendance fee is sometimes charged (Cabral et al., 2013).

Common formal supports identified by the participants were support groups, therapy groups, and abuse shelters. A counselor, JF, highlighted the various types of resources perceived to be beneficial for deaf individuals: "Work groups, grief groups, family therapy, even social groups outside of the school, the YMCA type of programs." Another therapist, LR, spoke about the frustration with connecting clients to formal resources, citing confidentiality in the deaf community: "Therapy groups are really hard for us to get going. I think because of the confidentiality in the deaf community. It's a small group in addition to just timing, schedules and so on." Again, mention was made of needing to protect the privacy and confidentiality due to the close-knit nature of the deaf community, yet this restricts individuals' potential to utilize resources.

Informal Supports

Defined as "…the web of relationships that people use to exchange resources and services." (McGuire, 2001, p. 1), informal support structures were recognized as something much less formal than institutional and therapeutic support; decentralized and unregulated, informal supports include nuclear family members, and community and civic organizations. Participants identified these types of informal supports common to the deaf community not just as a tangible resource but also an activity: reaching out to family and friends, counselors, clergy, to whom to confide in, and socialize with in ASL, which provides a sense of comfort (Cabral et al., 2013).

However, utilizing informal supports within the deaf community is often approached with trepidation due to the tight-knit nature of the deaf community

where general support or even confidentiality can be lacking. MH said, "The problem with informal, I'm thinking too is do people have access to friends who are just supportive? Supportive friends but is that there or not?"

Counselors appear to be aware of the effect of the "small world" nature of the deaf community and the way this phenomenon restricts the potential benefit of informal supports. This frustration was echoed by several of the participants. While the usage of informal supports in social networks rose from 7% in 1957 to 28% in 1996 (Swindle, Heller, Pescosolido, & Kikuzawa, 2000), the availability depends on how vulnerable individuals are. Individuals may have strong negative experiences with the mental health service system, and if this individual's social support system is weak as well, this becomes a double burden for these individuals (Kogstad, Mönness, & Sörensen, 2013).

General Awareness/Stigma/Attitudes

The next theme covers attitudes and general awareness. The prevailing detrimental attitude or stigma upon the part of the service provider or employer, and the presence or lack of knowledge pertaining to working with deaf individuals and their trauma history, emerged as salient themes. Participant DT recognized the need for increased training and information about trauma:

> "Increase of the system's understanding of how to work with DHH people and understanding trauma so having the staff understand trauma better and how our attitudes and approach can make a big difference as well as those little things. […] Yes, and training for clients themselves to understand how trauma can impact them, body language, psych education…"

Regarding negative and stigmatizing attitudes, JA, a therapist who is deaf, said, "AA sometimes feels like the interpreter is an outsider and they are not keen on interpreters." That stigma, along with lack of confidence in others maintaining privacy, is also revealed to occur within the deaf community, according to JF:
> "[…] plus the deaf world gossip is such a huge thing that nobody wants to talk to each other. Even though you say what happens in this group stays in this group…by the time the school day is over what's happened is all over [city]. It is a very big barrier that we have to work with."

It becomes apparent that a combination of having service providers be more cognizant about how to work more effectively with deaf individuals, and remediating the concerns regarding privacy becomes increasingly necessary (Gutman, 2005).

Gap in Resources

Unsurprisingly, the lack of resources, informal or formal, emerged as a notable theme among the study participants, along with the lack of accommodations for deaf individuals to access available resources. Common sentiments included, "It's very limited here. Really resources are limited*"* (JA) and *"*Interpreters! Interpreters are very important access. It's difficult to set up, especially for free 12-step programs" (JG). As stated earlier, although some locations do have services, there are many other geographical areas that do not.

JF shared a similar insight:

"Programs to where they can go, but there are none for these kids to go to. But these things that in a perfect world, they would have. They would have the grief groups, the support groups, kids all being able to share their own stuff and their own commonalities together."

Another participant, MN, added: "[…] they don't have the money or don't have the ability to cook. I think we need more wellness programs, more of just teaching people about coping skills and giving them opportunities for yoga, exercise, or healthy eating."

This scarcity of accessible resources was echoed among the study participants, which appears representative of any type of resource, and often is tied to a lack of awareness of resources and a lack of funding.

Other Themes

The participants offered additional themes that appeared pertinent despite their not being prevalent enough to be considered standalone themes. Three subthemes emerged in the "other" category: external agency/support, online resource, and treatment approach/curriculum.

External Agency/Support. Participants mentioned making referrals to external agencies that had certain capabilities beyond their therapists' capabilities:

"Well, it's interesting. […] there's a program, called DAWN. Deaf Abused Women's Network. So for some people, I've referred them to the program to get some workshops and different things. So if it's appropriate, I'll refer to my clients there. They don't do therapy so I would do the therapy and I would be the therapist and I would get

DAWN to work with some of these people. So that's a really good resource I've used around here." (ES)

Within this theme, participants identified additional external agencies, including Cincinnati's Trauma Treatment Training Center, Health Bridges, and Volunteers of America. These external resources have varying purposes, from being an informational clearinghouse to serving as an abuse shelter.

Online Resources. Therapists participating in this study also acknowledged that they sought informational resources online to supplement their therapy. One therapist, KS, stated: "Resources on the internet: there's a lot of videos, signed clips about trauma, overcoming trauma or sexual abuse, a lot of educational things out there now that I refer people to." Similarly, LW said, "I like the National Child Traumatic Stress Network. They have a lot of basic information: What is trauma, the types of trauma, and they have some certain information that's specific for school personnel, and specific for deafness." The Internet has become a boon for information sharing and makes for obtaining information effortless. This makes for easier resource consulting and learning of new treatment approaches, although some will argue that it does not replace in-person training due to lack of accountability (McMillen, Hawley, & Proctor, 2016).

Treatment Approach/Curriculum. The theme of treatment approaches and curriculum appeared to be common among the therapists as a resource to help with therapeutic endeavors. Materials could be provided in the form of an online resource but can also be a treatment approach that is taught as a curriculum or framework. For instance, ES said, "I would pull some from the incredible years. I'm not saying that it is trauma-focused approach but the activity itself can be effective. Just pulling from that."

KM agreed, saying, "It's not perfect but if I can ever find like little ditties by the American Academy of Child and Adolescence [Psychiatry] or real easy bullet points, all that stuff that's really well laid out."

Likewise, DT, a counselor, pointed out how to benefit from such resource: "Consulting with other professionals. Going to workshops, training from experts who work in the field of trauma, and victims. Those two tend to be the best resources. Learn how to improve, how to work with clients, those who have really bad trauma."

Discussion

This study sought to gather the perspectives of therapists working with deaf individuals, inquiring what they thought were resources used in the treatment of trauma. The research question was broad enough to gather a wide range of responses regardless of presence of or lack of resources.

Accessibility emerged as a stand-alone dominant theme, and was reported to serve a large role in whether deaf individuals can access and utilize supports in the community. Having clear and direct communication is essential regardless of context or situation, so accessibility becomes crucial in all aspects in the lives of deaf individuals. Accessibility was also identified as a major theme in a similar study with vocational rehabilitation professionals (Cawthon, Fink, Tarantolo-Leppo, Schoffstall, & Wendel, in press). An additional study lends further support to this finding, in which 72% of the respondents with a disability reported accessibility as a major barrier to services; of that 72%, 38% reported a lack of sign language interpreters as the most significant barrier (Leigh, Powers, Vash, & Nettles, 2004).

As the result of the thematic analysis, a strong recurring theme was discovered regarding privacy and confidentiality, appearing more salient than the accessibility issue. The close-knit nature of the deaf community, along with the need to openly share information — while predominantly a positive trait — has been found to affect individuals' ability to benefit from resources due to the fear of having their confidentiality breached. This appears to result in a stigma and fear of utilizing resources (Cabral et al., 2013; Mathos & Pollard, 2016; Steinberg et al., 1998). The confidentiality issue is not unique to the field of deaf mental health, having been frequently raised in discussions of ethics for other communities in numerous publications. This creates a quandary for many therapists who genuinely wish to workw ith the deaf community, yet must abide by the ethical principles of beneficence and nonmaleficence (Gutman, 2005; Leigh & Lewis, 1999; Steinberg et al., 1998).

Limitations

There are a number of limitations to this study that should be considered when reviewing the results. One limitation is the differences in the work contexts of the study participants. More specifically, some of the therapists and counselors work with adolescents in educational settings while others work with adults in the

community. The resources they identified were more likely relevant to the clients they served, and may not be applicable beyond their specific professional contexts.

Secondly, the qualitative nature of the grounded theory approach looked primarily to identify salient themes common among participants. The structure of the interview did not allow for an in-depth discussion of resources, specifically, and restricted the range of responses only to the information that was most salient to participants. This may have prevented an opportunity to investigate nuanced understanding of the strengths and weaknesses of various resources available. Because the research question for this specific study was a subset of a larger study, participants' responses about resources may have been influenced by their responses to previous questions, therefore shaping the direction of their responses differently than if the analysis had been a stand-alone study regarding resources.

Lastly, the narrow scope of the deaf population consistently referred to in this study may limit the findings to this particular reference group. As such, individuals who are late-deafened, or those who are oral deaf may have experiences that are different from those who are culturally deaf, possibly creating difficulties in applying the developmental and cultural lenses. Individuals who are late-deafened or hard of hearing may experience mental health side effects resulting from poor social outcomes, such as anxiety and depression. Additionally, the inability to apply the cultural developmental lens may exclude this subpopulation from having this factor hypothesized as a cause for trauma. That may lead to encouraging researchers to investigate other possible factors possibly generating trauma in these individuals.

Conclusion

Deaf individuals and hard of hearing are consistently under the threat of maladaptive development, educational delays, and cultural misappropriation, leading to higher chances of being diagnosed with a mental or personality disorder later in life. Further, the contexts and nature of the systems that avail these resources continue to be rife with barriers to proper mental health care. Mental health providers who work with deaf individuals continue to experience challenges when working with trauma. The perspectives of counselors and therapists in this study confirmed much of what literature has proposed to be important about resources related to trauma for deaf individuals.

Most importantly, the findings of this study revealed that counselors and therapists are aware of the need for confidentiality through firsthand experiences with their clients. Although this is a foundational concept within the therapist-

client relationship, for deaf individuals, there are unique and pervasive barriers to achieving this goal. Without systemic approaches to changing both the accessibility of resources and the prevalence of culturally responsive practitioners, it is likely that these difficulties will persist.

Lastly, the research was conducted through a collaborative effort between both deaf researchers and hearing researchers, which helped ensure credibility and validity of the research design and data interpretation as they relate to deaf individuals. At the same time, while this study sought the perspectives of mental health providers regarding the resources used in the treatment of trauma, the study also highlighted the complex relationships involved in trauma that have an adverse effect on an individual's development. Therapists must be mindful of such factors when working with deaf or hard of hearing individuals. Further, efforts must continue in the propagation of culturally affirmative mental health care, educational resources, and the training of culturally and linguistically competent mental health providers.

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