Trauma-Informed Forensic Practice

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Deafness and Trauma

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When I joined the National High Secure Deaf Service (NHSDS) as its psychological lead, I considered myself experienced both in forensic mental health and trauma, having developed knowledge and expertise throughout my forensic work for almost two decades. However, I soon discovered that the trauma-informed working I had invested so much in for a hearing population was vastly different with the Deaf population in prison and hospital. This unique, under-served, under-researched, and often misdiagnosed or misunderstood population was far from having trauma-informed pathways comparable to the rapidly developing pathways experienced by their hearing peers. In this chapter I will explore the unique relationship between Deafness and trauma, and how this is experienced by individuals within forensic services. This is a vast topic and I am unable to cover everything in depth. However, I hope to increase awareness and inspire further curiosity from the reader. I am also aware, as a hearing psychologist, that I am far from an expert on the isolation and discrimination Deaf people have endured (and still endure). However, through my own work and research I hope to speak as an advocate for increased understanding and equality in care. Although at present the service users in the NHSDS do not feel able to engage in sharing their experiences in this chapter for a number of reasons, I hope to help build a platform where they can safely share their voice and feel more empowered to do so.

**Deafness and Hearing Loss**

Within the UK, hearing loss affects 1 in 6 people (over 11 million), with approximately 900,000 experiencing severe/profound deafness (Royal National Institute for Deaf People, RNID, 2021). The Deaf and hard of hearing population represent a highly diverse continuum. Deafness can be classified by degree of hearing loss, age at onset of deafness, or by cultural and linguistic identity (Austen & Coleman, 2004).
Hearing loss is categorised from mild to profound by the World Health Organisation (2020). There is also an important distinction noted between the capital and small D/d used with the word D/deaf. Those who are predominantly prelingually Deaf, who do not recognise their deafness as a disability or medical diagnosis, who identify with the Deaf cultural and linguistic community identify with the use of a capital “D”. For those who predominantly do not identify with the Deaf community, and most often have become deaf, the lowercase “d” is used.

The loss of hearing later in life is clearly traumatic. However, for the purposes of this chapter I will be focusing primarily upon the prelingually Deaf population and exploring what is needed to provide them with equitable trauma-informed care.

Trauma in the Deaf Population

Trauma has already been defined in earlier chapters of this book, and in relation to these definitions (complex, polyvictimisation, betrayal) the Deaf population not only experience a high prevalence of such childhood maltreatment but a greater one; with the rate of maltreatment estimated to be twice that of the hearing population (Tate, 2012). Vernon and Miller (2002) for example, suggested that up to 50% of Deaf children suffer childhood sexual abuse, compared to 10–25% of hearing children.

This pattern unfortunately remains throughout adulthood with Deaf people reporting nearly twice the rates of intimate partner violence and sexual assault (Anderson & Leigh, 2011), physical and emotional abuse (Öhre, Uthus, von Tetzchner, & Falkum, 2015), and ongoing communication abuse (causing harm through misuse or neglect of effective communication), compared to hearing people (Mastrocinque et al., 2015). It has been suggested that Deaf people may experience at least six types of unique trauma across their lifespan (Schild & Dalenberg, 2012a discussed below) which affect multiple domains of functioning, leading to higher levels of trauma responses such as mental health difficulties, anger, sexual issues, substance use, anger/frustration, and rates of suicide in adults compared with a hearing population. It is likely that these are an underestimation due to the vastly unmeasured experiences of Deaf people and, in my experience, there is much greater disparity and inequity in access to services, support, and treatment.

Deafness and Childhood Trauma

Childhood maltreatment can be experienced similarly in many ways across both a hearing and a Deaf population; however, Deaf children potentially experience trauma not commonly experienced by their hearing peers. Approximately 90% of Deaf children are born to hearing parents who have little or no experience of Deafness. For Deaf children this can mean parents’ non-acceptance of Deafness, leading to obstructed communication; difficulties with attachment; isolation from families; memories of parents’ grief and attempts to “cure” their deafness; as well as incurring developmental delays, language, and cultural deprivation (Brice & Adams, 2011). Longstanding beliefs that sign language prevents or delays development of spoken language (which can be more highly valued) has led to some Deaf children being
deprived of all language due to their parents’ attempts to “correct” their Deafness, and the development of their brain can be subsequently affected (Hall, 2017). Delayed language development and problems with theory of mind and challenging behaviour are also observed in Deaf children with hearing parents (Austen, 2010). Communication deprivation (the withholding of development of healthy communication methods and style), as described above, may be formulated as a unique form of neglect that has longstanding consequences for Deaf children.

Deaf children have been recognised as more susceptible to neglect and abandonment, are more vulnerable to early attachment disruptions, and there is evidence to suggest that Deaf children born to hearing parents are disciplined more harshly and with greater physical force (Knutson, Johnson, & Sullivan, 2004). Deaf children may be perceived as less likely to disclose maltreatment, to complain/resist less or to be naïve or overly trusting, all of which increases their vulnerability to maltreatment and abuse. Perpetrators may also assume that Deaf children are less likely to understand something is wrong, will find it harder to report abuse, and may be less likely to be believed if they do report abuse (Denmark, 1994). Overall, Deaf children potentially become more vulnerable in both the home and school environments.

Deaf children who attend mainstream school face potentially vast communication barriers, especially without adequate adaptation to support their learning style. Many mainstream schools still do not have sufficient access to British Sign Language (BSL) or assisted signing. Deaf children in mainstream schools are probably more vulnerable to isolation and bullying, and their educational and developmental needs are often left unmet (formulated as systemic neglect).

In my experience, Deaf children who stay in residential Deaf schools (a common experience) can suffer increased isolation and perceived abandonment by family. Placement in residential schools has been shown to increase the risk of sexual and physical abuse (Miller, Vernon, & Capella, 2005), leaving many Deaf children in these placements with little or no healthy understanding of sexual behaviour. Patients in NHSDS have spoken about communication deprivation (neglect) experienced in residential Deaf schools where their signing was prohibited to promote spoken voice. This included being physically forced to use their voice rather than sign by being made to sit on their hands or having their hands taped together or being beaten if they would/could not use their voice. Given the disconnection between themselves and the adults holding responsibility, Deaf children may forge deeper connection to peers with whom they are able to communicate, but who may not be able to model sophisticated coping skills. If such skills are absent, Deaf trauma survivors may develop more unhealthy survival strategies to cope, including strategies that potentially develop into offending (e.g., inappropriate sexual behaviour, substance use, aggression).

Ridgeway (1993) noted that many Deaf individuals believe that maltreatment (maybe perceived as care/normality) is simply “part of being Deaf” and this certainly seems to be the experience of some of the individuals I have worked with who accept their experience as “normal”.

Based on the histories of patients in the NHSDS, alongside increased exposure to maltreatment, there is also vast inequality in access to information and education; awareness and knowledge regarding trauma; support, care, and services; and
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to opportunities to share experiences with others. Deaf people face limited access to incidental learning and have less opportunity to develop language relating to understanding what traumatic experience is and how it may affect them. This is known as the “fund-of-information deficit” and can represent a distinct limitation in a Deaf person’s knowledge base due to being unable to access information compared to a hearing population, despite normal IQ and capability (Pollard, 1996). This can represent systemic neglect of Deaf people’s needs.

Deaf people are over-represented in the prison population, both in the UK and in the USA, particularly for sexual offences (Williamson & Grubb, 2015). While there remains little research into why this is the case, high rates of ongoing trauma may well be a contributory factor. As already discussed, approximately 50% of Deaf children experience sexual abuse. Many Deaf children grow up with a limited knowledge of sexual boundaries and behaviour (Schild & Dalenberg, 2015). Deaf children in residential schools are more likely to experience sexual abuse. A number of patients in the NHSDS have described engaging in sexual activity in residential school with peers (either forced or as means of meeting their unmet needs) and had little understanding of their own boundaries/rights. Such school age experience seems also to be linked to attachment difficulties, a mistrust of adults and difficulties with self-esteem, identity, and relationships. Combined with the lack of culturally and linguistically accessible assessments and intervention at an early age for Deaf children, and limited or no access to health literature and sex education, all these factors could contribute to increased risk of sexual offending.

Of course, not all Deaf children go on to sexually offend, and although some researchers have proposed a “Deaf personality”, characterised by impulsive, selfish, and aggressive behaviours (Miller, Vernon, & Capella, 2005), brain damage and intellectual disability may be additional factors (Williamson & Grubb, 2015), it is perhaps more useful to formulate a Deaf Individual’s offending in the cultural, linguistic, and trauma-informed context of their life (including factors that influence their own resilience, protective/risk factors).

Unique Characteristics of Trauma in the Deaf Population

Like their hearing peers, Deaf people experience a full range of trauma responses. However, there are unique differences in what influences trauma experience that can have long-term implications for equity in care.

Language Deprivation and Disfluency

Glickman (2008) defines language disfluency as the inability to communicate fluently in any language. Language disfluency can be understood to have three general causes. The first two – physical causes and mental illness – are experienced by both hearing and Deaf individuals, while the third – language deprivation – is recognised as almost exclusively experienced in the Deaf population (Gulati, 2003). Language deprivation is the failure to develop fluency and refers to individuals with poor or no language skills in any language (spoken or sign). It is caused by insufficient
exposure to language, leading to the child not acquiring language at the expected rate or developmental level (Glickman, 2008). It has been suggested that 75% of Deaf individuals receiving services in psychiatric hospitals have some level of language disfluency (Black, 2005) though the actual proportion is likely to be higher. I would suggest that in forensic populations the population is greater still, and this is certainly the case in NHSDS.

Language deprivation is common in Deaf people due to hearing families holding beliefs that learning sign language could prevent the development of spoken word, or the delay in learning a language due to the seeking of surgical/ cochlear implant as a way of “fixing” Deafness. These are potentially examples of neglect of a child’s core language, communication, and emotional needs. Similarly, failure to recognise and rectify when a Deaf child of normal intelligence is not at the same developmental stage as hearing peers in schools and other areas could be formulated as systemic neglect (Gulati, 2003). Without language, a Deaf child could potentially suffer isolation unlike anything a hearing peer may have to experience, and without language it may be very difficult for them to become aware that they have experienced trauma, or to access services/support that they may not even know exist and that are predominantly language-based.

Öhre et al. (2015) highlight that communication and language form the basis for the conceptual and emotional processing of stressful events and therefore play a crucial role in preventing subsequent traumatisation and in facilitating recovery. Therefore, its absence can put Deaf people at a disadvantage when processing trauma. Hall (2017) found that a fully accessible language is a protective factor for healthy development, and language disfluency and deprivation are key in understanding the impact of traumatic events, the internalising of misunderstood traumatic experience, managing trauma responses, and providing support for recovery for the Deaf population. In my experience without language and effective communication to facilitate processing traumatic experiences, Deaf people may be more likely to develop survival responses – often conceptualised by the individual as “helping” – such as dissociation, substance use, and behavioural methods of communicating need or expression such as aggression and challenging/ offending behaviour.

**Information Deficit Trauma (IDT)**

Schild and Dalenberg (2012a) define IDT as an event that is experienced as traumatic (or more traumatic) because information about the event is limited or not available. The lack of information increases the impact of factors such as unpredictability, suddenness, and uncontrollability. When a lack of information is associated with a traumatic event, this is likely to exacerbate the traumatic experience in a way that may not be experienced by someone without this deficit. IDT is probably more common in Deaf individuals and is an important factor in understanding their unique traumatic experiences. Öhre et al. (2015) add that Deafness can interfere with the interpretation of verbal information and consequently with the appraisal of situations. Deaf people may perceive events as traumatic that hearing individuals do not. Anecdotally, Deaf
people may be over-protected by families (not told details about relatives’ deaths or not communicated to about something that has happened to them), as information is often not overtly offered in a way that can be understood, and this form of information deprivation (formulated as neglect) can worsen a person’s reaction to a situation and heighten the traumatic response, as well as perpetuate survival strategies.

**Assessment**

Many researchers warn that achieving validity and reliability in diagnosing disorders in the Deaf population is extremely difficult, and it requires specialist knowledge, experience, and skill. Inaccurate assessment often leads to this population being misdiagnosed and mistreated at a much greater rate than hearing peers (Du Feu, 2017). This is particularly the case for trauma. Du Feu emphasises the importance of specialist assessments when it comes to mental health examinations of Deaf individuals to minimise any over- or under-emphasis of the impact of a person’s Deafness on their mental health difficulties. Furthermore, she states that any assessment should be done with support from an appropriately qualified and registered sign language interpreter (RSLI) who has experience of working in mental health settings. Inaccurate diagnosis may stem from misunderstandings of cultural and linguistic differences and variations in manifestations and expressions of traumatic responses. All assessments for mental health and trauma are normed on hearing populations, and therefore not culturally or linguistically valid for Deaf people (including ICD classifications). Accurate clinical decisions and formulation require knowledge and understanding of cultural and linguistic information and appropriate adaptions to assessment methods. In my experience, cultural differences in labelling affect or behavioural states may influence measures of both mental health and trauma, and somatic presentations are much more likely in the Deaf population that many cognitively orientated assessments would not capture.

Assessments and classifications also need to explore traumas unique to the Deaf population, as well as generalised to both hearing and Deaf. Studies exploring trauma assessment tools have noted that Deaf people were more likely to score highly on “other traumas”, highlighting that their experience is not captured equally (Schild & Dalenberg, 2012a). They also concluded that the psychometric properties of the Trauma Symptom Inventory (TSI) and the Clinician administered PTSD checklist (CAPS) are excellent for both Deaf and hearing populations.

When assessments, clinical opinion, and formulation are not rooted in cultural and linguistic understanding, do not facilitate shared language, meaning, and understanding or are not communicated effectively, then the Deaf person is at a significant disadvantage for trauma recovery and the barriers for developing protective factors remain. The same issues are relevant for risk assessment. Anecdotally, this is more likely for those Deaf individuals in the criminal justice system (CJS) where specialist assessment and care is sparse or non-existent. In my experience this is another example of ongoing systemic neglect where Deaf people, who have offended, face the ongoing adversity of inequitable care.
PTSD

Schild and Dalenberg (2012b) suggest that Deaf individuals are more likely to develop PTSD than their hearing peers, but their research also found lower prevalence rates than expected, different predictors of PTSD, and different symptom constellation. They questioned whether the current definition of PTSD is appropriate for Deaf people, since expressions of trauma often displayed in Deaf people, such as avoidance/numbing, internalisation of expression, hyperarousal, and re-experiencing symptoms internally (Gulati, 2003), may not be captured. Schild and Dalenberg explored the importance of how Deaf people express trauma responses, concluding that, as in hearing samples, dissociation (both psychoform and somatoform) was significantly related to PTSD symptoms but that psychoform dissociation was significantly more common in Deaf adults than in hearing adults. In addition, those with dissociative PTSD displayed significantly more symptoms of depression, anger, impaired self-reference, tension reduction behaviour, and somatoform dissociation than did the non-dissociative PTSD group. Therefore, scales of assessment normed on hearing people may underestimate trauma experience in Deaf people (which of course has implications for recovery and care).

PTSD classification focuses on short-term impact of trauma and “in the moment” expressions of distress. However, Deaf people are more likely to internalise their experiences with limited ways/ability/language to express them externally. Anecdotally, Deaf people’s experiences of trauma are also more likely to be pervasively experienced throughout the lifetime; therefore, focusing on the immediate short-term impact of a traumatic event is incomplete. Even when a Deaf individual experiences trauma in adulthood, this is often on top of trauma already experienced. Therefore, PTSD criteria/classification will probably miss Deaf people’s experiences and present as another ongoing barrier to receiving equitable trauma care.

Dissociation

Dissociation is highly correlated with PTSD in the hearing population and is widely recognised to be a trauma-related avoidance strategy (Briere, 1995). Schild and Dalenberg (2012b) highlighted that despite the recognition that the Deaf population experience high rates of traumatic experience, little is studied relating to dissociation. They noted that both Deafness and dissociation disconnect an individual from certain aspects of their external environment and, as a population that is at a greater risk of not being able to share experiences with others and express reflections using shared language skills or experience an information deficit, they are more likely to internalise their experiences and dissociation is more likely to be a trauma response (Freyd, 1994). Schild and Dalenberg also add that by closing their eyes, a deaf person can more fully, consciously, or unconsciously refuse to know. The use of the body to consciously avoid knowledge and/or experience may be an alternative to or an antecedent of dissociation (Stern, 1997) that serves a similar purpose. I have often witnessed this in NHSDS; what might be perceived as “being dismissive” or “ignoring” could in fact be a trauma response.
Isolation throughout a Deaf person’s lifetime is also more likely to perpetuate dissociative experiences (such as derealisation, “spacing out”, detachment from feelings) as survival strategies. Potentially when a Deaf person is already prevented from accessing information, support or shared experience, trauma responses may not be as obvious to the assessor (perhaps even looking like there is little effect, with the Deaf individual seeming resilient in their self-management). Therefore, it is important that the Deaf individual is assessed and formulated in a trauma-informed way that allows their differences in trauma response to be considered, and that any assessment of PTSD highlights the importance of evaluating dissociation (Schild & Dalenberg, 2012b).

**Psychosis**

Deaf individuals are equally likely to experience psychosis, thought disorder, mania, and depression as trauma responses (Du Feu, 2017). In my experience Deaf people can experience auditory hallucinations, but they can be difficult to identify accurately. Some Deaf people may be classified as “delusional” or “thought disordered” when in fact they just have difficulty with placement in time and place, have little access to information to clarify, struggle to understand interactions around them, or difficulties in interpreting thoughts and feelings. Hallucinations and delusions are both culturally influenced. In NHSDS, I formulate psychosis within the cultural and linguistic context of their experience, often developing a shared meaning using the individual’s preferred communication to facilitate a shared understanding of trauma at the onset of their care.

**Resilience**

Of course, I cannot talk about trauma without talking about resilience, and this is no different in the Deaf population. In my experience the ability to adapt and survive in the face of adversity is clearly a trait of Deaf people. However, in the forensic environment it may have come at a higher cost to themselves and others. The Deaf community’s strong identity and cultural roots probably offer the opportunity to make connections and to feel a sense of belonging and identity without having to express need or “adapt” to a less open hearing population. Johnson, Cawthon, Fink, Wendall, and Schoffstall (2018) studied resilience in a Deaf population and found that resilience is formed and utilised in similar ways to hearing populations. Additionally, five themes were identified as crucial protective factors in the resilience process for Deaf people: individual assets (personal characteristics viewed as having positive value e.g., self-awareness, motivation, purpose in life, sense of humour), identity development, access to language and communication, access to information, and supportive networks. These are clearly important factors that need to be in place to enable Deaf people to understand and process their trauma experiences, to recover, and to build healthy protective responses. Unfortunately, when Deaf people are placed in a forensic service without contact with other Deaf people or any community, and where there is little Deaf awareness, let alone adapted assessments, treatments, and limited access to basic human needs (communication, healthcare, supports), there are far too many
barriers to the facilitation of resilience. To provide equal trauma-informed care for Deaf people in forensic services, we need to not only understand the unique nature and presentation of their traumatisation but also provide equal access to recovery. The resilience literature tells us that without these key features it will be harder for these individuals to manage their mental health, personality, and risk.

Johnson et al. (2018) helpfully reframe resilience as a product of living life as a Deaf person. Where being Deaf is a resilience- and resourcefulness-promoting characteristic, we should utilise it in our care and treatment of Deaf people who have offended. Johnson et al. show how Deaf identity (if understood, valued, and encouraged/supported) can be held internally as a protective factor and utilised to promote recovery from trauma – a useful concept to bear in mind for all trauma-informed care in Deaf services.

**Being Deaf in the Criminal Justice System (CJS): Isolated Inside**

In my experience from initial contact with the CJS, there is an ongoing theme of being disadvantaged. Deaf Prisoners serving indeterminate sentences are often long over tariff and seem to easily become the forgotten population, scattered across prison systems with little support for their specific needs. The NHSDS's prison in-reach programmes have found it very difficult to even identify where Deaf prisoners are located (hearing level is not routinely screened or recorded and many Deaf people would not class or record their Deafness as a disability), let alone offer access to specialist support.

As Race, Todd, Kaler, Dobson, and Lowe (In press) summarise in their review of the NHSDS's in-reach programme, Deaf prisoners are more likely to become socially isolated due to communication barriers and lack of access to support networks and the cultural benefits of the Deaf community. Some have described this as a “prison within a prison” (HEARD, 2018). This is often exacerbated by having limited available healthy coping strategies or protective factors. Not only are these prisoners socially isolated within the prison but also in relation to external support, due to complex systems and procedures, and barriers to using telephones. A further example that highlights the need for greater awareness of the needs of this population comes from the British Deaf Association (2015) report which described a failure to provide counselling services to Deaf prisoners, despite a large proportion of them expressing suicidal intent. Even when there are available specialist Deaf services or prison in-reach, because this resource is so scarce it often results in the Deaf prisoner being located a long way from family/community support. In addition, there is limited access to educational and health support, exacerbated by limited access to RSLIs. Thus, survival strategies are not only in response to traumatic experience in early life but are adaptations to ongoing adversity.

Gibbon and Doyle (2011) also highlight that social isolation and lack of access to appropriate communication also place Deaf prisoners at increased risk of developing mental health difficulties once in prisons. In fact, it is suggested that while some Deaf people who have offended enter the CJS with anxiety or mild mental health difficulties, many will experience dissociation, paranoia, psychosis or PTSD once incarcerated (Tate, 2012) indicating that stronger trauma survival strategies may be required for surviving the prison environment.
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It is not uncommon for Deaf people who have offended to be labelled as isolative, disobedient, intimidating, or aggressive. It is often acceptable in the Deaf community to be very straightforward, blunt, and “say it as it is”. This can lead hearing people to misinterpret a Deaf person’s behaviour as rude, blunt, or dismissive, and in prison settings that may be seen as challenging and incur punishment.

Gahir (2007) describes how aggression and violence may be a language substitute to communicate unmet needs and frustration when communication barriers are extensive and inequity apparent. Without being Deaf-aware, skilled in communicating fluently in sign language or having access to RSLIs, it is harder to read indicators of anger/frustration which may be missed or misunderstood, leading to frustration that can escalate to violence. In prison, where there is little or no access to interpreters or signing staff, Deaf prisoners can become frustrated in not being able to communicate, and then face punitive and re-traumatising consequences for the resulting behaviour (which may have been avoided if adequate communication was facilitated). This seems to correlate with Deaf prisoners not achieving parole, spending more time in isolation, and being unable to access support and treatment programmes.

By the time Deaf people first come into contact with the CJS, their vulnerability to traumatization is great and their survival strategies are often misunderstood and entrenched. The NHSDS’s Prison in-reach programme represents an attempt to provide an equitable trauma-informed service for Deaf prisoners, offering specialist assessment and intervention, training, education, and consultation. However, we are far from being able to offer a trauma-informed specialist Deaf service to all Deaf people who have offended in the UK.

What Is Needed to Achieve Equity in Trauma Care for Deaf People in Forensic Services?

Trauma-informed care should represent a shift from focusing solely on disease/symptoms and risk to include an individual’s self-determined focus, empowering Deaf people who have offended and giving them equal access to what they need to achieve recovery. Resilience research shows us that we need to attend to individual assets, including identity development, ensuring access to language and communication, and access to information and support (Johnson et al., 2018). We can look at the need for adaptations in two ways. Firstly, in the individual tools/models and processes we use to assess and treat trauma and secondly in the systemic changes needed to ensure an equitable trauma-informed care model.

Initially, a trauma-informed model needs to be evidence-based and include Deaf perspectives and experience in the research evidence, which is currently lacking. Investment and research are needed so Deaf people who have offended can access culturally and linguistically appropriate trauma care and risk reducing treatment programmes. However there has been a stark lack of Deaf experience represented in research. Anderson, Glickman, Mistler, and Gonzalez (2016) explored the barriers that prevented Deaf trauma survivors from being involved in health research and found that a need for communication access, empathy, respect, strict confidentiality procedures, trust, and transparency of the research process were key themes. They also
found that, unlike other minority groups, the inclusion of Deaf individuals in research trials was uniquely difficult due to Deaf people’s sensory and linguistic characteristics that needed to be adapted for research methodologies. Problems in other research were use of inaccessible recruitment, sampling, and data collection procedures and no adaptations for information processing, understanding, culture, and linguistic. If we are to improve trauma care for Deaf people, we need to account for such barriers.

It is vital that in all stages of the CJS, awareness and training is provided to help identify and meet the needs of any offender who has hearing impairment or is Deaf. This should also include specific safeguarding standards that allow staff to utilise linguistically accessible tools to measure individual Deaf people’s opinions, experiences, and feedback to be utilised to attend to re-traumatisation and to develop and maintain standards of equitable care. We need to develop and evaluate empirically validated tools that will allow early trauma screening and clinical assessments that are accessible and will allow early identification of trauma experience for Deaf individuals (the earlier the better!). Training in Deaf awareness and trauma are essential. This should include information on the manifestation of trauma in Deaf people and how to signpost/assess them reliably using trained clinicians and RSLIs. Awareness training relating to language disfluency and deprivation is also important, as is a compassion-focused approach in working with people who have offended. Finally, it is imperative that accessible information about trauma and how to access help are readily available to all Deaf people who have offended, throughout both the Deaf community and in forensic and mental health services.

In my experience like many minority communities that have faced oppression and discrimination, the Deaf community can hold negative beliefs about mental health issues and services, and it can be difficult for a Deaf individual to overcome these to seek support, especially in prisons. Prisons need to develop and disseminate stigma reduction strategies to help Deaf individuals with trauma experiences to access the treatment they need.

Consistent access to specialist RSLIs, and ensuring institutions recognise the importance of this at every stage of the CJS, is imperative. Funding is clearly a barrier in many services; in fact most funding has resulted from litigation and lawsuits rather than thought-out needs analysis. Deaf people need to be involved in research, analysis, planning, development, and delivery of trauma-informed care, though forensic services are far from this at present. Research is needed into identifying not only the mental and physical costs to both individuals and society of not providing accessible trauma care, but also the costs of Deaf prisoners serving indeterminate sentences being detained past tariff.

Tate (2012) highlighted the need for competent, culturally appropriate health professionals and peer support with demonstrated knowledge and experience in Deaf culture and trauma assessments/treatments. The current forensic workforce does not appear to meet this need, particularly in the prison service. Deaf staff who understand Deaf trauma are invaluable in spreading awareness and training other staff to be able to identify barriers. It is also essential that specialist Deaf services are known and made accessible to provide training, consultancy, signposting, and support.
It is accepted that the complexity of working with Deaf people who have offended increases the time required to comprehensively complete assessment and treatment. In addition, many Deaf people who have offended need a longer, individualised “pre-treatment” phase in their treatment pathway. Most require preparatory work which may include health, emotional and sexual literacy, trauma understanding, the development of a shared understanding of meaning and vocabulary for complex concepts and a basic understanding of the links between thoughts, feelings, and behaviour prior to any trauma work commencing. In NHSDS each patient has different linguistic ability, each using varying levels of BSL, signed English, self-taught sign, and communication through alternative means. Visual images are used alongside language, and roleplays and experiential/kinaesthetic work are facilitated to develop a shared understanding. Often a timeline mapping process is used to assist in developing a collaborative understanding of what may have happened in a person’s life, as well as exploring cultural and linguistic identity/understanding between patient and clinician. This is time consuming but essential to facilitating recovery and risk reduction.

This pre-treatment stage also allows the individual to get used to working with the clinician and start to build trust in a therapeutic relationship. Mistrust is a common theme within any marginalised or oppressed population and since many clinicians are hearing and represent prior inequity in interpersonal dynamics, we must attend to this in a culturally sensitive and compassionate way. At times there can be barriers to working collaboratively as many Deaf people who have offended have experienced little empowerment in their lives as seen in the “you’re the boss” response (Anderson et al., 2016) where responsibility and power is always deferred to the clinician. This is especially so in forensic services where there is a clear division in authority between people who have offended and staff. We know that a sense of autonomy and self-determination is vital to promote resilience and trauma recovery, thus collaborative working is essential. The clinician must remain self-reflective throughout and be aware of the ongoing dynamic of privilege and discrimination that could play out when the hearing clinician is trying to work with a Deaf offender. It is important to adapt and remain aware of an individual’s cultural and linguistic needs that even with an experienced RSLI may not be enough to meet fully.

Culturally and linguistically accessible trauma-specific treatments based on empirical research with the Deaf population are still sparse. Many standard therapies used to treat trauma are not accessible for Deaf people. Most therapies rely on abstract concepts, use metaphors/analogies, are spoken language, and are cognitively driven. Therefore, adaptions are necessary to ensure Deaf people receive culturally and linguistically valid and reliable Trauma treatment.

There is a strong need for somatic and sensory working with a Deaf offender population whose traumatic experiences may have occurred prior to or without access to language, and/or language surrounding the trauma may have been visual and linked strongly to felt experience. Trauma is often stored and re-experienced somatically in the body rather than linguistically or cognitively, and Deaf people who
have offended experience vast difficulties in accessing cognitive therapies and other language-based therapies. As such, sensorimotor psychotherapy for trauma is a useful component of a trauma-informed care pathway.

In NHSDS, Schema Therapy (Young, Klosko, & Weishaar, 2003) allows a collaborative approach to understanding each Deaf individual in the context of their life experience, highlighting trauma experienced and how it impacts upon their development of survival strategies (schema modes). It allows clinicians to incorporate trauma experience, manifestation, expression, and responses and link them to both protective factors/resilience and risk management. We do not focus upon the language used in schema therapy but adapt the schema mode way of working to individuals' own linguistic, cultural, and learning needs. An example is the formulation of survival strategies for one patient using masks that we were able to visually create together to show the function of survival responses and how to adapt and manage them in a healthier way to help the facilitation of core emotional needs. The masks in Figure 7.1 represent an understanding of their different survival strategies: (a) avoidant detachment, (b) daydreaming, (c) anger and violence, (d) predatory offending behaviour, (e) over-controlling through striving for perfectionism/order and (f) through suspiciousness/hypervigilance for threat, (g) the vulnerable sadness and isolation that is felt underneath, and (h) the healthy part that is working hard to manage these presentations and finding new healthy ways to meet needs and recover from traumatisation. The experiential and flexible nature of schema work allows us to find shared understanding, language, communication, and meaning and therefore use visual and roleplay methods to drive understanding, recovery, and change.

Figure 7.1 Visual masks that represent a shared understanding of different survival strategies
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In NHSDS we also use Eye Movement Desensitisation and Reprocessing (EMDR; Shapiro, 1995) adapted with the Deaf population. For Deaf people who have offended, trauma may have occurred preverbally or be nonverbal, thus visual and somatic flashbacks are common. EMDR allows the processing of visual and kinesthetic sensory experiences without the need for complex language. The option to use a body scan to attend to trauma responses felt in the body (without a need to verbalise) allows the Deaf person’s processing to be focused and for the clinician to assess change (as clenched hands, sweating palms, fast heart rate or tension in the body can all be measured nonverbally). The standard protocol may not be completed in its entirety; appraisals of distress (SUDS) or validity of positive feelings (VOC) can be replaced with visual images that better facilitate meaning for the individual (these are developed collaboratively so they have meaning for the individual such as emoji-like simple facial expressions). These can also be adapted for the individual’s developmental level. EMDR already positions the clinician in a less verbal or directive role which focuses more on identifying needs rather than “talking” through issues. In fact, the therapist does not need to know all the details of the trauma to assist in EMDR processing. An adaption of the bilateral stimulation modality may be needed; eye movements, self-tapping, and the use of buzzers can be used with success. Acceptance that we may not fully “know” if all channels are processed is needed, but experience indicates that enough of the trauma appears to be processed for the trauma responses to lessen and more adaptive changes to be noticed.

As well as adapting treatment modalities, the role of skilled RSLIs in bridging the communication gap in the delivery of trauma therapy for myself as a hearing trauma clinician has been vital! Many Deaf people in forensic services have no awareness of the word “trauma” (and have no sign for it), nor of words like recovery, trigger, trauma response, or survival strategy. In fact, many of the trauma-informed (and empowering) words, phrases, and understandings that facilitate recovery (used intrinsically in this book) have no meaning for many Deaf people. It is also worth reflecting that if they have never heard of these words, they are unlikely to have ever been asked to meaningfully share their experiences. In our service each patient has a different linguistic ability and communication style and, without experienced specialist RSLIs bridging the complex gap, we would not be able to meet their communication needs. For trauma-informed working I would suggest that these RSLIs are not easily replaced by bank interpreters and as the quality of RSLIs can vary widely. Training RSLIs in clinical and forensic trauma-informed language is a vital component to delivering equitable trauma-informed care.

We must also be aware of the risk of vicarious trauma. An RSLI’s role is to not only witness the traumatic experience of an individual as a therapist does, but often to express it for them in the first person. This puts an interpreter at greater risk of absorbing someone else’s trauma and others’ responses to it, as, due to the expressive nature of BSL, they often act out or embody the experience to communicate it. In a forensic environment this can include interpreting an individual’s own trauma and offending behaviour, as well as experiencing the transferenceal dynamics present in therapeutic interactions. Vicarious trauma can be linked to greater levels of stress, compassion fatigue and burnout, mental health difficulties, and impact upon
relationships. A trauma-informed service must provide support and supervision for its RSLIs to allow them to work in a safe and supported way, thus ensuring their efficacy and meeting ethical responsibilities. Interpreters may at times be overlooked because their job is often to “not be there as themselves”, so we must hold their experience in mind.

**Summary**

With vast experience of traumatisation throughout their lifespan and vast barriers to protective factors and support, it is little surprise that Deaf individuals are overrepresented (and often stuck) in forensic services. But when trauma is so intricately linked to offending, and with many forensic services’ focus on retribution, diagnosis, risk, and rehabilitation continues to re-traumatise, we must find a way of achieving balance to promote resilience, empowerment, and recovery for Deaf people in forensic services. This cannot be done without equality in research, strategy, delivery, and evaluation. The answer cannot just be trauma-informed practice; it must be trauma-informed care equitable to all! It will no doubt require systemic change on many levels, but Deaf experience must be included.

**Further Reading**

Department of Health. (2002). *Sign of the times: Modernising mental health services for people who are deaf*. Retrieved from www.nimhe.org.uk/downloads/signoftimes.pdf. For readers who are curious about Deafness and the difficulties Deaf people had endured, this is recognised as core to the changes that followed.

**References**


Deafness and Trauma


Tate, C. (2012). *Trauma in the deaf population: Definition, experience, and services*. National Association of State Mental Health Program Directors.

