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Private Practice

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Several months after beginning psychotherapy, Sue¹, a 40-year-old Deaf woman, told me about a recent event at work:

My coworkers and I are in a room together and they're saying something to me that I can't understand. Then they're talking to each other, some laughing, some looking serious. Now my boss is coming in and he's saying something to the group and they look anxious and are talking over each other. I'm able to pick up a few words – or at least I think I do – but most of the conversation is gibberish.

Initially, her story was unremarkable and felt quite familiar, having heard many variations on this theme from Deaf individuals. Alternately using American Sign Language (ASL) and Signed English, with a restricted signing space and flat affect, she nonchalantly and matter-of-factly acknowledged that the inadequate accommodations at her work were the norm and that she had resigned herself to the circumstance. It probably shouldn't have surprised me, but suddenly, seemingly out of nowhere, she sat upright in her chair, her signing became more animated and encompassed a larger space with less clear hand shapes, and her face became flushed. While clenching her teeth, she signed, "Then my heart starts to pound and I sweat and I want to get the hell out of there but I can't! I can't!" She repeated, "I can't leave, I can't leave" over and over again. Her respiration increased, then her breathing became shallow, her face more flushed, sweat began pouring down her forehead, her heart raced, and she held on to her seat for dear life. In a matter of seconds, she no longer simply recounted the event, but seemingly began to relive it in my office. She started to cry.

¹ *A composite case illustration with modified details to protect confidentiality. Approval for publication was granted by the respective individuals.*

How to understand what Sue had shown me? What fueled her apparent panic attack after her initial affective numbness? By her own report, the work meeting was routine; she signed “SAME, SAME, SAME.” What other event(s) might she had been reliving? Using terminology from *trauma informed care*, I wondered whether she was reacting to early trauma with characteristic alternating states of posttraumatic *hyperarousal* (panic) and *hypoarousal* (nonchalance).

Trauma-informed care involves professional relationships and interventions that take into account an individual’s trauma history as part of efforts to promote healing and growth. This includes understanding the connection between one’s present symptoms and behaviors and previous trauma, and one’s vulnerabilities or triggers that traditional service delivery approaches may exacerbate. “At the most basic level, trauma informed care involves the provision of services and interventions that do no harm – e.g., that do not inflict further trauma on the individual or reactivate past traumatic experiences.” (Hodas, 2006, p. 6). Unfortunately, even today, the professional training of most therapists does not include attention to trauma and posttraumatic responses, despite the fact that traumatized individuals make up high percentages of clinical caseloads. The consequences are often devastating. Quite frequently, those who have incurred early life trauma and the professionals they turn to for help misunderstand them, devalue their strengths, or view their survival adaptations through a lens of pathology – e.g., view them as over dependent, aggressive, or diagnose them as having borderline personality (Courtois & Ford, 2013).

The tenants of trauma informed care are particularly relevant for treating Deaf people. The prevalence of trauma for the Deaf population is significantly higher than for the hearing population (Anderson, 2010; Schild & Dalenberg, 2012). Deaf children are more than twice as likely to experience physical and sexual abuse (Sullivan, Vernon, & Scanlan, 1987) and Deaf females in a sample of undergraduate student were twice as likely to have experienced physical assault, psychological aggression, or sexual coercion in the past year when compared to their hearing counterparts (Anderson & Leigh, 2010).

In addition, in other publications, I described the traumatic effects of *ordinary evil* (Harvey, 2001/2003). Ordinary evil is when someone intentionally maltreats another person; the recipient perceives the act as evil or malicious; and the maltreatment happens so frequently as to be considered statistically ordinary. Such acts include various degrees of oppression and

discrimination and are more prevalent for Deaf people (Pollard, 1998).² As Glickman (2003) put it:

If you are hearing and if you are awake, if you seriously attend to what deaf people say, then you know that the mental health problems that some deaf people develop can not be separated from the abusive ways they have been treated by hearing people. (p. 2)

There is an important qualitative difference to how many Deaf people affectively experience trauma. This has to do with the acute and cumulative effects of linguistic isolation which impede access to information and often cause language deprivation (Glickman, 2009). As an example of the former, Schild & Dalenberg (2012) defined *Information Deprivation Trauma* as when a Deaf person has limited or no information or knowledge about the impending event and, as a result, the trauma is experienced as more sudden, unpredictable, and uncontrollable. In terms of the cumulative effects of linguistic isolation, depending on its extent and duration and when it occurs during one's development, this may cause varying degrees of language deprivation. As Gulati (2003) noted:

The acquisition of a fluent first language is essential to normal emotional, cognitive, social and occupational functioning. The human suffering created by language deprivation is profound, and is all the more heart-breaking because it is entirely preventable. Most Deaf people have firsthand knowledge of language deprivation. (p. 62)

Over 40 years ago, Mindel and Vernon (1971) noted that *communication* difficulty strikes at the heart of the deaf person's plight. Fifteen years later they again affirmed that "ambiguity in *communication* is one of the deaf child's greatest problems in the home" (Mindel & Vernon, 1987, p. 8). Glickman (2009) observed that "... the absolute core of oppression of deaf people, as I have come to understand from their stories is disempowering them around communication, resulting in communication isolation" (p. 3). Communication barriers continued to be implicated in the 2012 report on Trauma in the Deaf Population by the National Association of State Mental Health Program Directors (NASMHPD). A key consumer informant example from that

² *A caveat: ordinary evil versus ignorance. It is important not to overstate or exaggerate the prevalence of oppression done by hearing people to deaf people. Not every instance of apparent malfeasance is driven by oppression which, by definition, implies intent. Ignorance and naïveté are also common culprits. Indeed to the extent that an incident of oppression is traumatic to an observer, that observer may be hypervigilant for its reoccurrence and may perceive oppression when it, in fact, is not there.*

report: “The teachers for the Deaf forced all of the students to come down to their level of sign language ability. If we signed better than they did and they could not understand us, they punished us” (Tate, 2012).

It is one thing to academically study trauma and quite another thing to witness individual’s post-trauma reactions first hand. In all of the present-day stories that Sue had told me, this was the only one in which she exploded with so much emotion, particularly terror. I have to admit that like many newcomers, when I first entered the field, I was initially shocked to learn about many Deaf persons’ experiences of communicative isolation within their families of origin. But gradually and insidiously, their stories became the routinized expectation, the norm; I became numb, in a state of hypoarousal, secondary to vicarious trauma (Harvey, 1996). Thankfully, I am often reminded of the posttraumatic effects of restricted language accessibility by recurring narratives from Deaf persons.

It is standard practice in trauma informed care to use a phase-based treatment model that first addresses parameters of safety and stabilization before delving into the trauma narrative (Courtois & Ford, 2013). Easier said than done. In practice, treatment is never as sequential as it appears in print; the stabilization and uncovering phases frequently overlap. Nonetheless, Sue and my initial tasks were to explain the nature of trauma and post-trauma reactions so she would not feel so blindsided and besieged by reliving traumatic memories and for her to learn grounding techniques and stress management.

As Sue gained some mastery of safety and stabilization tools, the next phase of our work was for her to recollect and articulate the relevant trauma narratives and process unacknowledged and unintegrated feelings, thoughts, and beliefs (Courtois & Ford, 2013). I asked for any earlier life events that her work meeting may have triggered. She needed no prodding; after only a few seconds, she recounted her mainstream academic environment:

Before and after classes or during recess, everyone would talk about stuff: gossip, who they’re hanging out with, friends, movies, etc., but I could understand only enough to know I was missing a lot. So I would just sit down in my front “preferential seat” and do nothing. Looking back, I realize that I couldn’t get much of the auditory information even from the teacher, even though I had an interpreter (who couldn’t sign well), but I didn’t know that then. I thought I was stupid or lazy.

Sue then described what she termed “torture”: frequently feeling embarrassed, scared she would miss important information, feeling alone in a crowd, and being bullied for appearing “out of it” (not being able to participate in conversations): “I would be scolded by my teacher and parents for daydreaming in class,” she continued. “All of the hearing kids could pay attention for a long time so I assumed that maybe being deaf had kind of shortened my attention span. And sometimes the teacher used an overhead projector and I would look at the screen but then fall behind with the interpreter. I remember going to a psychologist who gave me a bunch of tests and he talked with my parents and pediatrician who then put me on Ritalin for my A.D.D.”

Although Sue scored in over the 99th percentile on both verbal and nonverbal intelligence testing, with impressive bilingual proficiency in English and ASL – she is a voracious reader – her Attention Deficit Disorder diagnosis was the beginning of a long list of psychiatric diagnoses that would include Adjustment Disorder, Bipolar Disorder, Intermittent Explosive Disorder, Oppositional Disorder, and Borderline Personality Disorder. A plethora of psychiatric misdiagnoses is a common occurrence for deaf persons in treatment (Gulati, 2003) and they are more likely to be diagnosed and misdiagnosed as having a personality disorder than their hearing counterparts (Pollard, 1998). Such misdiagnoses serve to further exacerbate the traumatization of deaf persons. In Sue’s case, she was left with feelings of inadequacy (stupid, A.D.D., lazy, etc.), anxiety, fear, embarrassment, and shame.

A timely coincidence: During the time period of my meetings with Sue, I happened to be reading a memoir by Sonia Sotomayor, Associate Justice of the U.S. Supreme Court. In *My Beloved World*, she recounted that her family of origin was marred by her father’s alcoholism, a mother who was emotionally distant, marital conflicts, and being diagnosed with Type 1 Diabetes at age seven. I thought of Sue for two reasons. First, as an avid reader and follower of current events, she closely followed Sotomayor’s Supreme Court confirmation hearings in 2009. In Sue’s words, “She’s a woman who had to fight real hard to get where she is.” The second reason I thought of Sue was Sotomayor’s vivid description of her constant “surveillance activities” with her family: “...Much was said at home, and loudly, but much also went unsaid, and in that atmosphere I was a watchful child constantly scanning the adults for cues and listening in on their conversations. *My sense of security depended on what information I could glean, any clue dropped inadvertently when they*

didn't realize a child was paying attention." (Sotomayor, 2013, p. 14)

I wondered about Sue's *sense of security* in her family of origin. Like many deaf-member families, she was the only deaf member, her primary and preferred mode of communication was sign language, and her family did not sign (Harvey, 2003). I gave her Sotomayor's passage and asked what resonated for her. In contrast to Sotomayor whose *sense of security depended on what information she could glean*, Sue had felt anything *but* secure. She kept nodding her head while reading the passage and then recalled a dark, rainy day when she was maybe four years old. Her parents were crying, several other people were over the house also crying, but Sue didn't know what was wrong. Maybe she was sick and would die? Maybe the monster that her mom kept assuring her was make believe was, in fact, real and would eat her or even the whole family? Maybe she did something so wrong, so bad that she is being sent away to jail? Then her mom and dad started to scream at each other, about what she had no idea. Sue was so terrified of these and other possibilities that she hid under the bed. She found out the next day that it was "only" that her uncle suddenly died. She felt guilty for feeling relieved.

I continued to elicit trauma narratives. For Sue, as for many victims/survivors, there was an initial period of trust building before she divulged increasingly shameful recollections that were more destabilizing. She produced memory fragments of many years of physical and sexual abuse by her uncle. His abuse started off innocently enough, as her uncle was a regular visitor to the house and had become a confidant for Sue, someone she could talk to, who would listen, who even had taken several sign language classes, and who even invited her to stay at his house on many weekends. His abuse began when she was 14 years old and continued for three years. It was their secret, as he threatened harm to Sue and her parents if she dared tell anyone. We spent over two years very slowly and carefully piecing together a coherent narrative of the abuse chronology and her resulting feelings of helplessness, terror, guilt and shame while frequently cycling back to our initial focus on stabilization and safety. A delicate balance. Her memories were split-off and dissociated and heralded marked anxiety, suicidal ideation, and intermittent cutting of her arm (attempts to interrupt the flashbacks via pain). At times, hospitalization seemed imminent.

The posttraumatic sequelae of her physical and sexual abuse were inexorably connected to other information deprivation triggers in that

often any one memory would trigger others. A common factor was her fantasy that if only she could discern auditory cues, maybe she would be more prepared and could cope better – whether the context be with her uncle, within her family, or in school. When her uncle came over for dinner, he would often wince at her a certain way which sometimes indicated a high probability of later abuse and at other times, he was only maliciously teasing her. At home, her parents would often fight and become physically aggressive without warning – she was sure that there were auditory cues that she missed – and Sue would have no idea of what they were screaming about or what was to happen. And at school, she would see her peers’ mouths move as if they were ridiculing her which may precede physical bullying. In all these contexts, she was desperate for any means of predictability but to no avail. This exemplifies how information deprivation increases factors that increase severity of trauma: suddenness, unpredictability, uncontrollability, incongruence, and novelty of experience (Carlson, 1997; Carlson & Dalenberg, 2000).

Her memories kept on coming, often flooding her emotionally. An important caveat: If I had only elicited Sue’s trauma narratives – e.g., repeatedly asking her to elaborate how she was victimized – it would have been re-traumatizing her. In addition to “Tell me more,” another intervention is critical. Michael White (2006) referred to *double listening* – seeking double stories: the trauma story in which a person was victimized and the concomitant story of how that person responded to it; how that person held on to certain values through the trauma; how one utilized internal resources to protect the preferred sense of identity or “sense of myself.” This core sense of self reflects what one gives value to in life. Stated differently, no-one is a completely passive victim to trauma. When people cannot prevent a trauma, they take steps to try to modify it in some way or to modify its effects on their lives. Consider an example of a deaf person who was sure to sleep a lot while residing in an oral program because “I can sign in my dreams and no one will slap my hands.” His active resistance vis-à-vis sleep reflected his culturally Deaf sense of self or identity that included his valuing American Sign Language, not speech.

Double listening is useful to facilitate the integration of trauma with one’s current and future life values and goals. One’s recollections of distress offer significant openings for a conversation about *why* one felt a certain way and how those feelings reflect one’s values. In Sue’s case, it was noteworthy that her initial defense of passive resignation – “Same, Same, Same” --

regarding the linguistically inaccessible work meeting, morphed into feelings panic and sadness. Moreover, these emotional responses also fully characterized her responses to the linguistically inaccessible academic and family environments. I asked her, “Would you say more about any ideas you have about *why* you might have felt terror and sadness when you couldn’t understand communication around you? I don’t yet have a sense of what feeling left out meant to you, means to you, and about what your thoughts and feelings mean about who you really are and want to be.”

Sue’s eyes sparkled. She disclosed that full communication feeds her sense of competence, of empowerment. “Even if I were not deaf, I think I would value my own competence, maybe because society doesn’t tend to value women’s competence, but, as a Deaf person, being told so many times “What he was just saying isn’t important’ has come to mean that they think *I’m* not important, *I’m* incompetent. F### you! So I need to show myself that I’m smart, that I’m capable.” I was reminded of an interpreter’s description of her own feelings when interpreting a situation in which a deaf person was oppressed (vicarious trauma): “I sometimes wonder if tomorrow I lose my hearing, whether people will treat me in the same way – as if I suddenly become stupid” (Harvey, 2001).

“Competence is an important value in your life, one that got threatened. Would you tell me how, or if, you were able to somehow hang on to your competence when being treated otherwise?” I asked.

“As I told you, in school, I often daydreamed in class because I couldn’t understand the interpreter.”

“What did you daydream about?”

“Painting. I would paint different pictures in my head.”

“How did they come out?”

“Perfect” Sue smiled.

“Your painting pictures was a private and clever coping strategy, but was pathologized as Attention Deficit Disorder!” I wasn’t shocked.

“Yeah, that’s what everyone said: my parents, teachers, doctors. But I still do that to this day. About that work meeting; I fought for an interpreter or CART reporter but they said No. So in that meeting when I couldn’t understand the back and forth, I was painting an ocean scene with bright colors and a beautiful sunset over the water.”

“You were painting and no one even knew it! And what was it like painting?”

“I take pride in it.”

“You felt competent even though you were left out of the conversation?”

Sue smiled, nodded and then squirmed in her seat. She emphasized how much is at stake during these meetings, that it was hard, that her boss was a powerful “asshole,” that she often didn’t know what was coming, and that she was constantly fearing she would be fired. Her constant state of disempowerment and fear were palpable. I then flashed back to her uncle and referenced him to Sue.

She paused, looked up and rubbed her forehead (which I knew indicated that she was experiencing flashbacks) and said slowly, “I even painted in my head while he was raping me. I wouldn’t give him the satisfaction of raping my mind, only my body.”

“It was your way of holding on to an inner core, to your integrity.”

“Yeah.”

We discussed more about Sue’s values of competency, empowerment, and integrity and how they had been threatened, but not obliterated, by her trauma experiences. An important principle: “Victims and survivors are viewed as resilient, capable, and resourceful, although injured by what has befallen them” (Courtois & Ford, 2013, p. xvii). At this juncture, it would be important to bolster and expand Sue’s resiliency, her values and self-identity, so that she would be more able to counteract the plethora of posttraumatic triggers which have squashed her sense of self. Our identities are forged through our relationships with other people (Russell & Carey, 2004). Archbishop Desmond Tutu described this succinctly: “People become people through other people” (Morrison 2002, p. 5). These people

may be real or fictionalized. I shared with Sue that reportedly Sotomayor was first inspired by the strong-willed Nancy Drew book character, and then after her diabetes diagnosis led doctors to suggest a different career from detective, she was inspired to go into a legal career and become a judge by watching the *Perry Mason* television series. At the age of 10, she knew she would go to college and become an attorney (Smith, 1998).

Our task was to generate positive characters in Sue's life -- real or fictionalized; past, present or future -- that she could, in her words, "double click" in her mind get support (self-talk) to bolster her resilience (protection) against posttraumatic triggers. This intervention is what Michael White (1997) termed *re-membering practices* with respect to one's "club of life." This club of life metaphor introduced the idea that for all of us there are people or fictionalized characters who have had particular parts to play in how we have come to experience ourselves. These so-called members of our club of life have often had different ranks or status. For instance, we pay more attention or give more credibility to what one person thinks about us than another. The person or persons whose views matter most to us, who influence our identities the most significantly, can be seen to have highly regarded and respected membership status within our club of life. Those to whom we don't give so much credibility can be seen to have low or less significant membership status. Re-membering practices provide a context for people to revise or re-organize that membership status. The hyphen is all important in thinking about the distinctions between re-membering and remembering, as it draws our attention to this notion of membership rather than to a simple recollection of history.

Thinking about Sue's life as a "club with members" offered new possibilities for therapeutic conversations. Who were the people in Sue's past who helped shame her sense of who she is? Who were the people who served as positive influences? I asked her for the most influential club members in her life and she gave me her initial list: "The teachers who kept scolding me, the shrinks who kept on diagnosing with different disorders, the uncle who raped me, my parents who kept scaring the crap out of me with their fighting. ... it was full of toxic influences, all of whom held high status."

It was time to ask Sonia Sotomayor for a psychological consult. Of course, I knew she that was an attorney, not a psychotherapist, and regardless, that she surely wouldn't take time off from her Supreme Court obligations to

come to my office for a consult, but this is the advantage of make believe. Given that Sue had a fantasized mentor relationship with Sotomayor, it would be helpful to explicitly afford her high status in Sue's club of life. She needed no persuading. Once in a while, we had shared passages from her book, and at the beginning of one meeting, Sue read to me what was particularly inspirational for her: "Most essentially, my purpose in writing is to make my hopeful example accessible. People who live in difficult circumstances need to know that happy endings are possible" (Sotomayor, 2013, p. 2).

My first question to Sue: "If Sotomayor learned that you paint in your head in order to be less victimized by trauma and feel competent and empowered, what do you imagine she would think? What would resonate for her?" (I finger spelled "resonate").

Sue gave me a weird look, but then considered her response. "I think she would approve. Maybe she would even be impressed. She'd think back to what she learned from her mother – a single parent who tried as hard as she could, and, at the same time, had to kind of let go, do her own thing, take care of herself. Her mom probably cooked fun recipes in her head. I bet Sotomayor cooks fancy meals during boring courtroom testimonies."

"Try your best to change what you can and then take care of yourself." It was my inadequate summary of the Serenity Prayer. I continued: "If Sotomayor were listening to our conversation, what advice would she have for you for how to cope with trauma, past, present, and future?"

"Sotomayor would say to me, 'Use your intelligence! Try to figure out *why* your parents fought, *why* they didn't learn sign language, *why* the interpreter at your school kept at her job even though she couldn't interpret. What was ordinary evil, what was ignorance? Try to figure out what it was about your uncle's background that led to his abusing you.'" Indeed, Sue's intelligence and inquisitiveness were huge positive prognostic factors.

I then asked Sue to speculate how her Sotomayor would respond to an important and difficult piece of our work: her guilt and shame regarding her uncle's abuse of her – a common sequelae of ongoing sexual abuse of children (Saxe et al, 2007). We had spent many sessions examining her belief that she somehow could have stopped his abuse; that she visited him knowing he would abuse her; and her belief that she had initiated the abuse

and therefore was a whore. For example, he would ask her if she wanted to give him a blow job or a hand job first and if she replied “Neither” he would punish her severely; she had to respond with one or the other. In the Holocaust literature, this is referred to as a “choiceless choice” (Langer, 1982).

Sue thought for a moment and reiterated what we had been working on for some time, but now via an imaginary dialogue with her mentor. “Sotomayor would help me understand what you and I have been talking about: the nature of abuse, the power differences between me and my uncle, that he was an adult and I was only a child and was very naive about a lot of things, that I was scared, that he kept threatening me if I didn’t comply, and that he would brainwash me to make me think I led him on to have sex. She would tell me to read psychological books about all of this so I could understand it. And then she would ask me to imagine that he’s in court on the stand and both she and I are cross examining him and how the jury only took practically no time to deliberate and rendered a verdict of “Guilty, guilty as charged!” Sue raised her hand in triumph. Sotomayor would have been proud. Her uncle and the traumatic agents in Sue’s club of life were guilty as charged; Sue no longer had to hold the guilt and shame. Thus, our work of over 4 years came to an end.

A month after our last session, Sue sent me an email that read, “Can I ask you something? And think about it before you answer. I’m really not looking for you to say ‘we all are’ or whatever you might be inclined to say so I don’t feel bad. Okay here goes... Am I permanently damaged (at least in some areas) because of what happened?”

My response:

What happened to you will always be there somewhere in your brain/mind, in or around the amygdala³. You could also call that “permanent damage.” Is that the only thing that’s there? No, because you’ve added a lot more strengths for how to manage that “damage” Will that “damage” be triggered? Yes. Will there ever be a time that it will be impossible for it to be triggered?

³ *The amygdala is a structure in the limbic system that is implicated in storing and modulating traumatic memories (Saxe, Ellis & Kaplow, 2007).*

No. Under times of stress, will it always be more likely for it to be triggered? Yes. Will it get easier, quicker over time to manage triggers and recover from them? Yes. Do survivors often do a big chunks of work (e.g., 5 years) and do short pieces of work intermittently – called “long brief tx” (I think we talked about this) – and does this help? Yes. Am I saying you will need intermittent tx for the rest of your life? No. Am I saying you need tx now? No.

Hope this is helpful. Mike.

Sue’s response:

First, again thank you for this — this validates a reality that I’ve had so that in itself is relieving.

I’ve never heard you say this before, or at least I haven’t heard it in this way before. I’ve always thought you were trying to tell me that I’m not damaged at all, (and I know that word is harsh). I think in the past I’ve used it as it sounds- damaged, but now I think I mean it to mean “permanently impacted” which I don’t think it’s just watering it down, I think it’s how I’ve come to accept what is.

So here’s what I think ... years ago, I slid into third base and really hurt my right knee. The doctor recommended exploratory surgery, the second opinion said wait and see what the long term impact is. I waited. Most days, my knee is fine. But when it rains, when I’ve worn high heeled shoes, when I’ve run, I get this ache- sometimes the ache is ever so slight and I have just a bit of a pain or sometimes the pain causes me to limp for a day or two. And then literally (I’m not making this up to have a cute analogy) every once in a while- it happens so infrequently that I don’t even have a number for it- but infrequently I’ll just be walking and my knee “locks” for split second, and I get this incredible pain running up my leg. It passes

so quickly and happens so infrequently, that although I checked with a doctor once, I've decided not to do anything about it.

So I think that's what's happening with my psychological injuries. That "permanent voice" that you refer to is more than just a voice I think- it's a psychological injury. And for the most part I am okay. There are plenty of other non-injured parts of me that are stronger and (in your way of saying it) more vivid than the damaged part, but it's there. And just like my knee there will be flare ups that will vary in intensity, duration, and impact. There will sometimes be identified triggers and sometimes something will just come up, but none of it is crippling.

I suspect that none of this is an "aha" moment for you, but it was for me in this way. So why is all this so important to me at this point? It's so important because I've been struggling for a little bit recently, as you know. And the thoughts that go through my head each time this happens is that "What the hell did I accomplish in therapy if this still bothers me?" "Did I end too early?" And most importantly - "Will I ever be okay?" And the answer I think lies in my knee situation... that yes, I did accomplish a lot in therapy - I'm no where nearly bothered by what happened the way I was and I function much better AND it'll never go completely away. And I AM okay even when this stuff happens. But there are parts of me that have been psychologically injured that will never completely heal, so yes, there are parts of me that are damaged. And it's okay. Because those parts have become much diminished and don't control my life anymore, so I'm okay and it's okay. So I guess I can stop "beating myself up" when I struggle from time to time. It's very similar to my knee.

Sue's response is the most erudite and articulate narrative I have ever received from anyone in my psychotherapy practice, deaf or hearing. I

asked Sue if I could share her instructive insights with other persons who are recovering from trauma. She readily agreed and requested that I share their reactions with her, as she deemed that as part of her healing process. I continue to send her emails from people who express their feelings of validation, inspiration, and their own catalyzed insights and stories. As for me, I often look at Sue's email, particularly when I lose sight of the goals of trauma informed care. I remain grateful.

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