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Working Therapeutically With Deaf People Recovering From Trauma and Addiction

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Objective: This article reviews what is known about behavioral health treatment of deaf persons with comorbid trauma and addiction. **Method:** We discuss how to work therapeutically with deaf people with comorbid trauma and addiction, both through a review of the literature and through clinical observations of the authors. The article also includes the personal stories of two people—a Deaf peer specialist and a hearing psychiatrist—who share their humbling stories about the recovery process for deaf people and the challenges of learning to become an effective Deaf mental health care provider. **Findings:** Deaf people report higher rates of mental health problems than the general population. Although initial empirical work with the deaf population suggests high rates of posttraumatic stress disorder (PTSD) and substance use disorder (SUD), little is known about the rates of comorbid PTSD/SUD or how to effectively address this comorbidity in treatment. **Conclusions and Implications for Practice:** Substantial work is needed to raise awareness of comorbid PTSD/SUD and provide treatment tools to agencies and providers who work with deaf clients, infusing trauma-informed care into deaf SUD services and SUD treatment into deaf mental health care. Fortunately, several endeavors are on the horizon to disseminate assessment and treatment tools to work with deaf people recovering from trauma and addiction.

Keywords: deaf, trauma, PTSD, addiction, substance use disorder

Marco's Story: Part 1

My name is Marco Gonzalez. That is my real name, and this is my real story:

I am a Puerto Rican Deaf male. I lost my hearing when I was about 4 or 5. I got sick and my eardrums burst. Shortly after that, my father left the family. My mother had to take care of my four siblings and me. I saw her get more and more depressed. She

eventually killed herself in front of me. I was 6. My uncle and aunt adopted me, but my siblings didn't like living with them and all left. I suffered verbal and physical abuse there. I was lonely and afraid.

There was also a lot of substance abuse in my family. I started drinking and smoking marijuana in my teens. At 19, I started using heroin. I used heroin for years. Looking back, I feel like I lived in a cave all those years. I missed all family events. I was alone and depressed and deeply addicted to various drugs. I dreamed of becoming a professional boxer, but because of my drug use, it never happened . . .

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Recent research shows that deaf people¹ experience higher rates of interpersonal trauma, posttraumatic stress disorder (PTSD), and substance use disorder (SUD) than the general population (Anderson & Leigh, 2011; Pollard, Sutter, & Cerulli, 2014; Porter & Williams, 2011; Schenkel et al., 2014; Schild & Dalenberg, 2012; Sebald, 2008; Titus, Schiller, & Guthmann, 2008). Yet, little is

¹For the purposes of the current article, *deaf* refers to the diverse population of people with hearing loss and to the audiological fact of hearing loss; *Deaf* refers to the community of deaf people who share a unique culture and language—American Sign Language. The capitalized *Deaf* is used when referring to Deaf culture, the Deaf community, Deaf programs, and Deaf mental health care.

known about the rates of *comorbid* PTSD/SUD or how to treat this complex comorbidity among deaf people in recovery. This article reviews the challenges and successes of therapeutic work with deaf clients with PTSD/SUD. We include preliminary research on this topic, as well as direct observations from a variety of specialized deaf clinical settings where most, if not all, the clients we see are affected by trauma or addiction—inpatient psychiatric hospitals, outpatient psychotherapy offices, and community support services. We also include illustrative personal stories of two people: Marco Gonzalez, a Deaf peer specialist who shares with the reader his lengthy and difficult recovery process, and Lisa Mistler, MD, a hearing psychiatrist who describes her process of unlearning and relearning basic treatment strategies in order to be an effective Deaf mental health care provider.

Common Experiences of Deaf Trauma Survivors

For the 90% of deaf people with hearing parents, trauma experienced in adolescence or adulthood may be superimposed on childhood developmental disturbances (e.g., limited access to visual language, obstructed communication and attachment with parents, isolation, memories of parents' grief and attempts to cure their deafness; Brice & Adams, 2011). Additional traumas can occur within educational settings, especially those not designed to support deaf children's unique learning styles and communication needs.

Communication barriers experienced at home or in school can slow deaf children's acquisition of emotional expression and healthy coping—skills typically learned from parents and teachers (Dammeyer, 2010; Glickman, 2013a; Landsberger, Diaz, Spring, Sheward, & Sculley, 2014). They are, therefore, more likely to learn from peers with whom they can communicate but who may not be able to model sophisticated coping skills. If such skills are absent, deaf trauma survivors may use unsafe strategies to cope with posttraumatic anxiety, including strategies that develop into SUD or behavioral addictions (e.g., cutting, skin picking, inappropriate sexual behavior).

Treatment Considerations

Deaf people experience significant challenges to accessing behavioral health care, including limited availability of specialized deaf services, communication and language inaccessibility of services designed for the general population, and providers' failure to provide interpreters and other appropriate accommodations (Diaz, Landsberger, Powlinski, Sheward, & Sculley, 2013; Landsberger, Sajid, Schmelkin, Diaz, & Weiler, 2013). When deaf people *are* able to access services, whether in specialized deaf settings or in general hearing agencies, a variety of factors must be considered to provide effective treatment. In the following sections, we describe a number of evidence-based treatment approaches that we have used with deaf clients (i.e., Addictions and Trauma Recovery Integration Model, Seeking Safety, Motivational Interviewing, and Shared Decision Making) and the additional considerations and adaptations necessary to make these treatments more accessible, usable, and engaging for this population.

Pretreatment

We work with deaf clients whose language, cognitive abilities, fund of information, and literacy vary enormously. Some clients do not initially understand the concepts of "treatment" or "recovery" (i.e., that one talks with a counselor about one's life in order to get better). Thus, there is great need for "pretreatment" work—education and motivational work to prepare clients to make use of treatment and recovery strategies (Glickman, 2009a, 2009b, 2013b). For deaf clients with PTSD/SUD, educational pretreatment work may focus on the nature and impact of trauma; safe and unsafe coping skills; common effects of substance use, abuse, and dependence; myths about mental illness and substance use; and resources such as 12-step programs. Motivational enhancement for this population may include helping clients establish recovery goals and evaluate how their behavior affects these goals, especially how their substance use hinders recovery from PTSD.

These pretreatment strategies must often be adapted for deaf persons. For those with low English literacy, written educational materials are redesigned with pictures or administered in interview or discussion format. For those clients who also have delays in sign language acquisition, pretreatment includes developing a shared vocabulary of core treatment concepts. Establishing this shared vocabulary takes substantial time and care because many core relapse prevention concepts have no widely known, accepted sign equivalents (e.g., "treatment," "relapse," "trigger," "risk factors," "warning sign," "cycles," "seemingly unimportant decisions"; (Glickman, 2009b).

Trust Building

Just as important as building a foundation of knowledge is building a foundation of trust. Distrust is a common characteristic among trauma survivors (Herman, 1992). Many deaf people have had additional experiences of discrimination and oppression that elicit distrust of hearing providers and the health care system. When hearing clinicians work with deaf people, they are working cross-culturally and face similar barriers to establishing trust that occur in other majority-minority relationships (Gournaris & Aubrecht, 2013; Ladd, 2003; Lane, 1992).

Although providers' American Sign Language (ASL) fluency is typically the first priority of deaf clients, a close second is working with a provider who has the "right attitude." This usually means respecting Deaf culture, being sensitive to how hearing people have oppressed deaf people, and being receptive to Deaf ways of thinking and being in the world (Ladd, 2003). Humility is key—not assuming expertise on all things Deaf but acknowledging what one does not know and letting the deaf person teach you. Beyond the basics, learning about the "right attitude" is a complex process that must involve developing an awareness of Deaf/hearing cross-cultural dynamics and engaging in a process of self-examination about one's hearing privilege (e.g., Glickman, 2013b; Gournaris & Aubrecht, 2013; Lane, 1992). Clinicians who understand the challenges that deaf people face are more likely to develop a strong empathic connection with their clients.

Skill Building

Once a foundation of shared knowledge and trust is established, treatment can then proceed to skill building—developing skills for

copied, communicating, resolving conflicts, and problem solving. Establishing the schema that “getting better means learning skills” is useful because it establishes a clear, practical map of how one recovers.

Skill building for clients with PTSD often follows a three-stage model (Herman, 1992). Addressed first are skills to attain safety and stability. Second are skills to “work through,” “process,” and “grieve” the trauma. Third are skills to reconnect with people, take on meaningful activities, and move forward (Herman, 1992). The first stage is especially important for clients with PTSD/SUD because one needs strong coping skills to prevent substance relapse before processing traumatic experiences (Najavits & Hien, 2013). Examples of evidence-based therapies for comorbid PTSD/SUD that focus on this first stage include the Addictions and Trauma Recovery Integration Model (Miller & Guidry, 2001) and Seeking Safety (Najavits, 2002). These models focus on teaching “dual skills” to treat symptoms of both PTSD and SUD: education, self-care, setting boundaries, and changing beliefs about oneself, one’s world, and one’s future (Miller & Guidry, 2001; Najavits, 2002).

Focusing on the first stage of trauma treatment—safety and stability—also applies to deaf clients with PTSD/SUD; however, adaptations may be needed to improve accessibility of approaches at this stage. In the following, we present two simple examples of skills taught in Seeking Safety, a treatment that provides clients with a menu of behavioral, cognitive, and interpersonal skills to reduce symptoms of PTSD/SUD (Najavits, 2002). Teaching each Seeking Safety skill can be deepened through modeling, in-session practice, and the use of pictures and diagrams (Najavits, 2002)—all practices that improve deaf accessibility. Additional treatment adaptations that reduce reliance on written English tools and capitalize on ASL dialogue (whether in person or through video narratives) also improve deaf clients’ engagement in treatment.

For example, one cognitive skill helps clients prepare to give up substances and “Climb Mount Recovery” (Najavits, 2002). A visual image of “Mount Recovery” is presented, and clients are asked what they need to prepare for their journey to make it up the mountain (e.g., telling others about your recovery, bringing a list of safe coping skills). This exercise aligns with Deaf mental health care through the use of visual allegory to make the process of recovery more tangible. It also helps clients engage in treatment planning by actively identifying the skills they will need to acquire for recovery.

One behavioral skill guides clients to identify their “Red and Green Flags”; that is, signs of spiraling downward into danger/relapse or upward toward safety/recovery (Najavits, 2002). The materials include a written list of red and green flags for clients to identify their unique signs of danger and safety. To adapt this exercise for visual learners (whether deaf or hearing), the clinician could present this list as a series of pictures (see Figure 1 for an example we created). Alternatively, the client could draw pictures of his or her red and green flags.

In addition to making treatment materials more accessible through visual aids and role-plays, treatment relevance and engagement are generally increased by incorporating examples specific to the Deaf community and deaf experience. Culturally relevant adaptations might include encouraging clients to explore Deaf identity issues by socializing with and seeking support from other Deaf people; attending Deaf events, Deaf clubs, and grass-

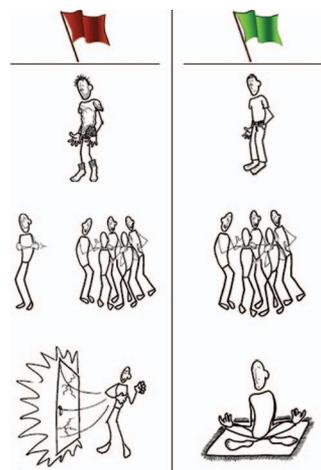


Figure 1. Example of possible adaptation for visual learners. Left column = red flags; right column = green flags. See the online article for the color version of this figure.

roots advocacy movements; and becoming involved in the developing Deaf peer recovery process.

Empowerment

The more that skill building can be elicited from clients themselves, the more efficacious the treatment. PTSD/SUD treatment with both deaf and hearing clients emphasizes increasing empowerment and self-efficacy; however, deaf people have often experienced additional layers of disempowerment in their histories and daily lives. Such forms of disempowerment include, but are not limited to, being treated as incapable, inferior, or deserving of pity; being excluded from conversations in which important decisions are being made; and being discriminated against in familial, educational, and employment settings.

Some deaf persons internalize these negative messages. They develop beliefs that deaf people are “less than” hearing people or that “deaf can’t.” Such a belief system makes it easier to rely upon chemicals, unhealthy behaviors, or unhealthy relationships in an attempt to cope. Therefore, an important role of the provider is to join the client in identifying and appreciating his or her strengths and skills, with an ultimate goal of building empowerment (Glickman, 2009b).

For these reasons, evidence-based therapies used to educate, empower, and motivate persons in recovery may be especially helpful for deaf clients in recovery from PTSD/SUD. One possible approach is Motivational Interviewing, in which clinicians employ skills of engaging, focusing, evoking, and planning to guide clients to participate in treatment and make changes in their lives (Miller & Rollnick, 2012). Similarly, in Shared Decision Making, the clinician and clients are each seen as experts—the clinician is the expert in the research evidence supporting treatment options, and the client is the expert in his or her historical experiences, values, goals, and preferences (Charles, Gafni, & Whelan, 1997). The clinician and client review the available treatment options and their associated risks and benefits. The clinician helps elicit the client’s values and preferences, and together the two negotiate a treatment

plan that is acceptable to both (Barry & Edgman-Levitan, 2012). Clinicians using these approaches need to realize, however, that adaptation for deaf clients may be necessary. The following narrative describes one psychiatrist's learning process as she used Motivational Interviewing and Shared Decision Making with deaf clients served in the public mental health system:

Lisa's Story

My name is Lisa Mistler. Prior to working on the Deaf Unit at an inpatient hospital, I studied approaches to increase collaboration and decrease the power differential between doctors and patients, including Motivational Interviewing and Shared Decision Making. Employing these skills on the Deaf Unit initially caused me to encounter difficulty. Fortunately, I was part of an extremely supportive group that had been working on the unit for years. They guided me in learning some things about Deaf culture and the unit's culture in particular, learning some of the rudiments of ASL, and learning how to work effectively and developmentally in a cross-cultural environment. There, I learned a different way to approach deaf patients, understand their difficulties, and achieve a therapeutic alliance around their goals for a better life. In parallel with my clients, I needed to start by recognizing and using the skills I already had: my adaptability to various situations, questioning of my own assumptions and biases, persistence in attempting to understand and respecting others' points of view, and focusing on each individual as the most important driver of his or her care.

With hearing patients, I conducted direct interviews to make diagnoses; elicit patients' goals, dreams, values, and preferences; and develop shared treatment agendas. The majority of my deaf patients were now individuals with whom I did not have a common language. My best tools, diagnostic and motivational interviews, were now only available to me through the use of interpreters and communication specialists. I was no longer the "expert" in communicating with patients and had to relinquish some of that identity in order to trust others' observations of the patient's mental status and use of language as keys to understanding more about the person's presenting concerns. This required a delicate "dance" between the interpreters and me, as interpreters are able to comment on language skills and patterns but are not able to tell me what those skills and patterns mean diagnostically. The job of diagnosis was still mine, yet challenging due to the lack of research on the presentation of mental illness among deaf people.

Sometimes Motivational Interviewing and Shared Decision Making strategies that I commonly used with hearing patients seemed to fall flat with deaf patients. For example, many patients were not familiar with common problem-solving strategies like brainstorming options or evaluating pros and cons. This was due in part to some individuals' tendency to think more concretely rather than abstractly. However, sometimes the strategies were not even indicated because of miscommunication, despite the treatment team's use of experienced interpreters and Certified Deaf Interpreters (CDIs). This is exemplified by one person who asked for a particular medication, then consistently refused it after it was offered. Believing that he was ambivalent about taking medications, we tried to develop a "pros and cons of taking medications" table. He had considerable difficulty engaging in the abstract process of considering, "If I take this medication, then ___ will

happen" and refused to work with the CDI and team to fill out such a table. It took a while for us to realize that his refusal of the tablets was due to two key deficits in his general fund of information: his identification of all medications solely by shape, size, and color, but not by name, and not understanding that various companies make the same compound in different-looking pills.

It also seemed that many of our patients lacked basic information about mental illness and its treatment. I modified my approach by learning as much as I could what each person's developmental and cognitive level was, then began introducing specific skills in a way that matched the individual's levels. For example, once I understood the aforementioned individual's thinking processes, I was better able to develop a strategy to address his "refusal." Once we knew from him that we were looking for a yellow pill with a particular number on it, we managed to get the hospital pharmacy to order this particular pill. The patient no longer "refused" the medication. Unfortunately, the patient's remaining beliefs that medications would solve his problems within a few hours and that he did not need to engage in "talk therapy" led him to quickly become disappointed in the medication and subsequently stop taking it within a few days.

In applying Shared Decision to deaf patients, I also learned that I was working with individuals who had experienced little empowerment in their history of medical encounters and, therefore, viewed the doctor as expert. When I asked deaf patients to tell me their preferences and opinions, on many occasions, I received blank looks or "I do not know . . . You're the doctor" responses. My Deaf colleagues enlightened me about the persisting stigma and misinformation surrounding mental health problems and treatment in the Deaf community and the need to exercise patience in guiding patients through the decision-making process.

I had come to this new job with the same goal as previous jobs—empowering patients through approaches like Shared Decision Making and Motivational Interviewing. What I discovered was a reminder to continuously check my assumptions and biases. I learned to engage in basic psychoeducation with patients; I learned to work closely with all of my communication resources; I learned to work cross-culturally and developmentally; I learned to teach fundamental decision-making skills in my encounters with patients; most importantly, I learned to humbly accept some new limitations, while striving to better meet the needs of this unique client population.

Resilience

The above discussion has focused mainly on barriers and challenges experienced by deaf people with PTSD/SUD. Yet, the deaf people who enter our agencies have often displayed resilience and survived in the face of considerable suffering and little formal support (Leigh, 2009). We often see deaf people who have capitalized on the support of the Deaf community to persevere. The Deaf community offers strong social bonds and rich opportunities for community participation (Rogers, Muir, & Evenson, 2003). Grassroots social change movements impart important lessons about human rights and self-advocacy (Rogers et al., 2003). In addition, many people in the Deaf community are at the forefront of technology, meeting self-care and interpersonal needs with a variety of electronic resources such as videophones, vlogging, and smartphone apps. Culturally competent clinical work revolves

around skillful assessment and treatment that recognizes and builds on these preexisting internal and external skills that clients bring with them to treatment. Marco eloquently describes such resilience, resourcefulness, and opportunities for social support in the second part of his story:

Marco's Story: Part 2

I received treatment in many detox, substance abuse, and psychiatric programs. Some of the hearing programs didn't even try to offer interpreters; one did offer occasional interpreters, but nothing else for me as a Deaf person. I have gone to AA meetings, some with interpreters, and some Deaf AA meetings. I have to say I do not fully understand all the steps, but I do understand about apologizing and being humble. I think I got my first real help on the Deaf Unit at Westborough State Hospital. I had Deaf peers there, even though some seemed to have very different problems than me. Most of the staff signed and many were Deaf themselves. I was there several times, for a few years in total.

I had a therapist there who supported me and believed in me, and I met one mental health worker who made a great impact on me. She told me I was smart and capable and could succeed. I wanted to believe her, but I was not ready. I felt so angry that I couldn't yet look at pain coming from the abuse I experienced and the suicide of my mother. I got into lots of struggles with staff. Sometimes it was my fault and sometimes it was theirs and often it was all of our faults. When I was in nonsigning environments, I couldn't get into the same kind of struggles because I couldn't communicate with people. On the Deaf Unit, at least I could communicate with staff and try to work things through.

On the Deaf Unit, I understood the treatment being offered to me. I was introduced to the idea of coping skills and came to understand some of my skills. Yes, I had to be dragged to groups sometimes, but the groups became more interesting to me when I was encouraged to help some of my peers. At Westborough, staff recognized that I had skills and could help my peers. I came up with ideas that the group leader actually built into the groups. I could tell them my story, hear their story, and offer them suggestions. I know some of them looked up to me as a role model. That was strange because I was struggling with so many problems myself, but it made a difference that people could see skills and strengths in me. That was exciting!

A few weeks after I left Westborough, I was back to using heroin, pot, and alcohol. I had more relapses to experience. I was suicidal many times. After another admission at Westborough, eventually I found my way into a Deaf group home run by Advocates, Inc. I had lots of struggles with these staff also. One time I pushed a staff person very aggressively. I tried to control the staff people. I was still feeling angry all the time, and underneath that I was deeply depressed and still not facing the demons I had to face.

Eventually, a new director for Deaf Services was hired. She was a strong Deaf woman and a person in recovery herself. She and I really struggled with each other. I insulted her and tried to keep the staff from listening to her. In spite of our struggles, she shared her story with me. She told me about her own long, painful path to recovery. It meant a lot to me to hear her tell her story and to see how similar we were in many ways. Eventually, I saw her as a support, not a competitor. She told me I was actually helping her.

She said I have gifts and do not know it. She said, "We are both waking up together." Wow! She helped me move out of the group home into my own apartment in "outreach." It was a step toward independence. It was a vote of confidence in me.

The new director also introduced me to the certified peer specialist program where they hire people they serve to help their peers in recovery. When Minnesota developed its program for Deaf peer specialists, I went to the first training class and was finally able to understand the course materials to pass the exam. Now I proudly put "Certified Deaf Peer Specialist" on all my emails. Part of my job is to share my story as the staff person did with me. It was very powerful for me that staff could see my potential.

I realize I've been so lucky to have all this support from Deaf people and in Deaf recovery environments. Most Deaf people who have trauma and addictions do not have that. In hearing environments, it was very hard for me to learn anything and to grow and recover. Deaf environments aren't perfect, but at least we can try to fix things there. In Deaf environments, people could see that I'm smart and can help other people. In hearing environments, maybe people just feel sorry for me because I'm deaf. They do not know me. They do not see what I can do.

The Future

The literature on PTSD/SUD in the deaf population is, thus far, largely informed by personal and professional impressions, many outlined above. Little research has explored this comorbidity in the deaf population, and there are no evidence-based treatments developed or evaluated for efficacy with deaf people with PTSD/SUD (or any other behavioral health condition for that matter) (Glickman, 2013a; Glickman & Pollard, 2013). Substantial work is needed to raise awareness of comorbid PTSD/SUD and provide treatment tools to better integrate trauma and addiction treatment within Deaf behavioral health care.

Fortunately, several endeavors are on the horizon to disseminate assessment and treatment tools to work with deaf people recovering from trauma and addiction. One such tool is the Substance Abuse Screener in American Sign Language, an adaptation of the Substance Abuse Subtle Screening Inventory (Guthmann, Lazowski, Moore, Heinemann, & Embree, 2012). In addition, current projects are underway to develop and test deaf adaptations of evidence-based treatments, including Illness Management and Recovery (Mueser et al., 2006) and Seeking Safety (Najavits, 2002). The shared goal of these projects, as well as others like them, is to partner with deaf colleagues, consumers, and peer specialists (like Marco) to improve access to effective, meaningful behavioral health treatment. Although such projects will not solve the current disparities in deaf behavioral health care on their own, they represent a significant step in the right direction.

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