Effective Techniques in Treating Survivors of Child Sexual Abuse: Problematic Areas in Their Application to the Deaf Population

Counseling Services for the Deaf

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Running Head: Deaf Child Sexual Abuse Victims

Abstract

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Problems exist in identifying and treating deaf "survivors" of child sexual abuse. Even once they are identified, there are still problems in effectively applying existing regimens of therapy to this special population. While mainstreaming the deaf person into society seems to be the wave of the future, and there are positive aspects to this, careful consideration, respect, and acknowledgement must be given to the special culture of the deaf person. Employing existing therapeutic methods, with only the adjustment of supplying an interpreter for the Deaf, may not be enough.

More attention is given to the child who is sexually molested/abused as a child than the adult who suffered this experience while a child (Courtois, 1988; Davis, 1990; Haugaard, 1989; MacFarlane, 1986; & Tower, 1987). The tide is changing though, and more attention is being focused on the increasing problem of the 90s; that of adults who have been sexually abused as children, and the latent discovery thereof. Unfortunately, it does not seem that the changing focus can keep up with the reported higher incidence of male and female adults stepping forward and coming to terms with their sexual abuse experience as children (Friedrich, 1990). Lew (1990), Davis (1990), and Everstine (1989) acknowledge that the adult is making the discovery in therapy, where the symptoms first present themselves as anxiety and Axis-II disorders, but the causal agent is not discovered until well into therapy. Even then there is a great deal of difficulty in finding qualified therapists in the area of child sexual abuse, and are further capable of treating adults who may be experiencing the trauma, via Post Traumatic Stress Disorder, for example.

The most successful form of therapy found throughout the literature was clearly the multisystemic approach, which used all available methods to deal with the families on a more personal basis (Brunk, Henggeler, & Whelan, 1987). The multisystemic approach incorporated the belief that behavior can be modified just as long as the targeted antecedent is appropriately addressed in a flexible manner. This took into account therapy approaches which were cognitive, emotional, psychodynamic, and client-centered in nature, or a mixing of the above, on an as needed basis.

Although Brunk et al (1987) did research focusing on family units which contained a child who had been sexually abused, the basic tenets of the therapy used can readily be applied to adult survivors. The eclectic approach incorporates the family, and looks at the Gestalt of the client. In so doing, the therapist treats not only the adult survivor, but also the significant others who have direct ties to this person. This is important, for it cannot be stressed enough how far-reaching the ramifications of sexual abuse are in later years and in the development of relationships,

intra- and interpersonal (Milner, 1991; and Swartz, 1992). Nicol, Smith, Hall, Barlow, & Williams (1988) also suggested the importance of a client- and family-centered approach. Nicol et al (1988) did work which focused on sexual abuse that was happening at present, similar to the work of Brunk et al (1987), the parallels are similar, and application can and should be made to the adult victim in "discovery."

Taylor, Garnder, and Lopez (1989) point out the importance of a didactic approach to therapy where medical, legal, education, and psychological realms are included in the scope of therapy. This appears to be prudent considering the nature of incest, where physical damage might have occurred, the abuse may still be continuing with other victims' well-being at stake, the legal system is involved, and the psychological implications and impact are self-evident.

The therapeutic approach used in the study by Scoyk, Gray, & Jones (1988) emphasized an openness to the individuality of each family and victim, rather than a preconceived treatment plan. The cognitive approach employed guided the family through the initial shock, secondary derailment of the normal family path,

and the dispelling of myths surrounding expected human behavior, the good of man in general, and formulating more workable beliefs in which to carry out daily life.

The dynamics of treating victims of child sexual abuse are enormous. One thing that should be of concern to those working in the field of child sexual abuse, whether it be in administration or at the treatment level, is whether or not the clients' needs are being met. Certainly treatment should be designed to meet the greatest needs of the greatest number of people. Unfortunately, in so doing, those in private practice, and those charged with public policy overlook or misunderstand a dynamic but small portion of our population-- the Deaf Community. Literature/research addressing the problem of child sex abuse in the deaf population simply does not exist, with most information and treatment methods for the Deaf Community addressed only in the pretext of alcohol and drug abuse therapy. Having worked as an interpreter and teacher in the Deaf Community since 1986, my contact with deaf people has been rather extensive. What brought me in contact with child sexual abuse were the many times that I interpreted for in SIA (Survivors of Incest Anonymous)

meetings and treatment programs throughout the Baltimore-Washington area. In each setting the deaf participant was in the gross minority; it was disturbing.

Even with the communication facilitated by an interpreter, communication on an interpersonal level is still prohibitive. The deaf person brings with them to any treatment program their own Deaf Culture. If there is a stigma attached to being sexually abused, then this stigma is worse in the Deaf Culture. The Deaf Community is extremely tightly woven, so everyone who is deaf and lives in the city in which the deaf client/victim/survivor is from are more than aware of the problem. The deaf client, unfortunately, must discount any hope of gaining support from their deaf peers once they are matriculated back into the community. In this sense, the deaf sexual abuse victim/survivor is quite different from the hearing one.

Although prevention is the obvious key in dealing with child sexual abuse across the board, its implementation is more complex when dealing with the deaf population. Few outreach programs are accessible

to deaf people due to language barriers; having an interpreter is often a luxury, not required by law until full implementation of the Americans with Disabilities Act, and even then this will undoubtedly be challenged. The media in its attempts to address sexual abuse does well in addressing the hearing population, but misses almost entirely the needs of the deaf person. Television commercials are not closed-captioned (or open-captioned for that matter), and public campaigns waging war sexual abuse awareness barely scratch the surface in penetrating the communication walls of the Deaf Community (McCracken, 1992).

Once the deaf sexual abuse victim/survivor has entered the treatment phase the manner in which they are treated is crucial. First and foremost an approach must be implemented that dispels the perception of the need to fix the deafness before you can treat the individual for child sexual abuse. Often times the deaf person is treated as an oddity, doubly handicapped because of the child sexual abuse and the hearing loss.

In most urban areas the best a deaf client can hope for is treatment with minimal to moderate

communication support of a sign language interpreter. This says nothing of rural settings, where it is the rule rather than the exception that a deaf person, whose primary mode of communication is American Sign Language (ASL), is "lucky" if they can find a therapist willing or able to see them. Even then, the deaf person is placed in the precarious position of having to speechread the therapist, a skill few deaf people have mastered (Lane, 1989). If the service is not delivered in the deaf person's language (ASL) then they are not enabled to focus on the real issue at hand, that of recovery.

Pervasive throughout the helping professions is the prevalent opinion that an audiologist is automatically qualified as an expert in the field of deafness. Although this may be an overstatement to a degree, and awareness has improved over the past ten years, grassroots America depends heavily upon those with minimal knowledge of deafness. What is more distressing is that deaf professionals are not being tapped to enter the treatment field (Ferrell & George, 1984). It is foolish at best, and harmful and wasteful at worst to exclude deaf people from the process of

improving the quality of treatment for members of their own community.

Some may argue that the cost is too great; that establishing such a networking system in dealing with a small deaf population (approximately 2 million as of the 1990 census) is not cost-effective. We then must ask ourselves if we are perpetuating a cycle of abuse and neglect which leads to crime (Swartz, 1992).

Only when policy makers and practitioners fully address the special needs of the deaf victim/survivor can we effectively treat the true problem, not the hearing impairment/handicap. Education facilities are not geared towards the dual teaching of working with deaf clients and an in-depth understanding of the unique culture of The Deaf. There exists only one doctoral program in clinical psychology, with its focus on deafness, in the United States. This program, at Gallaudet University, is struggling and has not yet received accreditation from the American Psychological Association. At most this program will turn out 5 clinical psychologists annually, hardly sufficient to meet the needs of the deaf population.

Even if the best techniques for dealing with child

sexual abuse are known, with the multi-systems approach seeming to be the most promising (Carroll and Gottlieb, 1983), the Deaf Community does not have access to these practitioners on even a small scale. While the seeds are effective treatment for child sexual abuse are being sown, and there appears hope and promise on the horizon for the general population, the deaf population is still struggling for basic, broad, minimal mental health care.

At present it appears that the best this population [the broader spectrum of deaf adults (and children) who have been sexually abused as children] can avail itself of are monitors and texts which are of a self-help nature. Davis (1990) and Lew (1990) have written excellent texts which go a notch above being self-help, and have practical applications across culture.

Davis' (1990) book is filled with many activities which stimulate thought, creativity, assessment of effective and counter-productive survival skills, and a lowering of defenses, all necessary when confronting child sexual abuse in adult survivors, and guiding them towards healing. Effective survival skills are taught

whereby the client learns how to create a safe and supportive environment. The survivor is instructed in the development of healthier ways of coping.

Another critical part of the book is that therapy is encouraged and should parallel the use of the book. Many exercises done in the book can (and should) be done in conjunction with a therapist. Unfortunately, this is where the deaf survivor will confront many an obstacle in locating effective mental health care.

Lew's (1990) helps male survivors to: come to grips with their childhood experiences; develop strategies for survival and healing; re-discover trust, intimacy, and sexuality; establish a support network; strive for future goals.

With regard to the latter, this is an important issue explored in Lew's text. He addresses societal pressure for boys and men to keep the secret of child sexual abuse, that men should be self-sufficient in dealing with pain and the "shame" associated with sexual abuse. This focus on emotions and the realization of them is a thread that is woven throughout the entire text, and it is a welcome one.

Lew offers minimal guidance for the male survivor

in seeking therapy, at least individualized therapy. He gives more information for those searching for support through groups, either conducted by professionals or survivor-only oriented. Unfortunately, it is much more difficult for the deaf individual to find effective group therapy, exponentially more so than individual therapy.

In Swartz's account (1992) there exists one of a handful of books that are available written first person on the aspects of child sexual abuse, and possibly the only one written from the perspective of a male. Even though the media has hopped on the "bandwagon" of the relatively hot issue of child sexual abuse, this text goes much further in personalizing the effects of child sexual abuse without "Hollywoodizing" it.

There exists among survivors of child sexual abuse the singular issue of being violated which all survivors share, and it is this issue which nearly makes it a members-only issue. In this respect, it is very difficult for an outsider, one who has not experienced the trauma of child sexual abuse, to be trusted and believed in the context of their expertise,

empathy, genuineness, and ability to offer realistic therapy. There is very much the feeling that "you just had to be there" among adults who have experienced child sexual abuse. The fact that nearly all texts in this area are written by professionals and lecturers who are well-schooled, but have no first hand experience with child sexual abuse, places barriers initial barriers between the reader/client and the author/therapist.

These texts are good in and of themselves, but they are no substitute for effective therapy. Absolutely no published researched exists on the incidence of child sexual abuse in the deaf population (Gregory-Billis & Vincent, 1989). Although this is true, there is reason to believe that the incidence is higher among this population for a number of reasons: easy access to the child while in school (residential schools for the deaf); communication barriers which inhibit reporting; dependency bred by the system by deaf children upon hearing authority figures; paternalism by the hearing majority which fosters a false sense of trust; and unresolved issues surrounding the disabling effect of deafness in the nuclear family

which manifests itself in abuse of the child by the parent (Edelin, 1992).

It appears that the Deaf Community is reticent when it comes to examining these problems within their own population due to the fear of increasing the stigma of deafness, and the hearing population has great difficulty in gaining access to this population for testing and assessment. Bearing this in mind, the number of unreported cases of child sexual abuse among the Deaf is assumed to be much higher than in the mainstream population.

The special needs of the deaf sexual abuse victim/survivor go beyond the understanding for special communication needs. In defining quality treatment and recovery programs we must also consider the special technology required in meeting the special needs of the deaf alcoholic. The treatment approach, and application thereof, must be completely accessible, which includes having a TDD (Telecommunication Device for the Deaf), interpreters, closed-captioned decoders for television and video-tape viewing, and flashing devices that cue audio information (Roth, 1991). Having current technology, and the know-how in using

it, is an excellent start, but by no means an end-all answer or solution in dealing with the special needs of deaf population in terms of prevention, diagnosis, and treatment.

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