

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

CHILDHOOD SEXUAL ABUSE: PREVENTION, EDUCATION, AND AWARENESS FOR  
THE PARENTS OF DEAF CHILDREN

A graduate project submitted in partial fulfillment of the requirements for the degree of  
Master of Science in  
Counseling, Marriage and Family Therapy

By

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## DEDICATION

To my mother, Leslie Macchhiarella, who has always been there for me. Through challenges and achievement, she has supported me during it all. I love you ma.

## ACKNOWLEDGEMENTS

I would like to acknowledge my three siblings, Gretchen Macchiarella-Biasotti, Lindsey Macchiarella, and Michelangelo Macchiarella. With their support and guidance, I was able to accomplish all that I have, without them I would not be where I am today. I also appreciate the much needed review and corrections they all gave this paper, many times, late at night with little notice before a deadline.

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## TABLE OF CONTENTS

Signature Page .....	ii
Dedication .....	iii
Acknowledgement .....	iv
Table of Contents .....	v
Abstract .....	vi
Chapter I .....	1
Introduction.....	1
Background of the Problem .....	1
Statement of the Problem.....	3
Purpose of the Project .....	4
Terminology.....	4
Chapter II .....	8
Introduction.....	8
Childhood Sexual Abuse Among the General Population.....	9
Statistics .....	9
Consequences of Childhood Sexual Abuse .....	9
Factors that Influence Outcomes after CSA .....	16
Childhood Sexual Abuse Among Deaf.....	17
Statistics .....	17
Consequences of Childhood Sexual Abuse and Deaf.....	19
Deaf and Psychological Disorders .....	20
Barriers to Sexual Abuse Prevention Education .....	23
Education .....	23
Language.....	30
Stigmatization of Deafness .....	35
Communication Barriers.....	36
Access to CSA Information .....	39
Prevention Programs.....	45
Parent-Child Communication as Prevention.....	48
Conclusion .....	48
Chapter III.....	50
Introduction.....	50
Development of Project .....	50
Intended Audience .....	51
Professional Qualifications .....	52
Environment and Equipment .....	53
Project Outline .....	53
Chapter IV.....	56
Summary of Project .....	56
Recommendations for Implementation of Project .....	56
Recommendations for Further Research.....	57
Limitations of Project .....	57
Conclusion .....	58
References.....	59
Appendix: Videos .....	68

## ABSTRACT

### CHILDHOOD SEXUAL ABUSE: PREVENTION, EDUCATION, AND AWARENESS FOR THE PARENTS OF DEAF CHILDREN

By

Julie V Macchiarella

Master of Science in Counseling,

Marriage and Family Therapy

The purpose of this project is to provide an accurate and accessible resource for the education of parents of Deaf children about child sexual abuse prevention and awareness. While there is limited research on the Deaf community and child sexual abuse, researchers have found a higher vulnerability to child sexual abuse in the Deaf population. The best prevention for child sexual abuse is education, awareness, and communication between caregivers and children. For Deaf children communication with those around them can be difficult. It is vital that parents and caregivers are educated about the need for conversations with their children about the possibility of abuse, and how to handle it. Many parents, hearing or Deaf, struggle to understand how to have these conversations, yet the hearing population has more access, resources, and support. It is crucial that projects such as this exist to provide full and culturally sensitive information about child sexual abuse to the parents or caregivers of Deaf children.

## CHAPTER I

### **Introduction**

Childhood sexual abuse (CSA) is defined as an inappropriate sexual act perpetrated on children for sexual gratification of the perpetrator. CSA can happen to any child, no matter what their cultural background, race, ethnicity, or economic status; any child can become a victim. For the Deaf, this epidemic is compounded due to the risk factors that make this population vulnerable to CSA (Ridgeway, 1993). This vulnerability is not inherent to deafness or to the physicality of deafness but inflicted upon the population by society's view of deafness which oppresses and devalues the Deaf community by denying access to language and by restricting access to CSA information. This project will attempt to mitigate some of these barriers by providing access to CSA prevention information and education about the importance of American Sign Language (ASL) in an online video format. These videos will provide critical information on the threat of CSA and how parents can best talk to their Deaf children about these dangers.

### **Background of the Problem**

The Deaf community is at high risk for CSA due to the barriers to fully accessible information, which is critical in the prevention of CSA. These barriers include, but are not limited to, deprivation of language and literacy because of limited or no access to adequate education through sign language (Glickman & Hall, 2019; Gulati, 2019); communication barriers with family and caregivers due to no common language (Hardin et al., 2014; Sullivan et al., 1978); and inadequate access to education and information regarding CSA for Deaf children and their parents (Pollard & Barnett, 2009; Schild & Dalenberg, 2015).

The Deaf community has struggled for hundreds of years to acquire equal access to education, healthcare, and other social services (Schenkel, et al., 2014; Sullivan, Vernon, & Scanlan, 1987). The struggle for proper, full, and meaningful communication with family and caregivers has also been a long-standing battle for the Deaf community (LaBarre, 1998). Many deaf children are plagued with language deprivation which deprives the child of any fully accessible language and results in lifelong difficulties with acquiring and comprehending language and information (Glickman & Hall, 2019). While this may not be an intentional result, it is a grim reality that the lack of exposure to an accessible language has dire consequences for the Deaf population. While many factors contribute to the lack of success in academics in the Deaf population, access to language is the most formidable.

In addition to language and education, lack of access to communication can create barriers to adequate familial relationships between the Deaf population and caregivers and parents (Hardin et al., 2014). Around 96% of Deaf children are born to hearing parents who, more often than not, are not aware of the different linguistic needs of Deaf children and do not learn American Sign Language (ASL), or any signed language, to communicate (Mitchell & Karchmer, 2004). This lack of awareness is not intended to harm but rather comes from the discourses in our society about deafness as a deficit and a terrible burden to live with, rather than simply a different and positive linguist need (Komesaroff, 2002).

Without access to meaningful family and other interpersonal relationships, Deaf children are more vulnerable to abuse (Sullivan et al., 1978) and are at a higher risk of developing psychological disorders (Fellinger, Holzinger, & Pollard, 2012). In the general population, it has been found that positive support from close family members and friends can mitigate the effects of CSA (Musliner & Singer, 2014). For the Deaf population, the lack of access to adequately

supportive relationships not only creates more vulnerability but also compounds the damage after sexual abuse. It is necessary that Deaf children be fully able to communicate with family members through ASL and to develop these relationships that may protect them from CSA.

Due to language barriers and inconsistent familial support and direct communication, Deaf children are still struggling to understand the basic concepts of what sexual abuse is, how to protect themselves, and what to do if someone approaches them in a way that makes them uncomfortable (LaBarre, 1998). The Deaf population does not have access to the same preventative information as the hearing population in their everyday lives. This deficiency of access to everyday information impedes Deaf children's ability to know when a situation is safe or unsafe and thwarts their understanding of the basic concepts of sexual abuse. A misunderstanding of sexual boundaries and normal sexual development results, as well as an incomprehension of even common health concepts (Ridgeway, 1993).

### **Statement of the Problem**

It is evident that the Deaf population must be able to understand the world around them through the use of basic, accessible communication. Despite this apparent and critical need, there is an immense gap in research relating to the Deaf population. Much of the research conducted about CSA is performed only with hearing participants; the Deaf community is not even considered. Much of the information in this project is based on research dedicated to researching and understanding CSA exclusively within the general hearing population. The information regarding the extent of CSA in the Deaf community varies widely and, in many cases, is conducted with a small sampling of participants, creating a scarce amount of data to enable recognition of the breadth of the problem. The research varies to such an extreme that, in one study, the estimated rate of CSA in the Deaf population was shown to be as high as 50%

(Sullivan, et al., 1987) and, in another, as low as approximately 30% (Kvam, 2004). Although the range is vast, one thing is certain, the rate of sexual abuse in the Deaf community is significantly higher than in the general population. In the general population, it is estimated that 22% of adults have experienced CSA as children (Felitti et al., 1998).

It is, therefore, imperative that research continues to determine the actual impact of CSA for the Deaf community so that steps can be taken to properly protect Deaf children. There is little to no research on prevention methods and education about sexual abuse in the Deaf community. Relevant research must be conducted so that children and parents of Deaf children can be properly educated, and the risk of CSA can be properly mitigated.

### **Purpose of the Project**

The purpose of this project is to inform and create awareness about the risks of CSA for the parents or caregivers of Deaf children. This project will be fully accessible to all linguistic needs. It will be conducted in ASL in order to be accessible to Deaf parents of Deaf children, as well as to support hearing parents that use ASL. Using ASL is also a means of educating the parents of Deaf children on critical communication skills. The videos will also be captioned in English and have a voice translation in English to accommodate those parents that do not sign.

### **Terminology**

Terms specific to the Deaf community are used in this project as well as other vocabulary used in the mental health field. These terms are defined below.

American Sign Language (ASL): ASL is a three-dimensional language that uses the hands, body, and facial expressions to convey meaning and does not follow English word order. It is the preferred method of communication in the Deaf community (Arnold, 1998). ASL is used in the

U.S. and Canada. Although there are other signed languages throughout the world, this project will focus on ASL.

Deaf/deaf: Uncapitalized deaf is often used to refer to “the audiological condition of not hearing”, while Deaf with a capitalized “D” is used to refer to “a particular group of deaf people who share a language and a culture” (Padden & Humphries, 1988, p. 2). This population identifies with a shared Deaf experience and generally prefer communication through ASL (Liddell, 2003).

Deaf community: A group of people that are “bound by their use of ASL and are drawn to the community by a shared culture – Deaf culture” (Holcomb, 2013, p. 21). The Deaf community is not geographically bound; Deaf people exist all over the world and it is this community that acts to bring Deaf people together. For those who identify as part of the Deaf community, “deafness is not only a sensory condition, but also a way of life characterized by membership in a signing community” (Padden, 2000, p. 57).

Deaf culture: Deaf culture can be defined, essentially, as any other community that shares languages, values, customs, and beliefs. It is a community of people that share signed languages, Deaf values and customs. (Holcomb, 2013).

Oralism: The education method that dominated Deaf education for 120 years (Liddell, 2003). This method required deaf students to speak vocally, to lip read, and banned all signing in the classroom in order to assimilate children into hearing society (Hardin et al., 2014). The concept derives from the idea that speaking is superior to signing and was historically considered the only way to educate deaf children.

Mainstream: The education method of assimilating children into hearing school in order to result in an inclusion of all children without specifically identifying and segregating Deaf students.

While more modern methods support ASL in the classroom, this is done through the use of an interpreter. Often, the Deaf student may be the only non-hearing student in a traditional school, which can result in feelings of isolation for the Deaf student (Holcomb, 2013).

Residential school: Residential schools are schools established specifically for the Deaf that primarily use the manual method of communication, be it full ASL or total communication (signing and speaking at the same time). These schools, while rare, are still in operation. The concept is generally considered historic, with some schools of this type continuing to instruct exclusively with oral methods.

Cochlear implants: A small device surgically implanted behind and within the ear canal to stimulate the auditory senses. The device is stimulated by sound, sending signals directly to the auditory nerve in the brain recognized as sound (“Cochlear Implants,” 2018). This is a commonly used solution to deafness and is widely supported by the medical community.

## **Summary**

The idea of providing Deaf children with access to education about sexual abuse awareness is not a new one, however, it is one that introduces many other questions in terms of communication, education, and providing children with the ability to understand sexual abuse. This project seeks to bridge the gap between Deaf and hearing parents and their children. It will also provide information that is accessible to any parent regardless of their hearing status. It is imperative to understand the barriers that are in place which inhibit the ability of Deaf children to comprehend typical sexual abuse awareness and prevention material.

The following literature review will discuss and analyze existing research on the consequences of CSA for the general population and then focus on the limited research relating to the impact of CSA and the Deaf population. The project will then concentrate on the barriers

that prevent access to appropriate CSA prevention and education including a history of education in the Deaf community and the effects that continue into modern education; language deprivation and dysfluency and the effects on comprehension; the stigmatization of deafness and communication barriers, including the ramifications relating to the vulnerability of the Deaf population; and the barriers to accessing full and coherent CSA prevention information and prevention programs. Following the literature review will be a description of the project in detail.

## Chapter II

### **Introduction**

Several studies have found that the Deaf population has a higher chance of experiencing Childhood Sexual Abuse (CSA) than their hearing counterparts (Bisol, Brewer, Shor-Posner, Kato, & Sperb, 2008; Kvam, 2004; Sullivan et al., 1987). There is debate regarding the degree to which the rate of CSA is higher in the Deaf population, but it is clear that there is a significant difference between Deaf and hearing experience. While there may be a variety of reasons for this disparity, a few main factors contribute to it, including (a) deprivation of language and literacy, (b) communication barriers with family and caregivers; and (c) inadequate access to education and information regarding CSA for Deaf children and their parents

Mitigating these barriers has the potential to greatly improve the safety of Deaf children. It is vital for the protection of Deaf children that parents and caregivers are properly educated about CSA and that they work toward improving communication with their Deaf children. Specifically, parents and caregivers must know how to communicate with their children about sexual abuse and to prevent victimization. Once a child understands the potential danger of CSA, they will be better equipped to deal with potential hazards. Even for the hearing population who has access to services and information regarding CSA, the consequences after victimization are severe. For the Deaf population the consequences can be much worse. Lack of access to essential information about CSA can lead to becoming the victim of sexual abuse and then dealing with trauma for the rest of their lives.

The purpose of this literature review is to explore the limited research on the Deaf population and child sexual abuse and what factors influence the higher rates of sexual abuse in the Deaf population. This literature review will explore CSA and the consequences of CSA in the

general population to make up for the lack of research on CSA and the Deaf population. The review will also include a discussion of the barriers to preventing CSA in the Deaf populations in the context of (a) Deaf education and history of education, (b) language acquisition and language deprivation, (c) stigmatization of deafness, (d) communication barriers (e) and limited availability of accessible CSA information.

## **Childhood Sexual Abuse Among the General Population**

### **Statistics**

The National Child Traumatic Stress Network (NTSN) lists both physical and nonphysical types of sexual abuse. Physical sexual abuse includes fondling, touching, penetration, etc., relating to a minor. Non-physical sexual abuse includes showing or talking to a minor about sexual acts, in addition to showing pornography or exposing sexual content to a minor (Peterson, 2018). Childhood sexual abuse is a global issue, with 11.8% of children experiencing some form of sexual abuse (Stoltenborgh et al., 2011). The United States Adverse Childhood Experiences study (ACEs) found that, nationally, 22% of the population surveyed reported that they had experienced CSA – 28% of women and 16% of men (Felitti et al., 1998). Other studies show that by the age of 18, roughly one in four girls and one in six boys in the general population experienced CSA (Felitti et al., 1998; Pulido et al., 2015).

### **Consequences of Childhood Sexual Abuse**

One defining consequence of CSA is an increased risk for the development of psychological disorders. Individuals who experience CSA are significantly more likely to develop psychological disorders than those without CSA experiences (Kendler et al., 2000; Pérez-Fuentes, 2013). These psychological disorders vary, but most research on the subject report increased anxiety (Briere & Elliot, 1994; Cutajara et al., 2010; Molnar et al., 2001)

depression (Cutajara et al., 2010; Kendler & Aggen, 2014; Liu, Jager-Hyman, Wagner, Alloy, & Gibb, 2012; Molnar et al., 2001), and post-traumatic stress disorder (Briere & Elliot, 1994; Buren & Weierich, 2015; Cutajara et al., 2010; Molnar et al., 2001).

**Anxiety.** Childhood sexual abuse is inherently threatening and dehumanizing and may create lifelong distrust of others, a fragile view of the world, and constant anxiety concerning physical and emotional safety (Briere & Elliot, 1994). These consequences are common and can lead to anxiety disorders as abused children mature into adults (Briere & Elliot, 1994; Cutajara et al., 2010; Molnar et al., 2001). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) defines anxiety by at least three of these symptoms: restlessness or feeling “keyed up,” fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbance (APA, 2013). The key feature for diagnosis is excessive worry and stress about everyday activities. This excessive worry causes distress to the victim and difficulties managing even commonplace stressors. The extreme worry that accompanies anxiety may hinder the victim’s ability to make decisions quickly and efficiently, causing daily distress that leads to further issues with social interactions, which may lead to social anxiety (APA, 2013).

Several studies show that CSA may also lead to issues with different anxiety disorders in later life (Cutajara et al., 2010; Molnar et al., 2001). A study conducted in a random sampling of 8,098 participants, ages 15 to 54 living in 48 U.S. states, found that 10.7% of women with a history of CSA met the criteria for generalized anxiety disorder, nearly double that of the rate for those surveyed who had no CSA history. Similarly, 10.7% of male participants with a history of CSA met criteria for generalized anxiety disorder as compared to only 3.3% of male participants without CSA history (Molnar et al., 2001)

The study also found that 24.4% of women and 20.9% of men with CSA history met criteria for social anxiety disorder (social phobia) as compared with 14.5% of women and 11% of men with no history of CSA (Molnar et al., 2010). Briere and Elliot found that victims of CSA struggle with intimacy and sexual relationships as adults (1994). Experiencing CSA is a violation of the victim's most personal and intimate boundaries, so it is understandable that anxiety about physical safety and sexual safety would impede a typical, healthy, sexual relationship.

**Depression.** CSA also has a profound correlation on depression in adults (Cutajara et al., 2010; Kendler & Aggen, 2014; Liu et al., 2012; Molnar, Buka, & Kessler, 2001). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) defines Major Depressive Disorder (MDD) as a combination of depressed mood and loss of interest for most of the day, nearly every day, for a minimum of two weeks (APA, 2013). This may be accompanied by significant weight loss or weight gain, sleep disturbances such as hypersomnia or insomnia, fatigue, feelings of hopelessness or worthlessness, as well as inappropriate guilt. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) further elaborates that those with adverse childhood experiences, especially those who have experienced multiple forms of abuse, may be at higher risk of MDD (APA, 2013). Similarly, Pérez-Fuentes et al. (2013) found that those with CSA histories were more likely to experience other forms of child abuse, such as physical abuse, maltreatment, and neglect.

Studies vary on the percentage of CSA survivors with depression, however, the direct correlation between CSA and depression in both children and adults is clear. Kendler and Aggen (2014) who conducted a study with 1,493 female twins between ages 17 and 55, found that there was a strong potential for major lifetime depression in women who experienced CSA. The authors found that 26% of the study's all-female participants self-reported having experienced

CSA. Of those women with CSA history, 30% met the criteria for lifetime MDD as determined during their first, face-to-face interview. Moreover, during the fourth telephone interview, with each interview averaging a span of seven years apart, 29% of the women with CSA history continued to meet the criteria for lifetime MDD, showing that the prevalence of lifetime MDD did not decrease over time. Another such study conducted with 8,098 participants, ages 15 to 53, found that 39.3% of adult women with CSA history met criteria for depression compared to 19.2% without CSA history, and 30.3% of males with CSA history met criteria for depression compared to 11.4% without CSA history (Molnar et al., 2001).

When trust has been broken between a child and a caregiver or parent, it can break the trust with other adults as well, despite the amount of support received from friends and family. According to Musliner and Singer (2014), social support (from friends, caregivers or parents) decreased the odds of depression in adult survivors of CSA in situations where the perpetrator was not a caregiver or parent. In those cases, involving a caregiver or parent who was the perpetrator, the rate of depression did not change, despite social support. Musliner and Singer posit that the reason behind this outcome could be distrust towards adults or people close to the survivors after abuse at the hands of a loved one. The trust between a child and a caregiver or parent is so central to development that, when this bond is broken via abuse, it can have tremendous consequences for the victim.

Furthermore, survivors of CSA with multiple perpetrators may have more depressive episodes, according to a study conducted with college freshmen in Wisconsin. The research attributes this finding to the idea that many survivors of CSA experience depressive rumination and negative cognitions about the self that lead to depressive episodes (Liu et al., 2012). Unexpectedly, the types of sexual abuse correlate to different psychological outcomes. Chronic

molestation has been associated with PTSD and mood disorders, while chronic rape experiences have been associated with anxiety disorders (Molnar et al. 2001). Conversely, Pérez-Fuentes et al. (2013) found that the type of abuse suffered did not have a strong relation to diagnosis for pathology, though the frequency of abuse had a negative impact.

**Post-traumatic stress disorder (PTSD).** Many researchers have found an association between CSA and PTSD symptoms (Briere & Elliot, 1994; Buren & Weierich, 2015; Cutajara et al., 2010; Molnar et al. 2001). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) explains that PTSD is the result of exposure to one or more traumatic events (APA, 2013). A distinctive symptom is called re-experiencing in which the person relives the trauma emotionally. This is most commonly experienced through recurrent, involuntary, and intrusive memories or recollection of the event (APA, 2013). Another key element of PTSD is avoidance. Avoidance occurs as a natural reaction to being overwhelmed by anxiety and re-experiencing symptoms. The symptom avoidance can look like amnesia of the event or specific details; it may also look like depersonalization and dissociation. Avoidance can be voluntary or involuntary; a victim may purposely avoid certain places where the abuse may have occurred, or even avoid odors that trigger a recollection of the abuse (Carlson & Dalenberg, 2015).

Specifically, some of the other prominent features of PTSD for CSA survivors include flashbacks or intrusive memories of the abuse, nightmares, and hypervigilance (Briere & Elliot, 1994; Carlson & Dalenberg, 2015). A key component of PTSD is negative cognition associated with the CSA event, and can range from an inability to remember important aspects of the event due to dissociative amnesia to “exaggerated negative expectations regarding important aspects of life applied to oneself, others, or the future...that may manifest as a negative change in perceived identity since the trauma” (APA, 2013, p.275). Many survivors blame themselves for the abuse

and experience guilt and shame surrounding the event, which can impact relationships with family and friends, as well as intimate relationships in the future. Most importantly, survivors of CSA may have altered perceptions of themselves, others, and the perception of the world around them for the rest of their lives (Briere & Elliot, 1994).

Relational conflict and dissatisfaction may be just one of the many consequences of the distrust that may build after abuse is inflicted by a trusted person. Stein et al., (2017) found that 76.1% of survivors reported that their abuse was at the hands of someone they trusted--38.4% of perpetrators were a biological parent and 28.3% of perpetrators were a non-parent relative. This rupture of a child's trust leads to relational problems in the future with family and adults in general.

Shockingly, Molnar, Buka, and Kessler (2001) found that 39.1% of women with CSA history met criteria for PTSD, compared to 5.7% of women without CSA history, and 29.1% of men with CSA history met criteria for PTSD, compared to 3.8% of men without CSA history. A similar study, conducted with 139 Norwegian women aged 19 to 71 who experienced CSA before the age of 18, found two distinct groups in the results: one group had a high post-traumatic symptom score, meeting clinical necessity with a slight decrease over time, and the second group was under the threshold for clinical necessity.

This study found that those in the higher post-traumatic stress symptoms group were more likely to have experienced more severe CSA involving physical violence and threats, as well as more painful CSA incidents. This group also experienced lowered perceived social support and more current relationship problems. Those with higher post-traumatic stress symptoms were found to have multiple abusers (61%) as well as other types of child maltreatment occurring in their lives (Steine et al., 2017). In some instances, trauma may lead to

tonic immobility, which is defined by Buren and Weierich (2015) as “a set of involuntary motor responses elicited under conditions of extreme fear and perceived inescapability” (p. 959). Tonic immobility is peritraumatic, meaning it occurs during abuse and takes the form of temporary muscle paralysis with an inability to call for help. Buren and Weierich (2015) conducted a study with a sample of 46 women from the ages of 18 to 37 with CSA history from before the age of 18. The authors found that tonic immobility was a strong predictor of post-traumatic stress symptoms and that it also resulted in a high probability of symptom re-experience.

According to Carlson and Dalenberg (2000), there are three distinctive features of a traumatic event: negative valence, lack of controllability, and suddenness. Negative valence refers to the perception that the traumatic event was inherently negative. Extreme physical and emotional pain are factors in victims' perception of the event, and in many instances, the traumatic event may not be physically dangerous but the perception of the event as overwhelmingly negative may cause emotional damage.

Lack of controllability, or the perception of not being in control of what is happening, may increase the likelihood of PTSD symptoms. Conversely, if a person is confident in a stressful situation and has the perception of being in control, they are less likely to experience PTSD symptoms. Along with negative valence, victims tend to blame themselves for not being able to change what happened. They are plagued by thoughts like, “What if I had...,” or, “If only I did something different.” As Briere and Elliot (1994) discussed, victims of CSA have an utter lack of control in what is happening to them, so “chronic perceptions of helplessness are thought to result from the fact that the child abuse occurred when the victim was physically and psychologically unable to resist or defend against the abuser” (p. 56). As these victims grow older, they ruminate on what they could have done differently to have controlled the situation.

The last feature of trauma is the suddenness of the event. Carlson and Dalenberg discussed that immediate threat of danger or harm may cause overwhelming fear, as opposed to drawn out threats. When danger occurs very suddenly, a person will not be able to process it cognitively or prepare themselves for impending harm. When there is more time to psychologically prepare for the impending harm, the resulting PTSD symptoms may be less severe.

### **Factors that Influence Outcomes after CSA**

Numerous factors occur that may change the outcome or consequence for each child who experiences CSA. Various studies show that different negative factors in abuse create different outcomes for children. One such study reviewed 2,759 cases of sexually abused children who were aged 16 or under at the time of abuse, from the period of 1964 to 1995 (Cutajara et al., 2010). This study showed that the severity of the abuse (penetrative versus non-penetrative) had a profound impact on mental health. The victims that experienced rape or other penetrative abuse were found to have a significantly higher chance of mental health problems than those with non-penetrative abuse (Cutajara et al., 2010). Another factor that significantly raised the severity of consequences was relative to the age at which the abuse occurred. Cutajara et al. (2010) found that when abuse happened at an older age or during adolescence, the consequences were more severe. This has been attributed to the cognitive awareness, or recognition of the sexual boundaries of the violation, whereas younger children are less cognitive of what constitutes sexual abuse, and so were less likely to perceive it as a gross violation until they reached an older age.

In contrast to the negatives factors, a protective factor and mitigator that stood out from much of the literature on the subject was the impact of positive social support. As cited in

Musliner and Singer (2014), perceived emotional support is defined as “beliefs that love and caring, sympathy and understanding, and/or esteem and value are available from significant others” (p. 64). This support improves the survivors’ sense of self and emotional well-being, as well as decreasing the chances of depression and other psychological consequences (Musliner & Singer, 2014). Hyman, Gold, and Cott (2003) indicated that increased perceived social support predicted lower levels of PTSD symptoms in women survivors of CSA. Furthermore, self-esteem support (referring to communication with others indicating that the abused individual is valued) has been shown to be the type of social support most linked to lower PTSD symptoms. When survivors perceive that others value their experiences with CSA, this may counteract the high rates of self-blame found for many survivors of sexual abuse (Hyman, Gold, & Cott, 2003).

### **Childhood Sexual Abuse Among Deaf**

#### **Statistics**

The prevalence of CSA in the Deaf population varies and is greatly limited, yet the data that exists shows that the Deaf population experiences CSA at incredibly higher rates than the general population. One study, conducted with Deaf men and women with ages of 18-65 in Norway that used a self-report questionnaire in both written language and in signed video format to analyze prevalence of CSA victims, found that Deaf females experienced CSA more than twice as often as hearing females, 45.8% compared to 30.6% (Kvam, 2004). The same study revealed that Deaf males experienced CSA more than three times as often as hearing males, 42.4% compared to 15.8% (Kvam, 2004). Another study, conducted with a total of 92 students in Brazil, 42 Deaf from a residential school for the Deaf and 52 hearing students from a nearby mainstream school, found that 31% of Deaf students reported a history of CSA, compared to 2% reported from hearing students (Bisol et al., 2008). Schenkel et al. (2014), conducted a study on

child maltreatment with 86 Deaf, 61 hard of hearing, and 317 hearing students at Rochester Institute of Technology the authors found that 32% of Deaf and hard of hearing students reported CSA compared to 13% of hearing students.

One of the highest estimates of CSA in the Deaf population was from study by Sullivan et al. (1987) that was conducted with 100 Deaf students from both mainstream and residential schools in 18 states. The results estimated that 54% of Deaf boys and 50% of Deaf girls experienced CSA, compared to 10% of hearing boys and 25% of hearing girls. The study indicated that of the 64% of Deaf students who attended residential school, 40 of those students were abused in school, 10 in home, and 15 in both school and home, whereas 35 who attended mainstream school only nine were abused at school and 21 were abused at home. Those in the residential schools typically live in dorms on campus for much of the year, this may lead to a higher vulnerability for the Deaf children there due to lack of supervision, limited contact with parents, and lack of CSA education (Ridgeway, 1993).

These numbers may be limited or less generalizable due to the fact that many of the studies focused on CSA experiences in Deaf residential schools, which are separate schools for the Deaf; it is easier to acquire data when the subjects are in the same school (Ladd, 2003). The data is also less able to be generalized to the whole Deaf population because the studies focusing on Deaf students in college who may not have the same responses as Deaf people who are less educated. Additionally, these findings may not be applicable to the overall Deaf population, as this population reflects a large variety of cultural backgrounds, educational backgrounds, and language skills. The Deaf population is extremely diverse, and attention to the different cultural and racial backgrounds is an area that needs attention in the field. Most of the research is focused

on the Caucasian Deaf populations, which does not take into consideration the cultural and ethnic backgrounds of this diverse group of people.

It can be difficult to understand the true scope of the problem, which shows that much more research is needed about CSA and the Deaf population in general, as well as more focused research on subsets of the Deaf populations, such as fluent ASL users versus non-fluent ASL users. Despite difficulties in generalizing statistical information, however, these extraordinarily high numbers tell a shocking story of CSA in the Deaf population, when compared to those in the general population.

### **Consequences of Childhood Sexual Abuse and Deaf**

While anxiety, depression, and PTSD have been reported as a consequence of CSA in the hearing population, there is little to no information about the consequences of CSA and the effect it has on Deaf victims. The findings above cannot be generalized to fit the Deaf community, due to the fact that Deaf people were not taken into consideration during research studies. The vast majority of the research on childhood sexual abuse is conducted with hearing participants and focused on the impact of CSA on the hearing population. While the main difference between the Deaf community and the hearing world is the physical function of hearing, there are critical factors that these results do not consider. Omitted, yet significant considerations include: (a) communication barriers between the Deaf child and family or caregivers; (b) deprivation of language and literacy; (c) inadequate access to vital CSA education and information for Deaf children and for the family or caregivers of Deaf.

The Deaf community is defined as a group of people that are “bound by their use of ASL and are drawn to the community by a shared culture – Deaf culture” (Holcomb, 2013, p. 21). Deaf culture can be defined essentially like any other, a community that shares languages,

values, customs, and beliefs. In many definitions culture is defined by geographic location, people that live in the same area share a similar culture, but the Deaf community is not geographically bound as there are Deaf people all over the world, there is a shared community and culture anywhere there are Deaf people (Holcomb, 2013). The Deaf community is a “historically created solution that has naturally emerged and evolved over many generations as a result of Deaf people coming together” (Holcomb, 2013, p. 21). The community provides safe spaces for Deaf people to come together and gain a respite from the barriers of living in the hearing world.

### **Deaf and Psychological Disorders**

Despite the lack of research on Deaf individuals, there are a few studies indicating that Deaf individuals may experience anxiety at higher rates than hearing individuals (Fellinger et al., 2005; Kvam, Loeb, & Tambs, 2006). In a Norwegian study conducted with 431 self-identified Deaf individuals with 41% male and 59% female respondents, researchers found that the Deaf respondents were more likely to experience anxiety and depression when compared to the hearing respondents (Kvam, Loeb, & Tambs, 2006). The authors hypothesized this higher rate of mental distress may “stem from childhood, or, for example, from different etiologies of deafness, socioeconomic issues, or different experiences related to stigma and discrimination” (Kvam, Loeb, & Tambs, 2006, p. 6).

Another study conducted with 233 Deaf individuals, 131 men and 102 women with an average age of 45.3, focused on the quality of life of Deaf people in Austria. The authors found that Deaf individuals had a higher chance of psychological distress when compared to the general population, including high rates of anxiety. The study also found no difference in social satisfaction between the Deaf population and the general population, signifying that a common

language socialization remained the same (Fellinger, et al., 2005). Deafness does not change the way people socialize; if anything, the Deaf community increases self-esteem and positive identity by providing safe spaces to be Deaf. It is important to note that both these studies attribute the high rate of Deaf individuals with anxiety, not to the physicality of deafness, but to the way in which our society views Deafness and how Deaf individuals are treated by others.

Similarly, there is extremely limited research on the effects CSA has on the Deaf in regard to depression and PTSD. One study, conducted in California with 77 Deaf adults, men and women aged 18 to 83 years old, found a connection between CSA and depression in survivors. The authors, Schild and Dalenberg (2015), found that participants with sexual abuse histories had significantly more PTSD and depression symptoms compared to other types of abuse.

Although the limited research available suggests that Deaf individuals (with or without trauma histories) have a higher rate of psychological disorders, some researchers say otherwise. A study conducted by Diaz et al., (2013) with a sample of 241 outpatient Deaf men and women with a mean age of 35.7 receiving mental health services, and a comparison group of 345 randomly selected hearing men and women with a mean age of 37.7 also receiving mental health services, found different results. The study found that 18.7% of Deaf patients met the criteria for anxiety disorders while 30.1% in the hearing group met the criteria for anxiety disorders. Substance use disorders were found at significantly lower rates in the Deaf sample, 27.8% compared to 48.4% for the hearing group. The study also found many other psychological disorders manifested at the same rate as the hearing sample, including “depressive disorders, psychotic disorders, adjustment disorders, eating disorders, cognitive disorders and personality disorders” (p.993). Only a few types of disorders were found to be more common in the Deaf

sample and those were “impulse control disorders, attention deficit hyperactivity disorder, pervasive developmental disorders and intellectual disabilities” (p.993).

The authors did not find immediate and clear evidence for the reason behind their findings. Interestingly, the authors found very low rates of substance use disorder, they posit that the lower rates of substance use disorders may be due to a lack of health education information and that substance abuse may be considered normal, or not seen as a problem due to lack of understanding of the effects of substance use disorders (Diaz et al., 2013). While the authors did not find clear evidence, one can posit that there is not a significant difference between hearing people and Deaf people, aside from the physicality of deafness, and if the Deaf community were considered equal to the hearing community then perhaps, we would find no difference whatsoever in their psychological disorders.

**Deaf identity and self-esteem.** A strong and positive Deaf identity can greatly improve life satisfaction and overall psychological well-being yet attaining a positive view of deafness can be a long and difficult journey (Holcomb, 2013). This struggle manifests due to shame, ignorance, and not being provided Deaf role models that can demonstrate a healthy Deaf identity. Identity is constructed and molded through life experiences, socialization, and role modeling throughout a lifetime (Hintermair, 2007). Throughout a person's life, one must construct and reconstruct their self-concept and identity as new information and experiences about oneself emerge. Deaf people come from all walks of life and have many intersecting identities, from ethnicity to age and gender; these identities impact each Deaf person differently.

The Deaf identity itself has many varying categories, Holcomb (2013) describes seven that vary from “balanced bicultural” (p.67) to “culturally isolated” (p.70). A balanced bicultural Deaf person would be one that is comfortable interacting with hearing people and the Deaf

community, they present with different language capabilities but ultimately, whether they speak or not, they associate with hearing and Deaf people alike. A culturally isolated deaf person does not interact with the Deaf community at all and rejects sign languages. The other categories of identity vary with their level of comfortability on interacting with hearing or Deaf communities, from “Deaf dominate bicultural,” or preferring the Deaf community but still interacting with hearing people, to “hearing dominate bicultural” in which they can interact with the Deaf community but for other reasons do not have access to the Deaf community; there are also those who “culturally separate,” which means interaction with the hearing world is rejected (p. 68-69).

Being bicultural and comfortable interacting with both “worlds” has been shown to be the healthiest and optimal option for many Deaf people (Hintermair, 2007; Holcomb, 2013).

Hintermair (2007) states that “bicultural acculturation seems by and large to be a safe option for the quality of overall psychosocial well-being” as well as leads to an increased “sense of self-esteem and general satisfaction with life” (p. 295). This sense of well-being and confidence in who they are is a difficult process and many Deaf people struggle to cope with their Deaf being and have a different view of their deafness, one that is not a loss of something but rather a positive way of life. Much of this positivity, along with positive role models, can be found in the solutions that the Deaf community provides, but is not available or accessible to many due to either ignorance of the Deaf community or being geographically isolated from the community and other Deaf people (Holcomb, 2013).

### **Barriers to Sexual Abuse Prevention Education**

#### **Education**

The Deaf community has been faced with many challenges in the field of education; over time there have been improvements, as well as setbacks. There has long been a struggle for Deaf

individuals to be educated with appropriate access to direct communication in ASL. Historically, there has been a belief that Deaf children must be taught to speak English vocally and use lip reading to understand spoken English (Ladd, 2003). Supporters of the oral method of communication consider it a valuable skill for the Deaf person in order to interact with the hearing world on a daily basis. Oral communication is used when a Deaf person uses the remains of their residual hearing with assisted listening devices such as hearing aids (while many rely on speech therapy) in order to learn to speak similar to their hearing peers and ASL is rejected and viewed as inferior (Hardin et al., 2014). Many refer to this as the oral method, or Oralism. Oralism, historically, has been a popular method for the education of deaf individuals and prohibits Deaf people from using any signed language (Padden & Plan, 2000), which can lead to issues in adulthood such as poor self-conception and identity and is greatly opposed by much of the Deaf community (Ladd, 2003).

**Oral methods.** Oralism had a rocky beginning in the United States. In 1850, roughly half of the teachers for Deaf children were Deaf themselves, using various forms of signed language, called manualism, to teach. Throughout the next 200 years, the number of Deaf teachers continued to decrease until many of the teachers for the Deaf were hearing and used oral methods, including speech and lip reading, to teach Deaf children (Valente, 2011). The teaching theory that originated in the late 1800s had educators attempting to “save” or “cure” deafness by eradicating signed languages in schools. The debate between the two methodologies came to a head in 1880 during the Milan Conference, where educators for the Deaf came together from all over the world and arrived at a consensus that oralism and spoken language was superior to signed languages (Arnold, 1984). With the rise of oralism came the rise of the stigmatization of signed languages and the verbal and physical abuse that accompanied it. Signing was viewed as

animalistic and barbaric; children were often punished physically when they signed in schools or at home (Ladd, 2003). Those who believed in oralism, in many cases, were woefully ignorant of deafness. Their belief was more based on wishful thinking than actual evidence. In cases such as Alexander Graham Bell, a strong supporter of oralism, his supporters were more knowledgeable, yet their beliefs were based on eugenics and the eradication of deafness itself due to bias and fear (Baynton, 1996).

It was not until the 1960's that perspectives began to change. In 1965 the Babbidge Committee Report was published and illustrated the systemic failing of Deaf education in the United States. What is referred to as "The Babbidge Report," outlined the lack of education accessibility, the limited secondary opportunities available, the low levels of educational achievement made by secondary school graduates, and the overall lack of funding towards research (The Commission on Education of the Deaf, 1988). This was the first time a call to action was proposed to change the failing system that was in place.

The next study on the effectiveness of oralism was conducted at Oxford University in 1974, nearly a century after the Milan conference. The Oxford study found the effects of oralism to be catastrophic. English literacy was extremely low, the speech of deaf individuals, which had been the focus of the oral method, was found to be mostly incomprehensible, and the lip reading skills of many deaf people were ineffective (Ladd, 2003). While the study only focused on the academic success of the students, it was another important step in acknowledging the detriment of oralism on generations of Deaf people. Baynton (1996) discussed the failures of oral methods on the Deaf population; he compared the difficulty of learning of spoken English for a deaf person as akin to "a hearing American trying to learn spoken Japanese while locked in a

soundproof glass cubicle” (p. 5). That is, a select few may prosper, but for most, oralism meant years and years of frustration and failure.

Lane (1992) discussed several difficulties deaf children were faced with every day in oral education. He described a study where deaf children who finished school were no better at lip reading than an average hearing person, meaning that in class where they were expected to lip read every word the teacher was speaking would ultimately understand little. On top of their inability to understand the teacher, the teachers were also unable to understand their deaf students’. The communication between student and teacher was almost nonexistent. How were deaf children expected to succeed academically without communication? Lane (1992) continues on to say that “training in lip-reading and speech generally fails with children who have never heard speech, and most of the deaf children in school today have never heard speech” (p. 130)

Cultural shifts in the 1960s and 1970s, along with research, supported this shift in perspective on sign language. According to Baynton (1996), the changing attitudes began to evolve in a way that accepted people and embraced the body in its many forms. Americans began embracing the arts, dance, nudity, self-expression, and body acceptance. With this belief in freedom and acceptance came the rejection of the idea that sign language was “lower” or less than human. These underlying ideologies lost their meaning and with it lost their control of language and education of the Deaf.

We can clearly see the psychological effects of oralism even to the present day. When education, family, and society as a whole place such value on spoken language and degrade signed languages that are the natural language of the Deaf, this devalues the Deaf individuals themselves and creates a sense of being “less than” (Hardin, 2014). The concept of oralism is an

unnatural attempt to force Deaf children into appearing as hearing children and is “seen by many deaf people as cruel, unrealistic and unfair” (Gannon, Butler, & Gilbert, 2012, p.360).

**Residential and mainstream.** A more modern look at Deaf education can be categorized into two types of schooling: residential and mainstream. Residential schools are Deaf schools where the children live in dorms on campus, this is due to the relative isolation of many Deaf students that may not have access to a school near their home (Holcomb, 2013). Residential schools historically utilized the manual method of education and used sign language. These were seen as a haven for the Deaf community and Deaf culture to grow and prosper (Edwards, 2012). Mainstream, as defined by Ladd (2003), is the assimilation of Deaf children into hearing schools where they either use oral methods or are provided with an interpreter and use manual methods. In many of these situations, there may only be one Deaf child in a whole class, even in a whole school filled with hearing children and hearing teachers and one Deaf student (Bayton, 1996), this can be very isolating for the child. Even in the past when oralism reigned Deaf education, deaf students were still educated with other deaf students, there was an ability to bond as well as cultivate community in these oralist schools. In mainstream classrooms, there is a lack of access to Deaf friends or Deaf role models to look up to. In many cases, the only person the Deaf child can interact with in ASL is the classroom interpreter, that due to funding and lack of resource may not be qualified or easily understood (Baynton, 1996). Many communities struggle with finding qualified interpreters for the classroom and the standards for hiring an ASL interpreter are quite low in many places.(Lane, 1992). Without access to the same language, culture, community, as their peers, it is no wonder that Deaf children are more vulnerable to abuse and psychological disorders (Bisol, et al., 2008; Fellingner et al., 2005; Kvam, 2004; Kvam, Loeb, & Tambs, 2006).

Despite these downfalls, a majority of Deaf children are being educated in a mainstream setting over the more traditional residential school approach (Holcomb, 2013). In the early 20<sup>th</sup> century, around 80% of Deaf students were educated in residential school and 20% mainstreamed. Today this is opposite, with around 20% of Deaf students being educated in residential Deaf schools and 80% being mainstreamed in self-contained classrooms in hearing schools or in hearing classrooms (Hoffmeister, 2010), Ironically, after a century of oral methods ruling Deaf education, it only took a few decades of mainstreaming Deaf children into hearing school to radically shift the perspective of sign language used in Deaf education.

In the U.S., Deaf education has been changed by the enactment of the Individuals with Disabilities Education Act (IDEA) in 2004. The clause within the IDEA concerning the least restrictive environment for children with disabilities had a large impact on the rise of mainstreaming Deaf children. IDEA states that:

To the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are not disabled, and special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disabilities of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. (20 U.S.C.

§ 612(a)(5)(A))

The concept is called a “least restrictive environment,” and provides a space that is inclusive for all children despite disability to be educated together and not segregated from their able-bodied peers. For most children with disabilities this is a worthy and inclusive ideal, yet for Deaf students it can create a profoundly restrictive space resulting in the Deaf student being placed in

classrooms where the dominant language of learning is spoken English. IDEA focuses on pushing Deaf students to “gain access to school and school-related activities” (20 U.S.G. § 662(c)(2)(E)) rather than focusing on providing the least restrictive environment where Deaf students can gain access to communication with other students along with a full and proper education.

According to Mitchell and Karchmer (2006), the number of Deaf students attending residential schools has decreased by more than half in the past quarter-century. This decrease in residential school attendance causes many older Deaf adults to believe that Deaf children are missing out on an essential part of the Deaf experience. In the past, residential schools were a haven for sign language and, for many Deaf children, the places where they first met other Deaf children as well as where they were able to interact with Deaf adults perhaps for the first time, and thus able to begin to develop their Deaf identities (Holcomb, 2013). Residential schools have had their limitations and challenges with inadequate supervision of the children, leading to the potential for sexual abuse and bullying perpetrated by older students who have not been educated in appropriate sexual behavior themselves (Sullivan et al., 1987). Yet given access to the proper resources and education for all, these institutions can be a haven for Deaf students seeking properly to prepare for adulthood and the future.

Currently, Deaf education is generally deficient in providing Deaf students with access to the least restrictive environment, Deaf role models and education about the Deaf community, and lacks access to a full education through ASL. This failure on the part of Deaf educators can be seen in the fact an average Deaf high school graduate reads at a fourth-grade level (Holt, Hotto, & Cole, 1994). Without access to education that will provide Deaf children with the ability to

understand their teachers and peers fully through ASL, this may continue to be the sad reality for the next generation of Deaf children.

## **Language**

The Deaf community has unique linguistic needs and must be provided with access to a full understanding of language. As discussed above, historically there has been a push for speaking and lip reading, and many English based sign methods are still valued over ASL based on their connection to spoken languages. Generally, there is a misconception that signed languages are universal although there are many different signed languages for different countries or areas. For example, ASL is used in the U.S. and Canada while BSL, British Sign Language, is used mainly in the U.K. (Liddell, 2003). According to Hardin et al., (2014) ASL is the preferred language of the Deaf community in the United States over other oral methods. In a study conducted with parents and professionals that use ASL in some capacity, nine parents and one professional were interviewed in focus groups, six parents were Deaf themselves and four hearing, many of the Deaf participants shared that they only learned ASL after attempts at acquiring oral language failed (Hardin et al., 2014). ASL is easily acquired by Deaf children and those that were raised with ASL tend to have a higher understanding, easier acquisition, and better reading scores (Gulati, 2019).

There are several other methods that have been used to teach Deaf children to communicate. Signed Exact English (SEE), in its essence, purports to be able to support Deaf students in learning English without speaking. There are various forms of SEE signs, though the basic idea is to sign every word in English following English word order (Gannon, Butler, & Gilbert, 2012). This appeals to the hearing parents of Deaf children due to its closeness to

English. Yet SEE is difficult to understand, as each sentence takes up a good deal more time and physical effort.

Another form of communication preferred by many in the hearing world is simultaneous communication. This method is preferred by the hearing world because it combines signing and speaking at the same time. The problem with this method is that it will not be as easily understood by the Deaf student, though easily understood by the hearing person who is fluent in spoken English (Liddell, 2003). Lane (1992) explains that total communication gives the teacher “the illusion of making sense”(p. 134). A similar method is Pidgin Signed English (PSE), comprised of signs with no voice that follows English word structure but also contains some aspects of ASL. Historically, PSE has been viewed as more prestigious than ASL because of its close relation to spoken English and because it is easier to understand for the hearing world (Hardin et al., 2014). However, PSE is not easier to understand for the Deaf world because it may be confusing because ASL does not follow English sentence order, with PSE falling somewhere between ASL and SEE.

It was not until the 1960’s that ASL was proposed as a real and natural human language by William Stokoe, who noted that ASL had its own grammatical structure similar to that of spoken languages (Liddell, 2003). Baynton (1996) described what the meaning of “natural” is in context of sign languages, saying that the “naturalness” of signed languages is not the same as spoken language, if anything it is in opposition to it. He stated: “sign language was not a product of culture, as spoken languages were. It was instead a direct expression of nature itself” (p. 109). This concept of a “natural language” was debated between the manualists and the oralists for many years. The oralists commandeered the term and took “natural” as a synonym for “normal” and pushed for the use of spoken methods (Baynton, 1996).

Despite these competing definitions of “natural,” ASL is a language of its own, separate from spoken languages. It is a three-dimensional language that uses the hands, body, and facial expressions to convey meaning, and does not follow English word order. ASL has its own “syntax and morphology [having] been shaped by the visual-manual channel, just as the vocal-auditory channel has played some part in the evolution of spoken languages” (Arnold, 1984, p. 29). While English is produced vocally, “Signs – the words of a sign language – are produced by actions of the hands, arms, torso, face, and head that produce signals perceived visually” (Liddell, 2003, p. 1). Knowing that ASL is the best language choice for the Deaf population, meaning that the acquisition of ASL happens more easily and smoothly than oral methods, should have changed Deaf education back when it was proposed in the 1970s, yet there is still a huge divide in Deaf education as to the best way to educate Deaf children.

**Language deprivation.** Low literacy rates among the Deaf are caused by a lack of access to ASL, in what has been termed language deprivation. Language deprivation is defined as “deaf children growing up without quality exposure to any fully accessible language” (Glickman & Hall, 2019, p. 2). Language deprivation is common among Deaf children due to the reliance on oral methods of education and a lack of understanding of the benefits of ASL. Gulati (2019) has labeled the consequences of early language deprivation as Language Deprivation Syndrome, which he explains as a constellation of symptoms that include “social, emotional, intellectual, and other consequences” (p.24). Simply put, Language Deprivation Syndrome is incomplete neurodevelopment due to the lack of cognitive stimulation that arises from language development during the first five years of a child’s life. After deprivation for these critical first five years, language acquisition is possible, but the same kind of fluency as a “native” signer (one who has access to signing since birth) will never be accomplished. The sign language that is

acquired later in life may appear fluent to a non-signer, but to native signers it will lack the structure and grammar that is essential to ASL.

Gulati (2019) further explains that his reasoning for choosing the word “syndrome” is that “this name has the advantage of placing responsibility for a child’s language and associated outcomes on the surrounding environment. Poor language outcomes, though frequently tolerated, are not “normal for deaf people” (p.25). These outcomes are not from deafness itself but rather the English-only environment in which Deaf babies are brought up. According to Petitto and Marentette (1991), Deaf babies acquire language at the same rate as hearing babies when exposed to sign language from birth and they experience similar milestones. The language environment in which Deaf babies are brought up is imperative to the child’s language acquisition and brain development.

Developmental and physical issues are not the only consequences of language deprivation--the emotional cost is staggering. When the "spoken language only" mandates are followed, not only are children being deprived of their natural language, Deaf children may develop poor self-image and low expectations for themselves (Ridgeway, 1993). Language deprivation can result in “long-term damage to their emotional development and self-esteem” as well as the fact “that deaf children are more at risk of neglect and abuse” (Ridgeway, 1993, p.168). This can be seen by the strong sense of self and identity from those Deaf children of Deaf adults who are raised as native signers and with Deaf cultural values. With language deprivation comes a lack of access to natural language but also a lack of access to other Deaf adults, cultural connections, and most of all, connections to the Deaf community that supports a strong sense of self and Deaf identity.

**ASL and learning English.** There is a prominent belief that ASL will cause Deaf children to become incapable of learning English because it is not a language but rather a series of gestures and pantomiming (Ladd, 2003). This way of thinking leads people to believe that ASL will “hinder” acquisition of spoken and written English. Yet, children who are raised with ASL as their first language have a greater and more comprehensive understanding of English and a higher literacy rate than those who are not raised with ASL as their first language (Drasgow, 1998; Wilson, Teague, & Teague, 1984; Wurm, 1986). Cooper (2002) found that sign language increased “learning, [which] leads to greater motivation for reading, and reaches a broad spectrum of children” (p. 116). Through sign language, Deaf students will be able to learn English more easily than with English-based methods, discussed previously, which have been shown to be ineffective (Cooper, 2002; Liddell, 2003).

What leads parents and families to deprive their children of ASL? It is estimated that roughly 96% of Deaf children are born to a hearing parent (Mitchell & Karchmer, 2004). Educators and doctors that subscribe to oralist views warn parents of Deaf children that using ASL or other sign languages will reduce their child’s abilities in speech and lip reading, believing that ASL will then become the child’s “crutch.” This view frightens parents who wish their children to fit in with hearing society, causing these parents to keep their children from Deaf adults and mentors (Gannon, Butler, & Gilbert, 2012). The use of oral methods or other forms gives these hearing parents a sense of hope that their Deaf child will be able to live a “normal” life by being able to speak, lip read, and interact with the hearing world (Gannon, Butler, & Gilbert, 2012). These parents do not have the intent to cause harm to their Deaf child. If anything, these parents seek to give their child a “better” life, but what fails these parents is the

dominant social discourse that tells them that Deaf children need to be hearing to be “normal” in order to live a successful life.

### **Stigmatization of Deafness**

The stigmatization of deafness can be seen throughout the history of the world. Even as far back as the ancient Greco-Roman period, philosophers such as Aristotle had theories about the "unintelligent deaf-mutes." Aristotle posited that “hearing is the sense of sound and sound the vehicle of thought” (quoted in Ladd, 2003, p. 91). This negative viewpoint of deafness still prevails. The perception of Deaf people is heavily influenced by the views of the early Christian church, which viewed them as demonic. This belief due, in large part, to the view that one must quite literally, “hear” the word of God, effectively discounting Deaf people as capable of having a soul or being able to go to heaven (Ladd, 2003). While many of these extremely negative perspectives of Deaf people have mostly dissipated, there exists a more subtle form of stigmatization in today.

The stigmatization of deafness, and Deaf culture, in particular, can be seen in many facets of life. Komesaroff (2002) analyzes the language used as it relates to deafness and cochlear implants (a surgical procedure designed to aid Deaf children in auditory ability) in popular news articles. Komesaroff (2002) found during his examination of news articles that the language used to describe cochlear implantation was overwhelmingly positive and framed as a “modern day miracle” and a “gift of sound” (p.41). Deafness is either left out of the text and shown as a deficit or described as incredibly negative. Cochlear implants for children, which is highly contested and debated in the Deaf community, has been portrayed as a positive, life changing experience. The news articles examined completely ignore the concept of the Deaf community and also ignore the benefits of sign language. There are no alternative options given. These dominant

discourses give the hearing parents of Deaf children no alternative than to view their children as broken or needing to be fixed with a costly and risky surgery.

Valent (2011) describes cochlear implantation as “invasion of unruly, young deaf bodies that attempt to eradicate deafness and, by extension, Deaf culture and ASL, replacing these bodies with hearingness” (p. 643). He continues by stating that this colonization of Deaf youth begins “usually with parents realizing something is amiss, moving next to the pediatrician, who diagnoses and refers, then on to speech and hearing specialists, and finally to the cochlear implant 'support' teams and oral deaf rehabilitation programs” (p.643). Hearing parents of Deaf children are not villains; they simply desire their children to be similar to them and want to be able to communicate with their child. The issue stems from the way the parents go about fulfilling this desire. Rather than learning ASL and teaching their child their natural language, the parents, influenced by dominant discourses portraying hearing and speaking with voice as “healthy and normal” seek to have their child change to meet the parents’ needs by using this “miracle” medical technology. Oftentimes hearing parents are not provided education regarding Deaf culture and do not have a comprehensive understanding of all of the options for their children or long-term ramifications of their actions. There is much debate on the effectiveness and necessity of cochlear implantation on young children (Humphries et al., 2014), yet according to Humphries et al. (2014) “even under optimal conditions, CI implantation does not guarantee first language acquisition”. These debates and information must be shared with the parents of Deaf children in order to insure an informed and educated decision.

### **Communication Barriers**

Deaf children are faced with extreme communication barriers in many facets of life. Positive connections and communication from family are the greatest assets to children that are

at risk for sexual abuse. Sullivan et al. (1978) discussed family communication and contact as a barrier to sexual abuse in residential schools and stated that “children with frequent close family contacts and a shared language are less likely to be the victims of sexual abuse in schools” (p.260). As discussed previously, Deaf children are typically born to hearing parents (Mitchell & Karchmer, 2004) and subjected to oral methods of education, creating poor communication between family members. Poor communication skills and language barriers between family members are important factors when assessing the risk for CSA (Bisol et al. 2008). Effective communication with family is key to meeting appropriate developmental milestones, as well as vital for the development of psychological well-being. Deaf children who are not able to express themselves to their parents or other family members are 4 times more likely to experience mental health disorders than those who have effective communication with family members and are more likely to experience mistreatment at school (Fellinger, Holzinger, & Pollard, 2012). It is imperative that Deaf children have access to full communication and meaningful relationships with family members to be able to prevent abuse. Children without meaningful relationships in their lives are less protected and more vulnerable to being victimized by adults.

Deaf children born to hearing parents may struggle with the formation of their personal identities since there are such inherent differences between a child's and the parent's lived experiences. Furthermore, “the child and parent may grow further apart, either because parents are unable to sign or the child is unable to use spoken language skills” (Hardin et al., 2014, p.110). If a Deaf child is not able to communicate their needs, there is much less potential that the child would be comfortable disclosing sexual abuse to a family member. In the same study, Kvam (2004) found that 49% of sexual abuse victims never disclosed the abuse to anyone, and 10.8% of victims did disclose the abuse but were not believed. The relationship and

communication between parents and their Deaf child have a large impact on the child's development, including healthy and unhealthy cognitive and emotional function (Pollard, 1987). These unhealthy cognitive and emotional developments may lead the child to be more vulnerable to sexual abuse.

While mainstreaming Deaf children is more common now, in the past residential schools for the Deaf were the norm. Typically, residential schools were boarding schools and oftentimes Deaf children were physically far from the family home due to the limited number of schools in each state. Communication with family is a struggle for many of these children. Additionally, living most of the year at school can create emotional distance in the parent-child relationship. In many studies conducted with Deaf children at these residential schools, it has been shown that CSA is present in these education facilities at alarming rates (Sullivan et al. 1987; Kvam, 2002; LaBarre, 1998). In many cases, Deaf adults that experienced sexual abuse as a child at these residential facilities reported that CSA has become normalized for them due in part to the fact that it was such a common occurrence while they were growing up. Without access to education about what sexual abuse is, many Deaf children think that sexual abuse is “normal” or common (LaBarre, 1998), especially when many other children around them have experienced similar abuse.

Deaf students must also contend with a teacher's bias and lack of communication with their teachers in the classroom, in mainstream or residential settings, in addition to the lack of access to communication with families. Studies show that Deaf educators have, overall, low academic expectations of their Deaf students (Marlatt, 2004; Pagliaro & Kritzer, 2005; Wood, 1998). Marlatt (2002) found that teachers tended to expect their Deaf students to be more subordinate than hearing student populations. In addition, Teller and Harney (2005) found that

Deaf and hard of hearing programs tended to rely heavily on behaviorist classroom management, which tends to be stricter and with less room for student engagement. These teacher-biases lead to a lack of a student-teacher relationship which can impact student achievement and progress in learning as well as instilling a lack of trust in the student for his or her teacher.

To tie the student-teacher relationship back to CSA, students' trust in teachers plays a larger role in the disclosure of CSA. In many cases, children may be unable to disclose sexual abuse to their family, therefore, teachers can become incredibly important if children are able to trust them enough to disclose abuse. In addition to the relational impact of teacher-bias, the use of strong authority and behaviorist attitudes teaches Deaf children that adults and hearing people are superior and can be a great risk factor for sexual abuse (Sullivan et al., 1987). When Deaf children believe that they must be subordinate to adults and other older students, they can be easily taken advantage of, so sexual abuse may occur more often. Similarly, the study conducted with Norwegian Deaf students, Kvam (2004) found that Deaf children who had been abused tended to have stricter mothers and a poorer relationship with their fathers than the group of non-abused Deaf students. This concept of adults in their lives being strict or inflexible can lead to poor understanding of relationships and give them a misunderstanding about over respecting adults which can lead to high risk for abuse.

### **Access to CSA Information**

According to Pollard and Barnett (2009), typical services such as radio, movies, and TV, as well as public service announcements and overheard conversations, are not accessible to the Deaf population, leading to the “fund of information deficit” (p. 182). The concept of fund of information deficit is defined as the “distinct limitation in one’s factual knowledge base in comparison to the general population despite normal IQ and educational attainment” (Pollard &

Barnett, 2009, p.182). Many topics are covered by the fund of information deficit for Deaf and can be applied to the mental health field and sexual abuse awareness.

The low literacy rates of the Deaf population due to language deprivation and the lack of access to ASL impacts them in many ways, especially when accessing information, especially health and mental health-related information. According to Pollard and Barnett (2009), “the vast majority of health information available to the American public is written in English. There is a marked lack of available health information in non-English languages, particularly ASL” (p. 183). Pollard and Barnett (2009) conducted a study with 57 adults who identified as Deaf, 27 females and 29 males, and found that “1/3 (31.6%) were below the "9th grade" level of health literacy understanding” and “many high school graduates fell below the 9th grade level (29.6%) and (21.7%) of college grads were below 9th grade level” (p. 184). This lack of literacy is not due to deafness itself but provoked by the lack of access to education and ASL from a young age. As previously discussed, those with access to ASL from birth have higher literacy rates and are able to better understand written English material, yet the reality is that many Deaf people have low literacy rates due to their educational background. Health and mental health information is especially difficult for the Deaf population to understand due to the complicated terminology that is not commonly known or explained and, most of all, the assumption is that the people reading the material are hearing.

A study conducted with 37 ASL interpreters to gage a different perspective on access to health information during doctor appointments, found that in about 59.4% of the appointments they interpret for Deaf consumers that the Deaf consumer appeared unclear or confused about specific information the doctors conveyed (Hommes et al., 2018). While there are interpreters in place at these appointments, many times an interpreter is not qualified to convey fully

comprehensible and complex terminology, including specific instructions about medical needs. The interpreters cited time constraints as a barrier to full comprehension, stating that many appointments were rushed and the doctors did not follow up on comprehension and understanding of important facts such as directions for medication, follow-up appointments, and a full understanding of the Deaf person's diagnosis. Not only is there a feeling of being rushed when the Deaf person is not able to clarify information with the doctor, but many interpreters stated that there is a lack of empowerment in the Deaf community to speak up to ask for clarification or inquiries about their diagnosis, with the interpreters attributing this to many of the Deaf consumers' childhoods where they may not have had access to any information, or medical choices were decided for them by their hearing parents (Hommes et al., 2018). Gaining insight from interpreters provides a unique perspective as interpreters are third parties and are supposed to remain impartial during translation. They have the perspective of an observer without much of the bias on either side.

As explained earlier, Deaf children have a lack of accessible information provided in ASL, to allow for full access to information regarding mental health, sexual abuse, and prevention of sexual abuse (Ridgeway, 1993). Without proper access to language, Deaf children lack "access to child abuse prevention literature, as well as the pervasive culturally mediated education provided through literature and television on the appropriate response to predatory adult behavior" (Schild & Dalenberg, 2015, p. 250). Without access to sexual abuse information, sexual abuse prevention becomes nearly impossible. Yet, what does full access to information look like?

Some might believe that captions alone on videos or television are sufficient to provide access, yet the literacy rate in the Deaf population is low and these captions do not allow for the

full emotional impact of the information sought to be conveyed. In many cases one might think that an ASL translation of English material would suffice, however, while this may be a step forward from no translation, it is still not enough for full access. Translation is a complex task, especially with health-related words that have many complex meanings and are not commonly known or used in the Deaf community, and where, even with the most skilled translation, it “alone does not bridge cultural, social, and life experience differences that frequently exist between the source material’s target audience and the translated material’s target audience” (Pollard et al., 2009, p. 233). ASL is not English and therefore needs to be interpreted, not merely translated. Interpreting is more than translating in that it is not word-for-word English translation but adds the underlying meaning of words or phrases, such as English idioms which are not easily translated into ASL and can be confusing for the Deaf consumer.

Pollard et al., (2009) has a solution: instead of translating English material created for hearing audiences, the authors discuss creating a “from scratch” health information with the Deaf community in mind. However, this method does not have the same legitimacy as well-researched English information, as health information is not researched with the Deaf population in mind. Therefore, the authors have another solution: mixing these two methods together and using the pre-existing and proven valid English material and combining that source material with culturally, linguistically, and socially sensitive content “intended to maximize the clarity and relevance of the resulting material for the intended target audience” (Pollard et al., 2009, p.233). Using ASL, the English source material and culturally sensitive explanations of the material would provide full and necessary access when providing health and sexual abuse prevention information to the Deaf population.

**Access to sexual health education.** What is appropriate sexual behavior and what is not appropriate sexual behavior may not be fully understood by Deaf children. LaBarre (1998) states that “the opportunities for teaching sexual information, boundaries and relationships occur for hearing people in their homes often by osmosis or incidental overhearing” (p.322-323). These small instances and opportunities to overhear and learn new information is an essential part of developing boundaries and an understanding of what appropriate sexual boundaries are and, importantly, are not. Deaf children are deprived of these instances with the consequence of the fund of information deficit that plagues the Deaf community.

The greatest deterrent of sexually transmitted disease and sexual abuse is information and knowledge on sex education (The Joint United Nations Programme on HIV/AIDS, 2006). For the Deaf population there is no adequate access to this material in more accessible forms of information or to other health-related material (Pollard & Barnett, 2009; Pollard et al., 2009). In a study mentioned earlier on Deaf and their understanding of HIV conducted by Bisol et al., (2008) a gap was discovered in sexual health knowledge between the Deaf and hearing groups. While there was a similar understanding between groups of how HIV/AIDS were physically transmitted (sex, oral sex, anal sex, etc.), there was a gap in Deaf understanding. Many Deaf participants were inconsistent in their understanding of basic HIV/AIDS knowledge, such as whether transmission is possible between married people, between friends, or between those in a relationship. With the general understanding that the Deaf population does not have proper access to sexual health information, it can be surmised that Deaf children are at greater risk for HIV/AIDs as well as sexual abuse due to the lack of information available to them (Bisol et al., 2008).

The term "Trauma Information Deprivation" has been defined as “an event that is experienced as traumatic or more traumatic because information or knowledge about the event is limited or not available” (Schild & Dalenberg, 2012, p.123). Schild and Dalenberg (2012) found in a sample of 79 Deaf participants (45 women and 34 men) that those participants that had experienced minor earthquakes tended to view them as traumatic despite the lack of physical injury or destruction. The effect of trauma information deprivation caused these participants much distress due to the lack of accessible information and understanding of the traumatic event. This confusion and lack of understanding of what sexual abuse actually is can lead to some serious consequences.

LaBarre (1998) discussed the risk factors for sexual abuse she has observed while working clinically with Deaf clients. She reported that many clients minimize their sexual abuse history or do not raise or mention it as a problem at all. She points out that many of her adult clients that were sexually abused as children at residential schools “reported feeling "chosen" or "special" by a teacher or house parent who sexually abused them; they never considered this relationship abusive” (p. 322). She further explained the normalization of sexual abuse in residential school and the impact that this has when these adult clients learn that sexual abuse is inappropriate and not a “normal” experience. Similarly, in Kvam’s (2009) study with Deaf Norwegian adults, 13% of sexual abuse victims considered the abuse to be consensual and voluntary. Without proper access to understanding what constitutes abuse, Deaf children grow up normalizing their abuse, or something that should be seen as normal due to a lack of access to education and prevention information about CSA.

As previously discussed, the distinctive features of trauma generally include: (a) suddenness; (b) lack of controllability; and (c) negative valence (negative emotions, i.e. anger or

fear) (Carlson & Dalenberg, 2000). The concept of Trauma Information Deprivation can be applied to sexual abuse experiences (Schild & Dalenberg, 2015). The experience of CSA is inherently traumatic, and children who do not have access to information about what is happening to them can increase the consequences of trauma because of the increased lack of controllability in understanding, the suddenness of much of sexual abuse, and the negative emotion about the event when the victim learns more about what was actually done to them as they grow older.

### **Prevention Programs**

**School-based education.** School is where children learn the most about these matters, whether from peers or teachers. Most of the exposure children receive about child sexual abuse prevention occurs in school-based programs (Pulido et al., 2015). Schools provide access to large groups of children and adolescents, which is economical for the school as well as destigmatizes sexual abuse for those students that may have already been victimized or those who are at higher risk (Lynas, & Hawkins, 2017). These school-based programs differ, but the underlying message is to empower children to be able to recognize high-risk situations and improve their ability to keep themselves safe. Importantly, they teach children that they have the right to say no to unwanted touch and to assert themselves with adults and other figures of authority in possibly abusive situations. In addition, this education informs children about who they can talk to if abuse occurs. Most of all, they teach that sexual abuse is never the child's fault (Lynas & Hawkins, 2017).

**Educating parents.** An often neglected area of prevention education is parent or caregiver knowledge of sexual abuse. Parent or caregiver awareness is critical to prevent child sexual abuse as these people are often key figures in a child's life (Walsh & Brandon, 2011).

However, parents themselves may lack the knowledge and information to provide their children. Walsh and Brandon (2011) stated that “providing parents with information about child sexual abuse (for example, about prevalence, seriousness, and perpetrator strategies) has the potential to improve their ability to protect their children” (p. 742). When a parent is equipped with the proper information, he or she is more able to discuss and process that information with his or her children.

In many cases, sexual abuse education in the past focused on “stranger danger,” or the concept that perpetrators were mostly someone the child did not know. This myth has been disproved, as more than 80% of sexual abuse is perpetrated by someone the child knows (Pulido et al., 205). In their study conducted with 30 parents (mostly women aged 19 to 48 who had children aged 0 to 5), the authors found that many parents supported sexual abuse prevention for their children but held concerns about “frightening or corrupting” (Walsh & Brandon, 2012, p.742) with facts about CSA. The authors report an improvement in parental knowledge of sexual abuse when compared to the past and stated that their information was mostly accurate, but the issue was the parents' willingness to discuss these facts with their children, fearing they were too young (Walsh & Brandon, 2012). It is important that parents be able to provide education to their children in order to prevent possible instances of sexual abuse, as well as be aware of the red flags of sexual abuse themselves so they may recognize the signs that their child may be the victim of sexual abuse.

**Media.** Media plays a large role in proliferating information regarding sexual abuse prevention. Since the 1980s, a number of advocacy and community resource groups have attempted to make sexual abuse education more accessible to wider audiences using mass media, including TV, radio, and the internet (Smallbone, Marshall, & Wortley, 2008). These attempts to

inform the public reach hearing parents and hearing children. While these programs and organizations have the well-intentioned idea of bringing more education and prevention to general audiences, there is a gap in the ability for Deaf children and parents to be involved with and have access to these programs. As discussed, in-depth previously, these advocacy programs and media campaigns fall under the “fund of information deficit” heading and are not accessible to Deaf children and Deaf parents.

**The web.** The internet plays a crucial role in disseminating information for hearing parents. A quick google search for CSA and prevention will bring up hundreds of tools and handouts for hearing parents. One such website which provides a plethora of tools and handouts for parents regarding preventing CSA is [www.stopitnow.org](http://www.stopitnow.org). This website has what it calls “tip sheets” filled with information easy for parents to understand. These sheets range from topics as important as *Warning Signs of Possible Sexual Abuse* to *Age Appropriate Sexual Behavior* to tips for *Talking to Children and Teens* about sexual abuse. While this website does have a section for parents with children with disabilities, it does not specify Deaf children.

Another such resource that is highly beneficial to hearing parents is the National Child Traumatic Stress Network (NTCS) which provides guides for parents and caregivers with all the knowledge and facts they may need to know, including a guide titled *Caring for Kids: What Parents Need to Know about Sexual Abuse*. This guide goes through definitions of sexual abuse and other important terms, myths and facts about sexual abuse, and what to do if your child discloses sexual abuse. Lastly, [www.childmind.org](http://www.childmind.org) has informative articles for hearing parents about numerous types of abuse and mental health issues, including an article titled *10 Ways to Teach Your Child the Skills to Prevent Sexual Abuse* that details how and what to say to children about sexual abuse.

While these websites are incredibly useful to parents and caregivers, they are not created with the Deaf community in mind, do not take the vulnerability of Deaf children into account, and are not Deaf friendly for the Deaf parents of Deaf children. There is a great deal of information on the internet that could benefit many parents of Deaf children but is just out of reach.

### **Parent-Child Communication as Prevention**

Communication between parents and children is a vital tool in the prevention of CSA. It is imperative that parents are not only educated about sexual abuse but are willing to communicate with their children about sexual abuse (Walsh & Brandon, 2012). A study conducted with 1,089 mothers in Colombia, with an age range of 15 to 68, found that healthy parental communication was a strong protective factor from CSA experiences. The authors stated that “children from households in which parents regularly ask questions and listen to their children are significantly less likely to become victims of child sexual abuse” (Ramírez, Pinzón-Rondón, & Botero, p. 1029). The authors posit that this increased communication and interaction on a recurring basis provides the parents with insight and the ability to notice and identify the potential risk of CSA. It can also be easier to spot behavior or emotional differences in a victimized child, which is one of the most common red flags for CSA. For Deaf children, this lack of communication with parents is compounded due to language and communication barriers discussed above (Bisol et al. 2008; Sullivan et al.,1978). It is vital that parents of Deaf children develop adequate communication and healthy interactions to become a protective factor for their children.

## **Conclusion**

The limited amount of information and research on the Deaf community compounds with deficits in education, language acquisition, communication, health, and mental health services for the Deaf community. The high rates of sexual abuse in this population tell us that there is a need for more research on this marginalized group. This population is high risk and needs specialized services to combat the continued victimization of Deaf children. It is vital that Deaf children have access to natural language to communicate with caregivers and other adults to facilitate proper communication with those who are responsible for protecting them. The combination of barriers in these fields leads to the victimization of Deaf children and to severe mental health consequences for Deaf adults. Priority should be given to providing Deaf children with access to prevention information, parents or caregivers with access to this same information, *and* to support communication on this topic through the natural language of the Deaf population. There is much debate on the efficacy of the methods of Deaf education, cochlear implantation, language choice, and many other decisions surrounding Deaf children, but one thing remains clear: Deaf children and parents or caregivers need access to accurate, appropriate, and culturally sensitive information about childhood sexual abuse to be able to prevent and mitigate the risk of victimization. This project will attempt to bridge some of these barriers by providing information in a fully accessible manner to parents of Deaf children regardless of hearing status and in American Sign Language.

## Chapter III

### **Introduction**

This project will be in a series of four online videos providing accessible education and prevention information to the parents of Deaf children regardless of their hearing status. The series will be titled *Your Deaf Child* and will cover a variety of topics important to preventing and mitigating sexual abuse. This project will seek to reduce the barriers that surround Deaf children in accessing prevention information. Parent education on sexual abuse is a key factor in being able to protect their children from sexual abuse (Walsh & Brandon, 2011). Communication between a caregiver and a child is an important factor in mitigating the chance of sexual abuse as well as mitigating the effects if CSA has already occurred.

### **Development of Project**

The project will be using the Pollard et al., (2009) method of combining the “from scratch” method and the English translation method to create CSA information from English health education material, but reworked to fit the cultural, social, and linguistic needs of the Deaf community. Due to the dearth of resources for the Deaf population, it is important to gather information from English sources and create Deaf friendly content to educate the parents of Deaf children.

The sources I will use come from mostly English material created for hearing parents or academic journals that describe CSA. The websites I will be pulling CSA prevention information from are dedicated to educating parents and other adults. These websites include: Stopitnow.org, and NTCSN.org. These websites provide parents with a plethora of resources and information about defining sexual abuse, identifying red flags for abuse, talking about it with your children, and other educational handouts or guides to talking about sex and sexual abuse with children.

Stopitnow.org has convenient “tip sheets” on various topics about child sexual abuse prevention and how to talk with children. NTCSN.org has online guidebooks for parents that provide all the facts and information about what child sexual abuse is and what to do if a child is abused.

Hearing parents have access to this information easily, but Deaf parents do not, as the information is all in written English. These websites do not mention deafness and are made for general hearing audiences.

The following steps will be taken to create this video project: I will gather all the information necessary from English material online; I will begin to define child sexual abuse; and then move on to discussing the following: statistics for CSA in the Deaf community, myths that many parents may have been brought up believing, how to talk to your Deaf children about body boundaries, how Deaf culture affects body boundaries, the red flags for identifying child sexual abuse, and what to do if you suspect, or your child discloses sexual abuse.

### **Intended Audience**

The video project will be directed to parents that have Deaf children as well as Deaf parents with hearing children between the ages of 0 and 17, although it may have an added benefit of educating Deaf adults about CSA. As discussed previously, LaBarre (1998) reported that many Deaf adults were unaware that the sexual abuse experience they had as children was abusive or that it was wrong in any way. It may also be beneficial to older Deaf children that may not have parents who are able to communicate with them fully or who not have been exposed to proper sexual abuse prevention education. It would not be appropriate for children under 13 as the video may utilize concepts that are too advanced for that age range, but it will be able to provide caregivers with information regarding how to communicate with children under the age of 13 about CSA.

## **Professional Qualifications**

As a graduate of California State University, Northridge's Deaf Studies Department in 2017, I am equipped with much academic knowledge about the Deaf community and its linguistic needs. I have been practicing ASL since 2014 when I began learning the language in community college. I am uniquely qualified to write and direct this video because of my background in Deaf studies and extensive experience facilitating a court-ordered sexual abuse awareness group for non-offending parents of sexually abused children. I dedicated approximately one-and-a-half years to facilitating this group during my traineeship at the non-profit organization called The Road Ahead Family Services. While I did facilitate other groups, this group was my favorite. The topic of the group, albeit a difficult one, was critically important for these parents to understand in order to actively assist with the rehabilitation of their family following trauma. The parents all had open court cases with the Department of Child and Family Services and were mandated to participate in these group counseling sessions in order to learn about sexual abuse and the signs they may have missed in their traumatized children. In our discussions, many parents explained that they wished they had known the information provided before the sexual abuse occurred so that they could have protected their children better. One parent even said to me, "Every parent should be mandated to take this course when having children *before* something bad happens, then maybe there would be a lot less children that go through this". Although I am uncertain if mandating this course would be appropriate, I believe that every parent should have full and accessible information at their disposal in order to keep their children safe from the tragic consequences of CSA.

## **Environment and Equipment**

I will be utilizing a personal camera, a Nikon D3400, that has the adequate specifications and capabilities to capture ASL as it delivered in a clear video. I hired a Deaf actor and native signer to perform the videos for full compression and fully accessible information to any Deaf or hearing person that understand ASL. There is also a common belief in the Deaf community that it is important and respectful to hire a Deaf actor for Deaf parts, although this video does not talk about the signers hearing status, it is important to respect the Deaf community and including a person who is a part of that community to represent themselves. Ryssa Fleischer, Marriage and Family Therapist Trainee, was the perfect choice to perform these videos. She is a native signer from birth, learned English as her second language, and is also in graduate school to become a mental health therapist for the Deaf community. She is the right person to deliver this important information to her community in a clear, concise, and culturally appropriate way.

## **Project Outline**

### **Video 1 – What is CSA?**

- Define childhood sexual abuse.
- Discuss the difference between physical and nonphysical sexual abuse.
- Provide important statistics related to CSA in the general population and CSA for the Deaf population.
- Provide information about who the perpetrators typically are and how they relate to the child.

### **Video 2 – How to Prevent Child Sexual Abuse**

- Discuss red flags for sexual abuse.

- Discuss what warning signs parents should look for in young children versus adolescent children.
- Discuss physical signs of sexual abuse and the importance of taking the child to a doctor if these signs are noticed.
- Provide information on healthy sexual development and unhealthy sexual development.
- Discuss the common sexual behaviors and the uncommon sexual behaviors.

### **Video 3 – How to talk about sexual abuse with your child?**

- Provide information about what is important to talk about and how to explain it.
- Discuss what body boundaries are and how to explain them to children.
- Provide information about naming body parts and discussing uncomfortable topics with children.
- Discuss how to teach your child to say no to adults if they are uncomfortable.
- Discuss how to use concrete examples when talking about body boundaries with children.
- Discuss how to teach boundaries with different culture.
- Provide information on good touch and bad touch, as well as good secret and bad secrets and include concrete examples of each and when there are exceptions, such as going to the doctor.
- Discuss Deaf culture and the reliance on touch.
- Discuss the importance of understanding good touch and bad touch in Deaf culture.

### **Video 4 – What to do if you suspect abuse?**

- Discuss how to talk to children about suspected abuse. Provide information on staying calm and not asking too many questions.
- Provide information on what to do if the child does disclose sexual abuse.
- Discuss the steps to take after the child discloses sexual abuse.
- Provide information about how to report and how to get help from professionals.

## Chapter IV

### **Summary of Project**

The purpose of this project is to educate the parents of Deaf children about child sexual abuse in an accessible, culturally sensitive way, with broad lingual accessibility. The project will cover basic information about child sexual abuse awareness for parents of Deaf children. It will be divided into four videos that will include a) a definition of child sexual abuse; b) the warning signs and red flags of sexual abuse; c) how to talk to children about body safety and body boundaries to protect themselves from sexual abuse; and d) what to do if there is suspected sexual abuse. These videos are in American Sign Language, with English voice over and closed captions. This allows for full access to Deaf and hearing parents, and it also encourages hearing parents to learn ASL to better support communication and full understanding of the dangers of sexual abuse

### **Recommendations for Implementation of Project**

*Your Deaf Child* can be used in a variety of environments. First, parents will be able to find it on their own online when searching for sexual abuse and Deaf children. This is important because there a lot of information on Deafness on the internet, yet the information may be incorrect, misinformed, and biased. It is important that hearing parents of Deaf children have access to culturally sensitive information, rather than a negative medical model of deafness. In order to find information that is culturally sensitive about the Deaf community, one must first delve into the vast negative discourse the medical community has about the Deaf. The medical model is a perspective of deafness as something that needs to be “fixed” and much time, money, and energy has been poured into this perspective (Edwards, 2012). This means that there is a lot of information online backed by the medical community that puts Deafness in a very negative

light and not as a linguist minority. Secondly, this video can be used to educate parents of Deaf children in an educational setting as well. It can be utilized by Deaf schools and teachers of the Deaf to promote education for parents about sexual abuse and their Deaf child. Lastly, these videos may be used by community mental health agencies, such as Five Acres, a community mental health clinic that has a department dedicated to mental health services for the Deaf in Los Angeles, to educate the parents of Deaf children who participate in mental health services.

### **Recommendation for Further Research**

In general, there is a great need for further research into the Deaf community and their lived experience. There is little to no literature that is culturally sensitive related to the Deaf community and sexual abuse. Ladd (2003) contributes this arduous process of even being able to demonstrate to the academic community that the Deaf community exists as the chief reason there is a “almost total absence of any academic research into Deaf collective life on its own terms” (p. 171). This scarcity of research about Deaf lives in general is problematic, as is the dearth of research about the Deaf population and childhood sexual abuse. Based on the extensive literature review conducted for this project, it is evident that the prevalence of CSA in the Deaf community is varied and inconsistent and largely not well understood. There is great need for more research with the Deaf community and the prevalence, impact, and vulnerability, with regards to CSA. Ideally greater understand of the unique experiences of the Deaf community will be better understood with future research studies that are culturally sensitive and possibly conducted Deaf researchers themselves.

### **Limitation of Project**

As discussed above, there is limited data to support this project. Much of the research and the material used for the videos was not created with the Deaf population in mind. Being unable

to clearly state the prevalence, vulnerability, and impact of CSA on the Deaf community is a limitation.

## **Conclusion**

The Deaf community has long faced many difficulties with education, recognition, access to information, and discrimination. Recently, perspectives and understanding regarding the Deaf community has begun to change. ASL and other signed modalities are used in Deaf education, the Deaf community is protected from discrimination by legislation, and the view of ASL as a more natural and beautiful language can be seen in movies and TV shows. Deafness is not seen as demonic, or less than human. Yet, this change is not nearly enough. It is vital that Deaf education continue to be researched, explored, and transformed to allow Deaf children to grow up in a world that accepts and accommodates their linguistic differences. Deaf children have the right to grow up in a world that advocates and supports their development and education.

Access to fully comprehensible, researched, and culturally sensitive information is something that we, as a society, must be held accountable for. Projects such as this must continue to be created with the Deaf community in mind. Parents, regardless of hearing or Deaf, must have access to education and information about child sexual abuse to be able to protect their children from abuse and to be able to recognize the warning signs and know what to do if abuse occurs. The fact that parents of Deaf children do not have the access to appropriate and specifically made material to support them in increasing their awareness of CSA is a failure of humanity. We have a responsibility to our educate ourselves about the dangers of CSA and we have an obligation to educate others. We must protect the Deaf children and all children from the horrific experience that is child sexual abuse.

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**Appendix**

*Your Deaf Child*

Created by

Julie V Macchiarella

Performed by

Ryssa Fleischer

## **Table of Contents**

Introduction	70
Video 1: What is Child Sexual Abuse?	71
Video 2: How to Prevent Child Sexual Abuse: Warning Signs and Sexual Development	76
Video 3: Talking to Your Child About Safety and Body Boundaries	85
Video 4: What to Do If You Suspect Sexual Abuse	93
Refences	98

## **Introduction**

*Your Deaf Child* is a series of online videos conducted in American Sign Language, written and directed by Julie V Macchiarella, performed by Ryssa Fleischer and interpreted, voiced in English, and captioned by Julie V Macchiarella. These videos seek to educate the parents of Deaf children about childhood sexual abuse and increase awareness about sexual abuse. The series includes four videos that cover a range of topics that are pertinent for parents or caregivers of Deaf children to know about preventing sexual abuse. The first video is titled *What is Sexual Abuse* and details the definition of sexual abuse as well as the relevant statistics for the hearing population and the Deaf population. The next video is titled *How to Prevent Child Abuse: Warning signs and Sexual Development* describes the red flags, behavior changes, and abnormal sexual behavior in children that may suggest to a parent that sexual abuse is occurring. The third video is titled *Talking to Your Child About Safety and Body Boundaries*, which defines body boundaries and goes on to explain the best way to talk to children about staying safe. Lastly, the video titled *What to Do if You Suspect Child Abuse* provides steps for parents to take if they suspect sexual abuse is happening or if their child discloses sexual abuse. All these topics are important to keep children safe and provide parents and caregivers the information needed to be aware that CSA is preventable with good communication, education, and a willingness to discuss topics that may be uncomfortable to talk about.



**Video 1: What is Child Sexual Abuse?**

**Link to video -** <https://www.youtube.com/watch?v=5teICCsWIng&t=3s>



Transcript of voice over:

*Hello parents! You all have Deaf children. Welcome!*

*I want to discuss a really important topic: child sexual abuse.*

*There is really not a lot of information about the Deaf community*

*and sexual abuse, or the experience of Deaf children*

*with sexual abuse, so it's really important that we talk about it.*

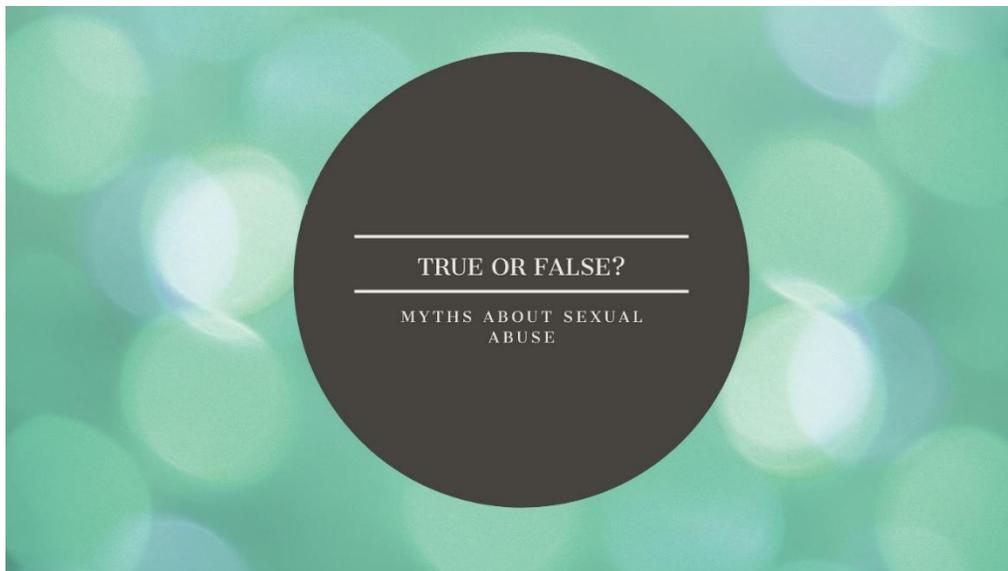
*Child sexual abuse has two kinds: there's touching, and non-touching.*

*Touching is with your body. It is physical.*

*[It includes] Touching genitals vagina, penis, touching anywhere on the body sexually, or sex.*

*Non-touching is when you are exposing children to child pornography or*

*viewing their body in a sexual way anytime there is an adult and a child in a sexual context.*



*[Myth] A child tends to be abused by a stranger.*

*[Fact] False.*

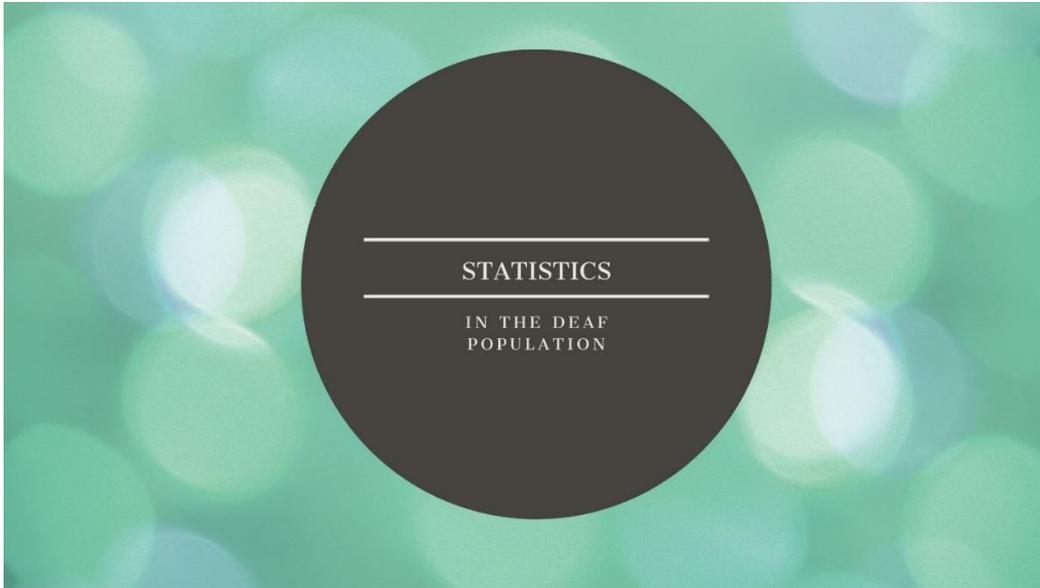
*Really, it's generally somebody that the child knows and trusts.*

*[Myth] The young children that you guys have in school - they really don't need to know about sexual abuse. All that information, you can't teach them, they are too young.*

*[Fact] False.*

*It's really important that at any age you expose them to sexual abuse prevention information.*

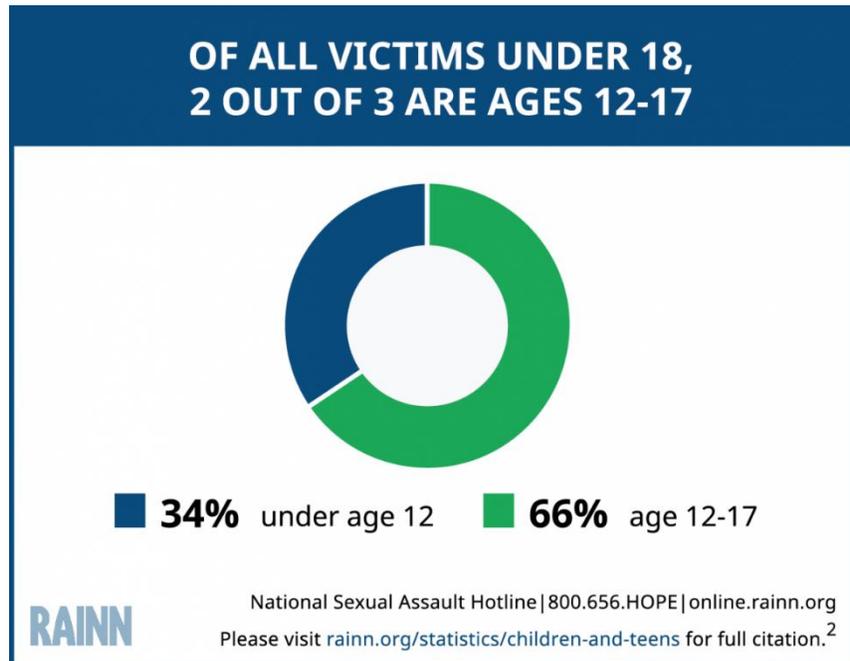
*The earlier the better, because they can absorb it easier.*

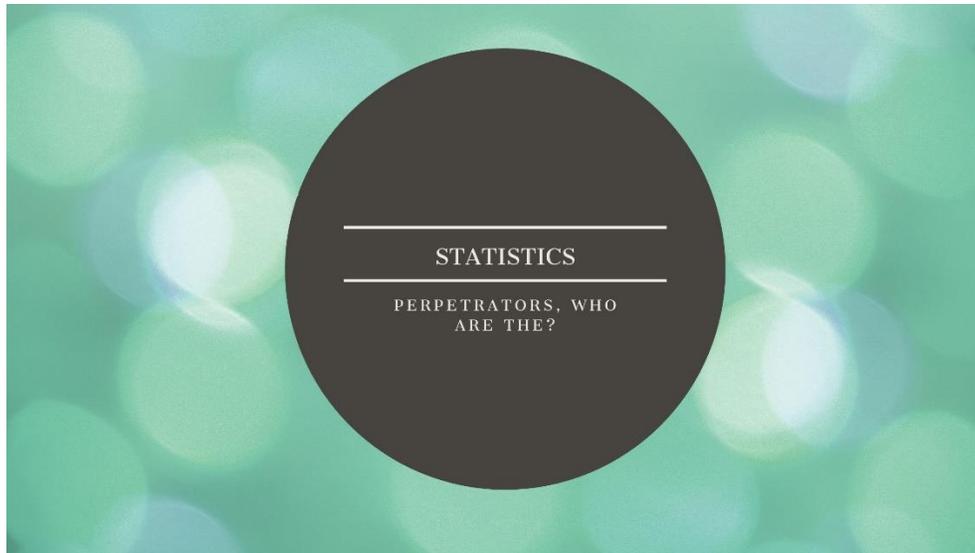


*According to the National Child Trauma and Stress Network, one in four girls and one in six boys experience some kind of sexual abuse before the age of 18.*

*However, child sexual abuse can typically be very secretive, and a lot of cases are not reported.*

*Also, according to RAINN most victims experience sexual abuse between the ages of 12 and 17.*





*As I mentioned before, the child typically knows the abuser and they trust the abuser.*

*Who are they?*

*According to RAINN around 80% of abusers are one of the child's parents,*

*6% are typically a relative, while 5% could be a sibling or stranger, and*

*4% of abusers are the unmarried partner of one of the parents.*

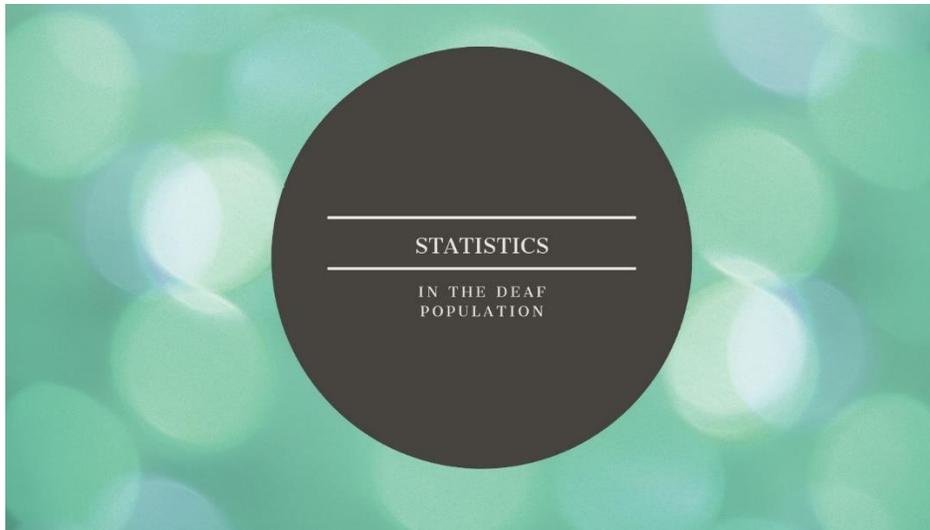
*Abusers are typically someone the parents know and trust as well.*

*This can be really shocking when they find out*

*that it is a family member or parent who abuses the child.*

*It's really important to understand that it can be a family member*

*or somebody that you know and trust.*



*For Deaf people there is really not a lot*

*of data on sexual abuse and that's why I am talking with you.*

*Deaf people typically experience sexual abuse 30% to 50% of the time.*

*Understand [that], compared to the hearing population, that's almost two times the rate of sexual abuse. So far, we've talked about what child sexual abuse is and also how often it happens for the hearing population and the Deaf population.*

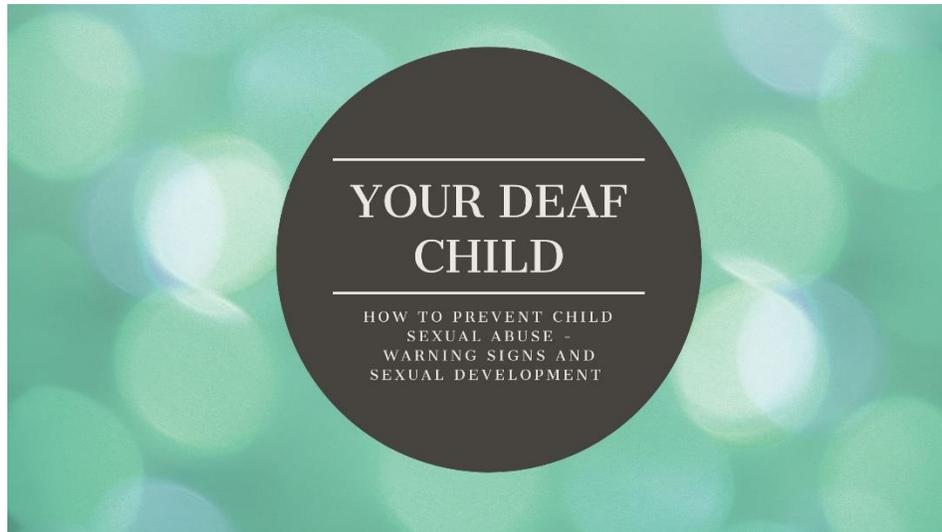
*Our next video will talk about what you, as*

*Parents can do to prevent child sexual abuse.*



## Video 2: How to Prevent Child Sexual Abuse: Warning Signs and Sexual Development

Link to video - <https://www.youtube.com/watch?v=QJwynJWyPII&t=347s>



Transcript of voice over:

*It can be scary to think about your child and sexual abuse but it's really important for you, as parents, to recognize these things in your children, these warning signs, these red flags.*

*Remember that these red flags and warning signs do not necessarily mean sexual abuse.*

*It can be related to school issues or it could be something else, [such as] big life changes, maybe divorce, or bullying. Those kinds of things.*

*But it's still really important for you to notice these signs in your children.*



*For example, their behavior might be different.*

*Maybe they have sleep disturbances – [perhaps] they're not sleeping well and that's not usual.*

*Maybe they seem really distracted or distant. They don't seem to be able to focus and that's not usual for them. That's really key, is that it is not usual, and it shows up.*

*Another example is that maybe they will show you artwork that involves sex and adult content and language and you'll notice that and feel a little weird.*

*There are also mood swings that can come up.*

*You notice their emotions go up and down.*

*There can also be a development of fear in your child of different places or people.*

*For example, you can go to your uncle's house or family's gathering and then all the sudden your child doesn't want to go.*

*We really want to think about why. What's happening there? What's changed?*



*For young children ages 0-13, they can have different behavior changes.*

*For example, a child who is older might show the behavior of a younger child.*

*Other examples are bed wetting, thumb sucking.*

*The child may also have some new words for body parts,*

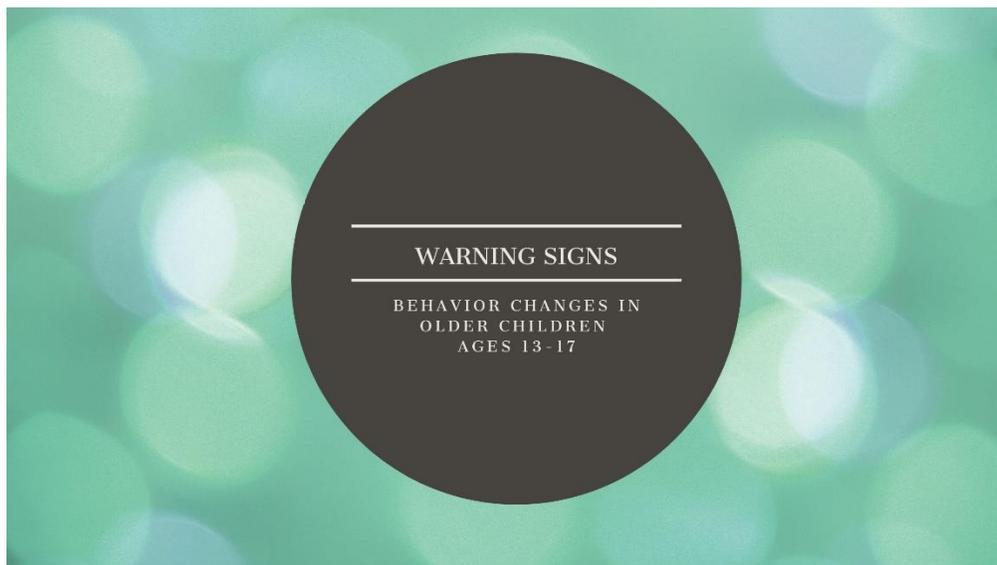
*words that you've never used, or you've never taught them.*

*The child might resist changing clothes at appropriate times.*

*The child might ask other children to play with them sexually or play sexual games.*

*You might also notice adult behavior and you might*

*notice them acting out sexually with stuffed animals or toys.*



*For ages 13-17, the behavior might look a little more severe.*

*For example, self-injury, maybe they will resist showering or brushing teeth or other personal hygiene. You might notice drug or alcohol abuse.*

*You also might notice over-sexualized behavior and running away from home.*

*You might also see suicide attempts or even eating disorders.*

*There are also physical signs in your child that are really concerning.*

*And if you do see this, we want to bring them to a doctor immediately.*

*Some physical concerns can be discharge or genital bleeding in the vagina or penis.*

*If that's a concern you should definitely bring them to a doctor.*

*Other physical concerns can be not being able to hold their bladder and maybe wetting the bed.*

*You should definitely go see a doctor to see what's happening with that.*

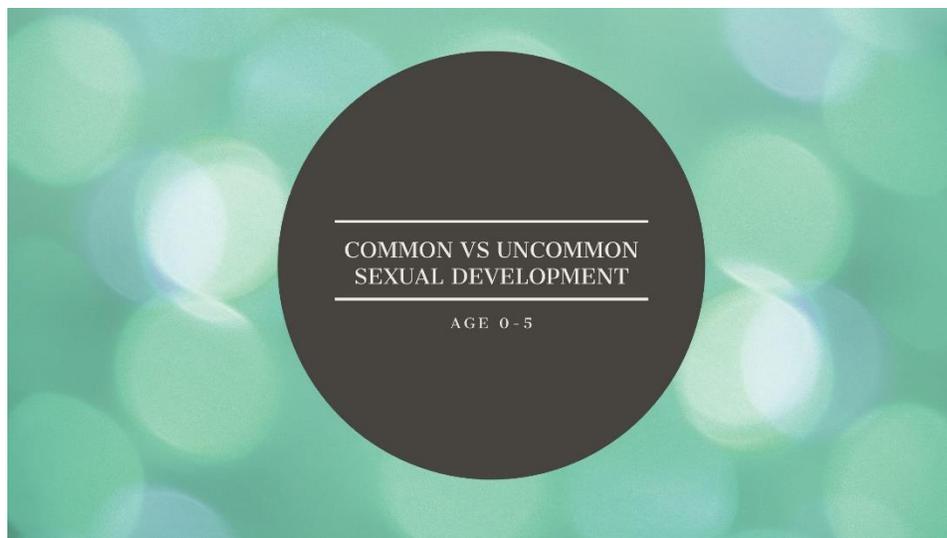
*Noticing these signs doesn't mean sexual abuse.*

*If you notice these physical and behavioral signs, don't always assume sexual abuse is happening.*

*It could be something else, but what's important for [you] is to watch our child and make sure that they are safe and healthy.*



*It's really important for us as parents to recognize the difference between the common and uncommon sexual development in our children because this can really help us identify sexual abuse.*



*Sexual development, common and uncommon, for children ages 0-5 typically looks like curiosity about their bodies, curiosity about their body parts, their vagina or their penis.*

*It's really natural but most parents are really surprised by this.*

*But we have to remember it is natural curiosity.*

*Other common signs are children's curiosity about their body parts.*

*They may ask lots of questions, maybe questions about pregnancy, really basic things.*

*They also might point and show their body parts but that's really normal.*

*Some abnormal, some not common things are having*

*advanced knowledge or language of sexual acts.*



*For ages 6-9, healthy sexual development looks like continued questions about body parts, maybe now questions about menstruation and pregnancy.*

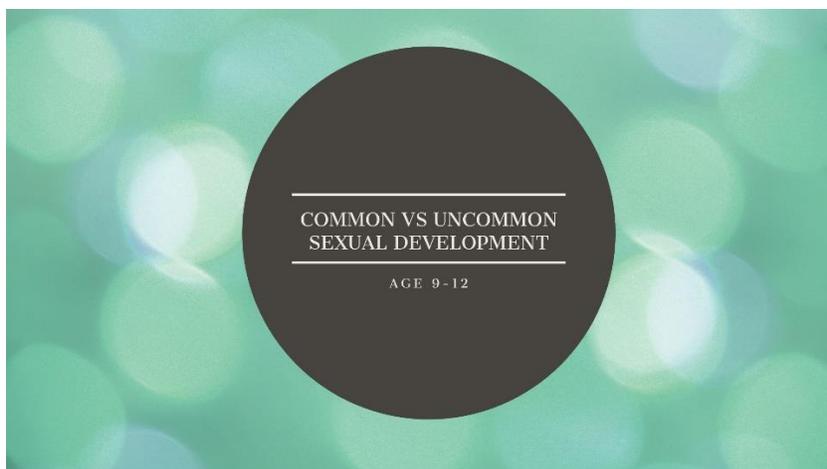
*Also, it will look like curiosity with other children the same age that includes role play games. Maybe things like playing doctor.*

*You also might see self-stimulation, touching, or experimenting.*

*Uncommon signs reference who is touching who and who is using their body parts in public? Maybe watching porn.*

*And definitely having more adult knowledge of sexual acts, words, and terminology.*

*That's important to look out for.*



*For ages 9-12 this is when typically, they start puberty and their bodies are changing, which means you'll see increased interest and awareness about sex.*

*You'll see them pursue romantic relationships and interests.*

*Maybe they'll begin talking about sex with their peers.*

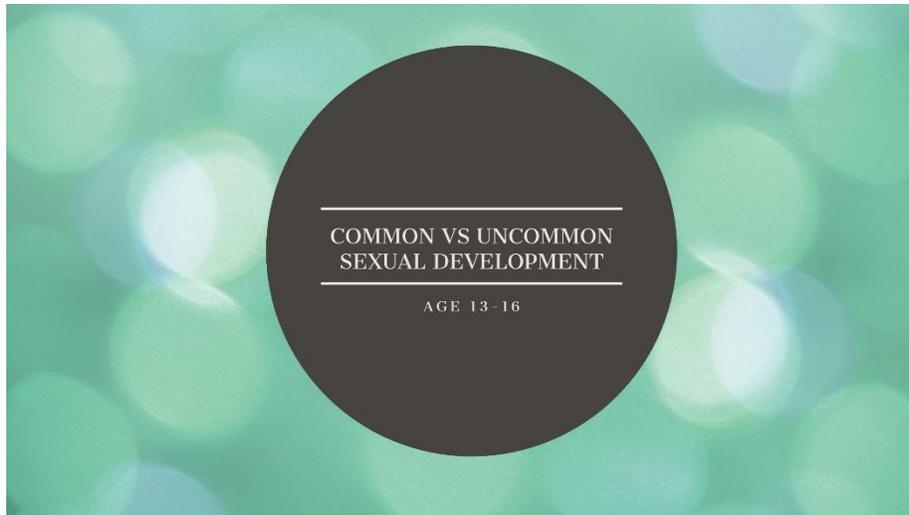
*And you'll really see more in depth discussion about sexual acts themselves.*

*There also might be an increase in self-stimulation or touching in private.*

*Some not uncommon development for*

*this age would be showing their bodies in public or touching themselves in public,*

*and also continued adult behavior.*



*For ages 13-16 you'll see an increase in questions about sexual activity and things like consequences, personal values, and customs about sex.*

*In this age range you'll typically see experimentation with same age and gender peers.*

*During this age range it's also really normal for them to have their first sexual experience.*

*Some uncommon things for this age range is public masturbation and also having interest in younger children.*

*It's really important for our children to understand healthy sexual development, for their safety and their self-esteem. It's really important for them to know about their bodies and their desires and everything else in between because you'll teach them not to be ashamed of their bodies or their experience.*

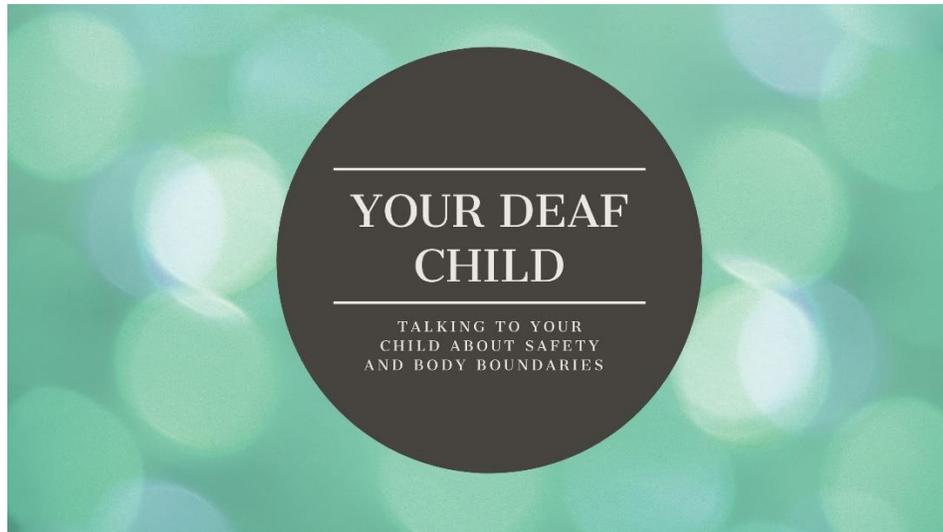
*In the next video we'll talk about how to talk to your child about sexual abuse.*

*What should we say? What should we not say? Those kinds of things.*



### Video 3: Talking to Your Child About Safety and Body Boundaries

Link to video - <https://www.youtube.com/watch?v=hKcrtvba59Y&t=37s>



Transcript of voice over:

*How do you communicate with your Deaf child?*

*You sign. You can use ASL or any other signed languages. You know that*

*it is really important to communicate with your child about safety*

*but sometimes we have concerns about how to start that conversation with you child.*

*What appropriate words, what signs?*

*How do you have an appropriate conversation*

*based on your child's age? It can be hard sometimes.*

*Luckily, there are a lot of online*

*examples and different resources you can pick*

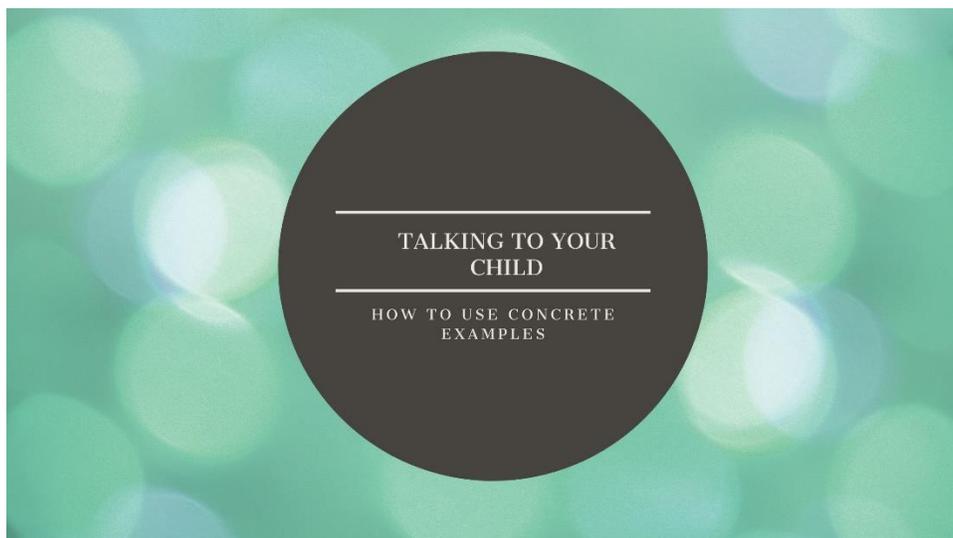
*from for your child. I have another example*

*for you.*

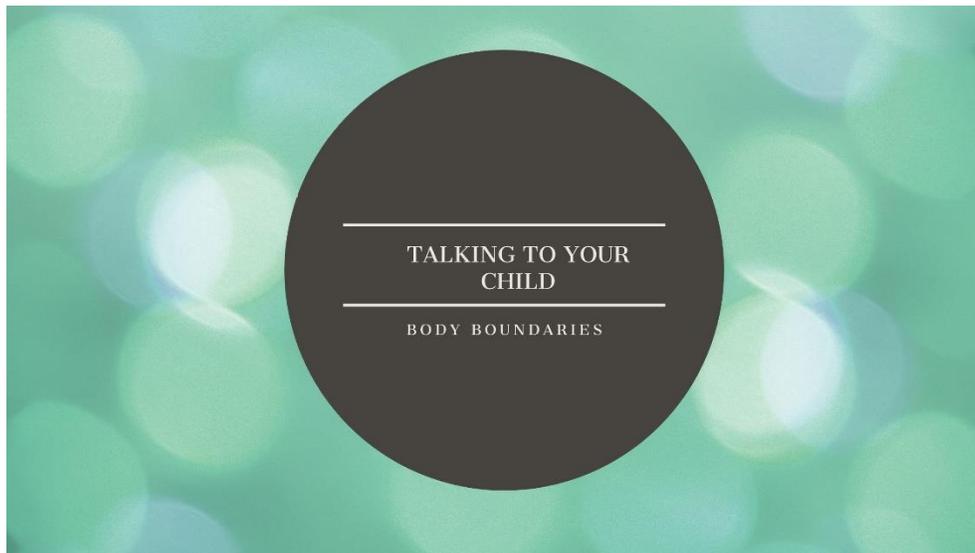
*This book is called "I Said No"*



*and it really relates with child sexual abuse and this book is really good because you can start a conversation with you child, you can read this book. You can read this book together, you can have a conversation, and you can develop a better idea about safety and the concept of child sexual abuse.*



*For over 90% of people who abuse children, typically the child knows who they are.  
Maybe it is somebody they trust, someone from home or from school. It really depends.  
It's really important for you to have conversations with your child and  
these conversations really have to be about concrete examples.  
Some concrete examples could be, like, situations that apply  
to your child's life and real life scenarios.  
For instance, maybe your brother wants to play a game with you  
but it doesn't feel comfortable. In that situation what do you do, what's your best response?*



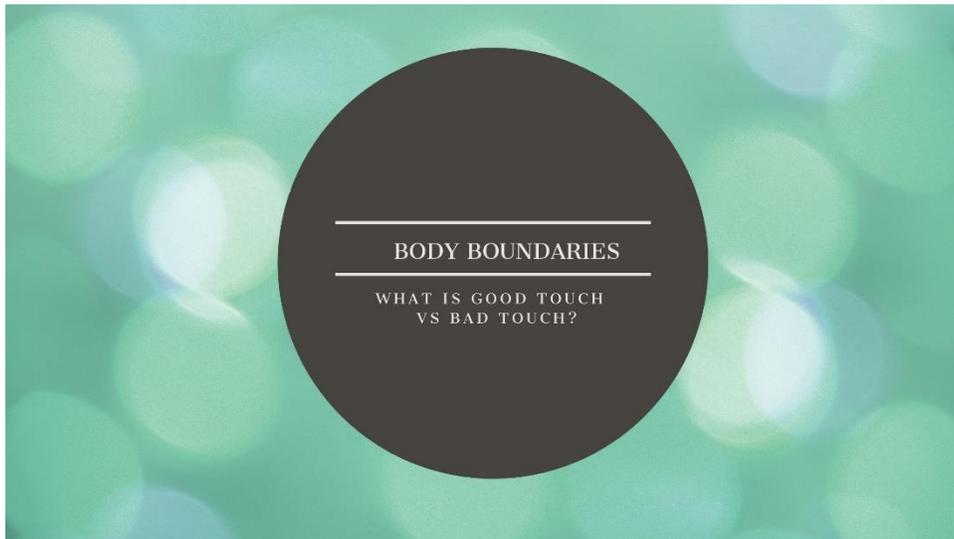
*It's also really important to talk to your child about boundaries.  
For example, sometimes people want hugs or people  
want different kinds of touches that are not comfortable for the child.  
We have to teach them how to say, "please," and "no thank you."  
Teach them those boundary concepts - that their body is  
their body. Some cultures are fine with touch;  
they enjoy hugs and we need to understand their cultural attitudes.*

*It's really important to teach your child how to say no.*

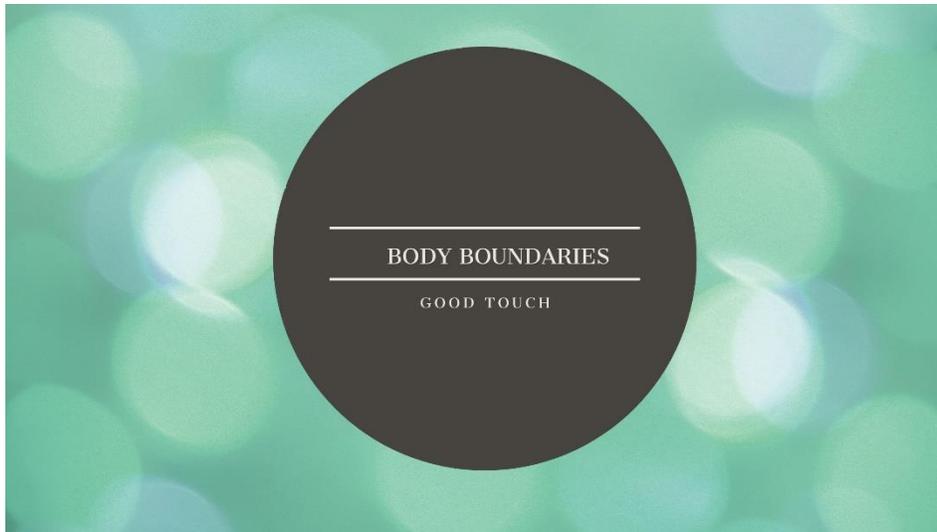
*Saying no to adults sometimes can be hard. It feels uncomfortable, maybe you're not sure how to say no; it feels like there is a power difference. "Can I even say no?".*

*We have to teach our children different ways to show that they are not comfortable and gain respect from adults. A really important part of teaching your children about body boundaries is being okay with naming and labeling the different body parts.*

*We really don't want to confuse them with secrecy and not talking about our bodies and we really want to know that it is okay. These are a part of your body boundaries and it is also part of body positivity. It will help your children develop body positivity later, knowing: this is my body.*



*An important part to remember to prevent child sexual abuse is to make sure you know the difference between "good" and "bad" touch. This really teaches children to respect their body boundaries and respect other people's body boundaries.*



*For example, good touch is part of consent.*

*Your child has to give someone permission to hug them or kiss them.*

*They have to feel comfortable in order for someone to touch the child.*

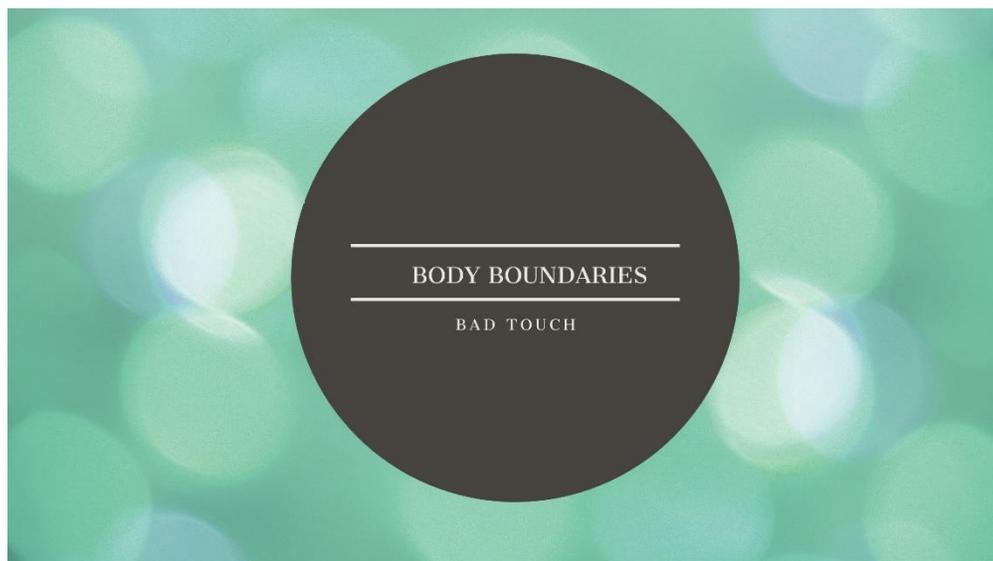
*It's important to teach your child consent now*

*because later it will help them develop a*

*better understanding about body boundaries -*

*their own body boundaries as well as other*

*people's body boundaries.*



*Bad touch is when an older person touches a child, their body parts, or when the child touches the older person's body parts. That it is really not a comfortable touch, so it is important that the child understands what's wrong with a bad touch and be able to recognize what a bad touch is, that this is not a good touch, and that they should be aware of that. It's really important for a child to be able to talk to you about anything that is uncomfortable; any touches that they experience that are uncomfortable. It's part of their comfort ability level.*

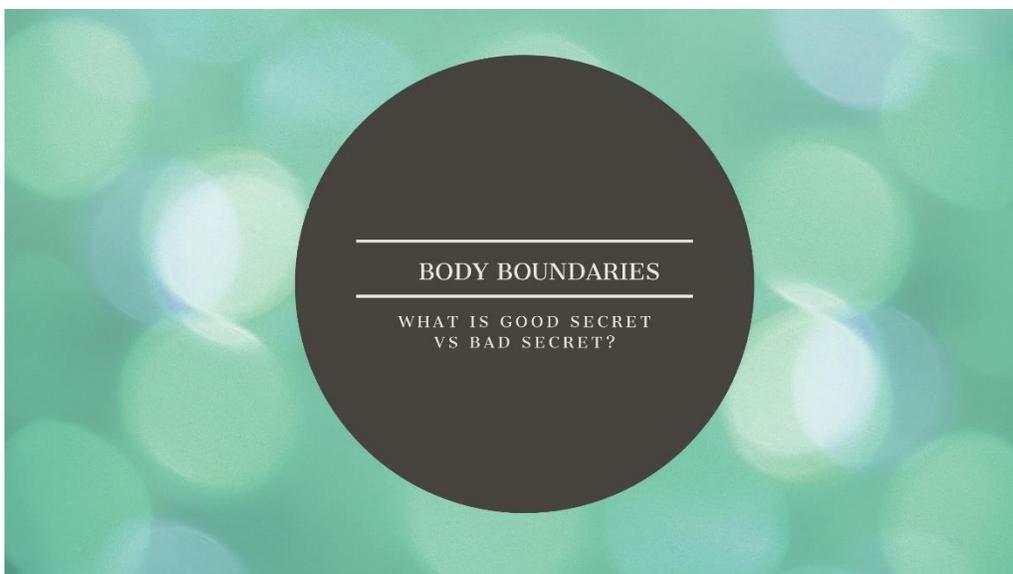
*When your child does talk to you, you want to make sure you don't become angry and that you just listen, and you talk to them.*

*This can be confusing for young children because sometimes adults are required to touch, maybe changing clothes or different things.*

*A child might feel confused about those kinds of touches and understanding what is acceptable.*

*For example, when going to the doctor it is really important that your child knows that touch is a different kind of touch. When a doctor examines your body, they are making sure you are healthy.*

*Any time your child might feel uncomfortable at the doctor, make sure you listen, you understand, and you support them through it.*



*There are other ways to teach your child about safe body boundaries:*

*good secret and bad secret. Good secret, for example,*

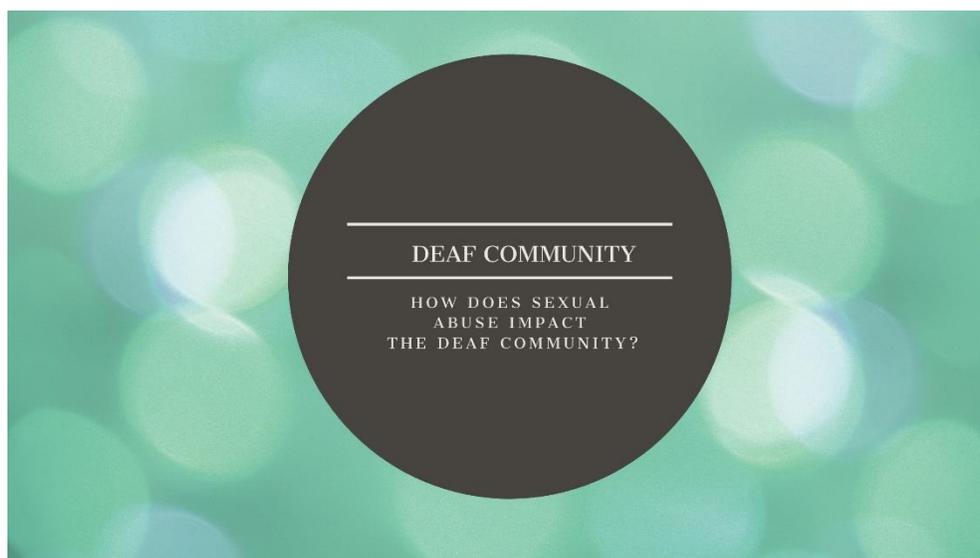
*is when your family is holding a surprise birthday*

*party. The child learns what a secret means but it is a good secret because you get to*

*surprise your family member whose birthday it is. A bad secret means an abuser telling you*

*“don't tell your parents”, “don't tell anyone you trust”, “don't*

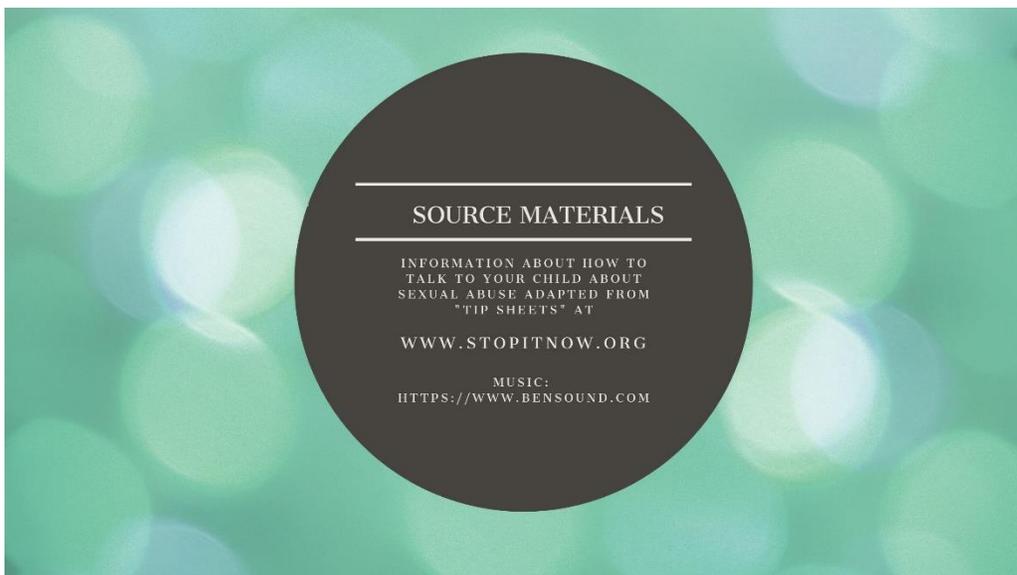
*tell anyone what happened” and really it is taking away your experience.*



*Now it's time to talk about Deaf culture. It's important to be aware that Deaf people have different ways of expressing themselves. Different ways of saying hello, different ways of getting somebody's attention. For example, if a Deaf person is on the other side of the room, you are going to wave your hands up in the air to get their attention, or you are going to walk over and touch their leg, maybe tap their leg, tap their shoulder. There is a lot more reliance on touch. So, it is important to teach your Deaf child that that is okay as a cultural part but also, it's really important to know and understand what good and bad touch is.*

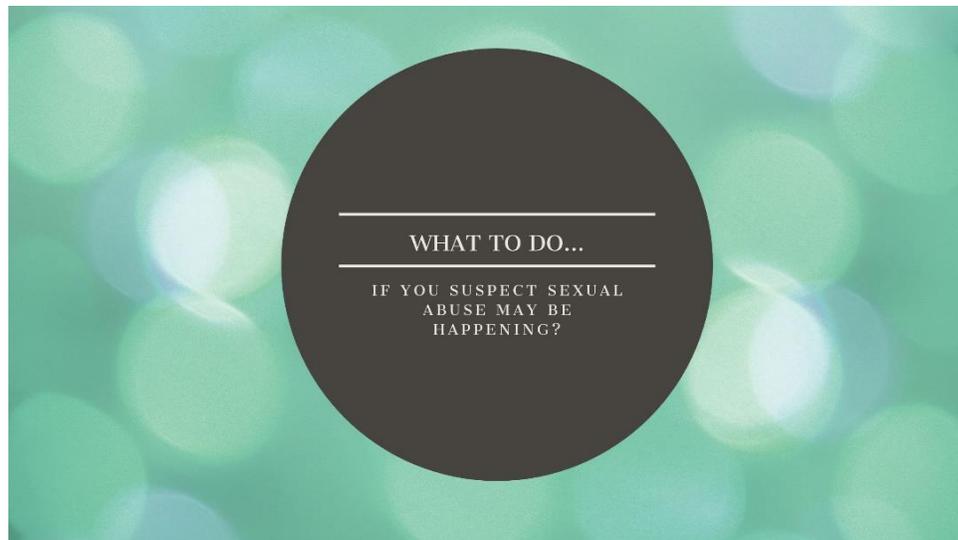
*As parents, it is really important for you to discuss with your children about body boundaries because you will teach them good communication but also, you will teach them to be comfortable talking to you in the future about sexual abuse or uncomfortable touches. Really, communication is the best prevention.*

*In our next video, we will discuss what to do if you suspect sexual abuse.*



## Video 4: What do You do if You Suspect Sexual Abuse?

Link to video - <https://www.youtube.com/watch?v=bvzZgeKzLVg>



Transcript of voice over:

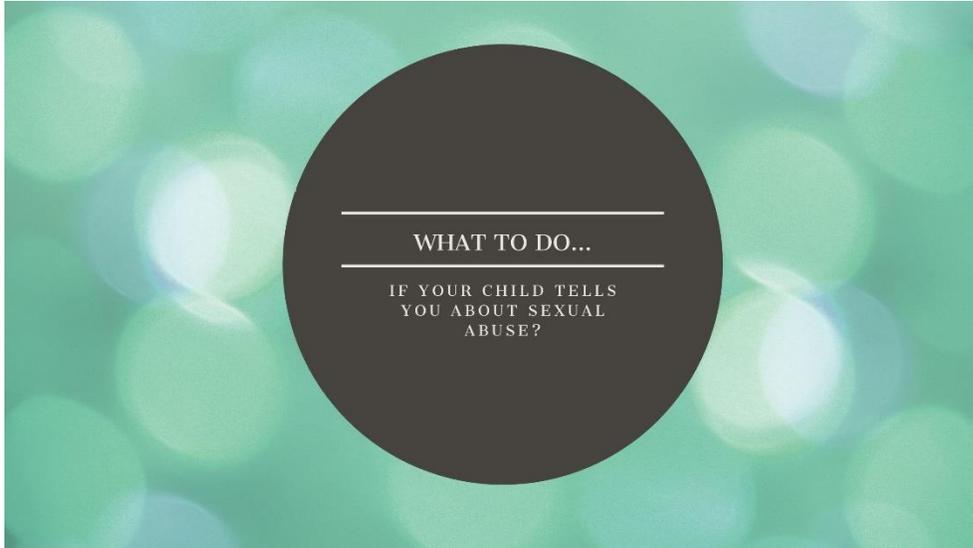
*The first thing you can do is stay calm. I know it is really hard to stay calm because this is a really emotional experience.*

*It can feel overwhelming to know what to do next.*

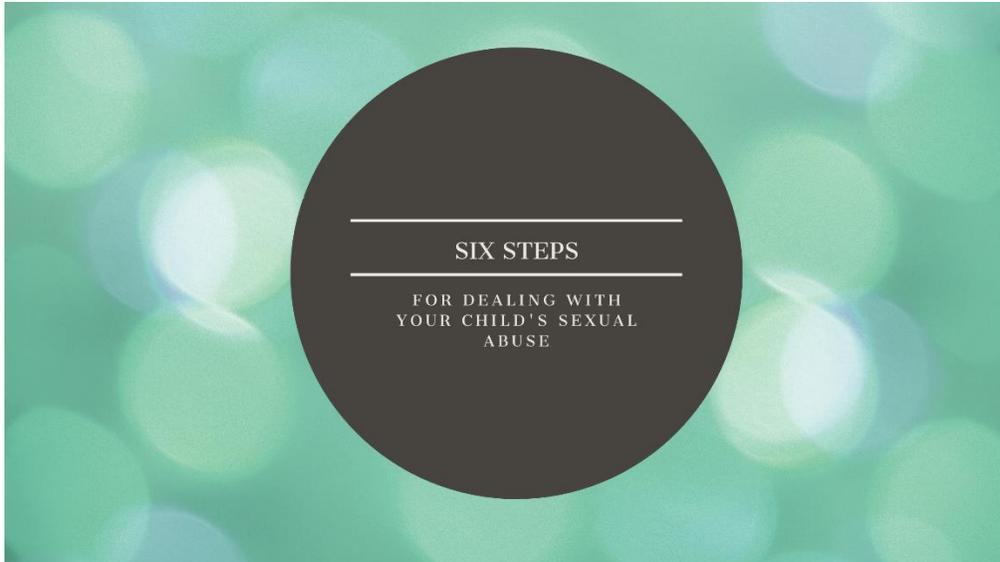
*It's really important for you to make sure your child feels comfortable sharing with you.*

*Just listen. If you ask too many questions,  
the child might resist telling you. They might  
feel they'll get in trouble, maybe feel guilty,  
and they want to protect your feelings also.*

*Make sure that you listen, you talk to them, and support them.*



*If your child opens up about sexual abuse with you,  
make sure you remember that your reaction and your awareness of the situation  
really impacts your child's recovery later.*



*The first step is to make sure you stay calm*

*because if you stay calm it will help your child feel comfortable sharing with you.*

*Make sure that you're aware that your own trauma needs to be processed at a different time.*

*It's important for your child to know that*

*you believe them and you support your child, and that it's never their fault.*

*It's really important for your child's recovery to be able to share with you.*

*Step three: it is important for you to contact 911 if you feel*

*like the situation is dangerous. You can also contact a child abuse hotline in*

*your area. Step number four: it's really important*

*for your child to get medical attention so doctors can examine their body and*

*make sure there's no more information they can gather.*

*It's also important for mental health support.*

*If your area doesn't have a signing therapist,*

*that's okay. You can find an available qualified interpreter for that situation. It's also*

*important for you, as a parent, to get the support that you need in this situation.*

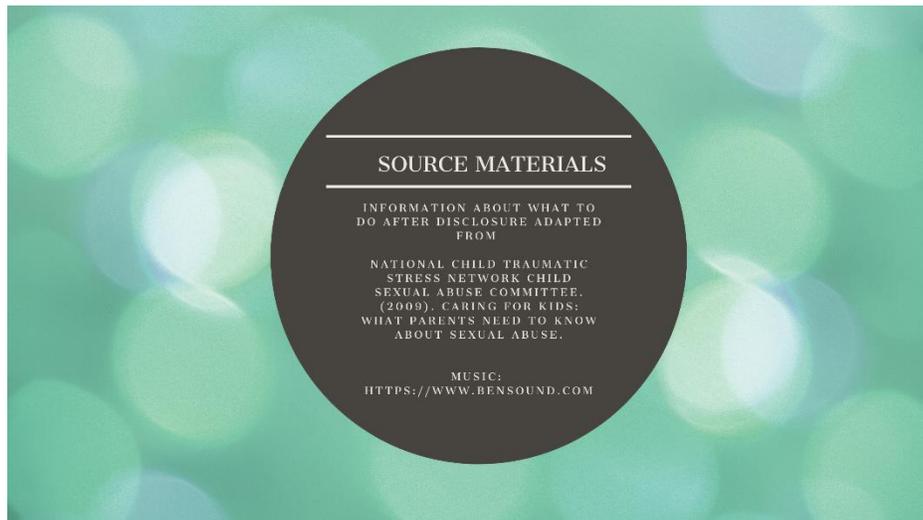
*Step number five: make sure your child knows that you love and support them through this process, But also make sure you don't make any promises based on something you can't do. For example, you can't say "I won't tell anyone about the abuse" because that is not something you can actually keep. You have to share it with other people in order to support your child through this process. For step number six, it's really important for you to inform your child about the different legal processes that are going to happen. Everything that's included. From going to the court, going to the doctor, and different situations to support your child through this. You have to discuss it and let them know: now we're going to court, now we're going over here, and every step, so you can educate your child about what's coming next so they feel safe and they can protect themselves.*



*It is really scary and difficult for everyone in the family to cope with the process of a child being sexually abused. It's really important for your child to understand that this process is difficult. Often, they may feel they have lost trust in the world and lost trust in people because often the abuser is someone they know and trust. So of course, that would destroy their trust in different areas of their life. It's really important for you to be aware of that also. It is important for your child to feel supported through this process 100% by you, as their parent.*

*Thank you all for watching our series of videos about sexual abuse awareness. It's really important for you to continue this education.*

*We hope you feel ready to discuss with your child possible sexual abuse and awareness.*



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