Trauma-Informed Education for d/Deaf and Hard of Hearing Children: Supporting Students Who Need It Most

MIKAH COVELLI
Yale College, New Haven Connecticut

Abstract:
This capstone investigates the potential pedagogical forms that trauma-informed education for mainstreamed d/Deaf and hard of hearing (d/DHH) students can take, and answers this question through two parts: a comprehensive literature review, and a creative project. The literature review investigates trauma experiences within the d/Deaf community; the general face of trauma-informed education in the United States; the impact of mainstream education on d/DHH students; trauma-informed special education; and culturally-competent models of pedagogy, care, and trauma-informed education. The creative project draws on the findings of the literature review to propose a professional development plan for mainstream teachers of the d/Deaf and hard of hearing students with trauma experiences. These plans outline the appropriate goals, objectives, and instructional strategies necessary for hearing teachers to accomplish and meet in order to best support their d/Deaf and hard of hearing students who have experienced trauma.

Terms to Know

deaf: refers to the physical condition of hearing loss, usually at the profound level

Deaf: refers to people who experience hearing loss and are culturally Deaf; they view their deafness as part of their identity, are actively involved in the Deaf community, and prefer to use American Sign Language (ASL) as their primary mode of communication

deaf or Deaf education: the education of students that possess any degree of hearing loss or deafness

Hard of hearing: refers to people with hearing loss that ranges from mild to severe

Mainstreaming: the practice of placing deaf children into the ‘mainstream’ of public schools rather than placing them into residential schools for the Deaf or other Deaf-focused programs

Residential Deaf schools: school for Deaf and hard of hearing students in which students eat, study, and live on campus among their peers during the week, return home for the weekend, and are taught by teachers and staff who are trained in working with students with hearing loss

Day schools for the Deaf: school for Deaf and hard of hearing students in which students attend classes with their peers during the day, are taught by teachers and staff who are trained in working with students with hearing loss, and then return home every afternoon

Trauma: a person’s emotional response to the exposure to an event or series of events that are emotionally disturbing, life threatening, and adversely impactful on the individual’s mental, physical, emotional, social, and/or spiritual functioning and well-being.

Trauma-informed education: a form of teaching that recognizes the prevalence of trauma and the ways that it impacts students’ learning, behavior, and well-being, and also prepares teachers and staff so they can properly support students who have experienced trauma
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**Introduction**

Trauma\(^1\) is highly prevalent in the d/Deaf\(^2\) community. As compared to hearing children, d/DHH children are far more vulnerable to neglect, abuse, and maltreatment (National Child Traumatic Stress Network, 2004). d/Deaf individuals in general are also more likely to have experienced emotional, physical, sexual and mental abuse, as well as physical assault (Johnson et. al., 2018; Schild & Dalenberg, 2012), not to mention the fact that d/Deaf specific traumas, which are traumatic experiences that d/DHH people specifically experience, exist, and have devastating psychosocial and emotional ramifications (Tate, 2012). Despite such a high prevalence of trauma in this community, this community’s access to mental health services and treatment is extremely limited, due to a scarcity of ASL-fluent/Deaf culture-fluent mental health professionals, the communication barriers that arise because of this lack, and the absence of publicization of mental health resources in general within the community (Steinberg, Sullivan, & Loew, 1998; Anderson, Craig, & Ziedonis, 2017).

Clearly, the level of exposure to trauma is quite high, while access to mental health resources is extremely low. This is a significant, unacceptable gap, and a solution must be offered to the d/Deaf and HOH community in the interim, while treatment is made more accessible. But what exactly could breach this gap? An intervention at the community level, a.k.a, at the level of education by way of trauma-informed education\(^3\), could be highly effective, since a slew of trauma-

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\(^1\) See Trauma-Informed Care (2021). See SAMHSA (2014). Trauma is defined as an emotional response that is a response to/consequence of “exposure to an incident or series of events that are emotionally disturbing or life threatening”. Trauma can have “lasting adverse effects” on a person’s mental, physical, emotional, social, and/or spiritual functioning and well-being.

\(^2\) Little d ‘deaf’ refers to a deaf or hard of hearing individual who does not identify with all or any aspects of Deaf culture, or the Deaf community. Little d ‘deaf’ individuals may rely on assistive listening technology, like hearing aids or cochlear implants, and lipreading to communicate rather than American Sign Language (ASL). Big D Deaf individuals have a strong connection to the Deaf community and to Deaf culture, and they primarily use ASL to communicate. Oftentimes, deaf individuals view their deafness as a disability, while Deaf do not.

\(^3\) See Trauma-Informed Education Strategy Guide (2021). The Colorado Department of Education defines Trauma-Informed Education as "a school-wide system that recognizes the prevalence of adverse and traumatic childhood
informed educational models for hearing kids have found great success in improving trauma-related outcomes, like the reduction of students’ trauma symptoms, students’ behavioral improvement, and an overall greater engagement in school (Dorado et. al., 2016; Perry & Daniels, 2016; Parris et. al., 2014). The presence of support built into the classroom environment might have the same powerful effect for d/Deaf and hard of hearing children, through its creation of more opportunities for the healthy processing of trauma.

Despite the great potential for a community-level intervention, research that specifically focuses on trauma-informed education for d/Deaf and hard of hearing students has not yet been conducted. The lack of focus on this area of research defies logic, given that a great deal of research on trauma in the d/Deaf community, and on trauma-informed education in general, exists, and that the prevalence of trauma and lack of accessible treatment in the d/Deaf community is so high. By growing the literature on trauma informed education for d/DHH individuals, we can reduce the harm caused by trauma experiences, since educators can learn how exactly to support students in their journey of processing by providing them with the appropriate tools, environments, and aid necessary for healing. The impossibility of totally eliminating trauma experiences within the d/Deaf community, coupled with the current lack of accessible treatment for d/Deaf and HOH individuals, only emphasizes the need for responsive strategies like trauma-informed education.

All d/Deaf and hard of hearing children are at risk of these types of traumatic experiences, and they all deserve accessible, appropriate services and support. However, this capstone will focus specifically on a subset of d/DHH students that I believe require the most aid: d/Deaf and hard of hearing students who have been placed in the mainstream. Generally speaking, mainstreaming refers to the placement of a d/Deaf or hard of hearing student in an educational experiences and equips teachers and staff with knowledge to recognize trauma and strategies to support students who experience trauma.”
environment full of hearing students, rather than in a school for the Deaf with other d/DHH children. Mainstreaming can be partial or total. In a partially mainstreamed environment, the d/DHH student is enrolled in a hearing school, but has all or most of their classes in a special education classroom with other d/DHH students or other disabled children. In a totally mainstreamed environment, the d/DHH child is placed in a general education classroom comprised of only hearing students (Hands and Voices, 2020; Raising Deaf Kids, 2004). Mainstreaming is accompanied by a number of challenges, as d/DHH kids (especially those who are totally mainstreamed) often face a serious lack of appropriate supports and access to communication. Deaf students may be provided with incompetent interpreters, while deaf/hard of hearing students may be forced to use interpreters they cannot understand or are denied assistive supports like closed captioning. Deprivation from clear and accessible socialization can also occur during mainstreaming, as many d/Deaf express feelings of isolation and separation from their hearing peers due to communication barriers (Foster, 1989).

My focus on mainstreamed d/Deaf and hard of hearing students, and especially those who are fully mainstreamed, can be further understood through personal anecdotes of my experience in mainstream schools, and my experience interning at a school for the Deaf over the past summer. This subject hits very close to home— I was mainstreamed all my life, and never experienced education in a Deaf environment. I found it extremely difficult growing up in a completely Hearing environment, as I was isolated and often set apart from the rest of the student body. While I was lucky enough and fortunate enough to have developed deep, meaningful friendships during high school with individual peers that were willing to meet me in the middle in terms of communication, I still struggled immensely with connection, accessibility, and communication, especially during my early years in elementary and middle school. It felt as if there was an unbroachable, invisible
rift between myself and the other students, one created by the social stigma of being Deaf in a world that is overwhelmingly Hearing, and by the deep shame I experienced as a child due to the perpetuation of stigma from close family members. And then this gap was widened, broadened, and deepened, time and time again, by my constant striving to be part of a world that was always just out of my reach.

The time I spent interning at the American School for the Deaf (ASD) and working one-on-one with d/DHH students only further emphasized the need to provide mainstreamed d/DHH children with support. I witnessed the ways that these students, many who had previously been mainstreamed, grappled with the ramifications of severe social isolation and disconnect, in addition to the preexisting burden of processing their own trauma experiences. These kids displayed serious behavioral challenges that developed in part due to years of being deprived of accessible language, meaningful socialization, and opportunities to develop the coping skills necessary for processing (and managing) their respective traumas and/or other disability experiences. As I worked with these students, I also had countless conversations with other Deaf adults during which we discussed the mainstream experience, and during which I noticed the emergence of a few central themes: loneliness, isolation, and a lack of true understanding and communication.

Simply put, being placed in a mainstream school environment can be very damaging for d/DHH youth. To clarify, I do not intend to portray this educational experience as being entirely negative— I am sure that many a d/Deaf and hard of hearing student has had a positive, fulfilling experience at a mainstream school, and I am still incredibly grateful for the academic opportunities that my mainstream education has provided me. I do emphasize, however, that both the academic literature and lived experiences of d/Deaf and hard of hearing people reflect the resounding
message that mainstreaming has the potential to cause incredible harm, which only compounds with the additional harms that the d/DHH face beyond the classroom. Thus, I have directed the focus of my capstone on trauma-informed education that is intended specifically for mainstreamed d/Deaf and hard of hearing youth.

**Main Research Questions & Scope of Research**

Research Questions to be answered by Literature Review:

- How can educators support the healing and growth of mainstreamed d/DHH students who have experienced trauma, through trauma-informed educational practices?
- What do positive strategies for healing and growth look like for d/DHH students, and how can these strategies be implemented via trauma-informed education?

Research Questions to be answered by Creative Project:

- What does a professional development plan on trauma-informed education for hearing teachers of mainstreamed d/DHH students look like in terms of pedagogy and teacher strategies?

Scope of Research

To answer the above questions about trauma-informed education for the d/DHH, I will dive into a few different areas of research. I will investigate trauma in the d/DHH community, the vulnerabilities of being mainstreamed as a d/DHH student, general trauma-informed education, culturally-competent trauma-informed education, and d/Deaf identity development. My capstone will focus on practices that can help d/DHH children safely process their traumatic experiences within the classroom environment. It will not strive to answer how we can prevent such trauma
from occurring in the first place, nor will it critique the audist, ableist, and oralist systems that contribute to the high prevalence of trauma and disruption of healthy identity development in the d/DHH— to do so would require taking on an additional (or perhaps multiple!) capstone projects.

**Methodology**

I plan to conduct a literature review, and design a professional development plan for teachers of mainstreamed d/DHH students. My literature review will cover the following areas: trauma in the d/Deaf community; deaf education; vulnerabilities associated with being mainstreamed (which are determined via research on student isolation, language deprivation, and language dysfluency in the d/Deaf); trauma-informed education and best practices associated with it; trauma-informed special education (for students with disabilities and special needs); culturally competent TIE; and d/Deaf identity development.

After my literature review is complete, I will create a professional development plan for mainstream teachers of the d/DHH. This professional development plan will draw on my findings from the literature review in order to develop hearing educators’ abilities to recognize the impact and signs of trauma on d/DHH students, and teach them how to appropriately support their students’ trauma processing, socioemotional development, and wellbeing.
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Literature Review

Introduction

The field of research on trauma in d/Deaf populations is quite extensive, and the same can be said about the body of work that focuses on deaf education. However, the literature situated at the intersection of these two domains, by way of trauma-informed education for the d/Deaf, is largely non-existent. This literature review will explore the research encompassing each area of study, and will also highlight the absence of research on trauma-informed educational practices for d/Deaf and hard of hearing students.

Research on Deaf Trauma

Research on d/Deaf trauma experiences typically centers around the greater prevalence of trauma in the d/Deaf community as compared to the hearing population. d/Deaf individuals are more likely to experience physical assault, sexual coercion, and psychological aggression, and d/Deaf children are especially vulnerable to sexual abuse and general maltreatment, at rates much greater than children without disabilities (Tate, 2012; NCTS, 2004). The literature also focuses on the different d/Deaf specific traumas that impact the community, like language deprivation, communicative isolation, and information deprivation trauma (Tate, 2012). The deprivation of language that occurs in d/Deaf people has devastating psychological consequences; such deprivation has been found to be linked to emotional disturbances, diminished optimism, greater motor impulsiveness, and higher distractibility (Archer & Zöller, 2018). Other d/Deaf specific traumas include physical and verbal punishment for using sign language in school environments.

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4 See Tate, 2012. Trauma research does not always recognize d/Deaf-specific traumas, nor does the definition of trauma always succeed at encapsulating d/Deaf trauma experiences. And this failure to recognize how broad the scope of trauma creates a problem: the world's conceptualization of different possibilities for trauma-informed education becomes incredibly hearing-centric, and thus, incredibly limited.
a lack of communication access in schools and hospitals, and zero communication access with parents and family (Anderson et. al., 2016).

Beyond identifying common features and patterns of such trauma experiences, the work on d/Deaf-trauma centers on clinical applications, and how to make treatment more accessible for d/Deaf and HOH clients. A commonly-faced barrier to accessing treatment is communication, and particularly the difficulty of navigating treatment when the practitioner does not sign and lacks knowledge of Deaf culture, and when the Deaf patient is not fluent in English. One study, which examined the perspectives of 54 different Deaf individuals from the Northeastern United States on mental health, illness, and treatment, all expressed that communication was the biggest challenge to accessing treatment; participants stated that mental health professionals who are not fluent in ASL or knowledgeable of Deaf culture often accept “a minimal level of communication with deaf clients that would never be tolerated with hearing patients” (Steinberg, Sullivan, & Loew, 1998), regardless of whether such communication is at the client-clinician level, or through client-interpreter-clinician interactions. The usage of interpreters was also cited as a common barrier, due to the interpreter’s possible incompetency in ASL, their failure to maintain confidentiality, and/or the impact of the interpreter on the client-clinician relationship (Steinberg, Sullivan, & Loew, 1998; Anderson, Craig, & Ziedonis, 2017).

An additional barrier to accessing treatment is a lack of awareness about what treatment is available. Since professionals are not always capable of conducting appropriate community outreach, whether it is due to geographic or lingual limitations, d/Deaf individuals are not aware of the different therapeutic resources they can access (Anderson, Craig, & Ziedonis, 2017). To combat these barriers, the literature recommends community outreach programs to broaden awareness of resources (Steinberg, Sullivan, & Loew, 1998), the development of professionals’
Deaf cultural competency via cultural consultation programs and interactions with the community itself (National Child Traumatic Stress Network, 2006), and the usage of certified interpreters (Deaf interpreters included) (Glickman, 2013).

It is clear that improvements to the clinical process of providing treatment to the d/Deaf community must be made. While the solutions offered up by the literature are crucial to reducing these lingual, communicative, and cultural barriers to treatment, there is also a significant gap in this trauma-focused literature that fails to make sense. The literature has not explored community-level interventions for the d/Deaf and hard of hearing, despite the recognition that most higher-level professional mental health services are inaccessible for this community, and that the majority of d/DHH individuals are put through the education system, which is a readily available vehicle for such community-level care. Mental health supports at the community level, by way of trauma-informed education, are a very clear way to bridge the gap between mental health services and the d/Deaf community, but the literature regarding d/Deaf mental health, trauma, and best practices for treatment is sorely lacking on this particular intervention.

**Research on Deaf Education**

A significant chunk of research in the field of deaf education centers on the disparities between d/Deaf and hard of hearing students, and hearing students, in terms of academic outcomes. d/Deaf students have been identified as performing lower than their hearing peers in language and reading ability on standardized testing, and these levels of performance typically are far below hearing norms (Antia et. al., 2020). d/DHH children have also demonstrated lower reading fluency than hearing students (Antia et. al, 2020a; Easterbrooks & Lederbergh, 2020), and d/Deaf kids have been found to perform mathematically at levels much lower than expected for their age group,
with many being behind on math skills even before beginning formal schooling (Pagliaro & Kritzer, 2013; Kritzer, 2009; Johnson & Mitchell, 2008).

While recognizing these disparities in academic outcomes is crucial to understanding the state of deaf education in the nation at present, it is important to understand that these gaps are just a small part of a much larger picture. There are multiple vulnerabilities that d/Deaf and hard of hearing students are exposed to over the course of their educational lives. Social isolation is a huge problem for disabled students in mainstream environments, and d/Deaf and hard of hearing are not exempt. d/Deaf and hard of hearing students who have been mainstreamed express common experiences of enduring loneliness, severe isolation, and repeated rejection from their hearing peers and the hearing world, all of which can have seriously damaging psychosocial and emotional impacts (Kent, 2003; Most, 2007; Foster, 1989). Language deprivation and language dysfluency is yet another vulnerability that d/DHH children face—these kids begin to experience deprivation of language at a very early age, and can continue being deprived as a result of the inaccessible nature of mainstream classrooms. And finally, a general lack of communication access can worsen both pre-existing (and produce additional) academic disparities between d/Deaf and hearing kids⁵, which subsequently introduces another vulnerability: the stigma that surrounds performing poorly academically as compared to your peers. For the d/Deaf kid who walks into the mainstream classroom already grappling with external trauma, these added vulnerabilities only exacerbate the damage that has been done. By understanding exactly how mainstreaming impacts vulnerable

⁵ See Glickman, 2008; Gulati, 2003; and Hall, Levin, & Anderson, 2017. The underlying factor that drives these academic disparities may very well be language deprivation, which occurs when the deaf child is robbed of exposure to accessible language during critical periods of language acquisition. Such deprivation has devastating effects— it prevents deaf children from developing any foundational language, and subsequently impacts their ability to learn, communicate, and succeed in any academic environment, whether it be hearing or Deaf.
children, we can deepen our understanding of why trauma-informed education for mainstreamed d/DHH students is so necessary.

Social Isolation

Social isolation is defined as “the perceived absence of feeling socially connected,” or the “absence of satisfying social relationships” (London & Ingram, 2018). Generally speaking, social isolation is damaging, and for students who face multiple barriers to communication and forging of connections, such isolation can be devastating. Perceived social isolation has been found to contribute to negative outcomes in attention and cognition, like poorer overall cognitive functioning, more rapid cognitive decline, and worse executive functioning, all of which are crucial to success in the classroom (Cacioppo & Hawkley, 2009). Being isolated can also lead to more depressed thinking and a greater sensitivity to social threats, which in turn, may produce paranoid, negative, and self-defeating social behavior during interactions with others. Within the classroom, these effects can play out as struggles to focus on work at school, to remain motivated to complete assignments, and to participate in the classroom. They can also emerge as vicious cycles in which a student’s experience of being isolated pushes them to assume the worst of their peers and self-isolate in efforts to protect themselves from further social harm.

The need to belong and avoid being isolated is so powerful that students will “exhaust themselves while seeking to satisfy this need and will not be capable of the higher-level functioning needed to excel in school” (London and Ingram, 2018). And given the toll this experience takes on both children’s physical and mental health, such exhaustion is not unreasonable. Social isolation is related to sadness, depression, suicidal thoughts, chronic loneliness, substance abuse, greater levels anxiety, and higher rates of mortality (London & Ingram, 2018; Hawkley & Capitanio, 2015). Socially isolated children also report greater rates of
aggression and hostility (Hymel et. al., 1990, Matthews et. al). Lonely, isolated adolescents also report a larger number of physical health issues than non-lonely children do, with the former group suffering from more frequent stomach aches, headaches, and sleep disturbances (Hawkley & Capitanio, 2015; London & Ingram, 2018).

It is clear that the experience of social isolation takes a heavy toll on young children and adolescents. By worsening mental and physical health outcomes, it increases the work that these students must do to get by in the classroom, since they are grappling with the mental and physical impacts of the isolation itself, while also struggling to reduce such loneliness at the same time. It is important to acknowledge these worrying trends between social isolation, rejection, and loneliness with students’ overall well-being. However, it is even more crucial for educators who work with young children, especially disabled children, to recognize that the above studies have explored these trends in the context of students in general, and have failed to account for the additional layers of social rejection that are more deeply entrenched in a disabled child’s classroom experience. And for the d/Deaf and hard of hearing students in mainstream classrooms, the heavy burden of social isolation is compounded even further by communication barriers that are generated by the inaccessibility nature of hearing spaces, like the challenge of attending to multiple speakers at a time, poor visibility for lipreading, and overly noisy environments.

Language Deprivation and Language Dysfluency

Language deprivation refers to the “chronic lack of full access to a natural language during the critical period of language acquisition”6 (Hall, Levin, & Anderson, 2017). It is another major

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6 See Friedmann & Rusou, 2015. The critical period of language acquisition refers to the child’s first year of life, during which the reception of language input is critical if the child is able to produce and understand language. Exposure to language during this limited time frame can make a world of a difference for a child, in terms of their lingual ability, neurodevelopmental progress, psychological health, and socioemotional wellbeing.
vulnerability that d/Deaf children face, at unacceptable and heartbreakingly frequent rates—90 to 95% of deaf kids are born to hearing families who do not know sign language, meaning that as many as 70% of deaf children may be deprived of language (Dougherty, 2017). When children are faced with such chronic, total deprivation of exposure to language during this crucial first year of their lives, the effects are devastating. They experience severe, long-term delays in neurological development, are unable to develop the language skills necessary to support meaningful, fluent communication, and suffer from an array of psychological symptoms that result from the inability to communicate their emotions, experiences, and thoughts (Hall, Levin, & Anderson, 2017; Gulati, 2018; Gulati, 2003).

Deaf children are subjected to language deprivation due to the pervasive notions of audism⁷, oralism⁸, and medical perspectives on Deafness⁹ that are espoused by a wide variety of professionals, like audiologists, primary care doctors, educators, social workers, and more, as well as the broader hearing community. Oftentimes, these professionals push hearing families to take the route of cochlear implant surgery and intensive speech therapy for the child, as a way to make them as ‘hearing’ as possible (Humphries et. al, 2012; Hecht, 2020). These parents are also told that acquisition of sign language will damage their child’s ability to acquire and develop spoken language (Henner et. al., 2016). And to parents and families with zero previous exposure to sign

⁷ See Gallaudet University Library, 2002. Audism refers to the system of practices, behaviors, beliefs, and attitudes that maintains that those with the ability to hear are automatically superior, more capable, and more able than those who are d/Deaf and hard of hearing. Since audists view life without sound as tragic, they stigmatize and pity the d/DHH, and shun Deaf culture and sign language, while emphasizing the need for d/DHH people to hear and speak.

⁸ See Matthews, 2022. Oralism refers to the system of teaching d/Deaf and hard of hearing people how to communicate through speech and lip-reading, instead of sign language. The sole usage of this educational approach can have devastating ramifications for d/DHH children, as it often deprives these kids of exposure to the one lingual modality that is fully accessible to them: sign. There is nothing wrong with providing spoken language to d/DHH children—but such provision should be accompanied by exposure to accessible sign language.

⁹ The medical perspective of Deafness is the idea that Deafness is a thing to be fixed through intervention, like extensive speech therapy, cochlear implantation, or other efforts. This perspective fails to recognize Deafness as a cultural identity and a gain—it only considers Deafness as a deficit.
language, the Deaf world, or successful Deaf adults, the path that these oralist, audist professionals laud seems to be the only approach possible; these families are told that there are no other options for their children, besides assimilation into the hearing world, and are actively warded away from the beauty and accessibility that the Deaf world and sign provides.

In reality, the advice that these professionals and members of the hearing world promote could not be farther from the truth. Exposure to American Sign Language does not hurt the child or their development at all. In fact, when deaf children are given the chance to learn American Sign Language (ASL) at an early age, during the critical period of language acquisition, they blossom and thrive—deaf kids who were exposed to ASL from birth by Deaf parents demonstrated higher morphology scores than kids that were exposed to ASL later in life, and higher scores than kids who were placed in Deaf schools between 4-6 years of age, which is long, long after the critical period (Hecht, 2020; Hindley, 1999). Deaf babies who were exposed to a signed language from birth passed all the same lingual milestones during early life as hearing babies did with spoken language (Meier, 1991), and Deaf adults who were exposed to sign language in early life were able to develop near-native fluency in a second language, an outcome much better than their language-deprived counterparts, who were unable to develop any fluency in a first or second language at all (Mayberry & Lock, 2003; Mayberry, Lock, & Kazmi, 2002). What’s more, the cochlear implantation that professionals laud so strongly produces dramatically variable outcomes, with no consistent, positive lingual outcomes occurring across the board, much unlike the case with deaf children who have been exposed to ASL from birth or in very early life. Implanted deaf children tend to demonstrate slower, more variable language outcomes than their hearing peers, with some children demonstrating zero ability to clearly express and perceive spoken English,
while others have almost 100% ability to do the same (Hall, Levin, & Anderson, 2017; Humphries et. al., 2012; Hall, Hall, & Caselli 2019)\textsuperscript{10}.

The promotion of such deeply audist and oralist interventional approaches set the stage for language deprivation and language dysfluency\textsuperscript{11}, and generate a slew of devastating consequences for the lingual, psychological, cognitive, and social development of d/DHH children. Children that have been language deprived suffer from a consistent constellation of behavioral patterns and psychiatric outcomes, called language deprivation syndrome (Gulati, 2018; Ryan & Johnson, 2019). Language deprivation syndrome is marked by a “global pattern of behavioral, social, emotional disturbances such as aggression, self-harm, a gross lack of social skills, and poor school performance” (Glickman, 2008). Individuals with this syndrome also tend to display impulsiveness, explosiveness, difficulty to demonstrate empathy, and immaturity, all of which likely stem from being totally and completely deprived of the ability to communicate to and with others about their internal states and experiences (Vernon & Raifman, 1997; Denmark & Warren, 1972; Glickman, 2008). It is important to note that these symptoms have been recorded as occurring in the absence of schizophrenia, conduct disorder, antisocial personality disorder, other psychotic disorders, and mental disabilities (Glickman, 2008), meaning that the deprivation of language is the driving force behind these horrific and devastating psychiatric outcomes.

\textsuperscript{10} To be clear, I have nothing against the usage of cochlear implantation, hearing aids, or speech therapy. I simply emphasize that such assistive technology should not be the only method of approach for d/DHH children. While cochlear implants and similar intervention methods have the potential to bolster language development and overall lingual outcomes in d/Deaf and hard of hearing children, they must be accompanied by exposure to a signed language. The research clearly shows that later exposure to accessible language results in poorer outcomes, and no exposure to accessible language results in horrific outcomes, whereas earlier exposure to accessible lingual modalities is a game changer.

\textsuperscript{11} See Hall, 2017. Language dysfluency is what occurs when a person is not fluent even in their best language. This condition emerges as a highly limited vocabulary, a lack of syntax, disrupted grammar rules/structures, and poor temporal organization in narratives.
Individuals with language deprivation also display a tremendous lack of information about the world, like social norms and current events, and they have impaired executive functioning\textsuperscript{12}—language deprived deaf often experience cognitive delays, poor memory organization, poor life skills, and illiteracy (Hall et. al., 2016; Humphries et. al., 2013). Yet the above outcomes are not the only consequences of being language deprived. The inability of a deaf person to communicate their experiences places them at risk for additional abuse (Humphries et. al., 2016). If the deaf individual lacks a language to communicate instances of abuse, they will be far less likely to report it, and far more likely to continue experiencing that abuse and any emotional/social isolation that might accompany it.

It is clear that language deprivation leaves no stone untouched, as it seriously damages linguistic ability, psychological outcomes, cognitive functioning, and psychosocial well-being. Language deprivation only adds to the painful experiences of social isolation and maltreatment that deaf and hard of hearing children are at greater risk of enduring, not to mention the fact that such deprivation may very well be the root cause of the academic disparities that exist between deaf and hard of hearing children, and their hearing peers. For the language-deprived deaf child that walks into a mainstream classroom with the odds already stacked against them, the need for an empathetic, knowledgeable, and trauma-informed educator becomes even more critical. Without appropriate supports, students like these will continue to remain vulnerable, isolated, and wholly in the dark.

\textsuperscript{12} See Hall et. al., 2016. Deaf individuals who are native signers have demonstrated health, age-normative executive functioning skills, as compared to non-signing deaf, with only a few differences in the areas of inhibition and working memory. What’s more, Deaf kids with exposure to sign from birth have shown much better nonverbal working memory skills, as compared to hearing children, than deaf kids who experienced some language deprivation. It is clear that exposure to an accessible language makes a world of difference.
Research on Trauma-Informed Education (TIE)

Trauma-informed education seeks to understand and recognize the impact that trauma has on students, their learning, and their socioemotional functioning within the classroom. Models of trauma-informed education recognize that schools are “often the primary provider of mental health services for children” (Cavanaugh, 2016), and strive to offer as much knowledge as possible to teachers, staff, administrators, and even families, so they can best support students. These models of education are crucial, and can greatly benefit kids that have and/or are experiencing trauma and chaos in their lives (Dorado et. al., 2016; Shamblin, Graham, & Bianco, 2016). Yet recognition of these benefits can (and should) be accompanied by a careful, critical lens in regard to TIE’s sufficiency. It is crucial to note where trauma-informed education fails to close the gap in regard to disabled students.

The vast majority of trauma-informed research centers around abled students, and the subset of literature that explores trauma-informed special education usually treats disability as a monolith. Disabled children in this literature are usually lumped together as a subset of students that can be served by the same model of TIE, rather than as individuals with unique, divergent needs and trauma experiences. Further, this subpopulation of kids rarely, if at all, mentions d/Deaf and HOH students; the disabilities in question are typically intellectual, developmental, or emotional. In order to understand these gaps in the literature when it comes to disability experiences, we must first explore general trauma-informed education, and then shift to trauma-informed special education.

Children who have dealt with major stressors like trauma, and the persistent, toxic stress that accompanies it, are impacted greatly. They might struggle with emotional self-regulation, verbalizing their feelings, and physical aggression (Walkley & Cox, 2013). And when children are
traumatized, they are also stuck in a state of hypervigilance, which means small occurrences in the classroom, like a change in regular routine or a disruption to normal class schedule, can trigger a major reaction. The major goal of trauma-informed education is to establish a learning environment where these struggling students feel safe, learn how to self-regulate in the event of a trigger, and express their emotional needs effectively and appropriately, all while having the support of professional staff and educators who truly understand trauma and its impact on the developing child (Cavanaugh, 2016). To achieve this, there must be multiple tiers of support designed to meet students of varying levels of need, an organization-wide push for education on trauma, and trauma screening to identify students at risk and in need (Cavanaugh, 2016; Perry & Daniels, 2016; Avery et. al, 2020).

Multi-Tiered Systems of Support

The primary tier of support is the broadest, and consists of universal, system-wide, preventative measures, like informing staff about the signs of trauma and how to reduce stress in the classroom, and continually monitoring students to see if they require additional, secondary support (Phifer & Hull, 2016). At this first tier, trauma-informed strategies can look like the establishment of routine and consistency in the student’s environment, and the usage of Positive Behavioral Intervention and Supports (PBIS) within the classroom (Perry & Daniels, 2016; Chafouleas, 2016). The second tier is more targeted—small group interventions may be used to better help the struggling student. At this tier, psychoeducation about trauma might be used to teach the student about how to better self-regulate, and educators/staff will rely heavily on social support systems to help the child. And at the third level, the most intensive support possible is

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13 For a trauma-informed classroom, the concept of safety refers to the student’s sense and understanding that they will not be subjected to violence, chaos, abuse, or traumatic experiences within the classroom.
provided. Students (and their families) may receive one-on-one therapy, like Cognitive Behavioral Therapy, teachers might receive crisis support, and wrap-around strategies may be put into effect, as the entire community ‘wraps-around’ the child in the domains of family, social life, education, vocational, legal, cultural/spiritual life, medical issues, and safety planning (Philer & Hull, 2016; AMCH, 2022, Perry & Daniels, 2016).

In addition to using multiple tiers of support, models of trauma-informed education also embody an organization-wide movement to become trauma-informed. And the first, most logical step of this process is to teach educators and professional staff about trauma, its signs, and ways to approach it. Teachers are one of the most crucial components in the system of support for the child, since they talk to, work with, and see their students on a daily basis for extended periods of time. If teachers work with students who have trauma histories, but do not strive to become more trauma-informed themselves, they can cause more harm than good by unintentionally triggering students, misreading their signals of stress and anxiety, and failing to provide them with stability and consistency in an environment where they spend the vast majority of their time. When educators are truly trauma-informed, they can use classroom time to not only teach their students, but to also build a trusting relationship with their students, help them develop better strategies for self-regulation, and provide them with opportunities to showcase their strengths and successes.

What Teachers Can Do

With that in mind, the next big question is: what must teachers do? To start, teachers need to establish safety and consistency in their classroom, so as to actively avoid re-traumatization. Teachers can create safety by being clear and intentional about the rules of their classroom. If they establish that “being safe” (and everything that comes along with it) is a key rule of the classroom, students will know they can expect safety, by way of others respecting their boundaries and not
getting physically aggressive or loud with them (Cavanaugh, 2016). To establish consistency, teachers can remind students of transitional changes like classroom switches, lining up, or snack time, and giving them a great deal of time to prepare for these transitions. Teachers can prompt students ahead of such transitions, and coach them through the process of transitioning throughout the day. Consistency can also look like providing students with a visual schedule to refer to, whether it be written on the whiteboard or posted on the wall of the classroom.

Teachers of children with trauma must also recognize the impact of inconsistency, namely, in alterations of routine. In the event that there are changes in a student’s schedule, (e.g. student will be pulled out of class to attend occupational therapy), teachers should tell them far in advance whenever possible, so the child does not feel caught off guard, upset, or shaken by the disruption in usual schedule\textsuperscript{14}. By providing students with consistency, safety, and information ahead of time, teachers can foster the gradual development of their students' ability to cope with change, thus setting them up for future success when they encounter alterations in routine during daily life.

Establishing consistency and safety are just two parts of a much greater process of becoming trauma-responsive. Teachers must be intentional, predictable, and reliable for their students, in every regard possible. There is no such thing as just happening to form a relationship with the child-- the responsibility is on the educator to consistently bridge the gap between them and the student, and build genuine trust.

Teachers can be intentional in the ways they interact with students by deliberately and consistently providing positive interactions that are not contingent on behavior (Cavanaugh, 2016; Minahan, 2019). For example, a teacher can greet the student every morning with a high five and

\textsuperscript{14} This reminds me of my time at ASD to a T. The students’ schedule for the day was listed out on the board with times, so kids knew exactly what was up, at any point in the day. If there were any transitions/changes to the routine, students were informed ahead of time-- their teachers told them far in advance if they had sports or therapy later in the day, in order to avoid blow-ups, outbursts, or emotional derailment during school hours.
the phrase, “It’s so good to see you!” Of course, positive feedback that is behavior-specific (and accompanied by tangible rewards) can help greatly— if students are directly told that one behavior is more desirable than another, they will be more likely to repeat the same behavior in hopes of achieving reward, and eventually alter their behavior overall. However, positive interactions that are unrelated to behavioral or academic progress, like the ‘good morning’ greeting I mentioned above, are crucial for students who struggle with trauma. These kids need to be uplifted, and treated with unconditional positive regard by the adults around them. They must be shown, in a consistent and deliberate manner, that praise and positive energy is not dependent on how perfectly they can behave or how well they perform in school—such goodness is something they intrinsically deserve.

Intentionality also looks like deliberate efforts to build relationships with students. Educators can and should carve out time to talk to their students about matters unrelated to academics and behavior, like discussing a student’s favorite thing to do outside of school, or finding something in common to bond over and discuss (Minahan, 2019). For students with trauma, a little relationship-building can go very far— they can come to see their teacher as an individual beyond an instructor, and as a person they can feel safe with, and trust.

This type of trust and relationship-building can be developed even further by teacher predictability and reliability. Students who have trauma histories are accustomed to chaos due to the nature of their background, and require its exact opposite if they are to thrive emotionally, socially, and academically in school. One way that teachers can practice predictability is by providing predictable, positive attention; they can inform the student that they will check on them at a specific time, whether it be for academic support or a simple check-in, and consistently be available at that time for the student (Minahan, 2019). When educators are predictable and dependable, students learn that the teacher is an adult figure to be trusted, and also learn how to
better self-regulate. Rather than being reactive when they need attention or if they are struggling with an activity in class, students can remain calm and remind themselves that their instructor will be available to talk at the specific, agreed-upon time.

Calmness on the teacher’s part is another crucial element of predictability. When educators remain cool, calm, and collected in the face of a student’s outburst or blow-up, they avoid triggering students any further, thus de-escalate the situation (Walkley & Cox, 2013). Such calmness also demonstrate predictability for the student, and signals that regardless of how they lash out, the educator is still a reliable, dependable, and trustworthy figure– they will not withhold positive regard from the child, even in the event of bad behavior, nor will they respond in an emotionally triggering manner (i.e. with negative affect and reaction). However, this is easier said than done– remaining calm and predictable in the face of such outbursts is very difficult. One key strategy that educators can employ is to remind themselves that their students’ aggression, anger, or negative reactions should not be taken personally– the students are simply reacting the only way they know how, with the only regulatory tools and coping mechanisms they possess to deal with their internal states.

A large part of trauma-informed education and practice is recognizing where students can grow and where students are already strong, particularly in self-regulation, i.e. emotional management. Educators that teach students how to bolster their abilities in this domain, and also provide them with opportunities to showcase the skills they are already strong in, are on the right track to becoming trauma-responsive in the classroom. To improve students’ abilities to regulate their emotions and emotional responses, teachers can utilize structure, encouragement, and rewards (Brunzell, Stokes, and Waters, 2015). By setting limits on undesirable behaviors and coming up with consequences, like the failure to continue working towards a specific reward,
rather than punishments, for such behavior, teachers provide a logical framework for students to situate their negative behaviors. When done consistently, this approach can help students clearly understand that their behaviors are choices that lead to specific consequences. By encouraging and rewarding positive behaviors, teachers further signal to students the behavior-consequence relationship. Through these tactics, students can feel safer in the classroom, since they recognize that their behaviors lead to predictable, logical outcomes, which is an experience that is often lacking in children with trauma histories. Teachers must also provide students with choices for when they are struggling with self-regulation, like the option to go for a walk down the hall if they feel overwhelmed, or an opportunity to chat with trusted staff before, during, and after difficult moments. By ensuring that students possess autonomy in the classroom, students can learn to feel more in-control of their current situation and grow more comfortable with reacting in a more regulated, appropriate manner (Brunzell, Stokes, and Waters, 2015).

In addition to improving skills areas where students are lacking, teachers must also play to students’ strengths by showcasing and emphasizing them whenever possible. This can apply to self-regulatory skills, and beyond. By having students identify their own values, strengths, and positive regulatory skills during activities and class time, teachers create positive emotional experiences for their students, and encourage them to see themselves through a strengths-based lens, rather than a deficit-based one (Brunzell, Stokes, and Waters, 2015). Teachers can also create ‘islands of competence’ for their students, in which they create opportunities for the child to feel competent and capable at some point during the day, perhaps by having them support a peer in an academic area they are strong in, or asking for their aid for a task they can complete successfully (Minahan, 2019).
Clearly, trauma-informed education is multi-fold, with a slew of necessary approaches and tactics that educators and staff can take to address trauma and its impacts in students. The next big question is whether the same model should be applied to disabled students, or if more specialized forms of TIE must be created in order to support student healing and growth.

**Research on Trauma-Informed Special Education**

The core of trauma-informed special education is very similar to general trauma-informed education. Both push for teacher and staff education on trauma, call for intentionality on part of the teachers and staff, utilize relationship building between educators and students, and promote safety and routine in the classroom (Szarkowski & Fogler, 2020; Chudzik, Corr, & Wolowiec-Fisher, 2022). And much like general trauma-informed education, trauma-informed special education also faces similar challenges with implementation of TIE strategies. The absence of school-wide support for TIE (i.e. support for TIE strategies among administrators and co-workers) make it difficult for special education teachers to implement trauma-informed practices, while the lack of consistent teacher and staff training on trauma increases the amount of pressure and stress on these educators, since they are not taught how to best support the students and families they serve (Chudzik, Corr, & Wolowiec-Fisher, 2022).

While there are many similarities between these two forms of trauma-informed education, there is one key difference that we must consider: trauma-informed special education integrates trauma-informed Individualized Educational Plans\(^{15}\) (IEPs) into its approach and seeks to make the IEP process more accessible, more family and student-friendly, and overall more trauma-informed. But first, what are IEPs, and what does the IEP development process look like? We must

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\(^{15}\) See U.S. Department of Education. Also referred to as Individualized Educational Program.
understand the general process of developing such plans for disabled students who have not experienced trauma, in order to grasp what alterations are necessary when designing IEPs for disabled students, like d/Deaf and d/Deaf Plus\(^{16}\) students, who also have trauma experiences.

**Individualized Education Plans (IEPs)**

An IEP is a plan or program designed for a student with an identified disability (or disabilities) that is meant to ensure the student’s access to specialized services and instruction that is carefully tailored to their unique needs\(^{17}\) (University of Washington, 2022). These plans are intended for students attending elementary school or secondary educational institutions, and are designed by a team composed of regular education teachers, special education teachers, parents/family members, advocates/professionals that know the child well, individuals that represent the school system\(^{18}\), representatives of transition services\(^{19}\), and in some cases, the student themselves (U.S. Department of Education, 2019). These team members come together to structure the program appropriately, with a deep consideration of the child’s specific needs.

A student’s IEP typically consists of the student’s current level of educational performance, their progress in terms of general curriculum trajectories and goals, the various services that the student qualifies for and should receive, and the necessary academic accommodations they need to achieve success. Another crucial element of a child’s IEP are the measurable annual goals set

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\(^{16}\) See Hands and Voices, 2017. Deaf Plus refers to d/Deaf children with other disabilities, like d/Deaf kids with vision loss (Deaf Blind), on the Autistic spectrum, and/or with other cognitive/neurodevelopmental and physical disabilities.

\(^{17}\) See Apfed, 2012. See Nemour’s Kids Health, 2022. To qualify for an IEP, the student must have a disability, and their disability must directly (and negatively) impact how they perform in school, in terms of academic, social/emotional, and/or behavioral performance/outcomes.

\(^{18}\) See U.S. Department of Education. School system representatives are able to inform the team about the resources a school system can and cannot provide the child with—without such feedback, a student’s IEP might wind up listing specific services and resources that the school can’t actually provide, creating barriers to student success and development.

\(^{19}\) See U.S. Department of Education. Transition services can delineate the supports and resources that must be put into place in order for the child to thrive beyond the parameters of secondary education, especially if the child is aging out of the system (and no longer receives IEP or school system benefits).
for them by their IEP team. A student’s measurable annual goals are statements that identify the specific skills, knowledge, and behaviors that the child is expected to demonstrate between the time the IEP is implemented, and the next scheduled review of the IEP (NASET, 2019). Such goals should be meaningful, challenging, and most importantly, measurable, in that they can be quantified and periodically evaluated with a set of specific criteria (e.g. a goal of “student will request breaks from work when they feel overwhelmed,” rather than “student will not walk out of the classroom when they feel overwhelmed”). In clearly outlining the objectives for the student’s future academic performance and educational development, these annual goals also include a series of benchmarks that lead up to the achievement of these aims.

Trauma-informed special education takes these annual goals a step further by integrating an understanding of trauma into their creation. Rather than centering the IEP’s goals around behavior reduction, trauma-informed IEP goals call for a shift in perspective. The goals are designed with the student’s various triggers and stressors in mind, and with an understanding that the undesirable behavior reflects a deficit in skill (e.g. a deficit in coping skills) (Rossen, 2018; Zee, Esquire, & Fennick, 2019). Thus, the mere reduction of the behavior itself does not tackle the real issue. A trauma-informed IEP team designs annual goals that target these skill deficits in order to facilitate behavioral improvement. Goals can include the fostering of skills and activities unrelated to academic achievement, like a focus on improving the child’s social relationships with their peers, or the development of specific self-regulation skills through the teaching and modeling of appropriate coping strategies for the child (Rossen, 2018). For example, if a student tends to flee the classroom when they become triggered, educators should not force them to stay in the room the next time they are overwhelmed—all this approach does is rob the child of the singular coping skill they possess for moments of distress. Instead, educators (and other support staff)
should foster the usage of alternative coping skills, like communicating to their teacher that they require a break or by introducing new self-soothing strategies (e.g. taking a walk, using art for self-expression).

Trauma-informed perspectives also apply to other facets of the IEP process, such as assessments and interactions with families. Before any type of IEP plan can be drafted, whether it is a general or trauma-informed plan, students must be assessed to determine whether they possess a qualifying disability and are eligible for special education services (DREDF, 2021). Trauma-informed assessments ensure that all steps of this process are carried out with a clear understanding of how trauma histories can impact the student’s performance during the assessment and more generally, (i.e. within the classroom) (Rossen, 2018). Such assessments consider the student’s family history, potential triggers, and areas of strength, as well as the opinions of the child’s educators, practitioners, and the child themselves, and consider the potential impact of each of these factors when screening the student.

Of course, the inclusion of trauma-informed assessments may very well be for naught if providers, educators, and team members fail to make families and parents feel comfortable, safe, and secure during the IEP process. After experiencing trauma, families may feel overwhelmed and alone, and can experience continued discord within the family unit, posttraumatic stress symptoms, and intense difficulty with functioning normally as a family (NCTSN, 2011). With this in mind, it

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20 See Rossen, 2018. So far, trauma-informed IEPs appear to be the most prevalent approach to making special education more supportive of students with trauma histories, as there are no real supports or resources already built into the system for students like these. The Individuals with Disabilities Act (IDEA) has only one section (Title 1, Part C) that acknowledges trauma and trauma services, and it focuses on early intervention services for babies and toddlers without consideration of older children who may require trauma-informed services as well. This lack of consideration is unacceptable and illogical— if you examine statistics on trauma and disabled children, it is clear that these kids (d/Deaf and HOH included!) are at a greater risk of experiencing abuse and trauma. The provision of trauma-informed services to all students via the IDEA should be a no-brainer, and yet, trauma-informed IEPs are the only vehicle for such services as it stands today.

21 Triggers can refer to specific behaviors, certain environments, types of interactions, specific people, and transitory/predictable life events, such a loved one’s death anniversary, major holidays, or changing residences.
is crucial that IEP team members ensure the family’s comfort, especially since the IEP process directly addresses trauma in its discussion of the child and their needs as they relate to trauma. A child’s IEP team can ensure that the IEP process is trauma-informed by clearly communicating with parents and families about their own and their child’s legal rights, as well as when the IEP meetings will take place, which topics that will be covered during the meeting, and who exactly will be in attendance (Rossen, 2018). This mirrors the tenet of trauma-informed education that seeks to establish predictability for students, and ensure they know what to expect when walking into potentially overwhelming situations.

IEP team members can also encourage parents and family members to participate in the meeting itself, in order to demonstrate that their input and their opinions are valued and important to the process, as well as provide them with ample time to voice questions before, during, and after IEP meetings. Following up about post-meeting plans for students is also key to making families feel comfortable, as is the team’s consideration of how the physical meeting space might feel for families; the team can ensure that the meeting room is oriented in such a way that it feels welcoming, non-intimidating, and safe.

When carried out appropriately, trauma-informed special education appears to have the potential to serve disabled students with trauma histories, as well as their families, in a competent, appropriate manner. It draws on many of the same tenets of general trauma-informed education, which are designed to address the whole child, and includes these principles in accommodations processes that families with disabled children face on a regular basis as they navigate the education system. This integration of trauma-informed practices into disability specific processes is key, and demonstrates a bridging of the gap between the educational experiences of students in general education, and those of students with a disability.
It is crucial to recognize the ways that trauma-informed special education can be utilized by educators and professionals to best support d/Deaf and hard of hearing children. However, it is not the only form of TIE worth examining as we hold the question of d/DHH trauma-informed education in mind. We must recognize that additional layers of cultural and linguistic diversity also impact the d/DHH child’s experience in the classroom and beyond, especially as they relate to experiences of trauma, and that these experiences should be taken into consideration via culturally-competent models of TIE.

**Research on Culturally Competent Trauma-Informed Education**

It is crucial to understand what culturally-competent trauma-informed education for d/Deaf students might look like in terms of pedagogy and curriculum, because the d/Deaf and hard of hearing experience is not, and has never been, limited to White d/Deaf students. d/Deaf and hard of hearing children of color do exist, and their lived experiences, which are unique to those of White d/DHH children due to additional cultural and lingual nuances that they navigate alongside their d/Deafness, have not been given the recognition and acknowledgement they deserve in either social settings or in academia (Leigh, 2017). The lack of focus on the experiences of d/Deaf and hard of hearing people of color speak to a broader, pervasive issue within the Deaf community: the tendency to homogenize the d/Deaf experience as being White and Deaf, and the assumption that Deafness as an identity automatically supersedes or ‘cancels out’ all other additional identities an individual has (Stapleton, 2015; Parasnis, 2012). d/Deaf and hard of hearing students of color come from diverse cultural and lingual backgrounds, and these backgrounds definitely influence their lived experiences as d/Deaf individuals, since they must navigate racism, discrimination, systematic oppression, and cultural beliefs and attitudes on disability/Deafness, all in addition to
the audism, oralism, and ableism that are already common themes of the d/Deaf experience (Leigh, 2017; Anderson & Miller, 2014; Stapleton, 2015). Since the literature that explores the experiences of BIPOC d/DHH adults and youth is still growing, teachers and educators unfortunately do not have a robust body of work to refer to when they strive to understand the specific needs their d/DHH BIPOC students may have. Thus, culturally competent trauma-informed education, culturally responsive pedagogy, and culturally competent trauma-informed care are three crucial areas of research that can inform educators on best practices on how to support culturally and lingually diverse students more generally, in addition to the community work they should be carrying out to determine how to best support their d/DHH BIPOC students.

Culturally competent trauma-informed education is a form of trauma-informed education which utilizes compassionate, culturally-responsive approaches when working with students who have experienced trauma. This model recognizes the prevalence and impact of trauma for children of culturally and lingually diverse, who experience trauma and Adverse Childhood Experiences (ACEs) at rates disproportionately higher than the national average (Hurless & Na Young Kong, 2021; Sacks & Murphy, 2018). Culturally competent trauma-informed education also acknowledges the impact of trauma on school staff, families, and communities (Blitz, Anderson, & Saastamoinen, 2016), and considers how the healing of growth of individual children can be connected back to the healing, growth, and perceptions of the communities these students are part of. To fully understand what forms culturally competent trauma-informed education can take, we must examine the principles of culturally responsive pedagogy and of culturally competent trauma-informed care, since each of these models address the educational needs and psychosocioemotional needs, respectively, of students, especially in the context of cultural, social, and historical experiences specific to children of culturally and lingually diverse backgrounds.
Culturally Responsive Pedagogy

Culturally responsive pedagogy is a form of education that recognizes the lived experiences and realities that students of color face, acknowledges the ways that systems of racism and discrimination impact children and the way that they learn, and engages in teaching that runs directly contrary to the status quo of systems of oppression (Ladson-Billings, 1995). This type of education places the empowerment of students and communities at the fore, and strives to create a healthy, healing, and positive learning experience for these students, via appropriate, culturally-competent curriculum and pedagogical practice (Ladson-Billings, 1992; Ladson-Billings; 1995). Culturally competent pedagogy also strives to teach students how to recognize and challenge the social oppressions that they experience on a daily basis, transforming students from consumers of information, into critical thinkers that understand how to oppose the sociopolitical systems of oppression at work around them (Blitz et. al., 2016).

Clearly, this type of education has a number of significant goals it seeks to achieve for the children it serves. But how exactly do culturally competent educators go about doing this? In order to foster such development, teachers must bolster students’ academic success, students’ cultural competence, and students’ critical consciousness, as well as also adopt specific teaching strategies that bolster the educator’s own cultural competence and awareness (Ladson-Billings, 1995; Milner, 2011). First, educators must foster student academic success and generate opportunities through which students can succeed in the domains of literacy, numeracy, technology, politics, and socialization (Ladson-Billings, 1995). By creating opportunities for students to excel, educators can foster students’ feelings of competence, confidence, and self-esteem, all which promotes future academic successes and also bolsters students’ abilities to fight the status quo.
Keeping in line with being culturally responsive, teachers must also promote their students’ development and maintenance of cultural competence. In other words, students must learn how to value, appreciate, and understand their own “culture, traditions, and cultural systems of knowing the world” while also developing their ability to access and engage with the dominant culture’s ways of knowing, communicating, and transmitting information (Milner, 2011). Educators can foster such appreciation and recognition by integrating students’ culture into their learning. This might look like a poetry analysis workshop that uses rap music as a model of analysis, or a lesson on chemical transformation that bakes specific traditional foods to show chemical processes. Educators can also incorporate students’ home languages into classroom learning, and support their ability to communicate ideas in both their home languages, and in the dominant language, in order to emphasize the value and capability of each language (Milner, 2011). Finally, culturally competent educators must encourage and develop students’ critical consciousnesses, which refers to their ability to engage with each other, with the content they learn within the classroom, and with the world as a whole, in a critical, thoughtful manner (Ladson-Billings, 1995). Children must learn how to move beyond the simple consumption and regurgitation of information they learn, especially when such information relates to systems of power, money, and resources. Instead, they must be taught how to actively criticize this information, the sources it comes from, and the ramifications of the current societal systems (Milner, 2011). Teachers can achieve this by posing critical questions, encouraging students to voice their own thoughts, opinions, and perspectives on

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22 This tenet of culturally competent pedagogy is especially applicable to Deaf students who have been exposed to the oralist and audist notions that ASL is inferior to spoken English. By supporting students’ abilities to express and share complex ideas and thoughts in their native language, especially in an academic setting, teachers can help transform their students’ perspectives on sign languages. It could enable students to take pride in ASL, and do away with audist notions that English is the only language they can ‘be smart in’.
material learned within the classroom, and allowing for the subversion of the typical teacher-
student/learned-learner relationship (i.e. students can be teachers, and teachers can be learners).

At the same time as educators are developing the above domains of learning, they must also embody care, empathy, and self-awareness, in order to truly teach in a culturally responsive manner (Rychly & Graves, 2012). Teachers must demonstrate genuine empathy and care—they must be capable of understanding the classroom from the student’s perspective, and be willing to push students to achieve as much as possible, all out of a genuine desire to see them grow, flourish, and succeed. Self-awareness on part of the teacher is also crucial. Teachers must be cognizant of their own attitudes, beliefs, and biases about other cultures, do the self-work necessary to dismantle any biases, and also understand that there is a great deal of additional learning to be done for them to become more culturally-aware—they must learn, not only about cultural traditions, food, and values, but also understand the different learning and communication styles that exist across different cultures (Rychly & Graves, 2012). Finally, teachers must acknowledge their own cultural blindness, which refers to any policies, practices, or behaviors that they engage in, within and outside the classroom, which ignores cultural differences and erases nuances in teachings about diverse cultures, languages, and communities.

Culturally Competent Trauma-Informed Care

Culturally competent trauma-informed care refers to the provision of care in medical or psychiatric settings by professionals who are cognizant of the signs, impacts, and effects of trauma on the individual, as well as the ways in which different cultural, ethnic, and lingual backgrounds can influence a patient’s experience with trauma, with medical professionals, and the recovery process (Butler, Critelli, & Rinfrette, 2011). This type of trauma-informed care seeks to empower clients, avoid retraumatizing them, and foster the development of a positive relationship between
the client and practitioner (Ardino, 2014). Much like culturally responsive pedagogy, respect and relationship building are crucial components of culturally responsive trauma-informed care, as practitioners must develop relationships with their clients that are grounded in respect for these individual and their cultures (Muñoz, 2017). Practitioners must also ensure that they embody cultural humility. In other words, the clinician must recognize that they are not the expert on their clients’ cultures, and that they must assume a life-long responsibility for learning about client’s background, cultural identity, cultural norms, and experiences, namely through active engagement with the client and with the community that they come from (Tervalon & Murray-Garcia, 1998). Finally, medical professionals must establish and promote safety, trustworthiness, collaboration, predictability, and client empowerment during every interaction they have with their clients, in order to foster the healing and recovery of those they (Butler, Critelli, & Rinfrette, 2011).

Culturally Competent Trauma-Informed Education

With the principles of culturally responsive pedagogy and culturally competent trauma-informed care in mind, the picture of culturally competent trauma-informed education slowly becomes clearer. In a culturally competent classroom where TIE is employed, educators must demonstrate cultural humility, emphasize student empowerment and voice, and integrate students’ culture into the learning itself and curriculum. Respectful collaboration must also be emphasized between teachers and students, so as to avoid the regurgitation of paternalistic and/or racial power dynamics, as well as feelings of safety, predictability, trustworthiness, and consistency. Educators must take advantage of any opportunities to teach their students crucial skills of how to self-regulate in emotionally triggering or upsetting situations, and also reframe their trauma experiences as being products of broader systems of oppression (i.e. racism, discrimination, ableism), rather than as individual, familial, or community deficits. Running in line with this
reframing of trauma experiences, culturally competent TIE would also teach students how to appropriately criticize the systems of oppression that contribute to their experiences of trauma within society. Such instruction could contribute to student healing and growth, as it empowers them to reframe their personal narratives, which may provide them with a sense of control amidst very uncontrollable, difficult experiences.

**Research on Deaf Identity Development**

The final area of study we must examine in order to best support mainstreamed d/Deaf and hard of hearing students is d/Deaf identity development. The cultural identity that a d/DHH individual develops and aligns themselves with can have long-lasting, significant impacts on their psychosocial outcomes, like self-esteem, life satisfaction, and overall well-being (Hintermair, 2008). For d/DHH students who are grappling with trauma experiences that further impact their psychosocioemotional well-being, the development of a cultural identity can contribute to, or detract from, their ability to maintain positive, stable, and healthy well-being. Thus, it is crucial that educators foster their understanding of d/Deaf identity and the factors that impact its development, like educational experience, family environment, preferred language, and age of onset of hearing loss (Bat-Chava, 2000; Chen, 2014). A lack of understanding on this issue will only limit the educator’s ability to support their d/DHH students, as teachers cannot fully foster a d/DHH child’s healing if they remain clueless about the ways that child views themselves as an individual and in the context of broader culture and communities.

So, what different conceptualizations of d/Deaf identity exist? The current models of d/Deaf identity either follow a linear, stage/status framework, which explains that d/Deaf people evolve through different stages of identity at different points in their lives, or an acculturation
framework, which posits that d/Deaf people undergo in a dynamic, multi-dimensional psychological and behavioral process of change as they engage with different communities and cultures (Glickman, 1993; Glickman & Carey, 1993; Maxwell-McCaw & Zea, 2011). The former framework considers d/Deaf identity as being more discrete categories, while the latter describes d/Deaf identity in terms of a spectrum of acculturation, and views behavior and identity as distinct from each other.

Keeping in line with the stage framework, we can consider d/Deaf identity as falling into one of four different domains: culturally hearing (i.e. ‘little d’ deaf), marginal, immersion (i.e. culturally Deaf; ‘big D’ Deaf) or bicultural. Culturally hearing individuals tend to utilize oral means of communication like speech, when interacting with others, prefer and feel most comfortable with the hearing world, and decenter their deafness when referring to themselves or their identity (Glickman, 1993; Glickman & Carey, 1993). These individuals often use the hearing world as their reference point for what is considered normal, and they view their deafness as a disability or abnormality. Finally, culturally hearing deaf people might prefer to use the terms ‘hearing impaired’ or ‘hard-of-hearing’ when referring to themselves.

The immersion identity, i.e. the culturally Deaf identity, is almost opposite. People who identity as culturally Deaf tend to prefer manual communication (i.e. American Sign Language), feel most comfortable in the Deaf world, and take great pride in their Deafness, sometimes even taking the perspective that ASL is superior to spoken English/spoken language (Glickman, 1993). Culturally Deaf individuals often immerse themselves in the Deaf world and prefer to not act/appear ‘hearing’ (e.g. use their voice, wear hearing aids).

Unlike culturally Deaf and culturally hearing people, marginally identifying individuals do not feel like they fit in either the Deaf or hearing world, and struggle immensely with their
relationship to and identification with, their deafness (Glickman & Carey, 1993). Marginal individuals are often deaf individuals who are born into hearing households and have no exposure to sign, or to examples of positive Deaf role models (Marschark, Zettler, Dammeyer, 2017). They express discomfort with both culturally Deaf and culturally hearing identities, and feel as if they belong in neither the Deaf or hearing worlds. In other words, marginal individuals seem to belong neither here nor there, and are left straddling the line between two dramatically different identities, cultures, and communities.

Finally, bicultural d/Deaf individuals typically feel comfortable in both Deaf and hearing environments, and can maintain a balance between valuing their Deafness, Deaf culture, and Deaf community, valuing their relationships with hearing people, and still being critical of hearing paternalism and oppression (Glickman, 1993). Within the bicultural identity, there are different sub-identities, like balanced bicultural, deaf-dominant bicultural, and hearing-dominant bicultural, all of which refer to d/Deaf individuals with varying levels of comfort, preference, and association with the hearing and Deaf communities (Holcomb, 1997).

Each of the above d/Deaf identities are accompanied by a unique set of lived experiences, and thus have different impacts on psychosocial outcomes, with specific identities being related to more positive outcomes than others. For example, marginal individuals have shown lower self-esteem, less life satisfaction, and overall poorer well-being than bicultural individuals, who displays higher psychosocial measures across the board, as compared to culturally hearing, culturally Deaf, and marginal identifying people (Hintermair, 2008). Interestingly enough, culturally Deaf individuals have been demonstrated levels of life satisfaction that are comparable the levels of satisfaction that bicultural individuals display, while culturally hearing people show lower levels of life satisfaction (Hintermair, 2008). And for measures of self-esteem, culturally
Deaf and bicultural individuals have shown higher self-esteem than those with culturally hearing identities (Bat-Chava, 2000). When we place these findings in context for d/DHH students with trauma histories in the mainstream, the result is striking, since these students must learn how to heal from and cope with the traumatic experiences they have faced, while simultaneously navigating the development of their own identity as d/Deaf and hard of hearing individuals in a hearing world, and within a hearing, mainstream educational environment that places them on the outs, every single day. Teachers must be cognizant of the additional identity struggles that d/DHH children may be undergoing in their classroom, and respond with sympathy, understanding, and kindness, if/when they realize that their students are at this pivotal stage in their lives.

**Best Practices**

Clearly, hearing teachers in mainstream schools have much to consider when they welcome d/Deaf and hard of hearing students with trauma histories into their classroom for the first time. The process of becoming trauma-informed appears to be a multistep process. Educators must learn about the principles of trauma-informed education (and how to model them), recognize the shared and divergent experiences that d/Deaf and hard of hearing kids have, and tailor their teaching approaches in order to accommodate different students. This is quite the undertaking, especially for teachers with zero exposure to the Deaf world, community, and culture, and little to no experience teaching students who are d/DHH or and/or have trauma histories. So how should these hearing teachers go about becoming trauma-informed educators who are serving this specific population of students? In this section, I have outlined a number of best practices for hearing educators of mainstreamed d/DHH children with trauma histories. These recommendations were
informed by the findings of my literature review, as well as by the lived experiences I have accrued over the course of my time in mainstream education.

First and foremost, educators must strive to meet the needs of the student in the context of their trauma. The major goal of these hearing teachers is to create and maintain an environment in which d/Deaf and hard of hearing students feel safe, can develop the regulatory skills necessary to appropriately deal with their trauma, and have opportunities to showcase their areas of strength, regardless of whether those skills fall into academic, social, or emotional domains. Teachers can accomplish this goal by establishing safety, predictability, and trustworthiness within the classroom, devoting ample time towards relationship building and teacher-student collaboration, and by demonstrating empathy towards their students, day-in and day-out. The principles of trauma-informed education should be modeled as much as possible, so as to create a highly supportive, stable, and healing environment for these students.

Second, educators are required to demonstrate cultural humility. In other words, they must recognize that there is so much that they do not know, and so much that they need to learn. Self-education on part of the educator becomes a primary goal; they must make a concerted effort to learn about issues of language deprivation, social isolation in d/Deaf and hard of hearing students, d/Deaf identity development, the impacts of being mainstreamed, the experiences of Deaf Plus children and their families with the special education system, and finally, the intersectional experiences of d/DHH students of culturally and lingually diverse backgrounds. By beginning to learn about these topics with a culturally humble mindset, hearing teachers in mainstream schools can become better equipped to support their d/DHH students with trauma experiences, since they consider this process of learning as being life-long, constantly in flux, and always with room for improvement. And such mental flexibility is key to understanding a student population as diverse
as d/DHH students, who vary immensely in the domains of language access, identity development, and cultural/lingual backgrounds, to name a few.

Finally, hearing educators of mainstreamed d/Deaf and hard of hearing students must absolutely engage in community work and relationship building with the parents, families, and communities that their students are part of. Teachers must make a concerted effort to familiarize themselves with the culture, traditions, customs, and issues that are present in their students’ communities, as understanding the student’s experience outside the classroom is one of the first steps teachers can take to better supporting them within the classroom.

While these recommendations are crucial parts of the approaches hearing teachers of mainstreamed d/DHH students must take, they are not the only methods that educators should incorporate into their trauma-informed teaching toolkits. In the second half of my capstone project, the professional development plan for hearing teachers of mainstreamed d/DHH kids, I expand on these recommendations by exploring a set of key goals that educators should set for themselves, both within the classroom, and outside of it. To clarify, a single professional development plan could never fully prepare an educator for the challenges they will face when working with d/DHH youth that have been traumatized. True cultural competence and deep understanding can only be fully developed after years of focused professional development, genuine community engagement, intense focus on the skills of cultural humility and cultural competence, and the development of knowledge of ASL, Deaf culture, and the d/Deaf experience. This single professional development plan is only the beginning of what I envision to be a long series of plans that are accompanied by intentional, consistent, and meaningful community work in both the Deaf and hearing worlds.
Professional Development Plan

When an educator wants to improve their teaching and promote their own professional/career development, they can turn to professional development plans. These plans utilize self-assessments, goal-setting, and action plans in order to foster teacher growth—and in turn, student achievement (School District of Philadelphia, 2020; Duke Human Resources, 2021). Educators that seek to develop themselves must assess their current skills, generate goals that push them to progress in these skill areas, and then measure this progress via action plans that are outlined with appropriate deadlines and timeframes.

For the purpose of this capstone, I have designed the following professional development plan for a hearing educator of mainstreamed d/DHH students with trauma who knows little to nothing about d/Deafness or trauma. The plan contains the following 5 sections: self-assessments, setting goals, accomplishing goals, generating an action plan with timelines, and measuring progress. This plan was informed by the findings of my literature review, and additional resources that model professional development plans for educators. Within each section, I have included notes with asterisks as necessary that indicate the purpose and aims of each section, as well as example objectives teachers may have, for additional clarification.
### PDP for Hearing Educators of d/DHH Students with Trauma Experiences

**Self-Assessment: “Where are you now?”**

*Each educator will present with a different set of skills, capabilities, and prior experiences with this subpopulation of students. The overarching goal of the self-assessment is to increase the educator’s awareness of their current strengths, while also encouraging them to be honest with themselves about their areas of growth.*

<table>
<thead>
<tr>
<th>What are your current skills, experiences, and background in working with...</th>
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<tbody>
<tr>
<td>.... d/DHH students?</td>
</tr>
<tr>
<td>.... students with trauma histories?</td>
</tr>
<tr>
<td>.... d/DHH students with trauma histories?</td>
</tr>
</tbody>
</table>

*What are your strongest skills as an educator and individual?*

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**Setting Goals: “What do you want to achieve?”**

*When creating objectives for themselves, teachers must keep a few things in mind. First, these goals should be specific, measurable, achievable, realistic, and timely. In other words, teachers should not create overly broad, vague, or unactionable objectives—doing so will only set them up for failure.*

<table>
<thead>
<tr>
<th>What goals do you want to achieve within the classroom, as you strive to create a trauma-informed learning environment?</th>
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<tbody>
<tr>
<td>What are your objectives outside the classroom, as you strive to become a trauma-informed teacher of the d/Deaf?</td>
</tr>
<tr>
<td>What other goals do you set for yourself as an individual who is supporting children with trauma experiences?</td>
</tr>
</tbody>
</table>

See below for recommended goals.
failure. Second, these goals should build on pre-existing areas of strength, and support areas of growth that educators need to improve.

<table>
<thead>
<tr>
<th>Goals within the classroom:</th>
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<tbody>
<tr>
<td>… recognize and identify the signs of trauma in students, its impact, its prevalence, by reviewing the literature on trauma occurrences within and outside of the d/Deaf community</td>
</tr>
<tr>
<td>… promote safety, trustworthiness, consistency, predictability, and intentionality in the classroom by utilizing the tools from the Trauma-informed Toolkit</td>
</tr>
<tr>
<td>… employ a strengths-based approach with students by identifying their areas of strengths and creating opportunities to showcase these skills</td>
</tr>
<tr>
<td>… increase the number of positive interactions between educators and student by engaging in at least 1 positive interaction with the child every day</td>
</tr>
<tr>
<td>… model regulatory skills by providing and explicitly explaining different self-regulatory options for students during difficult situations</td>
</tr>
<tr>
<td>… build a relationship with students outside the scope of academics by intentionally engaging them about their interests and their life outside of school (e.g. check-ins for 30 minutes twice a week)</td>
</tr>
<tr>
<td>… encourage student empowerment, student voice, and student choice by creating opportunities for kids to provide</td>
</tr>
</tbody>
</table>
feedback and share their opinions within the classroom, and especially during difficult situations

… center student culture within the classroom by integrating it into lesson plans and curriculum

… welcome d/DHH community members into the classroom to expose students to positive, affirming role models

… center the healing and growth of students by providing them with unconditional positive regard and support

Goals outside the classroom:

… communicate with parents and families on a consistent basis by following up via phone call, email, text, and/or video phone after every school meeting, IEP meeting, etc.

… amplify family and parents’ voices by ensuring their involvement and participation during any and all meetings/general educational process

… collaborate with families and parents by directly asking for, and incorporating, their feedback into educational plans that the child requires, whether they be IEPs, 504s, or informal approaches

… engage with parents, families, and the broader community by attending community events (when
appropriate) on a regular basis, and by inviting parents, families, and communities to collaborate with schools for joint community-school events

 Goals for the educator as an individual:

 … actively engage with each of this PDP’s training modules during professional development workshops with fellow educators, administrators, and staff

 … practice cultural humility on a daily basis by assuming the role of learner when engaging with families, communities, and students, especially when it involves issues that impact a community of which you are not a part of

 … develop a highly personalized toolkit of self-care tools by identifying personal triggers and stressors, and developing appropriate self-care/coping strategies to address them

**Accomplishing Goals: “What do you need to achieve these goals?”**

*The training modules listed in this section hold so much potential, and require an

| What resources do you require to accomplish the above objectives? |
| What skills must you develop to achieve the above goals? |
| What learning will you do to fulfill the above aims? |

See below for recommended resources.
additional year’s worth of capstone work, if not more, to fully design, flesh out, and create. In another reality in which I could complete a second capstone project, I would base each of these modules on the findings I have accumulated via my literature review, and space each module out over the course of a full school year. The modules would be taught one at a time, on a monthly basis during a day-long professional development workshop, in which teachers, administrators, community members, and experts on each topic would attend, and engage in hands-on PDP learning activities together. It truly takes a village!

<table>
<thead>
<tr>
<th>Trauma-Informed Teaching Toolkit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educator’s tools: empathy; calmness; predictability; intentionality; engagement in positive interactions; strengths-based perspective; cultural humility; collaboration; trustworthiness; amplification of student voice; creation of predictable routines; building of meaningful, intentional relationships; fostering of students’ voices, empowerment, and agency; employing self-care practices; practicing cultural humility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training Modules:</th>
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<tbody>
<tr>
<td>Trauma, d/Deaf-specific Trauma, Trauma-informed Practices, d/Deaf education, Language Deprivation, Social Isolation, d/Deaf Identity Development, the lived experiences of d/Deaf Plus children and their families, the lived experiences of d/Deaf BIPOC children and individuals</td>
</tr>
</tbody>
</table>
### Action Plans with Timeline:

**“When do you want to get there?”**

*This is variable from plan to plan and educator to educator, especially depending on the amount of time they have available to spend with their students. For educators who are working with students for a single semester or even a single quarter, their goals and timelines may be much more compressed, and focused on immediate healing and support, rather than longer-term goals. Teachers who are working with students for a year or longer, however, can establish more ambitious objectives and have much more flexible timelines.*

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**How and when would you like to meet your objectives to become more trauma-informed?**

*E.g.: “At the end of this quarter/trimester/year, I would like to...”*

See below for recommended action plans with timelines.

Some goals focus on personal development, while others engage students and communities.

*“At the end of this quarter/trimester/year, I would like to…”*

...triple the number of positive interactions I have with my d/DHH student(s) each week as compared to the beginning of the quarter/trimester/year

...attend at least 5 community events

... develop 3 new self-care strategies to better maintain life-work balance, especially as I deal with trauma in the classroom

... implement and use 3 new tools from this PDP’s Trauma-informed Teaching Toolkit

... contact parents and families on a biweekly basis to check in and emphasize positive feedback about the student

... meet with parents and families every month to have serious check-ins about how the family is doing as a unit,
especially in terms of trauma, and discuss their child’s progress, areas of growth, and areas of improvement

<table>
<thead>
<tr>
<th>Measuring Progress: “Where are you now?”</th>
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<tbody>
<tr>
<td>After engaging with and learning from this PDP, what progress have you made, what skills have you developed, and how will you assess this growth?</td>
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</tbody>
</table>

Measures of progress can be independent and/or collaborative. See below for recommended measures of each category.

**Independent measures of growth:**

- **Journal writing:** Engage in freehand writing, for 20 minutes each day. Intended to be a holistic recounting of the day. Can discuss emotional and social components of teaching. Should reflect on occurrences inside and outside the classroom, like which strategies were successful, which tactics went poorly, instances of student growth, nature of family and parent interactions.

- **Community event attendance:** Create a checklist of “have you ___ this day/week/month?”. Checklists can include contacting families and parents, meeting self-care objectives, daily utilization of specific tools from the TIE Toolkit.
<table>
<thead>
<tr>
<th>Collaborative measures of growth:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer visits in the classroom complete with reflection and conversation:</strong> On a monthly basis, fellow teachers and administrators can visit your classroom, assess your usage of the tools within the TIE Toolkit, note areas of growth/strength, and provide both written and verbal feedback.</td>
</tr>
<tr>
<td><strong>Curriculum re-assessment and re-development workshop with colleagues and peers:</strong> On a monthly basis, teaching partners and teaching teams can come together to discuss which trauma-informed strategies, curricula approaches, and teaching tactics are (and are not) succeeding in the classroom, and adjust curriculum, goals, and educational approaches accordingly.</td>
</tr>
</tbody>
</table>
Conclusion

It is evident that the absence of research on trauma-informed education for d/Deaf and hard of hearing children, coupled with a high prevalence of traumatic experiences within the community and a lack of widely-accessible mental health supports, demonstrates a deep need for trauma-informed education for d/DHH kids in the mainstream. These children deserve the opportunity to heal, and establishing a community-level intervention in schools, like trauma-informed education, is the first step towards achieving such healing.

While the need for trauma-informed education of this nature is extremely necessary, the road towards it will not be easy. Teachers, administrators, and school staff must be committed to educating themselves about a slew of different issues. They must develop a fundamental understanding of what trauma is and the signs of it within the child. Then they must learn about traumas specific to the d/Deaf community, and place those experiences in context of broader systems of oppression, like audism, oralism, ableism, and racism. And finally, these educators, administrators, and staff must strive to create school environments that feel safe for these children with trauma, no matter how many obstacles they encounter along the way.

This is an undertaking. It requires immense collaborative effort, effort enacted between teachers and students, between educators and families, between entire schools and entire communities. But it is possible. Healing and growth are always possible, especially with the right mindset, the right resources, and the might of community behind you. By supporting hearing educators and teachers on their journeys towards becoming more trauma-informed, we can create genuine change, and drastically improve the outcomes for d/DHH children in the mainstream.

What’s more, the potential for this field of work is not limited to education. Developing new educational models that support d/DHH children with trauma could have spillover effects into
the emerging field of d/Deaf mental health. This model of education, which is deeply cemented in collaboration and community, might inspire the development of new and improved models of community mental health care, created for the d/Deaf community, by the d/Deaf community. In my eyes, the possibilities are endless. I see a path towards more accessible school environments, more accessible mental health care, and improved educational experiences and psychosocial outcomes for d/Deaf and hard of hearing children. There is so much promise in this field of research and body of work. There is so much more to be done. And I cannot wait to be a part of it.
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