

Information Deprivation Trauma: Definition, Assessment, and Interventions

Sven Schild  and Constance J. Dalenberg

Trauma Research Institute, Alliant International University, San Diego, California, USA

ABSTRACT

Information deprivation trauma (IDT; Schild & Dalenberg, 2012b) is a concept that has not been adequately addressed in the trauma literature. IDT is a concept requiring a negative emotional response (e.g., fear, helplessness, horror) consequent to (a) a lack of understanding of the extent, magnitude, consequences, and probability of a current or impending meaningful event; and (b) an inability to access information about this event that would reasonably allow a person to prepare, appropriately respond, or self-protect. Arguments are presented that information deprivation itself might constitute a trauma, in addition to and apart from the possibility that information deprivation might enhance vulnerability to traumatization. Clinical examples are provided, and the Information Deprivation Trauma Interview (IDTI) is introduced for use in clinical and research settings.

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The last decade of research has brought increased attention to the role of culture in trauma assessment and treatment (Brown, 2008; Drozdek & Wilson, 2007; Marsella, Friedman, Gerrity, & Scurfield, 1996). The focus of the majority of this work has been on increased respect for the integration of cultural values into therapy; for instance, the increased inclusion of folk healers and folk wisdom in the therapeutic process (e.g., *curandero* in the Latin culture; Conradi, Hendricks, & Merino, 2007) and the enhanced recognition of the cultural context in which trauma symptoms emerge (Watters, 2011). A by-product of the globalization of trauma research has been the recognition of the cultural specificity of trauma itself. Loss of a religious site through an act of aggression, for instance, could have dramatically different meanings depending on the role of the place itself in the lives of the religious community. Along the same lines, sexual assault in the context of a country where female victims are also shunned and blamed by family and friends for allowing the violation to occur is likely to produce increased vulnerability and self-blame (rather than other-blame) than is generally the case after a sexual assault (Lisak, 2010; Murthi, 2009).

CONTACT Sven Schild, PhD  sven.schild@gmail.com  Alliant International University, Trauma Research Institute, 4350 Executive Drive, Suite #255, San Diego, CA 92121.

One understudied and underserved cultural group that has experienced a high prevalence of trauma is the Deaf community (Schild & Dalenberg, 2012b; Sullivan, Vernon, & Scanlan, 1987; Vernon & Miller, 2002). According to the National Center for Health Statistics, approximately 1.2 million adults in the United States are profoundly deaf, and the overall number of people with all types of hearing losses has been estimated to be as high as 37 million (Schoenborn & Heyman, 2008). Among a general deaf community sample of 79 deaf adults between the ages of 18 and 83, Schild and Dalenberg (2012b) found a prevalence of sexual trauma of 44.1% in men and 53.3% in women.

Deafness is often viewed and discussed from two opposing perspectives: medical and cultural. Most people who embrace the medical, clinical, or pathological view consider deafness to be a disability or undesirable physical impairment (Lane, Hoffmeister, & Bahan, 1996). Accordingly, deafness is often discussed in terms of degree of hearing loss, type, age at onset, and so on, and terms such as “hearing impaired” are used to refer to individuals who cannot hear. In contrast, the cultural or humanistic perspective views deaf people to be a cultural and linguistic minority, similar to other types of ethnic minority groups (Austen & Coleman, 2004). The term *Deaf* (uppercase) is often used to denote the cultural view, whereas lowercase *deaf* is generally used to refer to one’s lack of hearing. These two terms are also used throughout this article to denote this distinction.

The Deaf community has its own culture in terms of knowledge, values, beliefs, practices, and rules, which are, as pointed out by Schein (1989), “not completely different from its surrounding culture, but sufficiently so to warrant its designation as a separate culture” (p. 23). The majority of Deaf people who embrace their deafness are born deaf or lost their hearing prelingually. Membership in the Deaf community is a matter of choice and provides for most deaf people a sense of belonging and strong social support (Austen & Coleman, 2004; Schein, 1989). The most distinct, central, and cherished feature of the Deaf culture is its language, which facilitates communications and social connections among its members (Lane et al., 1996). In the United States and Canada, the most commonly used language among people who are Deaf is American Sign Language (ASL), which is a visually based language that is linguistically distinct from English.

During one of the first large-scale trauma studies with the Deaf community, the California Deaf Trauma Study (Schild, 2007; Schild & Dalenberg, 2012a, 2012b, 2015), a common theme emerged that has not yet been adequately addressed in the trauma literature: *information deprivation trauma* (IDT). The purpose of this article is to expand on our brief introduction of IDT (see Schild & Dalenberg, 2012b) and to provide a more in-depth analysis of the concept, explore various examples in both hearing and deaf samples, and discuss assessment issues.

What constitutes an IDT?

IDT is defined as a negative event that is experienced as traumatic or more intensely negative because information or knowledge about this event is limited or not available, preventing a person from fully assessing the threat and engaging in self-protective behaviors (Schild & Dalenberg, 2012b). In other words, IDT is a concept requiring a negative emotional response (e.g., state of fear, helplessness, or horror) consequent to (a) a lack of understanding of the extent, magnitude, consequences, or probability of a current or impending meaningful event; and (b) an inability to access information about this event that would reasonably allow a person to prepare, appropriately respond, and self-protect. For example, when the second author was evacuated from her home during San Diego wildfires, she noted the intense distress of a family of Vietnamese immigrants who had become separated from their only English-speaking relative. On overhead televisions, scenes of burned buildings and hillsides ablaze with massive unchecked fires were being displayed, and the family was shouting, pointing, showing panic symptoms, and calling out their questions to the crowd in hopes of finding an interpreter. The interpreter did arrive, and the family calmed significantly, although the children were crying and breathing quickly as they glanced up at the screens. The family's distress, as indicated from their questions, centered on the unknowns, not the knowns. Had the announcer stated which homes had been burned? Which direction were the fires going? What did the family need to do to get shelter for the night? In the same evacuation center, a number of deaf adults and children were showing similar distress.

The case of IDT as a distinct trauma type

As the trauma literature has matured, many research groups have noted that trauma is not easily defined by a specific event, such as an earthquake, fire, or assault (Berger et al., 2012; Kilpatrick et al., 2013). Similarly, several research groups have criticized the definition based on distress alone (McNally, 2003; Rosen, 2004), arguing that those responding with symptoms similar to posttraumatic stress disorder (PTSD) due to a minor event are a separate group and should not be considered "traumatized." A strong theme in trauma definition work in recent years has been the role of meaning, going back to Freud's definition of trauma as being in excess of the ego's ability to cope. Thus, Freyd's (1996) work on betrayal trauma emphasizes a distinct, and at times, a serious set of symptoms, which can be tied to trauma in the context of betrayal.

We would argue here that information deprivation is such a context variable, powerful enough to change the nature of the focus of many of the survivors and to create a meaningful subtype of trauma experience. In light of this, we believe that information deprivation itself constitutes a potentially traumatic experience. In other cases, information deprivation might enhance vulnerability to traumatization from the event itself by negatively affecting factors such as controllability, suddenness or predictability, and negativity (Carlson & Dalenberg, 2000), changing the nature of subsequent symptoms. There are certainly circumstances in which the feature that converts the negative event or emotionally meaningful event into a trauma is virtually solely the absence of information. For instance, a particularly cogent reader of this article asked if the fire mentioned in the previous section was the index trauma (with missing information as the factor that enhanced the negativity of the situation), or if it was instead the missing information that defined the trauma. In this case, did lack of information transform the moderately negative experience into a trauma, or did it aggravate a situation that would have been traumatic without the missing information? We would argue here that, depending on circumstance, either could be true, but both options suggest the importance of attending to the information deprivation issue. Learning that one has cancer, for instance, could be a trauma; in that instance, not knowing the pervasiveness or prognosis—a form of IDT—could be an aggravator of the trauma of cancer. In contrast, in the case of an individual who is blindsided by a negative event due to inaccessibility of information (e.g., the Deaf adult who was unaware that a relative had died until months after the fact), the realization that information about important events could be missing (and thus that any relative could be now deceased and the individual might not be aware) could itself be the trauma. This might be a separate trauma, distinguishable from the trauma that might or might not be directly associated with the loved one's death. In our clinical experience, some IDT survivors have recovered from their grief about a given death, but remain disturbed and anxious regarding the manner in which the death had been communicated or not communicated.

In our continued evaluation of IDT, we have also discussed whether mildly negative or even neutral events could be converted into a trauma by circumstances related to information deprivation, particularly if they happened unexpectedly or chronically. For instance, in our trauma practices, we have had clients, often Deaf clients, who became aware only during the week of a move out of state that their lives were being uprooted. For several clients, the move took on all features of a trauma (move-related nightmares, fears of future sudden moves, alienation and hypervigilance, etc.), but the content of trauma description contained not only the mildly negative features of a move, but the more noxious possibility that one cannot know when one's school, home, and friends would be taken away.

General wisdom suggests that what you don't know won't hurt you. This idiomatic expression exists in different cultures and languages, suggesting a protective mechanism by being deprived of certain, often painful, information. For example, the Spanish version of this idiom (*Ojos que no ven, corazón que no siente*) literally translates to What the eyes don't see, the heart won't feel. At times it is argued that harm is avoided if information is withheld from a person who might not have the emotional, intellectual, physical, or psychological capacity to deal with the situation at the given time. The discussion of IDT would suggest some negative consequences to such a strategy.

Vulnerability to IDT in the deaf population

To acquire information, two conditions must be present: (a) the person must have the ability to access the information, and (b) the person must be able to comprehend the information once acquired. It has been well established in the literature that early and severe hearing losses among children constitute a major disadvantage when it comes to their ability to acquire fluent language skills (Marschark, 1993). This is complicated by the fact that the majority of deaf children (i.e., over 95%) grow up in family environments (Mitchell & Karchmer, 2004) that are largely communication-inaccessible and language deprived. Sadly, the vast majority of hearing families never acquire fluent sign language skills to communicate effectively with their deaf children (Gulati, 2003; Marschark, 1993). As a result, it is perhaps not surprising that many deaf students lag behind their hearing peers in academic achievement, including reading (Holt, Traxler, & Allen, 1997), which limits a person's access to the wealth of written knowledge. Although the majority of Deaf people have at least fluent ASL skills, there are also some deaf individuals who are language dysfluent, which is often directly linked to the origins of their hearing loss (Fellinger, Holzinger, & Pollard, 2012; Glickman, 2003).

However, even with fluent English and sign language skills, a large portion of information in our society is simply not accessible to deaf people because it is transmitted through sound and received aurally. Hearing is a relatively passive process in which information can be transmitted without the receiver being required to actively focus on the source of the information. For example, a hearing person might overhear a conversation between two individuals in a restaurant or glean information from the radio that is playing in the background. These incidental learning opportunities are not available to the deaf person. Although information is also transmitted visually in our society, visual information requires directed attention on the part of the person to register and process these data. In the authors' clinical experience, Deaf people frequently complain of being more tired than hearing people

from focusing on visual information all day. Because acquiring information requires both ability and access to the information, deaf people appear to be particularly vulnerable to IDT.

Examples of information deprivation trauma

IDT and the experience of societal trauma

After the terrorist attacks on the World Trade Center on September 11, 2001, a lot of media attention focused on the atrocities that had occurred in New York City. Throughout the day, both authors rewitnessed on television how the two planes crashed into the Twin Towers, killing thousands of people. For educational purposes, many school classrooms equipped with television sets repeatedly broadcast the same news throughout the day to keep students updated on current events. Whereas most adults understood that the attacks on 9/11 were isolated to a few areas on the East Coast, some children who lacked a full understanding of the situation believed that hundreds of planes were falling from the sky. Each rebroadcasting of the destruction of the Twin Towers was interpreted as a separate, distinct event, which caused much fear among some children.

Along the same lines, the first author was told by an acquaintance who had been to Sri Lanka after the devastating tsunami in 2004 that many orphaned children were later terrified by the idea of water. In their eyes, water would “take you away,” as it did for their parents. In these examples, the children were traumatized not necessarily by the terrorist attacks or the tsunami, but because many of them lacked full knowledge about what had happened or what was happening in the present moment.

IDT and inadequate information about an illness

John, an 11-year-old client who was evaluated by one of the authors, had an older brother who was autistic and suffered from a number of related disabilities (in addition to being deaf). The parents attributed their older son’s illness to an accident that the mother had experienced during her pregnancy. When John was in a traumatic accident, he developed depression, which was eventually shown to be partially attributable to his fear that he would become autistic due to his injuries. For John, a car accident, which in most cases does not produce pronounced PTSD or depression (Tierens, Crombez, Loeys, Antrop, & Deboutte, 2012), did produce serious mental health outcomes.

IDT and the information hostage

Our clinical experiences from our private practices contain several examples of young adults, typically female, who were kept under such close surveillance that they were entirely cut off from their familial and peer communities. Tanya, a 14-year-old hearing Japanese American child, was home

schooled by her parents and was allowed no contact with children her own age or any adults outside her own culture. When she came to the attention of one of the authors after a physical abuse incident involving her brother, which led to a removal of both children from the home, her central descriptions of distress were focused around inadequate information. When she saw peers looking at her in public, she did not know if she was being judged harshly due to her dress. In the temporary shelter where she met other girls, she was extremely fearful due to the lack of information regarding both the process and content of U.S. society. Again and again she reiterated that her parents had not physically, sexually, or psychologically abused her, but that the shield they created between her and the information that she needed to form bonds with other individuals her age was the central metaphor in her nightmares.

IDT and the personal trauma

Heather, a 6-year-old deaf client who was evaluated by one of the authors, lost her mother in a tragic car accident. The child was brought to a physician, who consulted with the author, because she was wandering through the home at night (attributed to insomnia) and had become hysterical during her mother's funeral. The child's father, who was completely unable to communicate with his child, a duty that he had deferred to his wife, was at a loss. In the evaluation of the child, 8 months after the mother's death, it was learned that the child was not aware of the accident and believed that her father was keeping her mother from her (based on witnessed arguments between the adults). At night, when she thought that her father was asleep, the child would search the home for her mother. At the funeral, which the child interpreted as a party, she expected that her mother would rejoin them, in part because of the presence of her maternal grandparents and other relatives.

The process of explaining the accident to Heather was complicated by many related IDT issues. Heather was shocked and upset regarding her mother's death but also overwhelmed at the knowledge that "no one told me." Her grief, mixed with anger, was extreme and difficult for a 6-year-old to communicate with or without language limitations. Nonetheless, in our interview with her, the most frequent refrain was not "I lost my mother," but instead "No one told me."

IDT and protected or marginalized groups

Although IDT might be especially relevant and prevalent within the Deaf community, this concept also likely extends to other protected or marginalized groups among the hearing population. For instance, vulnerable populations might include those who are shielded by others from information that

might be upsetting (e.g., young children shielded from knowledge of the death of a grandparent), those with impaired mental capacity due to illness or increased age, or those with limited access to information due to language barriers (e.g., recent immigrants who are not fluent in the dominant language). Further studies are needed to explore the potential influence of information deprivation trauma on traumatic outcome in these and other populations.

Why would the addition of IDT create or transform a negative event into a trauma?

The “too muchness” of trauma: Trauma as fear, helplessness, or horror

The word *trauma* is often loosely defined in the literature and frequently used interchangeably with other terms such as *disaster*, *catastrophe*, *psychologically distressing event*, *extreme stress*, *stressor*, or *atrocities* (Green, 1990). The word itself is derived from the Greek language and literally means *wound* (Wilson, 2004), generally defining an objectively identifiable event (e.g., car accident, fire, physical assault, rape, etc.) that elicits some kind of negative emotional response (American Psychiatric Association, 2013).

In a related but not identical set of definitions, a trauma has also been conceptualized as a stressful event that temporarily overwhelms a person's internal resources (Briere & Scott, 2006), reminiscent of the psychoanalytic definition of stimuli in excess of the ego's ability to cope. In other words, traumatic events are perceived as “too much” or “too overwhelming” (Green, 1990). The same event can be experienced as a trauma by one person and not by another due to a wide variety of individual differences and context variables. We would maintain that IDT is one such context. Information can provide the individual with knowledge of protective resources, specific detail that minimizes the likelihood of harm or danger, the ability to predict and perhaps control future dangers, counterarguments for common fears that occur in specific trauma circumstances, reassurance that help is coming or that traumatic circumstances will be short-lived, or information regarding practical solutions to maintain safety in the present. Helplessness, horror, and fear are all potentially greater in the absence of information.

A hell or heaven of one's own making: The importance of meaning

The event-driven definition of trauma does not formally take into account that all trauma is mediated through the self-awareness of the trauma survivor. Posttraumatic results from an accident, for instance, could be reduced, if not eliminated, if the individual was rendered unconscious by the accident itself (Glaesser, Neuner, Lütgehetmann, Schmidt, & Elbert, 2004). The same act (e.g., sexual assault) might have differing consequences if the perpetrator is a known versus an unknown person, potentially creating a betrayal trauma

(Feinstein, Humphreys, Bovin, Marx, & Resick, 2011). Treatment efforts in trauma research, in addition to exposure treatment (Riggs, Cahill, & Foa, 2006), often target the meaning of the trauma itself, and the self-appraisals that stemmed from it (Cloitre, Cohen, & Koenen, 2006). A number of trauma-focused treatments, such as narrative exposure therapy (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004) or Logotherapy (Frankl, 2006), highlight meaning as a key focus for treatment and recovery of trauma. IDT is a direct assault on the individual's ability to make acceptable meaning and generate reasonable appraisal of any past, current, or future traumatic event.

Ignorance might not be bliss: Information as protection

Information serves many protective functions during a traumatic event. For example, the hearing citizen of San Diego County in the midst of the 2003 wildfires would have known (a) which areas were evacuated or on the list of potential evacuations; (b) the direction of the fires; (c) the shelters that were open, that had food available, or that allowed overnight stays; (d) the success of the firefighters in areas under threat; and (e) the predicted time for which citizens should stay away from their fire-threatened homes, and so on. After the fires, this citizen would have had easy access to information regarding (a) short-term shelters, (b) insurance information booth locations, (c) when outages of various types would be addressed, and (d) available health and mental health services. In other words, information allows prediction of the likelihood of continuation of the traumatic conditions and methods of addressing trauma consequences. Absence of such information renders the trauma more negative in valence, and less controllable and predictable, all factors that enhance trauma response (see the next sections).

How does IDT increase vulnerability to trauma?

As argued earlier, IDT could transform a negative or emotionally meaningful event into a trauma, or might simply increase vulnerability to the development of trauma-related symptoms. As a modifier or aggravator, information deprivation could affect trauma severity by influencing factors such as (a) controllability, (b) suddenness or predictability, and (c) negative valence (Carlson & Dalenberg, 2000).

Controllability

Dohrenwend (2000) wrote that that the likelihood of PTSD and other types of trauma-related psychopathology (including major depression and alcoholism) relates to “the proportion of the individual's usual activities under which uncontrollable changes take place following a major negative event” (p. 1). Somer, Weitzman, and Heth (2004) argued that controllability awareness, the

ability to be attentive to what is and what is not controllable in one's environment, is predictive of the capacity to tolerate acute and chronic stress, correlating both with physical symptoms and psychological impact. The authors recommended training these skills to enhance general coping capacity.

The unavailability or inaccessibility of information can be an obstacle to one's capacity to develop controllability awareness. At a residential school for the Deaf where one of the authors has consulted, a molested deaf teenager claimed that one reason he did not report the ongoing molestation by a counselor was that he was unaware of the existence of mechanisms for reporting. The young man also reported that he believed there were few options for him other than the current school and that he therefore feared alienating the existing authorities. The young man did not have the language to describe his violation and did not have communication access to his parents. In addition to the shame and trauma that is common in molestation cases, this child described a sense of inevitability of exploitation given his lack of control over his circumstances. Less than 5% of the Deaf adults in the California Deaf Trauma Study reported that their parents were fluent in sign language (Schild & Dalenberg, 2012b), further limiting the children's ability to use the parents as a surrogate for controlling potential negative events.

Suddenness and predictability

It is clear that many events might be uncontrollable, yet partially predictable. The wall of fire advancing toward a vulnerable town in California, for instance, might not be controllable for any given individual, but news coverage could give a window of predictability for those in the fire's path. The finding that uncontrollable and unpredictable shock leads to greater fear of a conditioned stimulus than controllable shock is well replicated (Foa, Zinbarg, & Rothbaum, 1992; Szpiller & Epstein, 1976). For example, animals presented with reliable predictors of an imminent negative stimulus (i.e., danger signal) are then able to discriminate between signal and context and thus do not become as fearful of the context (Fanselow, 1980).

Deaf individuals might lack information in a given situation that would allow predictability during a disaster. One female participant in the California Deaf Trauma Study, for instance, reported being stuck in traffic in San Francisco when a major earthquake hit the region. The earth was shaking, and buildings, streets, and bridges were collapsing (Schild & Dalenberg, 2012b). This event by itself could have been traumatic to most hearing people, but this woman's fear and helplessness were exaggerated by the lack of information about the event. Information from the radio was inaccessible to the deaf woman during the earthquake, and due to the lack of technology at the time, she was also unable to contact her family to find out about their well-being. She could not localize the earthquake, could not learn

the safe and unsafe routes to her home, and could not take advantage of the small to moderate levels of predictability that would be available to her hearing friends and relatives (Schild & Dalenberg, 2012b).

Many deaf research participants in the California Deaf Trauma Study reported that the first occurrence of an earthquake in their lives was experienced as being among their worst three life experiences. Deaf adults reported that they were unaware of the likelihood or typical aftermath of an earthquake, with some individuals not even aware of the existence of earthquakes. For those with sophisticated language skills, in contrast, earthquake information is available in every major newspaper (or through phone applications that notify the recipient of the location and magnitude of the quake). The lack of information or knowledge about these events, which were often only minor incidents in our hearing samples, made them less predictable and less controllable to deaf adults (Schild & Dalenberg, 2012b). These observations are congruent with other research findings suggesting that prior knowledge about a trauma, for instance the previous experience of a flood, had a desensitization effect and played an important part in enhancing the recovery process (Kalayjian, Kanazi, Aberson, & Feygin, 2002; Norris & Murrell, 1988).

Negative valence

As is true for many cultural groups, specific traumas might have an enhanced negative valence for the Deaf individual. The terrible losses associated with removal from an abusive parent, for instance, can be worsened by lack of knowledge of the communication capabilities of those in the new setting. Many deaf children, particularly young children, have idiosyncratic signs that would be unknown even to the reasonably fluent ASL user. Thus, the deaf foster child or the orphaned deaf child might have a loss of an entire realm of communication on top of the loss of connection to a loved one. Consistent with our observations, Vernon and Andrews (1990) noted an increased likelihood of PTSD in deaf adults who lost a parent or caregiver on whom they depended for their emotional and physical needs.

More “severe” sexual abuse has been shown to be more likely to lead to trauma-related outcomes (Carlson et al., 2001) than is less “severe” abuse (in this case defined by chronicity and presence of penetration). Although some dimension of severity might not be entirely defined by meaning-related dimensions (e.g., pain), other dimensions (penetration vs. nonpenetration or the degree of closeness of the perpetrator) are severe partly by virtue of the greater confusion, shame, and guilt that the victim might suffer. Both authors have participated in evaluations of deaf children who have experienced sexual assault or sexually inappropriate behaviors, almost all of whom were confused and shamed over some aspect of the adult reaction to the experience. Just as the confusion of a sexual assault is thought to add to the severity of

the symptoms of assaults for young children, the greater confusion due to information deprivation would aggravate the negative consequences of a traumatic event.

Assessment of IDT

Table 1 includes a brief set of evaluative questions that would allow a clinician to evaluate for IDT. During the IDT interview, clients are asked to describe the event and their emotional response. Following are six specific IDT questions that were developed based on descriptive qualities of trauma (i.e., controllability, suddenness or predictability, and negativity) that are known to predict the magnitude of a traumatic response (cf. Carlson & Dalenberg, 2000). These questions were developed by an expert in deafness and trauma and refined and affirmed as face valid by a second expert. The final test was given to six members of a trauma research institute who judged the questions as applicable to IDT on a 1 to 10 scale. All questions were judged highly applicable (mean scores over 7).

The dimensions assessed by the instrument alert the interviewer to aspects of the trauma that might not be normally emphasized. For example, Question 1 (“Do you know when this event or the next stage of the event is going to happen?”) taps into the client’s ability to predict recurrence of the event and the evolution to a new stage. Question 4, on the other hand (“Do you have a way to protect yourself so that this will not happen again?”), accesses information about protective or recuperative resources. The interviewer is also encouraged to more explicitly address the client’s view of the

Table 1. Information Deprivation Trauma Interview (IDTI) Questions.

Identified trauma or threat: _____

When did this event/trauma/threat occur?^a _____

Is this event still ongoing? _____

How did you react emotionally to the event/s? _____

1. Do you know when this event or the next stage of the event is going to happen? (Suddenness and Predictability)
 - Not at all (2) Some information (1) Definitely (0)
2. Do you know what will happen next in regard to the event? (Predictability)
 - Not at all (2) Some information (1) Definitely (0)
3. Do you know where to get more information about this event or threat? (Predictability)
 - Not at all (2) Some information (1) Definitely (0)
4. Do you have a way to protect yourself so that this will not happen again? (Controllability)
 - Not at all (2) Some information (1) Definitely (0)
5. Do you know of any way of making it less painful to you and your family? (Negativity)
 - Not at all (2) Some information (1) Definitely (0)
6. Do you know how you could recover from this event? (Negativity)
 - Not at all (2) Some possibility (1) Definitely (0)

^aThe words *trauma*, *threat*, *event*, and *situation* are used interchangeably and could be replaced with the actual identified trauma or threat during the IDT interview.

seriousness of the event, such as aspects of the trauma that render the negative valence more salient in a given case (Question 5: “Do you know of any way of making it less painful to you and your family?”). Each question is rated by the clinician on a 3-point scale ranging from 2 (*not at all*) to 1 (*some information*), to 0 (*definitely*), thus creating a scale ranging from 0 to 12, with higher scores indicating more support for IDT as a potential feature of the current traumatic event description.

Development of IDT-specific interventions

Just as Schild and Dalenberg (2012a) showed that deaf populations are vulnerable to specific traumatic responses, such as psychoform and somatoform dissociation, other vulnerable groups have been shown to react differently or more strongly to specific types of trauma. It is widely accepted, for instance, that childhood trauma is more related to complex PTSD reactions than is adult trauma (Courtois & Ford, 2009). Yet the specific facets of childhood that mediate or moderate this vulnerability are largely unknown. Specific measurement of the percentage of variance accounted for by IDT in traumatic response to interpersonal and noninterpersonal trauma could be used to inform interventions targeted toward those populations. IDT-specific research would ask questions such as these:

- Does Population X have the information on the seriousness of Trauma or Threat Y?
- Does Population X know the likely evolution or predictable next steps in Trauma or Threat Y?
- Does Population X know where to access resources for protection or mitigation of the consequences of Trauma or Threat Y?

Many trauma survivors frequently ask the question during treatment, “Why did this happen to me?” (Dalenberg & Jacobs, 1994). In many cases, there is no clear answer to this question, or the person would not like the actual answer (e.g., “I was sexually assaulted as a child because my close relative is a pedophile”). The trauma survivors might generate harmful self-statements to fill the void created by IDT, such as beliefs in their own inherent worthlessness, beliefs that their assailants were reacting to some signal or defect, or beliefs that they could have engaged in preventative behaviors (Courtois, 2010; Heath, Donnan, & Halpin, 1990). Information or answers about a specific traumatic event might not always be available, which leaves the trauma survivor to ponder in agony and uncertainty. Further, the trauma survivor might withhold denigrating self-views from potential helpers. The integration of an IDT perspective would encourage the provider to more routinely provide the trauma survivor with understandings of the trauma and its features or consequences. Table 2 also

Table 2. Information Deprivation Trauma Resources and Interventions List.

1. List family members or friends able to access information about the trauma/threat and keep the individual informed: _____
2. List individuals or services that can reliably or automatically notify the individual about impending threats in their area of concern: _____
3. List community resources (with VP/TTY/TDD access for d/Deaf clients) that is relevant to the person's needs: _____
4. List Internet web sites that are specifically oriented toward the needs of this client: _____
5. List emergency preparedness materials/kits that could be given to the client and that are specifically oriented toward the client's need: _____

Note: Items 2, 3, 4, and 5 are clinician-generated resources. VP = videophone; TTY = text telephone; TDD = Telecommunication Device for the Deaf.

includes a list of interventions that the clinician could provide to the trauma survivor to encourage acquisition of information and self-protective behaviors.

Conclusion

This descriptive article introduces the concept of IDT and raises a number of questions regarding its usefulness in clinical trauma work, particularly for those working with the Deaf community and other marginalized groups. Lack of access to the central information that is needed to guide one's everyday life (education, work, taxes) could move from frustrating to terrifying when the issue is emotionally meaningful (Am I ill? Is my caretaker ill? Are we under attack? Is there a dangerous situation pending?). IDT issues might be complicating the diagnosis and treatment of a given patient, and IDT-related distress could remain after the central trauma itself (a loss, an injury) has been thoroughly discussed and processed. In beginning this dialogue, we hope to encourage further thought in this area and to raise the likelihood that IDT-related questions will be included in therapies with individuals who have limited information sources due to cultural difference, disability, or individual difference.

ORCID

Sven Schild  <http://orcid.org/0000-0003-3573-9721>

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