

I attended a three day Conference which focused on recovering from trauma and addictions through wellness. **Peggy Swarbrick, PhD** discussed the concepts of personal wellness, recovery and quality of life. **Candace Tate, PhD** discussed her paper entitled **Trauma in the Deaf Population; Definition, Experience, and Services** for Deaf and Hard of Hearing adults who have experienced trauma in the United States. In addition, a Deaf woman named **Diane Squires** and I led a group discussion with Deaf and Hard of Hearing adults on their experiences with mental health diagnosis or addiction. We also discussed barriers encountered and suggestions for improving mental health services.

In her lecture, Dr. Tate brought out the issue that Deaf individuals receiving services in a mental hospital have a high rate of language “dysfluency.” This means that they are unable to communicate in either spoken English or American Sign Language. As Dr. Galuti, a Deaf psychiatrist points out, since social and emotional development depend on learning a language, Deaf individuals who have language dysfluency may not develop the emotional and social skills needed to prevent traumatic experiences. Language also helps to increase trauma resilience during recovery.

It was rather shocking to learn that trauma is significantly higher in the Deaf population than in the hearing population. According to Dr. Tate, **“Deaf children are more than twice as likely to experience physical and sexual abuse compared to their hearing peers. In addition Deaf female undergraduates experience physical assault, psychological aggression, or sexual coercion at twice the rate of hearing female undergraduates. It is therefore clear from scant research that the prevalence of trauma in the Deaf community is a significant issue and much higher than in the hearing community.”**

More research is needed to examine the risks of trauma and the resulting symptoms in the Deaf community. Deaf individuals face major challenges in obtaining behavioral health system treatment for trauma because of misunderstandings about Deaf culture and treatment. There is also an alarming lack of service providers who are culturally and linguistically competent to provide treatment and a lack of sign language interpreters for basic communication.

Candace Tate made several recommendations for improving mental health treatment services for the Deaf and Hard of Hearing population including more intensive research on the risk and preventive factors of traumatic events, symptoms of trauma and evidence based trauma assessment and treatment.

Diane Squires and I also had the opportunity to lead a group discussion with several of our Deaf and Hard of Hearing peers on their experiences within the mental health system. We also discussed wellness tools we used to empower ourselves. Many of us enjoyed hobbies such as art, knitting, crafts, computers, laughter yoga, meditation, music, karaoke. Photography, comics, reading, movies, vlogs (video blogs), kayaking, and deep breathing were other wellness tools mentioned during the discussion.

We also asked the group what services they found most helpful in the mental health service delivery system. Some peers found the Recovery Learning Communities very helpful in their recovery. Others enjoyed having peer support and wish for Deaf Peer Specialists to be incorporated in their treatment plan. Deaf forums and discussions were viewed as being very helpful and supportive. A few peers mentioned that WRAP,

Wellness Recovery Action Plan was very helpful in their wellness initiatives.

Many stated that transportation posed a dilemma and wished Deaf and HH peers could get together more often to go on social outings. They stressed sober gatherings as a chance to network because many Deaf go to bars where alcohol is provided to socialize.

Diane asked the group what barriers they encountered in their personal life. A few said they had patronizing bosses and couldn't find support groups with interpreters. There is a lack of signing therapists and often those who are culturally and linguistically competent go into private practice and insurance doesn't cover the cost. Treatment centers not willing to provide interpreters for communication access was a barrier experienced by many. Another problem that has been encountered is going into the emergency room for a non mental illness related condition and being immediately evaluated by the crisis team because the psychiatric records are in the computer data system.

It was suggested that one write a letter to the Department of Public Health to file a grievance regarding these types of incidents. It was stressed that one must know one's five fundamental human rights as a psychiatric patient because many Deaf and Hard of Hearing persons do not understand the posted rights in the hospital settings because of the English barrier. One person recommended adding advance care plans to the WRAP and teaching the ATRIUM model, Addiction Trauma Recovery Integration Model.

One Deaf peer would like to see a respite care facility run by Deaf and Hard of Hearing peers in her geographical area of Massachusetts. It was also noted that many of us have dual roles both as a professional provider in the mental health care system and as clients ourselves and the difficulty we encounter because of it. The group was very informative helpful and supportive.

The conference was an uplifting and informative one. We learned that trauma and addiction is high in the Deaf Community, but we can as peers strive for recovery by using wellness tools to seek a greater balance in our lives. This in turn will give us greater resiliency to cope with life's challenges and reduce the impact of trauma and mental illness on our social and behavioral health.