

Research Statement

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Overview

My research asks a question that behavioral health has mostly avoided: what happens to people when the system meant to treat them cannot understand what they are saying? Deaf, DeafDisabled, and hard-of-hearing people carry a burden of psychiatric and substance use conditions that is at least comparable to that of hearing people and by most measures higher (Anderson et al., 2018; Fellingner et al., 2012; Kushalnagar et al., 2019), and they receive treatment that is later, thinner, and less accurate. The prevailing explanation is that interpreters are scarce. My work argues that this is the wrong diagnosis. The barrier is structural: intake, assessment, documentation, treatment planning, and the interventions themselves are built on hearing norms, and those norms generate the appearance of noncompliance, low insight, or cognitive limitation in clients who are in fact responding sensibly to an inaccessible environment. Fixing the interpreter supply without fixing the system produces accessible entry to an unchanged room.

This claim grew out of more than fifteen years of trauma-focused clinical practice in a bilingual English and ASL setting, and it now organizes a research program with three connected lines: (1) language deprivation and its consequences for identity and social-emotional development across the lifespan; (2) behavioral health service access and treatment engagement for Deaf and disabled people, approached as a systems and intervention problem; and (3) Disability Justice critique of social work's foundational theory and assessment tools, including development of the Embodiment-Identity-Access (EIA) Assessment as a clinical alternative to deficit documentation. The three lines share a single logic. Line one explains the population and the harm. Line two is where intervention research happens. Line three supplies the theory and the instruments that make line two possible. What follows describes each line and the funding trajectory built on them.

Line One: Language Deprivation, Identity, and Development

Most deaf children are born to hearing parents, and a large share grow up without full access to any language during the years when language is most easily acquired. The developmental and psychiatric consequences of that deprivation are now documented well enough to have a name (Hall, 2017; Hall et al., 2017; Glickman & Hall, 2019), but the lived experience of it, and the way it shapes adult identity and help-seeking, has been studied far less. My phenomenological study of adults who grew up deaf in hearing families (Wetmur, 2024) addressed that gap. It found that participants described their childhoods less in terms of missing sound than in terms of missing membership: being present at the table and absent from the conversation, learning to read a room without knowing what was being said in it, and building an identity around the gap. The study received the 2026 Council on Social Work Education Disability Manuscript Award, and it is the empirical foundation for everything that follows, because the adults in that study are the adults who later arrive at behavioral health services with histories that intake forms are not built to capture.

The line continues in two directions. With Dr. Kristel Scoresby I am completing a collaborative autoethnography of Deaf faculty experience in American academia, which extends the identity work into professional adulthood and into the institutions that train social workers. With Dr.

Michael Skyer I am developing a coalitional account of Deaf political identity and disability (Wetmur & Skyer, under review; Wetmur & Skyer, in preparation), drawing on DisCrit (Annamma et al., 2013) and Disability Justice (Sins Invalid, 2019) to move past the “Deaf, not disabled” divide that has kept Deaf communities and disability communities from organizing together for access. That divide matters for behavioral health directly, because the two communities are served by different systems, funded under different authorities, and rarely studied together.

Line Two: Behavioral Health Access and Intervention for Deaf and Disabled People

This is the line where intervention research happens, and it is the one I intend to build most. The evidence base on Deaf behavioral health is small, and most of it is descriptive. We know that Deaf adults report elevated rates of substance use (Anderson et al., 2018), depression and anxiety (Kushalnagar et al., 2019; Kvam et al., 2007), and trauma exposure, including traumas that are specific to growing up Deaf in a hearing world (Anderson et al., 2016). We know that Deaf trauma survivors face distinctive barriers to help-seeking, including the reasonable fear that a clinician will not be able to communicate with them and will not know what they do not know (Anderson et al., 2017). We also know that health literacy measures, screening tools, and outcome instruments developed in spoken English do not transfer cleanly to ASL users (McKee et al., 2015). What we do not have is a body of intervention research that starts from Deaf and disabled people’s experience of the system and redesigns the system’s tools in response.

My planned program of work takes that on in three stages. The first is a descriptive and qualitative study of treatment engagement among Deaf and DeafDisabled adults in Connecticut’s public behavioral health system, tracing where people enter, where they drop out, and what clinical records say about them at each point. Connecticut is an unusually good site for this: it has a Deaf and hard-of-hearing behavioral health services infrastructure within state government, a long-standing Deaf school and Deaf community in the Hartford area, and a population small enough to study as a whole. The second stage adapts and tests the assessment and treatment-planning tools those systems rely on, beginning with the EIA Assessment described below and extending to ASL-accessible screening for substance use and trauma. The third stage is intervention development proper: technology-mediated adaptations of evidence-based practices, including DBT skills and trauma treatment, delivered in ASL with Deaf clinicians and peer specialists, and evaluated for feasibility and acceptability before efficacy. Video technology has changed what is possible here. Telehealth in ASL, asynchronous signed video content, and captioned and signed psychoeducation are already used informally in Deaf communities; almost none of it has been studied. For this population, technology-based intervention is not an add-on but the main route to scale.

I bring practice credibility to this work that is uncommon in intervention research. I have run a bilingual English and ASL trauma practice since 2017, worked as a clinical social worker at the American School for the Deaf, and treated Deaf and hard-of-hearing clients in community mental health. I am DeafDisabled myself and a native user of the language the interventions would be delivered in. That positioning shapes the methods I use: community-engaged design, Deaf and disabled co-investigators and advisors from the start, and instruments that are developed in ASL rather than translated into it.

Line Three: Disability Justice, Theory, and the EIA Assessment

Behavioral health systems fail disabled people for reasons that are theoretical before they are logistical. Social work's foundational frameworks, from its Rawlsian account of justice to its person-in-environment model to its documentation conventions, treat disability as a deficit to be assessed, accommodated, or corrected, and the tools built on those frameworks reproduce that stance at every encounter (Slayter et al., 2023). With my collaborator K. T. Durant I have developed an argument that access and accommodation are different things, and that a profession organized around accommodation will keep producing systems that disabled people have to petition their way into (Wetmur & Durant, under review). That argument draws on care ethics and on the ten principles of Disability Justice (Piepzna-Samarasinha, 2018; Sins Invalid, 2019), and we are extending it into a full-length critical text for MSW education (Wetmur, Durant, & Jackson, in preparation).

The practical output of this line is the Embodiment-Identity-Access (EIA) Assessment, a structured clinical assessment designed to replace deficit documentation with an account of how a client's body and mind actually work, how they understand themselves, and what access they need from the systems around them (Wetmur & Durant, in preparation). The EIA is built to be usable by clinicians who are not disability specialists, to produce documentation that supports rather than undermines a client's claims on institutions, and to be validated. A pilot implementation of the EIA in clinical settings is my first funded-study target, and the development-to-validation-to-implementation path it follows is the kind of translational work I intend to lead.

Funding Trajectory

I want to be direct about my funding record. My current appointment carries no research allocation, and the publications and studies above have been produced alongside a full instructional load. I have not yet held external funding as principal investigator. What I have is a program that maps cleanly onto identifiable mechanisms, a population that federal funders have named as a priority and underserved, and a start on the preliminary data that early-career mechanisms require. The trajectory below is what I would execute from a research-active line.

In years one and two, the priorities are pilot data and the first external submissions. I would apply for internal seed funding to support the EIA pilot and the Connecticut treatment-engagement study, and I would pursue the NASW Foundation and Connecticut state sources for the community-engaged elements. The first federal submissions in this window would be a NIDILRR Field Initiated Projects application (research track) for the EIA Assessment development and pilot, and an NIH R21 or R03 for the treatment-engagement study, most likely through NIMHD, with NIDCD and NIDA as alternatives depending on how the aims settle. Deaf and hard-of-hearing people are designated as a health disparity population within NIDCD's portfolio and fit NIMHD's framework for populations experiencing disparities, and NIDA has an explicit interest in populations with limited access to substance use treatment. I would also apply for the SSWR Innovation Incubator, a peer-reviewed grant-readiness program for early-career scholars that workshops a Specific Aims page and a funder-formatted Letter of Intent with SSWR mentors; the EIA pilot is the project I would bring to it. I expect to seek an NIH loan repayment award or a career development award if my appointment and the timeline make one appropriate.

In years three through five, the goal is an R01-scale or NIDILRR-scale project on technology-mediated, ASL-delivered behavioral health intervention, developed from the pilot work above, with Deaf community partners and implementation collaborators. Along the way I would pursue PCORI engagement and capacity-building awards, which fit the community-partnered design of this work, and foundation support for the Disability Justice curriculum and assessment translation. The intended outcome by tenure review is a sustained line of externally funded intervention research on Deaf and disabled behavioral health access, a validated assessment instrument in clinical use, and a set of trained doctoral students carrying the work forward.

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