Stepping Forward

Creative Approaches in Prevention, Treatment and Recovery for Deaf People

Conference Proceedings:

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Creative Approaches in Prevention, Treatment and Recovery for Deaf People

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Natasha M. Kraft, Editor

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Stepping Forward: Creative Approaches in Prevention, treatment and Aftercare for Deaf People was the third national conference sponsored by the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals focused on alcohol and other drug use and deafness. This conference was made possible through a federal grant from the Center for Substance Abuse Treatment. As in 1992 and 1994, the 2000 conference brought together community members and professionals from all over the United States and Canada. This proceeding, representing many of the conference sessions, highlights the growth of knowledge, skills and experience in this field. Innovative ways of providing alcohol and other drug services signal improvements in the quality and quantity of prevention, treatment and aftercare services. However, also apparent at the conference, was the sense that we still have work to do. Many gaps remain in the continuum of service provision and communication access continues to be a barrier.

The contributions made by Gallaudet University, the Gallaudet University Regional Center at Johnson County Community College and the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals are very much appreciated. Without the commitment and dedication of the individuals who work at these programs, this Conference could not have happened.

Thanks for your ongoing support and commitment,

Debra Guthmann, Ed.D
Co-Chair

Katherine A. Sandberg, B.S., LADC
Co-Chair

Deafness 101

Debra S. Guthmann, Ed.D
And
Lynn Bloom, MSW

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Introduction

Information about Deaf people, their culture and their language are rarely a part of chemical dependency counselor training programs. Although the Americans with Disabilities Act, which is a federal civil rights act, guarantees, access to treatment by Deaf people, few agencies actually comply with this legal mandate. Even programs that want to serve Deaf people and who are attempting to make programming accessible may not know have enough information pertaining to Deaf culture and related issues.

The Deaf Community

The majority of Deaf people use American Sign Language (ASL) as their primary means of communication. Like other minority populations, the Deaf Community has a rich history of social, cultural and linguistic features. Social norms and values shape life in the Deaf Community and therefore impact how treatment services should appropriately be delivered. People who are Deaf or hard of hearing are referred to as having a hidden disability. The disability does not become evident until the person begins to communicate. It is assumed by the hearing community, that if a person wears a hearing aid, then all listening and hearing problems are solved. Unfortunately, this is not true. Many Deaf and hard of hearing individuals are excluded from normal conversations because others do not realize that they cannot hear even with a hearing aid.

Some Facts About Deaf People

A collection of facts may help the person who is unfamiliar with Deaf people begin to understand the experience of being Deaf. The following are some key factors in the life of most Deaf people in the United States today.

*At least 90% of Deaf children are born to hearing parents;
*Deaf people have a wide range of hearing loss that may have very different effects on a person's ability to process sound and, thus, to understand speech.
*Hearing aids help some people but do not allow individuals to hear in the same manner as a person who does not need hearing aids. Hearing aids are not a cure for the condition of Deafness;
*Deaf people have varying abilities to produce speech. This is typically related to the amount of hearing loss, the frequency range of the loss, the age of onset of the loss and other factors.
*Lip-reading/ speech reading is a skill that varies from person to person (hearing and Deaf alike) and is generally ineffective for communicating since many spoken words look alike on the lips.

*Many Deaf people, although intelligent, do not have a good command of written English.

Cultural aspects of the Deaf community

In this day and age, a Deaf person can do almost anything that a hearing person can do. However, there are some aspects of a Deaf person's life that may be different from a hearing person. Deaf people have access to TV programs only if they are captioned. Deaf people have telephones but use them in a different way. The phones are called TTY's or TTD's (telecommunication devices for the Deaf) and are devices, which allow a person to type in their message instead of speaking. The emergence of relay services in most states, allows a Deaf person with a TTY to contact hearing people through their regular phone by using an operator to "relay" the messages back and forth. The use of current technology continues to enhance communication access for Deaf individuals. Currently, the use of hand held communication devices provides e-mail access to Deaf individuals in remote locations. These devices are used in a similar manner to the way a hearing person may use a cell phone. Software is now available for Deaf individuals to use their computers as telephones with a visual display so sign language can be used in the interactions. When Deaf people go to public events, like a lecture or a conference or a Twelve-Step meeting, they need to request a sign language interpreter. Even a visit to the doctor requires advance planning and securing a sign language interpreter to ensure clear and accurate communication. Many of the daily events and encounters we take for granted as hearing people, pose communication barriers for Deaf people.

In addition, the Deaf Community is rich with history and culture. Deaf people are part of a linguistic minority whose primary language is ASL. "The Deaf community is comprised of Deaf and hard of hearing individuals who share a common language, common experiences and common values" (Padden & Humphries, 1988). The language of most Deaf people, American Sign Language (ASL), is a visual language of hand shapes, hand and body motion and facial expression.

Among Deaf people, even those people who have intelligible speech rarely use their voices. Deaf people have developed methods to get one another's attention by waving, tapping on the floor or table (which produces vibrations that can be felt) or even throwing things. These behaviors substitute for our "shout across the room." Establishing, fostering and maintaining social ties with other Deaf people are of the utmost value. It is common to have friendships with Deaf people in other towns, states and all across the country. Deaf social events tend to attract Deaf people from hundreds or even thousands of miles away. Residential Deaf schools, found in most states, have historically been the core of Deaf education. These and many other factors come into play when we provide substance abuse services for Deaf clients.

The Deaf community is a small close-knit group of people who have a strong grapevine in which they share information on a national basis about each other. The idea of confidentiality is viewed differently among Deaf and hard of hearing individuals than it is among hearing people. This grapevine can cause unique problems when a Deaf person enters a treatment program because of the issues that may arise. Deaf people may have concerns about confidentiality or may know other patients or staff at the program. Hearing individuals would not typically encounter this type of situation since there are so many more treatment options.

Communicating with Deaf People

When communicating with most Deaf individuals, the use of lip reading alone is not adequate because of the large number of words that look alike on the lips. In tests, using simple sentences, Deaf people recognize perhaps three or four words in every sample that is used. Sit in front of a television set with the sound turned off and see if you can comprehend what is being said. The majority of what is being said would not be understood since only 20% of all speech is visible on the lips (Jeffers & Barley, 1971). This is what a Deaf individual is faced with on a daily basis. Lip-reading alone is not a feasible communication option for the majority of Deaf individuals! Deaf people are put in situations where they are forced to communicate by writing back and forth. For most Deaf people, when working with a hearing person who is not fluent in ASL, the use of a sign language interpreter is the only method of accurate and reliable communication.

It is important to remember that not all Deaf persons use the same mode of communication. You should always ask the Deaf person how he/she prefers to communicate. Oral or sign language interpreters are trained professionals who provide the necessary communication link between hearing people and Deaf or hard of hearing individuals. Interpreters facilitate communication for both parties involved with the conversation.

Interpreters are not simply individuals who know sign language. Like counselors, they are professionals who generally receive training from an Interpreter Training Program and are certified by the national Registry of Interpreters for the Deaf (RID) or other accrediting agencies. A “signer” is generally someone who has taken sign language classes. A “signer” may only communicate at a basic level and should not be thought of as an “interpreter.” A family member who has attended sign language classes, but is not a certified interpreter is also considered a "signer" and should not be used to interpret for a Deaf family member who may be a client in a treatment program. Sign Language Interpreters change the signed message into spoken English for the hearing consumer. They also interpret (using sign language) to relay the spoken message for the consumer who is Deaf or hard of hearing. Oral Interpreters work with consumers who are Deaf or hard of hearing and rely solely on speech reading for communication. An oral interpreter enunciates, repeats and/or rephrases a speaker’s remarks using natural lip movements and gestures. They carefully choose words that are more visible on the lips. Tactile Interpreters, are interpreters who work with Deaf or hard of hearing individuals, who have a visual impairment and receive their communication through touch.

When working with an interpreter, always ensure that the environment is conducive to visual communication, by making sure that the lighting is optimal and visual distractions are minimized. A neutral or dark background behind the interpreter is often a preferable setting. If you are meeting with a Deaf person in a room where there is poor lighting, it will be more difficult for you to ensure accessible and accurate communication. It is important to have the Deaf person’s attention before speaking. To get a Deaf or hard or hearing person’s attention, it is appropriate to tap on the shoulder or wave gently. Make sure to look directly at the Deaf person while speaking even though the natural tendency may be to look at the interpreter. Eye contact is important when communicating with Deaf people. Be aware that if you look away or look elsewhere, it may be distracting for the Deaf person.

During conversation, treat the Deaf person with the same courtesy that you would give to a hearing person. Do not place anything in your mouth while speaking to a Deaf person, and

avoid covering your mouth with your hand or with papers. Enunciate each word clearly, but do not exaggerate or over-pronounce words. When asked repeatedly for clarification, rephrase a thought rather than repeating the same words. Use "check-back" strategies to ensure that both parties understand each other clearly. Remember, the presence of an interpreter does not guarantee clear communication. Make sure that your messages are being relayed accurately.

Make sure you and the interpreter sit next to each other so the Deaf person can see both of you. Speak directly to the Deaf person rather than saying, "Ask him how he feels?" or "Tell her to explain again." Speak at a reasonable pace as the interpreter's signing usually lags about four seconds behind your speaking. The interpreter will interpret everything that you say. If you do not want something interpreted, do not say it. Allow time for questions from the Deaf person and time for the interpreter to finish signing your message and/or voicing the Deaf person's message. Most important of all, do not ask the interpreter for opinions.

Like other professionals, interpreters are bound by a code of ethics. They abide by standards of confidentiality and operate within the parameters of their training and skills. In the substance abuse setting, it is preferable to retain an interpreter who has some knowledge of the language and principles of the field of addictions. Keep in mind, that the presence of an interpreter, even a highly qualified, competent and ethical professional results in a change in the counseling or assessment session. The presence of a third person, even in the capacity of an interpreter cannot help but change the session dynamics. Be willing to talk about this as you would any other counseling issue.

Many agencies are not aware of how to secure an interpreter to facilitate their work with Deaf or hard of hearing clients. Most states have an agency that is responsible for the provision of information and services about Deaf and hard of hearing persons. Commissions for the Deaf and Hard of Hearing, Vocational Rehabilitation Services or Deaf and Hard of Hearing Services at the state level may be able to direct you to interpreter referral services. Costs for interpreters vary from place to place and also depending on the level of skill or experience of the individual interpreter.

Conclusion

By understanding hearing loss from different perspectives and by recognizing the barriers to effective service, counselors and agencies can enhance their ability to provide substance abuse services to persons who are deaf or hard of hearing. In addition, service providers are encouraged to become knowledgeable about resources and other kinds of service for deaf persons in their community or state.

Resources

Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals
2450 Riverside Avenue
Minneapolis, MN 55454
(612) 672-4402 V; (612) 672-4114 (TTY); 800-282-3323 V/TTY
e-mail: MNCDDeafHH@aol.com
Home page: www.mncddeaf.org

Debra S. Guthmann, Ed.D is the director of the Division of Pupil Personnel Services at the California School for the Deaf in Fremont, CA, and the former director and current project director at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals located in Minneapolis, Minnesota. Dr. Guthmann has written numerous articles and several book chapters, developed materials, provided outreach and training activities nationally and internationally regarding various aspects of substance abuse with Deaf and hard of hearing individuals. Dr. Guthmann is also the Treasurer of the American Deafness and Rehabilitation Association (ADARA) and Secretary of the National Association of Alcohol Drugs and Disability (NAADD).

Lynn Bloom, MSW is a chemical dependency counselor at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. Lynn attended a mainstreamed program for her K-12 education and graduated from Rochester Institute of Technology with a B.S. in Social Work. Lynn received her M.S.W. in Social Work from Augsburg College.

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Models of Alcohol and Other Drug Treatment for Consideration when Working with Deaf and Hard of Hearing Individuals

Debra Guthmann, Ed.D
Contributions by Katherine A. Sandberg, B.S., L.A.D.C. and Ron Lybarger, Ph.D.

Abstract

There are numerous models and approaches used to treat chemical dependency. The majority of these programs are used with hearing people, and there is a lack of experience in the use of these models within the deaf and hard of hearing community. This article will focus on the Twelve Step model, Cognitive Behavioral Therapy Model and the Bio-Psycho-Social Model (Social Program Model). A discussion and comparison with the harm reduction model will also be discussed.

Introduction

When looking for the most appropriate alcohol or drug treatment program for a deaf or hard of hearing individual, it's important for disability service providers, vocational rehabilitation counselors, clinicians, family, friends or others who are involved in the search to know the elements of the most common treatment models and of quality programs. There are several main models or approaches to alcohol and drug problems.

One of the most traditional and prevalent ways to treat substance abuse problems is with an abstinence-based approach. This model is based on the philosophy that once a person is addicted, he or she needs to stop using alcohol and drugs entirely; the person has gone beyond the point of being able to make choices about when or how much to use. Within the general category of abstinence-based programs, there are several components of these models that can be used in a treatment program, making the approach quite eclectic. Another model gaining recognition for the treatment of substance abuse is a harm reduction approach. People using this model don't necessarily disagree with the idea of abstinence, but believe that abstinence is an unrealistic goal, and instead focus on other goals such as less problematic use. For example, methadone maintenance programs-providing a drug called methadone to heroin addicts – are a way of ensuring the addict will not obtain narcotics illegally, and will not be exposed to the dangers of injection. Harm reduction approaches have also been found useful when a person is not at a point of addiction, but may be abusing chemicals and could be taught to use in a more responsible manner.

12-Step Model/ Disease Model / Minnesota Model:

The Twelve Step/Disease Model/Minnesota Model is a comprehensive, multi-disciplinary approach to the treatment of addictions which is abstinence oriented and based on the principles of Alcoholics Anonymous. There are a variety of elements that are commonly associated with primary treatment when using this model and they include: group therapy, lectures, recovering persons as counselors, multi-disciplinary staff, a therapeutic milieu, therapeutic work assignments, family counseling, the use of a Twelve Step program, daily reading (Twelve Step literature) groups, the presentation of a life history, attendance at AA/NA meetings and the opportunity for recreation/physical activity. These elements are generally

integrated into a structured daily routine. Local AA/NA groups provide the mainstay of the aftercare phase.

This model focuses on chemical dependency as the primary problem. It is neither blaming nor punitive and it views seeking treatment as an appropriate response. E.M. Jellinek was one of the most influential contributors to the disease concept of alcoholism. Jellinek characterizes alcoholism, as a progressive disease with several stages with the final stage as one in which there is liver, nervous system and other physical damage. This stage requires medical monitoring of withdrawal because of the serious symptoms that develop when alcohol intake is stopped. More recent studies suggest that not all alcoholics reach this stage. In fact, perhaps most do not.

This model is by far the most widely used treatment model. Using the Twelve Steps, individuals are guided through a process of understanding the nature and extent of their alcohol/drug problem, how their unique characteristics create barriers and/or strengths for recovery, and the importance of relying on a power or powers greater than themselves rather than willpower. According to this view, alcohol abuse is a disease. Treatment emphasizes admitting powerlessness over alcohol, and advocates adopting the norms and values of a new social group, the AA self-help group, in order to achieve total abstinence. These programs typically provide the best match for persons with the following attributes; physically dependent on alcohol, benefit from the support of a self-help group, and have a spiritual *orientation.* Hospital-based medical model programs are described as including the following components: inpatient detoxification and rehabilitation services, and day/evening outpatient services. The program capacity typically will vary in size and inpatient stays historically were about 28 days but have been severely shortened largely because of funding considerations. Day outpatient services and evening outpatient services are spread over a longer period and tailored to the needs of the individual.

In addition to the therapeutic portion of the program, as the name suggests, this model also attends to the physical/health/medical needs of the patient. Typically, alcoholics or addicts presenting for chemical dependency treatment have neglected their health and physical care. Symptomatic medical treatment may be required for malnutrition, liver problems or other health care concerns.

Twelve-Step programs emphasize treatment activities such as attending Twelve Step meetings in the community and/or facility, and participating in psychotherapy groups that cover topics such as working the steps, using the "Big Book," and writing an autobiography. Outcomes desired in Twelve Step treatment include acceptance of an alcoholic/addict identity, acknowledgment of a loss of control/ powerlessness over the abused substance, and adherence to abstinence as a treatment goal.

There is also an emphasis on a solid aftercare plan to support ongoing recovery after treatment completion. Typically, aftercare plans incorporate securing a safe, sober living environment; attending AA or other Twelve Step support meetings several times each week; securing a sponsor in AA; and ongoing support and counseling sessions to continue the work begun in treatment.

Cognitive Behavioral Treatment Model

The Cognitive Behavioral Model involves individuals learning how their thoughts, feelings and behaviors (especially drinking/using behaviors) are connected, and how to break

those connections. The counselor helps the person analyze his or her environment and ways of responding to cues to use alcohol or drugs, and establish new patterns of response to those cues. The Cognitive Behavioral Therapy Model is based on cognitive therapy, which is a system of psychotherapy that attempts to reduce excessive emotional reactions and self-defeating behavior by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions (Beck et al. 1993). Cognitive Behavioral Therapy (CBT) is particularly similar to cognitive therapy in its emphasis on functional analysis of substance abuse and identifying cognitions associated with substance abuse. It differs from cognitive therapy primarily in terms of emphasis on identifying, understanding, and changing underlying beliefs about the self and the self in relationship to substance abuse as a primary focus of treatment.

In the initial sessions of CBT, the focus is on learning and practicing a variety of coping skills, only some of which are cognitive. Initial strategies stress behavioral aspects of coping (e.g., avoiding or leaving the situation, distraction, and so on) rather than thinking one's way out of a situation. This type of program requires participation in relapse prevention groups and therapy groups as well as training in cognitive skills, behavioral skills, and abstinence skills. The goals of treatment are for the patient to develop ways of coping, enhanced sense of self-efficacy, and modification of expectations of the substances effects.

CBT is a short-term, focused approach to helping chemically dependent individuals become abstinent from alcohol and other substances. The underlying assumption is that the learning processes play an important role in the development and continuation of alcohol and drug abuse and dependency. CBT attempts to help patients recognize the situations in which they are most likely to use alcohol and/or other drugs, avoid these situations when appropriate, and cope more effectively with a range of problems and problematic behaviors associated with substance abuse.

For each patient who is in treatment, the therapist and patient do a functional analysis, that is, they identify the patients' thoughts, feelings and circumstances before and after the drug and/or alcohol use. Early in treatment, the functional analysis plays a critical role in helping the patient and therapist assess the determinants or high-risk situations that are likely to lead to chemical use. It also provides insights into some of the reasons the individual may be using alcohol and/or other drugs (e.g. to cope with interpersonal difficulties, to experience risk or euphoria not otherwise available in the patients life). Later in treatment, functional analyses of episodes of chemical use may identify those situations or states in which the individual still has difficulty coping. Training focused on interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships is a crucial element of the treatment process.

An individual format is preferred for CBT because it allows for better tailoring of treatment to meet the needs of the specific patients. Patients are better able to build relationships with the therapist over time, and have more flexibility in scheduling sessions. Also, the comparatively high rates of retention in programs and studies may reflect, in part, particular advantages of individual treatment. CBT is usually offered in 12-16 sessions, usually over 12 weeks. This comparatively brief, short-term treatment is intended to produce initial abstinence and stabilization. In many cases, this is sufficient to bring about sustained improvement for as long as a year after treatment ends. Treatment is usually delivered as an outpatient service focusing on understanding the determinants of substance use. By understanding who the patients

are, where they live, and how they spend their time, therapists can develop more elaborate functional analyses. It has also been found that skills training is most effective when patients have an opportunity to practice new skills and approaches within the context of their daily routine, learn what does and does not work for them, and discuss new strategies with the therapist. CBT is generally not appropriate for those who have psychotic or bipolar disorders and are not stabilized on medication, those who have no stable living arrangements, or those who are not medically stable.

CBT is highly compatible with a variety of other treatments including pharmacotherapy; self-help groups such as: Alcoholics Anonymous, family and couples therapy, vocational counseling, and parenting skills training. While Twelve Step meeting attendance is not required or encouraged in CBT, some patients find attending meetings helpful in their efforts to become or remain abstinent. CBT therapists take a neutral stance and may explore how going to a meeting when faced with strong urges to use may be a very useful strategy. However, therapists will also encourage patients to develop a range of other strategies. The characteristics that distinguish CBT from other treatment approaches include: functional analyses of substance abuse; individualized training in recognizing craving, managing thoughts about substance use, problem-solving, planning for emergencies, recognizing seemingly irrelevant decisions, and refusal skills, examination of the patients cognitive process related to substance use, the identification and debriefing of past and future high-risk situations, the encouragement and review of extra-session implementation of skills and the practice of skills within sessions.

Bio-Psycho-Social Model/Social Model:

The Bio-Psycho-Social Model is an experiential, peer-oriented process that represents a much less expensive alternative to medically oriented substance abuse treatment delivered by clinicians. The Social Model has broadly been categorized as a sociocultural model and believes alcohol problems stem from a lifetime socialization process in a particular social and cultural milieu that implicitly or explicitly encourages alcohol drinking. This model is participatory versus non-participatory; and the community orientation is integration versus introduction. Like Alcoholics Anonymous (AA), social model practitioners believe that alcoholism is a multifaceted disease, one that is caused by a combination of factors: moral/spiritual, biological, psychological, and social/environmental. This definition represents an expansion of the medical models conceptualization of alcoholism as a unitary disease with physiological roots only, best treated by medical expertise (Miller & Kurtz, 1994).

In the social model, chemical dependency is believed to result from environmental, cultural, social, peer or family influences. Substance abuse is viewed as an outcome of external forces such as poverty, drug availability, peer pressure, and family dysfunction. Using this model, the goal of treatment is to improve the social functioning of substance abusers by either altering the social environment or altering the individual's coping responses to environmental stresses. The strategies for changing the environment include family or couples therapy, attendance at self-help groups where one is surrounded by nonusers, residential treatment, and avoidance of stressful environments where substances are available. The strategies for changing a substance abuser’s coping responses include group therapy, individual therapy, social skills or assertiveness training, and stress management.

The Social Model Programs evolved in the late 1940's out of the AA 12th Step of reaching out to help other alcoholics as a way of sustaining sobriety. Known in academic circles as the helper-therapy principle (Reissman, 1965) and in AA as Twelve Stepping or Twelve Step work, a major principle guiding both AA and social model programs is that alcoholics are themselves helped when they provide service to others. Other similarities to AA include participant involvement in running the program (self-governance) and in maintaining it (self-supporting) and the eschewing of hierarchy. Unlike AA, Social Model Programs act as advocates for participants and put them in contact with community resources for legal, family, medical and employment problems. Some encourage the community to create sober activities and environments. Many Social Model Programs have paid staff, accommodate funders and regulatory agencies, and provide clients with educational sessions, relapse prevention groups and other structured activities that go beyond the AA paradigm.

In 1980, another feature of the Social Model Programs emerged which added community advocacy to the program services. Its proponents recognized the need to promote not only individual recovery but also to change the norms, values, policies and practices regarding alcohol in the community and society (Hayes et.al., 1993). This community aspect examines the context in which drinking occurs and seeks ways to modify the environment.

As mentioned above, the Social Model Program structure is based on the Twelve Traditions of AA and seeks to create democratic group processes in which leadership is shared and rotated with little hierarchy. Recovering participants are viewed as the top of an inverted pyramid, followed by the program staff, and then the board of trustees at the bottom. Individuals and groups of recovering participants are given as much authority as they can handle responsibly. Social Model Programs configure human resources differently than professional treatment programs. Directors, staff and volunteers who contribute to staffing are usually recovering alcoholics and drug addicts with experiential knowledge of recovery. Recovering residents/participants are providers as much as consumers of service and persons in recovery are viewed as critical to the peer recovery process. Programs are client run in day-to-day problem solving, rule making and enforcement by Residents Council of participants who have been sober in the program for a designated time period. There appear to be self-correcting mechanisms that discourage resident abuse of power, in part via AA Traditions 2 (“our leaders are but trusted servants, they do not govern”) and 12 (“practice principles before personalities”) (Alcoholics Anonymous World Services Inc., 1991).

Recovering alcoholics and substance abusers who staff Social Model Programs are often alumni of the programs in which they work, sometimes with degrees in related fields. This model of recovery emphasizes that the peer recovery process within programs does not need to be managed or controlled; the major objective of the director and his/her staff is to provide and sustain a physical, social and spiritual environment conducive to recovery. Clinical case-management programs schedule activities and use counselors and therapists to motivate clients and provide recovery information but the peer group serves as the primary motivator for the new resident to participate in recovery activities.

Harm Reduction

Harm reduction is a public-health approach to dealing with drug-related issues that places first priority on reducing the negative consequences of drug use rather than on eliminating drug

use or ensuring abstinence. The harm reduction model upholds that abstinence is the ideal goal for those using illegal drugs. Abstinence from drugs reduces drug-related harm completely. It is hoped that all individuals who use illicit substances will eventually come to give them up entirely. Proponents of harm reduction recognize that there will always be illicit drug use and that many people are simply unwilling or unable to give up drugs entirely but nonetheless could benefit from intervention. Harm reduction accepts that some use of mind-altering substances is a common feature of human experience. It acknowledges that, while carrying risks, drug use also provides the user with benefits that must be taken into account if drug-using behavior is to be understood. Ambivalence is such a strong factor in drug abuse that when the abstinence mandate is in effect, many people will just avoid addiction services.

Over the last decade, harm reduction has become a subject of growing discussion and debate within the addictions community, and increasingly, by the media and the general public. It has emerged as an alternative approach to abstinence-oriented drug policies and programs. A significant degree of confusion and controversy has also attended its rise to prominence. Some harm reduction advocates consider the reform of laws prohibiting drug possession to an integral part of harm reduction, while others do not. Some persons consider the imprisonment of drug users for simple possession to be a form of harm reduction. Practitioners dedicated to abstinence may also think of themselves as reducing the harms of substance abuse. It may help to distinguish between harm reduction as a goal and harm reduction as a strategy. As a general goal, all drug policies and programs aim to reduce the harm associated with drug use. As a specific strategy, the term harm reduction generally refers to only those policies and programs, which aim at reducing drug-related harm without requiring abstention from drug use. Thus defined, harm reduction strategies would not include strategies such as abstinence-oriented treatment programs or the criminalization of illicit drug use-even though these policies and programs share the same goals as harm reduction strategies.

Many harm reduction-based programs such as needle exchanges are of more recent origin. Others however, have a long and proven history. Methadone programs for example date back to the 1960's and have demonstrated their effectiveness in assisting drug users to stabilize and normalize their lifestyles and to provide many with a bridge to abstinence from narcotic use. Helping people avoid harm has also been an established part of the alcohol field for many years. Examples include promotion of responsible drinking, controlled drinking interventions, avoidance of drinking and driving, and low alcohol content beverages. Other approaches may also include finding a safer route of drug administration, safer substances, reduction of harmful consequences of drug use, reduction of frequency of drug use, reduction of the intensity of drug use and the reduction of the duration of drug use. Several European cities have developed facilities known as tolerance zones, injection rooms, health rooms, or contact centers where drug users can get together and obtain clean injection equipment, condoms, advice and /or medical attention.

The drug user’s decision to use drugs is accepted as fact. No moral judgment is made either to condemn or to support use of drugs, regardless of level of use or mode of intake. The dignity and rights of the drug user are respected. The fact or extent of a person’s drug use is secondary to the risk of harm consequent to use. The first priority is to decrease the negative consequences of drug use to the user and to others. Harm reduction neither excludes nor presumes the long-term treatment goal of abstinence.

Harm reduction approaches to addictive behavior are based on three central beliefs, which include: (1) Excessive behaviors occur along a continuum of risk ranging from minimal to extreme - addictive behaviors are not "all or nothing" phenomena. A drug or alcohol abstainer is at risk of less harm than a drug or alcohol user; a moderate drinker is causing less harm than a binge drinker; a crystal meth smoker or sniffer is causing less harm than a crystal injector. (2) Changing addictive behavior is a step-wise process, complete abstinence being the final step. Those who embrace the harm reduction model believe that any movement in the direction of reduced harm, no matter how small, is positive in and of itself. (3) Sobriety simply isn't for everybody. Bold and radical, this statement requires the acceptance that many people live in horrible circumstances. Some are able to cope without the use of drugs, and others use drugs as a primary means of coping. Until we are in a position to offer an alternative means of survival to these folks, we are in no position to cast moral judgment.

Case Study

Sue is a 29 year-old single white Deaf female who lives alone in an one-bedroom apartment. Sue graduated from a residential school for the Deaf and is the only Deaf member of her family. Sue's family signs very little, writing and lip-reading is how most of their communication occurs. The Deaf community near her home is very small with limited opportunities for socialization. She is not involved in a long-term relationship and works at a job located about 10 miles from her home. Her brother and mother lived about 200 miles away and have been concerned for some time about her drinking. They report she drinks heavily and that her apartment is extremely untidy and poorly maintained. They are concerned that she regularly over-eats to cope with her problems, and are afraid that she might attempt suicide.

Sue's supervisor at work became concerned due to frequent absences and some occasions where Sue fell asleep at work. He referred her to an EAP counselor affiliated with her place of employment. Sue went to see the EAP counselor because it was strongly recommended, but she didn't feel any need to see the person.

Sue met the EAP counselor and communicated using an interpreter. She appeared to the EAP counselor to be overweight, tired and sad. When asked by the EAP counselor about her drinking habits, she denied drinking excessively but admitted she did overeat. Sue stated that she had been stopped for driving while under the influence but had been let go when the police officer realized she was Deaf. Sue also talked about drinking alone at home to help her fall asleep at night. She described having a friendship with a man on e-mail. She stated that she hoped their relationship would become closer in the future. She talked about another male friend with whom she had discussed her depression, and who had been encouraging her to get help. She explained her absences as due to being tired and not feeling well. She admitted to drinking once in a while and to eating excessively in an effort to feel better. Sue's family has a history of depression, although neither her mother nor her grandmother had ever been treated. The family norms seem to discourage "complaining" about problems or admitting to depressed feelings.

The EAP counselor recommended that she attend outpatient chemical dependency treatment to further evaluate and address her drinking problems as well as the other issues.

Application of the Twelve-Step Model to the Case Study

When Sue is admitted to the Program, she meets with the nursing staff and is seen the same day by a physician. Her physical condition is assessed. Because she has been drinking so heavily, she is closely monitored for signs of withdrawal for the first 24 hours. Her doctor writes a standing order for Ativan to help her deal with withdrawal symptoms. As a part of her admission process, she is asked about her eating habits and her weight. A multi-vitamin is prescribed and an appointment is arranged for Sue to see the hospital dietician. Because of concerns about suicide, a suicide assessment is also completed with Sue.

Sue begins the process of treatment with an assignment designed to help her share her drug use history and the consequences of her use. Because she is deaf and English is not her first language, Sue will be asked to produce her work using drawing(s). The purpose of the evaluation assignment is to help Sue identify the extent of her alcohol/other drug problem and to enable staff to made a diagnosis. During the evaluation phased, Sue will also be monitored for signs of depression. Once she has been detoxed, a determination will be made about any signs of depression. If depressive symptoms persist, a trial on anti depressant medication will be implemented.

Once Sue has completed her assignment and presented her work in-group, she is referred into primary treatment. She will begin working on assignments related to the Twelve Steps of AA. Her Step One work will emphasize the concepts of unmanageable and powerlessness over drugs/alcohol. Step One work also emphasizes that Sue is not alone, that she is similar to her peers in-group. After completing Step One, Sue will move on to Steps Two and Three which will focus on developing a relationship with a Higher Power, developing a sense of hope and practicing new behaviors that support recovery. Steps Four and Five will be pursued with Sue if she is determined to be emotionally stable and willing to do a complete moral inventory. If Steps Four and Five are not appropriate at this time, Sue will be advised to pursue them at a later time with a minister or a sponsor. Family members will be encouraged to come and participate with Sue in a family week experience. Sue will complete her treatment stay by looking at relapse prevention information and skills and by working on an aftercare plan with the staff. Throughout her treatment stay, her eating problems and depression will be monitored. These factors will be taken into consideration when developing assignments but are not the primary focus of her treatment experience.

Aftercare recommendations for Sue will likely include abstinence from all mood altering chemicals (unless following the prescription of a doctor), ongoing counseling related to her eating problems and depression, attendance at Twelve Step meetings, securing a sponsor and participation in relapse prevention efforts and support groups. Ongoing family counseling should also be considered. Sue will need a safe, sober living environment and will be encouraged to develop new relationships with people who are sober.

Application of the Cognitive Behavioral Treatment Model to the Case Study

When Sue presented for a diagnostic interview, she reported to the counselor that she had been abstinent from the use of alcohol for approximately ten days. The clinician gathered a thorough history and scheduled Sue for bi-weekly individual sessions.

Based on the information gathered in the intake interview, it was determined that Sue was suffering from alcohol dependence, depression, and the counselor identified a possible eating

disorder. A referral was made for Sue to see a Psychiatrist so that she could be evaluated for the possibility of a trial on antidepressant medication. Sue and the clinician collaborated on a treatment plan that included a primary focus on her drinking behaviors. It was also decided to address negative thoughts and behaviors that contribute to her depression within the context of the substance abuse counseling. It was agreed that if Sue could continue to remain abstinent from the use of alcohol and begin to identify the thoughts, feelings, and behaviors that led her to drink and experience depression, she would be more capable of addressing her other issues in time.

In the first scheduled individual appointment, Sue and her therapist did a functional analysis of her alcohol abuse. The emphasis was placed on identifying her thoughts, feelings and behaviors that led to the use of alcohol. They reviewed this analysis and identified various high-risk situations that led to drinking behavior. Subsequent sessions focused on providing Sue with information regarding the process of addiction, recovery and relapse with an emphasis on the individual, idiosyncratic nature of Sue's drinking behavior.

Sue was supported in the process of developing more effective coping skills through focusing on tasks including emotional identification and regulation, self-efficacy development, problem solving, communication, refusal skills, self-regulation, and planning. She was also encouraged to attend support group meetings.

As Sue effectively maintained sobriety, she was supported and encouraged to identify ways her thinking, feeling, and behavior had changed. Her personal responsibility in the change that had occurred was heavily emphasized. Special emphasis was placed on how her decision-making had resulted in the outcomes she had experienced. Prior to the completion of Sue's treatment her family members were involved in a session and provided with information related to addiction, recovery and relapse and offered recommendations regarding how they could support Sue's ongoing recovery.

Sue and her counselor developed and implemented detailed relapse prevention during the later part of her treatment. In the last session of the sixteen-week course of treatment, Sue and her therapist reviewed her treatment and assessed her current status. Sue had successfully maintained sobriety for nearly 12 weeks and her feelings of depression were subjectively improved. Sue reported that she continued to be concerned about her eating behavior. She was referred for an assessment at a local eating disorders program. In addition to completing this assessment, follow-up sessions were recommended along with regular attendance at support group meetings and active practice of her relapse prevention plan. Medication compliance was also strongly recommended.

Application of the Social Treatment Model to the Case Study

Sue arrived at the program, located in a large refurbished boarding home, and immediately participated in a community meeting. During this community meeting she was introduced to the program staff, all of which were recovering and deaf. Sue was informed that she would receive support and encouragement primarily from her peers. She was instructed to seek them out for information and support. In her orientation to the house, she was educated about the community emphasis of the program. She was informed that she would be expected to participate in all program activities including: daily house meetings, peer government, regular attendance at AA/NA meetings, lecture/discussion groups with the other residents, and that she

would be responsible to maintain her living area as well as completing a community task each day.

Sue experienced some mild withdrawal during her first few days in the program. She was paired with another resident who was near the completion of her treatment. Her peer monitored Sue's situation and provided emotional support. This peer communicated with the program staff and there was a contingency plan in the event Sue needs medical attention. Sue did not require medical intervention and was soon participating in all aspects of the program.

Sue's typical day included morning lectures, noon meetings of AA/NA, afternoon skills building classes, and evening 12 step meetings. Morning lectures focused on topics such as the 12 Steps, the 12 traditions, the disease concept of addiction, the process of addiction and recovery, the dynamics of relapse, nutrition, family dynamics, community resources, and recreation. Skills building classes included interactive discussions of coping and problem solving strategies, assertiveness training, goal setting, communication, social competence, and emotional identification and regulation. Sue secured an AA sponsor and had frequent contact with her and began to establish a new peer group through people she met at support group meetings.

As Sue progressed through the program, she was given more responsibility and eventually became a leader within the community. Sue invited her family to participate in the later stages of her treatment and they became a source of support. She was able to communicate with them more openly and effectively. The program provided an interpreter for family groups and interactions between Sue, her mother and brother.

Sue returned to work after a month in the program and maintained residence at the house for an additional 30 days. She transitioned to an Oxford House and moved there upon completion of treatment. Upon discharge, Sue reported that she felt she had made significant progress. She had maintained sobriety for 60 days and reported that many of her depressive symptoms had improved. She indicated that she would seek medical assistance if her depression returned. Sue also reported that her eating habits had changed and that she had lost weight. She indicated that she would also monitor her eating and seek help if needed. Sue's goal in the near future was to return to the treatment program attended and provide support to other residents in the program.

Application of the Harm Reduction Treatment Model to the Case Study

Sue chose the option of participating in a Harm Reduction program in response to the recommendation by her EAP counselor to attend outpatient chemical dependency treatment. Sue met with her counselor and completed an intake interview. Based on information obtained during this interview, Sue's counselor, a deaf social worker, informed her that her drinking behavior constituted a moderate risk. Sue was referred to a psychologist for evaluation of her depression and eating behaviors. The psychologist recommended a trial on antidepressant medication and individual sessions with a therapist who specialized in working with individuals who suffer from eating disorders. Sue accepted and followed both recommendations.

Sue's chemical dependency counselor explained that the philosophy of the program was to encourage her to minimize the harm she caused herself and others through her use of alcohol. Sue was told that abstinence was the ideal goal but that she might reach this goal gradually over time or that she could possibly eliminate the risks involved with drinking and eventually be able to drink in moderation.

Sue was encouraged to abstain from the use of alcohol for at least 30 days and it was recommended that she meet with her chemical dependency counselor twice weekly. In counseling sessions, her counselor assisted her in the process of examining how her drinking had impacted her life including ways it had prevented her from pursuing her priorities in life. Sue and her counselor generated a list of Sue's life priorities and short and long-term goals. They worked together to assess how much, how often, and under what circumstances Sue drank and what the outcomes of her drinking behavior involved. In counseling sessions, Sue was given the opportunity to discuss her family history and other significant events of her development and reflect on how this history impacted her current drinking behavior. She was also provided with information on coping and problem solving strategies, assertiveness, communication, emotional identification and regulation, relationships, and sources of social support in the community.

Upon completion of the 30-day outpatient treatment program Sue reported that she had successfully remained abstinent for 30 days. She indicated that she had gained significant insight into how her drinking negatively impacted her life and expressed a desire to pursue ongoing sobriety. She was encouraged to continue practicing the new skills she had developed and to establish new social relationships. Her counselor recommended that she attend AA meetings and continue her sessions with her psychologist.

Debra S. Guthmann, Ed.D is director of the Division of Pupil Personnel Services at the California School for the Deaf in Fremont, CA, and the former director and current project director for a long-term training and conference grant at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals located in Minneapolis, Minnesota. Dr. Guthmann has published numerous articles, developed materials and provided outreach and training activities nationally and internationally regarding various aspects of substance abuse, mental health and other topics related to work Deaf and hard of hearing individuals.

Katherine A. Sandberg, B.S., L.A.D.C., is program manager of the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, located in Minneapolis, Minnesota. Ms. Sandberg was also involved in the development of a specialized version of the Drug Abuse Resistance Education (D.A.R.E.) Curriculum and has published articles, presented at conferences and workshops, provided material development and provided outreach and training activities in the area of substance abuse with Deaf and hard of hearing individuals nationally.

Ron Lybarger, Ph.D., has worked at the Kansas School for the Deaf, Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, Research Medical Center-Deaf Services, and is currently employed by the Missouri Department of Mental Health and has a Private Practice in the Kansas City Metropolitan area. Dr. Lybarger holds degrees in Sign Language Interpreting, Addiction Studies, and Counseling Psychology. Dr. Lybarger is also a published author and a frequent presenter at regional, and national conferences in issues related to mental health and deafness.

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The Use of Adventure Based Counseling With Chemically Dependent Deaf Individuals

Barry Blood, M.A., N.C.C., LCPC

Research has shown that relationships play an integral part in the recovery process for chemically dependent people. Healthy and supportive interaction with others offers a foundation for rebuilding their lives, and making changes that sustain their sobriety. A necessary component of relationships are the ability to trust and share intimately. There are indications that certain factors exist for the Deaf chemically dependent person that may impede the development of supportive relationships within the Deaf community. Alternative or adjunctive therapies may be considered when addressing the needs of these consumers. Adventure Based Counseling, a relatively new approach in the treatment of chemical dependency, has demonstrated positive outcomes with groups and may work as a catalyst in developing supportive peer relationships for Deaf consumers.

> *"To watch people recover, to see them help others, to watch loneliness vanish, to see a fellowship grow up about you, to have a host of friends – this is an experience you must not miss"* (A.A. Big Book).

This comment may have been intended more as a prediction than as an encouragement as it is commonly recognized that building healthy relationships is an important component for successful recovery from chemical dependency (Miller, Gorski & Miller, 1992; Beattie, 1987; Brown, 1985). On a daily basis people live within relationships to their family, work environment, social network, and community. These interactions are severely impaired by chemical dependency and are often altered in ways that serve to feed into a cycle of continued use (Miller, Gorski & Miller, 1992; Beattie, 1987). As the addiction to drugs and alcohol worsens, a person's ability to maintain healthy boundaries, share responsibilities, and support mutual trust is more harshly affected.

Because chemical dependency is viewed as being centered in relationships, changing their nature becomes a primary concern in the recovery process (Brown, 1985). For many, making changes in their interaction with "people, places and things" characterizes early recovery. Those who have access to stable, healthy and supportive relationships, such as those found in self-help programs, will begin to learn how to restructure and rebuild their life with others. It is however, considerably more complicated for those who do not have access.

The chemically dependent Deaf person is at a considerable disadvantage in regard to their access to stable, healthy, and supportive relationships. Although there are many factors that might contribute to limitations in access, one factor stands out as unique to the Deaf individual. This is the effect of the "Deaf Grapevine" which makes it difficult for individuals to trust their disclosures within a small group will not be shared with the larger Deaf community (Guthmann, 1994; Boros & Sanders, 1997; Miller, 1998; Chough, 1983; Kannapell, 1983; Jorgenson & Russert, 1982).

Much has been made of the evolution of the "Deaf Grapevine." Even before the "telecommunication era," it was an effective medium for sharing both critical and informal

information within the community. This phenomenon is a source of pride for its efficiency in sending out news, person by person, to a nation of Deaf individuals. However, it does come at a price. The Grapevine has at times, compromised the concepts of confidentiality and privacy. While for some this tradeoff has been worthwhile, for others, it has left them isolated and ostracized from their own community.

In the Deaf community, knowledge about the disease of chemical dependency is lacking. As a result chemical dependency is often regarded as a "moral weakness" and a "shameful sin" (Sabin, 1988; Boros & Sanders, 1977). An individual's admission of a drug or alcohol problem would likely be met with a flurry of gossip and certain rejection. As a result of this social stigma and moral pressure many chemically dependent Deaf persons do not seek help for fear of being identified in the community (Boros & Sanders, 1977). Even when successful in recovery, there are those who are reluctant to share their experiences as to avoid being the object of gossip. This compounds the difficulty deaf persons have in finding others to build supportive relationships with as part of their own recovery.

In her book, *Deaf and Sober: Journeys through Recovery*, Betty G. Miller (1998) addresses the complexity of recovering in the Deaf Community.

> "Ironically, the 'shame' of addictions is often attached to those known to be in recovery, rather than to those still abusing... Some deaf people in recovery refuse to go to all-deaf meetings because they feel their confidentiality will be violated, and they don't trust the deaf people in the group not to talk about them – especially deaf newcomers. Personal news, both good and bad, about deaf people spreads throughout the Deaf community fairly rapidly... [Some deaf people] may be hiding the fact that they are in recovery for various reasons such as not wanting members of the Deaf community to learn about their problem... [Some] deaf newcomers are often distrustful and skeptical [of other recovering deaf persons] and rarely go to them for advice and support."

The problems of confidentiality are further compounded by the fact that anonymity is almost nonexistent in the Deaf community because of its size and structure. Deaf communities tend to grow-up around larger metropolitan areas. Here the community is so densely populated that it is possible to have some general knowledge of most Deaf people who live there (Jorgenson & Russert, 1982). Many have known each other for years attending school together, working at the same job, or socializing at Deaf events. Arriving to a group, such as A.A. or N.A., for the first time and knowing most of the other members offers little anonymity and has a critical effect on the group dynamics by adding a discomfort to disclosing personal information. With very little exception, most feel self-disclosure with others is essential in making progress with recovery (Miller, Gorski & Miller, 1992; Lybarger & Sandberg, 1999; Guthmann & Swan, 1994).

In her research of variables that effect successful chemical dependency treatment outcomes for Deaf individuals, Dr. Guthmann (1994) found four variables that showed a significant correlation with maintained abstinence. Two of these variables were directly related to self-disclosure. Her study found that those who maintained abstinence following residential in-patient treatment reported being able to talk with friends and family about sobriety. Despite

the difficulty many Deaf individuals experience, having access to supportive peer and family relationships is indeed a substantial part of a Deaf person's recovery as this research points out.

Despite these odds, Deaf people do recover from chemical dependency. The effects of treatment and its long-term outcomes are continuously evaluated, as efforts are made to improve success rates. With the development of new treatments for chemical dependency, it is hoped that more and more people will find lasting recovery from drug and alcohol dependence. One of these new developments, Adventure Therapy, is a relatively new approach in chemical dependency treatment, and is showing signs of producing positive results for those participating. For Deaf individuals in treatment this approach may work as a catalyst in developing supportive peer relationships resulting in better outcomes.

Relatively new to the treatment field, the use of Adventure Therapy with chemical dependency clients began in 1978 in a program called Outward Bound (Schoel, Proudy & Radcliff, 1998). Since that time, more and more treatment programs have adopted some form of Adventure Therapy into their regular curriculum (Gass & McPhee, 1990). From its origin in education, adventure programming has seen numerous applications across a broad spectrum of clientele. Its foundation, however, has remained relatively simple: to use experiences in a variety of activities to facilitate learning about oneself and their relation to others.

Adventure Therapy uses small groups, typically those sizes normally seen in group therapies, and presents them with a series of challenging experiences sequenced to complement their treatment (Gass & McPhee, 1990). Experiences within the activities are then processed with the group to make the larger connection to their recovery. This "processing," when done in a therapeutic manner, opens opportunities for insight and growth into behaviors, thoughts and feelings (Schoel, Proudy, & Radcliff, 1998). Although research is limited, there are some favorable results suggesting its use in chemical dependency treatment is positive.

In a review of literature about adventure-based programs and their ability to improve life-skills for adolescents, Moote & Wodarski (1997) reported that those programs studied generally reported positive results including improved self-esteem, increased cooperative behaviors and general social and psychological growth. By developing participants trust in others and enhancing their communication skills, there is noticeable improvement in group cohesion. This allows for better peer understanding and ability to reveal issues of highly personal nature (James & Townsley, 1989).

Studies to determine how trust is affected by Adventure Therapy techniques have consistently shown that participants gain interpersonal trust when engaged in activities (Reina & Priest, 1999; Priest, 1996). It has also been demonstrated that the use of touch, which can be included into sequenced activities, has a positive effect on the experience of interpersonal trust. This "trust" was measured using the Interpersonal Trust Inventory – Group Version that included sub-scales for: acceptance, believability, confidentiality, dependability and encouragement (Reina & Priest, 1999).

In a survey of 61 programs using Therapeutic Adventure Programs for substance abusers, the five most frequently identified goals for this intervention were as follows:

- Increase self-esteem and self-concept
- Improve communication skills
- Increase levels of trust in others

- Increase the ability to accept self-responsibility
- Increase individuals' ability to change their life in a positive manner

Other goals that were noted in this study included teaching social integration skills, increasing the sense of self-competency and practicing goal setting strategies (Gass & McPhee, 1990).

Although it is clear more empirical data is needed, there is growing evidence that Adventure Therapy can be an effective approach in the treatment of chemical dependency. It has shown the potential to bring people together in supportive ways that lends to the personal growth and discovery needed in recovery. Learning to rebuild the relationships around them is a necessary step in this process (Miller, Gorski & Miller, 1992).

With the special considerations of confidentiality, perceived lack of peer support, the absence of anonymity and fear of rejection, Deaf individuals in treatment for chemical dependency may have something to gain by participating in Adventure Therapy. It will take time to study its efficacy but for programs that are looking for alternative or adjunctive approaches to use with their Deaf clients, Adventure Therapy programming might offer positive results.

Twelve individuals participated in a four-hour training entitled "What Do Porcupines and Pennies Have To Do With Recovery." The focus of this training was to introduce participants to Adventure Base Counseling by providing background information, theoretical foundation and information about the structure of Adventure based activities. Following the lecture part of this training, participants engaged in three hours of Adventure activities to gain experiential knowledge of this approach. The following activities were demonstrated:

- **Silent Line-Up**: participants are required to line up sequentially by date of birth without talking or signing to each other.
- **Bumpity-Bump**: participants stand in a circle and a person is designated "it." The "it" person stands inside the circle and approaches anyone in the circle to ask the name of the person standing to their left or right. If the answer is correct the "it" person moves to someone else in the circle. If the answer is wrong, the person who answered incorrectly becomes "it."
- **Magic Penny**: participants stand in a circle. The "magic penny" is revealed to the group and it is explained that once the penny is placed on the ground, no one is allowed to communicate. Anyone caught communicating will have to turn to face away from the group. Everyone holds hands while the penny is placed on the ground in the middle of the circle. The group's task is to turn over the penny without using their hands.
- **Trust Walk**: participants line-up facing forward with about 12 inches of space between each person. Masking tape is used to tape the group together. The group must navigate an obstacle course without breaking the tape holding them together.
- **Toxic Waste**: fifteen pieces of rope are attached around the circumference of a single cup. Each rope is 10 feet in length and can only be handled at its end. The group must pour the contents of the cup into a larger container by manipulating the ropes attached to the cup.
- **Stepping Stones**: the group must cross a large expanse of space (usually 20 or 30 feet) while only being able to stand on "safe stones." Seven pieces of 2 x 4 lumber are cut into two-foot

lengths to be used as “safe stones.” These are the only materials to be used for crossing the space. Falling off a “safe stone” results in a re-start of the activity. The group’s task is to get all members safely across the expanse.

Barry Blood is the Mobile Outreach Counselor for Family Service Foundation’s Deaf Substance Abuse Treatment Services in Maryland. He uses Adventure based counseling as an adjunctive therapy for chemical dependency treatment with consumers from around the state. He has also provided prevention services to both residential and mainstreamed Deaf students throughout the state.

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RELAPSE PREVENTION TOOLS: TYPICAL AND CREATIVE FOR WORKING WITH PEOPLE WHO ARE DEAF AND HARD OF HEARING

by
Erika Lohmiller

Abstract

Counseling or doing therapy work with chemically dependent Deaf and Hard of Hearing people can be challenging, since most use relapse prevention tools are not accessible for this population. Creativity is needed to assist this population to obtain the necessary tools needed to maintain and enhance sobriety. This document will attempt to identify commonly used relapse prevention tools, why they may not be readily accessible for people who are Deaf and Hard of Hearing, and how we as service providers can make these tools workable.

Introduction

Typically, when a hearing person seeks or is mandated to get help for chemical dependency problems, the most highly recommended tool is admission to a treatment center. A person who is Deaf or Hard of Hearing who is seeking help for chemical dependency problems will immediately find that these options are limited, as American Sign Language is not used in most facilities. “Chemical dependency services for alcohol/drug related problems can be found in most communities, but these services are rarely culturally appropriate or accessible for Deaf and Hard of Hearing individuals” (Guthmann, 1995). Some states have one treatment center that serves this population where the local Department of Rehabilitation Center can refer a person to the appropriate agency. Out of state referrals are often needed, as the person’s home state may not have an appropriate treatment center, be full, or that person may request a different treatment center from the one already in their state. Many insurance companies may ask why such an agency is the most appropriate, as they may want to hire an interpreter at a Hearing treatment center. Insurance companies are usually only willing to hire an interpreter for a couple of hours. Often, pointing out the cost of interpreters in such a situation, as well as pointing out that interpreters don’t necessarily make the program accessible, will help the insurance company make the decision to refer to a treatment center that serves Deaf and Hard of Hearing people. This often temporarily helps to meet the immediate inpatient need, but what happens when this person leaves or finishes inpatient treatment, and is then referred to an outpatient mental health agency, or a vocational rehabilitation facility? How can these professionals assist this person to obtain the necessary tools needed to maintain sobriety? What are some of the options?

An important tool that is commonly used are self-help meetings such as Alcoholics Anonymous, Cocaine Anonymous, and Narcotics Anonymous. These meetings are based on 12 Step principals, which can be learned at these meetings, or through various 12 Step literature such as “Alcoholics Anonymous” or the “Twelve Steps and Traditions,” Other reading materials such as the meditation book, “24 Hours A Day,” also enhance 12 Step learning. One of the greatest barriers for people who are Deaf and Hard of Hearing to attend these meetings is a lack of sign language interpreters, as there always is the question of who will pay for them. This is

where our work as service providers can start. All states have interpreter referral agencies, and many of these states have limited grants to provide monies for recovery needs. This information can be found through your state's Department of Rehabilitation Service office through the Department of Human Services. Alcoholic Anonymous has a general service office in almost every major city. These general service offices serve as basic information centers about Alcoholic Anonymous, where the meetings are, and it is also used, as a hotline number if a person needs help with an alcohol problem. Many of these service offices have a special needs committee that can help with questions of how to set up meetings, and they may even know of people in the community that use sign language and may be willing to get involved as part of their 12 Step service work. These service offices may be able to provide helpful, creative ideas to better serve people who are Deaf or Hard of Hearing in your community. If you do not know where the nearest AA general service office is, you can write requests to the AA's international general service center at Alcoholics Anonymous, Box 459, Grand Central Station, New York, New York 10018-0862. The NA world service office is: Narcotics Anonymous World Service Office, Inc. P.O Box 9999 Van Nuys, CA. 91409. The phone number is (818) 780-3951. If you live in a state that is lucky enough to have a treatment facility for Deaf and Hard of Hearing people, they will often have interpreted self-help meetings set up. These treatment centers can be excellent resources for any questions regarding recovery needs.

Tools

Twelve Step, relapse prevention, pharmacology, and other substance prevention information or materials for people who are Deaf and Hard of hearing, often needs to have a more non-traditional approach. This population tends to be very visual, and most reading material is not "Deaf-Friendly," as publications are not displayed in American Sign Language. Written materials or books should not be eliminated as tools, since many people can benefit from written materials, and often having substance abuse prevention materials at home can be a visual reminder to maintain sobriety. Meditation books, such as the popular "24 Hours a Day," and so many others, are usually short, to the point and without a lot of fancy and tough vocabulary. These meditation books address many topics that are helpful to recovering people, such as attitude adjustment, spirituality, sponsorship, self-esteem, and relationships. Hazelden, a famous substance abuse treatment center, has many of these publications for sale. A catalogue of their materials can be requested at (800) 328-0098, fax number (651) 213-4590, or their web site at www.hazelden.com. Most local bookstores, in the self-help section, also have great material. Encourage people to browse through the bookstore or library for ideas. Scriptographics, which are short, soft covered brochures, tend to be very informative and helpful reading materials, as they are illustrated and easy to read. They print information about a variety of topics pertaining to substance abuse such as, "About Recovery" or " About Multiple Substance Abuse." These illustrated publications are easy to read, and informative. Scriptographics catalogues can be requested at (800)-628-7733 or the fax number is (800) 499-6464. The Minnesota Chemical Dependency Program for the Deaf and Hard of Hearing has wonderful materials for working with people that are chemically dependent and Deaf or Hard of Hearing. One of the materials that have been developed by the program is "Clinical Approaches, A Model for Treating Chemically Dependent Deaf and Hard of Hearing Individuals," which can be very helpful and applicable for working with this population. Information and materials can be purchased through

the program. The phone number for the Minnesota Chemical Dependency Program for the Deaf and Hard of Hearing is (800) 282-3323 (v/TDD). These are just a few ideas of applicable written materials that can be used as relapse prevention tools.

Deaf and Hard of Hearing accessible videotapes are also excellent relapse prevention tools, as they can be watched in a treatment group and discussed, or a person can watch then in the privacy of their own home. Alcoholics Anonymous has the entire "Alcoholics Anonymous" and "The Twelve Steps and Traditions " book on videotape in American Sign Language, captioned and spoken. These can be ordered through the Alcoholics Anonymous service office in your nearest major city. The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals created "Dreams of Denial", and "An American Sign Language Interpretation of the Twelve Step Program." These can be used by individuals to watch if they are experiencing cravings, or simply for maintaining healthy sobriety. If you work for an agency that serves this population, why not make your own videotapes? These can be videotapes of treatment groups, or skits of specific topics, or educational videotapes pertaining to alcohol and drug information. Clients themselves can make videotapes, which can be a homework assignment that makes a lasting impression. Be sure to explain about confidentiality issues when making or showing these tapes. Captioned movies or TV documentaries and talk shows can also be used as lasting relapse prevention tools that a person can use if they have a temporary lack of support. These tapes can help remind a person about the positive reasons for sobriety.

Computer use is on the rise among people who are Deaf and Hard of Hearing and their service providers. There are many exciting resources and tools available today though the internet for this population, and their providers. "Health Resources Online A Guide for Mental Health and Addictions Specialists," has wonderful websites that can provide relapse prevention and addictions information. To order this book contact: Manisses Customer Service. Their phone number is (800) 333-7771, and their fax number is (401) 861-6370. Some of the online topics include: Al-Anon/Alateen (http://solar.rtd.utk.edu/~Al-Anon/), Alcoholics Anonymous (http://www.alcoholics-anonymous.org/), American Society of Addiction Medicine (http://members.aol.com/asamoffice/), Center for Alcohol and Addiction Studies (http://center.butler.brown.edu/), Cocaine Anonymous World Services (http://www.ca.org/), Narcotics and Substance Abuse-U.S. Information service (http://www.usia.gov/topical/global/drugs/subab.htm). The online AA resources address is http://www.recovery.org/aa/. Other topics that can be accessed by the internet that may be of interest include mental health issues, domestic violence, gang issues and sexual assault issues. The computer may be of immense benefit as a relapse prevention tool, as knowledge is power. More and more Deaf and hard of hearing people are gaining access to computers, and even if a person does not own a computer now, these addresses can be passed along for future referencing or be used at a local library computer. This can be another invaluable tool, and hopefully, as more and more people who are Deaf and Hard of Hearing become computer literate, the greater the variety of resources they will have.

The use of art modalities as relapse prevention tools could also be used. According to Beatriz Ledesma, (1996), Masters in Art Therapy (M.A.A.T), states that the use of art helps

people "demonstrate an increase of self-esteem and self-confidence as well as a desire to share with others about themselves, making the process of adaptation a less painful one. Through the process of art making they gained insight about the things they can change about themselves and the ones they need to accept." Gaining insight is fundamental to the recovery process, and art can be a powerful instrument. People can express their feelings about their recovery or demonstrate understanding of recovery issues through drawing, painting, clay work, or collages. An example is to have a person draw their understanding of the 12 Steps, or to express their positive feelings about being sober. A visual, artistic relapse prevention plan may be helpful for people who don't read very well. As art is a hands-on, visual activity, people who are Deaf and Hard of Hearing may find artwork to have more of an impact on their recovery than reading materials. Encourage a trip to a craft or hobby store if a person is reluctant to draw. They may find ideas like woodwork or weaving as a safe, sober outlet. Drama or role-playing can be used as another relapse prevention tool. Psychodrama is something that can be used as a clinical tool to help make a point in a more non-threatening way in a group or in an individual session. This can help with relapse prevention, as client can act out problems or situation with peers and help them think of outcomes to their problems. Encouraging people to get involved with Deaf theatre groups or watching interpreted plays can be a positive experience. Some people who are Deaf and Hard of Hearing in recovery may enjoy music or dancing. Art can be used as a clinical tool and also as a wonderful sober and safe leisure activity that provides relaxation throughout a person's entire life.

Along with art, other important tools are sober leisure options and a healthy support system. Boredom and isolation are some of the reasons why people who are Deaf and Hard of Hearing relapse. "For a recovering person, support means more than encouraging abstinence. It means everything that people do for each other that contributes to self-respect, growth, and drug-free satisfactions. Making major life changes requires especially strong support" (Zackon, McAuliffe, & Ch'ien, 1993). Providing safe and sober leisure ideas can help a person maintain longer, quality sobriety and encourage positive, healthy relationships. Deafness and economic problems should not rule out many fun and sober activities in your community. Unfortunately, many Deaf activities and clubs involve alcohol and/or drugs, and those activities may not be safe for a person with early recovery. There are so many other entertaining, safe options that can be suggested. Many self-help groups and clubs have AA, NA or CA baseball teams, bowling leagues, dances, picnics and retreats. Anyone with a desire to stay sober can attend these events. Museums, street art fairs and carnivals might be other options. Deaf churches also have events that may be alcohol-free. Planning a sober vacation could be excellent practice for recovering people to learn to budget and plan for entertainment. Some people may complain that they have "no money" to do any kind of activity. Explaining the positive benefits of staying sober and having fun, as well as reminding these people that they always managed to find money in the past for drugs and alcohol, may help convince them that sober activities should be a crucial part of staying sober.

Our creative efforts cannot guarantee sobriety, but perhaps our efforts can provide hope. Obviously, fully accessible meetings, documents, videotapes, and other aforementioned tools, will not happen overnight. Hopefully, each individual effort will help to eventually provide this

population with workable, useful, and a variety of creative relapse prevention tools. Remember, "the difficulties and struggles of today are but the price we must pay for the accomplishments and victories of tomorrow" (William J.H. Boetcker, Thoughts On Courage).

Erika Lohmiller has been an outpatient, inpatient, and now a staff consultant counselor at the Addiction Recovery Center of the Deaf for the past five years. She is also currently a staff therapist working at the Ravenswood Community Mental Health Center's Deaf and Hard of Hearing Program, in Chicago, Illinois. Erika works with deaf and hard of hearing children, adults, and their families who have mental health and/or substance abuse problems. She has a M.A. in deafness rehabilitation counseling from Northern Illinois University, and is a certified AODA counselor (CADC) in the state of Illinois.

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THE USE OF ART THERAPY WITH CHEMICALLY ADDICTED DEAF ADULTS

LESLIE TABIN, MS, ATR-BC, CASAC
John L. Norris Addiction Treatment Center, Rochester, NY

Abstract

This study reports how clinical art therapy can be used successfully with the Deaf and Hard of Hearing population in an inpatient setting. Deaf and Hard of Hearing patients participate in a specialized track, in addition to the mainstream program, while in treatment at John L. Norris Addiction Treatment Center (JLNATC). The weekly Deaf Art Therapy Group is designed to increase self-expression and to promote communication among the patients. The modality of visual expression and therapy is well suited towards a population where there is a heavy emphasis on visual communication. This article will examine three case studies of Deaf or Hard of Hearing (D/HH) substance abusers seen in the inpatient setting. The case study material demonstrates how art therapy was used as an adjunct modality to the patient's overall treatment plan. The use of art therapy permitted patients to utilize their images, with text, to describe their journey through treatment and recovery.

Introduction

The symbolic use of art goes back to the prehistoric era, as individuals have always sought to express themselves through symbolic imagery. The modern movement of clinical art therapy is an offshoot of the psychiatric movement. Art products developed as an important diagnostic tool. Later there was an emphasis on the creative process as "being" healing (Wadeson, 1980). Today, art therapy is a huge umbrella covering art expression for many purposes and in different clinical settings. The literature reviewed described substance abusers in a wide range of treatment settings with different orientations and models of treatment (Moore, 1983). Art therapist, like traditional chemical dependency counselors,

> "recognizes that the addicted population has a high incidence of resistance to treatment . . . that the classical defense mechanisms-denial, minimization, rationalization, projection, etc. – are characteristically overdeveloped in substance abusers. These liabilities have caused substance abusers as a group to be viewed as poor candidates for traditional verbal therapy" (Adelman & Casrticone, 1986, pp 53).

Individuals who are chemically dependent experience difficulty expressing themselves, they "release tension through angry behavior or numb themselves through alcohol or drugs" (Read-Johnson, 1990, pp 296). Deaf and Hard of Hearing addicts are additionally challenged with communication barriers. "For the Deaf . . . visual information constitutes inner language. Without expression or a way to communicate this language, the 'Deaf,' can become isolated"

(Horovitz-Darby, 1991, pp 251). Aspects of the Deaf culture, like other groups, are influenced by history, traditions, values, as well as language and communication styles (Coseo, 1997). Subsequently, it appears logical to utilize therapy that is more appropriate to the specific culture. Through the concrete use of materials and the symbolic use of imagery D/HH patients are encouraged to explore their realities, recognize attitudes brought into awareness through art, enhance their communication with others, reduce confusion and isolation, and develop an increased sense of mastery over themselves and their environment.

Model of Art Therapy Group

The literature reviewed indicates that art is a useful medium to promote health and healing of individuals suffering from chemical dependency and mental illness. Art can become a tangible expression of the integration of internal and external realities (Allen, 1985). Structure, to an art therapy session, can be a particular advantage for patients who are chemically dependent. The structure in the session correlates with their need for ego strength (Head, 1975). Knowing this influenced my goals for the development and structure of art therapy sessions. These facts are consistent with my goals for patients who participate in the art therapy groups.

- Increase the patients' ability to express their feelings and emotions
- Increase communication among group members
- Increase the ability of group members to express and accept feedback
- Increase a sense of peer support

The result of goal achievement is to mimic the climate of the self-help format. Such a climate provides a context for the patients to relate to within the inpatient setting (Humphreys, 1993). At the start of group, patients are instructed that the art product is not discussed in terms of quality; the focus is on the process of the experience. It is imperative that the projects are success oriented and the atmosphere of the group is one of support, not pressure. Inherent is my belief that the artwork is a metaphor and allows the patients to tell their own life story of addiction and recovery.

The art therapy session at JLNATC is scheduled weekly in a 75-minute block, with the use of an American Sign Language (ASL) interpreter. The group is integrated to the inpatient program. The group is often structured and relate to various themes of the disease model of addiction and the recovery process; such as creating symbolic representations of handling feelings of anger, loneliness or frustration, reviewing past (drug use), present (treatment), and future (continuing care), or developing a "road to recovery" (Hanes, 1995). Patients are also given the opportunity to create images of their own without direction from the group leader. Part of the group time is devoted to the creation of the art, and later to the sharing of the imagery with feedback from group members. Occasionally patients will title their own artwork. Results have been consistent with Moore's (1983) findings that art therapy in a group setting decreases the patients sense of isolation, increases self-esteem and acceptance, and is a means of confronting defenses and manipulative behaviors.

Case Study #1

S. was a 22-year-old, HH, Caucasian, male, admitted for his second inpatient treatment attempt. He was being treated for Alcohol and Marijuana Dependence as well as Bipolar and Anxiety Disorders for which he was prescribed Lithium. His most recent referral was made after an inpatient psychiatric hospitalization. He had successfully completed his first inpatient treatment; followed by an outpatient program and a six-month stay at a half way house. It was during his attempt to return to college, that he relapsed. He physically presented looking his age; was overweight with an androgynous body, and dressed neatly in prep school fashion. He also presented as more comfortable with his MI (Bipolar, Anxiety) than his CD (Alcohol, Marijuana) diagnosis. While hospitalized he requested to work with an art therapist, as he had previous exposure during his first treatment for chemical dependency. He spontaneously began to work and would review his artwork with group members during the weekly sessions. As the patient initially appeared depressed and was withdrawn from his peers this served as a mechanism for him to connect with others.

Early works (Fig. 1 & 2) reflect this period of sadness, confusion, and repression of self. The colors are overwhelmingly dark, divided into triangle sections, and there is a spotty quality to these images. In Figure #1 the spots and dashes indicate a high level of anxiety and a fragmented sense of self. This will become a common theme for later images. The cross figure on the right side appears to disintegrate from the bottom up. Besides the patients body image there had been suggestions made of a sexual identity issues. He reported sexually abusing his younger adopted sister, while in his teens. He was also concerned about his lack of sexual experiences. He admitted his first experience prior to this admission was with a prostitute and stated it caused him much shame.

His parents, who were active participates in his first treatment, had elected not to remain in contact with S. or the treatment team. He stated his father had been verbally abusive and that his parents adopted his sister, in part, to avoid another Deaf or HH child. This sense of being an outsider is a recurrent theme in later images. In Figure #2 there is a brightening of color, perhaps a lifting of mood. The yellow jagged edge, in the center of the image, may represent aggressive tendencies. He was very sarcastic and intellectual in the group with his peers. This appeared as another tactic that successfully isolated him from others. The yellow area also separates and appears to repress the anger/confusion (red), from his overwhelming depression (black). S. struggled between anger/depression, mental illness/chemical dependent diagnosis, as well as identifying himself with the Hearing or Deaf world throughout his treatment.

In Figure #3, “Blocking the Sun,” the hand does not appear to beckon us towards him, but instead states “keep your distance.” Hands are often a common theme of abused clients, but may also represent his struggle with ASL. S. often spoke and did not sign for himself in-group with his peers. At this point in treatment he felt as if there were too many demands placed on him, as he was beginning to explore halfway house placements again. He also expressed a reluctance to become involved in his own recovery program. There is a large area of purple, which is often associated with mania and strong power-striving drives. He expressed that this mania was like a high he was reluctant to give up. Though the sun (associated with paternal themes) is bright, the hand appears to protect him from it rays, as indicated by his title.

In Figure #4, “Well of Rage” we again see similar themes, the struggle between rage (red) and depression (black). Both underdeveloped figures are aspects of his own inner struggle.

These “embryo like” forms are repeated in his images, even as the other elements become more organized and sophisticated. In this figure we continue to see the disorganized thoughts in the fragmented image, and his need to control (i.e., pump) his rage, which he states he is pumping out. Again there is the jagged form in the lower right side that relates to his anger and continued sarcasm with others.

Figure #5 represents a time when the patient was willing to become more engaged in treatment (between week 2 and 3). He is less challenging, using more humor and less sarcasm with others. He continues to make frequent request to see the psychiatrist. This was seen by the staff as an attempt to separate himself from the group and his chemical dependency diagnosis. He was actively discussing his two worlds (Deaf and Hearing). He was scheduled for a visit to an area halfway house. This was one of the first times that S. initiated the discussion about the artwork. He discussed the image as a memory of childhood. He stated he would often sit in a tree, isolate himself, and listen to the birds. The bubble by his mouth says, “I hear you my friend,” referring to the birds. The bubble over his head represents his sense of separation from friends in childhood. He suggested that the safety net is broken to indicate he did not feel safe. Again, we see a large formless body, this time in the center of the image. Often, S., presented as narcissistic and stated he felt the other members of the Deaf group where jealous of his ability to interact with the Hearing world. Yet, none of his bodies depict ears. The tree, often a symbolic representation of self, is not grounded and has no base. We are only permitted to see a piece of the trunk, as he only shows small pieces of himself to others. The leaves are not connected to the tree and their dash like marks indicate a high level of anxiety. Though he indicated that the figures in the bubble represent friends, it can also be interpreted as his family (three members on the right) separated from him.

Figure # 6 is completed during his third week. He is beginning to recognize his fixation on his mental illness vs. his chemical dependency and is aware of the need to treat both. He is able to express his anger more directly in individual and group sessions and through his artwork. Subsequently group members give him the feedback that he is less sarcastic, yet, he continues to be critical of his peers’ in-group. The image represents themes of isolation. He identified sleep (bed), marijuana (leaf), television, reading and alcohol all as mechanisms he utilized to isolate from others. As in Figure #5 the tree is not connected to a trunk or base, but is free floating in space. The bed appears to be disintegrated and falling out of the tree. Consequently, S. had expressed fears of another psychiatric hospitalization. Again, we see the repetition of the jagged edge in the headboard of the bed. In the lower left and right side of the image are representations, according to the patient, of happy memories. One is of S. on a swing and the other riding down a hill on a bike with his hands in the air. The swing resembles a noose and neither the bike nor the swing has sufficient room. The bike could just fall off the page. This may relate to his Bipolar Diagnosis and an attraction to danger and destructive self-behavior.

During the later part of his fourth week there is a notable increase in the patient’s anxiety level related to discussions about discharge planning. He had been accepted into the halfway house and was waiting a tentative entrance date. This is illustrated in Figure #7, a formless body with indistinguishable sexual identity. The body remains undeveloped, even while his artwork demonstrated an increase in organization of thoughts and integration of self. This tree is well formed, but small and insignificant. In discussing this image with the group he stated he was “protecting himself from the storm.” Group members perceived the image as S. isolated behind a

book in a fenced off area. The dash marks represent his increased level of anxiety and the fence is his attempt to impose order on his internal chaos. The series of formless bodies may also indicate his sense of being ineffectual in his own life (Hammer, 1980).

The patient in total completed over 20 pieces of art. The following 6 pieces are a general representation of the last two weeks of his treatment. In Figure # 8 we have one of a series of landscapes he created. The image is much more controlled than earlier attempts. We have the sense that the viewer is on the outside looking in and not an active participate in the image, or in his own life. The house, like the tree in Figure #5, is partially drawn. Depiction of landscapes or isolated forms, which are rigid and emotionally empty note a strong tendency towards anxiety and a need to control what, he perceives as dangerous situations and his own impulsive behaviors and feelings. S. was actively working on resolving and developing new skills to cope with anger, and to insure a safe transition to his continuing care program.

Figure # 9 "Road to Recovery," the image is the beginning of his attempt to terminate with the inpatient setting and look forward towards his continuing care plans. On the surface it is a conventional image, with the bricks identifying relapse triggers (i.e., denial, old friends) and new sober supports (i.e., sponsor). Again, as in Figure # 8, there is a distance between the viewer and the road. The road is encased in a sea of red, purple, and yellow grass, as his anger is a barrier to his own recovery.

Figure #10 "Anger," though the face looks menacing it is his first well-formed human figure, as opposed to the "embryo like" forms of his earlier works. As in earlier pictures we see the repetition of red and black to represent his struggle between anger and depression. The head is very stylized with a deformed ear-like form in the center of the head. The neck is elongated, suggesting a separation of his intellect (head) from his emotions (body), with which he is uncomfortable. The overall impression of the figure is one of a hatchet.

One of his final images, Figure #11, is of a large head floating over the world. The patient had developed some insight and was able to comment on his old coping skills of detachment and isolation. The large head in the center still speaks to his sense of narcissism. This is a well-defined head with distinct features, but again lacks ears.

Figures #12 and 13 are similar in design. Figure #12 is of a room were he feels safe, but also caged inside. He is now on the inside looking out, but unsure how to connect successfully to the world. The room is empty except for his artwork that is displayed on the walls. The window resembles the bars in Figure #13. This is one of his last images, and in reviewing his artwork, to help him deal with termination issues, he titled it "My Rage in A Cage" and made verbal comments on the image; "The background is the sunset over the ocean, the foreground is the cage of rage that prevents me from serenity." I believe he picked an image that was his central theme throughout his struggle to regain abstinence and recovery from his mental illness. The patient was able to successfully complete the inpatient program, agreed to attend an intensive 5-day a week MICA program, and made the transition into a halfway house in the community.

Case Study # 2

H. was a 32-year-old, Deaf, African-American, female admitted for her second inpatient treatment attempt. She was being treated for Alcohol and Cocaine Dependence and a Depressive Disorder with Paxil and Trazadone. Her outpatient program made her most recent referral after a positive toxicology report for cocaine. The patient was married to a Deaf man, who was

currently residing in the only halfway house in her community that was designated for Deaf and HH patients. She had one child within this union, who was under Child Protective Services (CPS). She had lost contact with 2 previous children, also removed by CPS. H. presented as functioning at a higher level, especially in the Hearing world, due to her appearance and cooperative attitude. She was often seen smiling and presented superficially. This is evident in her first image, Figure #14, "Excitement." Upon initial observation it appears to be done by a child. The schematic age is between seven and nine years old, which coincides with her emotional development (Kellogg, 1969). She picked collage materials, which tend to be a safer art form than drawing or painting. Though she had other options, all of her images are of Caucasian women, pointing towards a sense of low self-esteem. The image reflects her limited understanding of the disease of addiction and the recovery process. To increase her use of materials and expression of feelings she was given the assignment to create a life book (Figures #15 -19).

The cover image, Figure #15, begins with her discussion of loss and grief issues. She relates the broken heart to her separation from her husband and child. Later, this will include her family of origin, of which she was the only Deaf member. The literature indicates that ripped or broken hearts may be an indicator of sexual abuse (Spring, 1985). The patient alleged that she had been kidnapped and held captive during a recent violent rape, which had not been reported.

In figure #16 "Pain Growing Up," the image on the left is reflective of her family of origin. She stated she was unable to communicate with her family members and remembers many fights within the home. She was able to discuss that she felt isolated within her family while growing up. During subsequent sessions she discussed her desire to reconnect with her family, who lived about 60 miles away. The image on the right refers to Deaf friends, who initially offered her marijuana. She discussed this experience and how the mood-altering drug helped her relax. Nevertheless, she was angry with her friend, as this was the beginning of her pattern of use. As in case study #1, her figures are lacking ears.

Figure #17, "Present-Relationships" reveals her superficial understanding and high level of denial regarding her family. The artwork remains at the schematic age between seven and nine years old. The baby is ignored at the bottom of the page. The reality was that her husband was further along in his treatment; he was successful in his placement at the halfway house. Subsequently, she had to look elsewhere for placement and interpreter services needed to be arranged. During this period she was informed that her youngest child was not making appropriate development markers, and it was attributed to her continued drug use during pregnancy. In reality she was fearful of losing custody of another child. The image on the right of the meeting has no details or specific individuals that will support her recovery from chemical dependency. In Figure #18, "Future-Dreaming" is a continuation of the same.

The picture in the life book, Figure #19, "Excited," lacks hands, which indicates a lack of control over her environment. It may have additional significance with a Deaf patient who relies on her hands for communication. The head is oversized and implies an overdeveloped reliance on fantasy.

Midway in her treatment, and after the information regarding her child's developmental problems, the patient completed Figure # 20, "Happy-Disgusted." Now her figures are facing forward and appeared more engaged in their environment. Though her child is small, there are toys and baby objects in the image indicating a real acknowledgment of his needs. She identifies

family roles and the responsibility of the parents to educate (i.e., learn sign language) the child. The image on the right side indicates her willingness to confront her fears. On the surface H. discussed how her husband would be inadequate to care for their son, as he got older. She sublimated her own fears that he will be the more successful parent. She is fearful that she will lose custody of this child, as she has in the past. Her body, behind the door, appears thin, small, and ineffectual also, is not grounded to the floor. The smile (i.e., her mask) is her biggest feature.

Figure #21 "Memories," is done during her fourth week in treatment. She has become more open and honest in her discussions and acknowledges her tendency to "put on a good front" with her smiles. The faces are now of Caucasian and African-American women. She illustrated how she becomes sad thinking of her family of origin (i.e., "family ignore me"), and separation from husband and child (i.e., "happy smile together not"). She discussed her desire to have a successful marriage as a substitute for her childhood losses. She indicates this visually in the example of "future marry."

As part of discharge planning she discussed her need for abstinence whether or not she was reunited with her husband or regained custody of her child. The last image "Precious," Figure # 22, was an attempt to review her treatment experience and to identify her needs. In this image the majority of the faces are of African-Americans. She identified herself as being "Precious." The various bubbles denote the things she has identified as important to herself and her family. She discussed how her son needs the love of both parents, whether they live together or not. She discussed her own need for a sponsor, and for the first time identified other women as part of her support system. She discussed a desire to find time for herself and to reconnect with certain members of her family of origin.

H. was discharged with a positive treatment experience and had increased her ability to access services and support in her community. She made the transition to a women's half way house, which provided interpreter services, and an intensive women's outpatient program.

Case Study #3

T. was a 34-year-old, Deaf, Caucasian, female admitted for her first inpatient treatment. Her chemical dependency diagnosis was Alcohol and Cocaine. She had a history of depression and was diagnosed with a Borderline Personality. She was treated for a sleep disturbance with Trazadone. T., a single mother, was mandated into treatment by family court, since she has already lost custody of her 2 children. She was an out of state referral, as she was unable to receive treatment in her home state.

T. had a history of severe childhood abuse by her mother and stepfather. She had many scars on her body from beatings by her stepfather, which her mother never stopped. Her biological father, who her mother did not allow her to have contact with, committed suicide when she was 19 after a brief reunion. She had a long history of self-inflicted wounds and openly told her case manager that she was gay, but did not discuss this in-group. She was the only Deaf female in residence, so T. was mainstreamed into a women's group 2 times a week with the use of an interpreter, to increase a sense of peer support.

Figure #23 was completed in the Deaf group. The patient utilized different scents to evoke memories, similar to utilizing music or sounds with Hearing groups. The patient titled the piece "Grandmother Memories." Her maternal grandmother had died 6 years before and T. stated she had been a constant source of support in her abusive childhood. The first image of a house is

the only image attributed to her parents' home, where she was routinely abused. The house has long been used as an indicator of a psychological profile (Burns, 1982). This house has no ground line; though there is a chimney it indicates no warmth or fire within. This also indicates her distrust of people. The windows of her house are vacant and empty. In contrast the other five images depict some form of nurturance (i.e., cookies, candies, cloths/bedroom). Images of overly large food may point towards a sense of depravation. There is an emphasis on cleanliness (i.e., soap, and bathroom) that the patient did not comment on.

Figure # 24 is one of the remaining six that appear split in two, as in splitting of self. This is a visual indicator of her Borderline Personality and her attempt to cut herself off from the unacceptable (past) parts of herself. The "Do Not Enter" sign makes it clear she does not want to revisit her traumatic past. At the top she pictures her children and herself. Her statement to the group that her "children have always been there for me" refers to the reversal of roles and the parentification of her children. The overly large hand may be an indicator of past abuse, but may have additional meaning connected to the use of ASL. She titled this piece "Bad Life Change to Good Life with Second Chance."

Figure # 25, "Looking at My Life," was completed during her third week in treatment. She was instructed to create a triptych of her past, present, and future. At this junction in treatment she was often attempting to split staff and create alliances with peers. The left, done in gray tones, represents her past. The images are dense and crowed together, as the past is easier for her to define. As in case study #2, we see broken or ripped hearts, denoting possible sexual abuse. The hand clearly indicates its relation to past abuse. Where the past is full of negative images, the present only has positive images, a very simplistic interpretation of recovery. It is interesting to note that at this point the patient ran out of room to complete her vision of the future, as evidenced by the footprints ending abruptly and in the past. She added a second sheet and changed to a simpler and less revealing medium, collage. The boot is to "stamp" out drugs, but it faces her past, not future, and resembles another broken heart. The image of the young women looking out the car window she stated was to indicate her freedom. This image is encapsulated, looking away from her children, and back towards the past. Though she communicated that she wanted to return to her children and regain custody, the image indicates the opposite.

Figure #26, "Bad-Good Relationships," was completed in a group with Hearing female patients and an interpreter. She was very passive and uninvolved in this group, and left early stating she didn't feel well. The bad relationships refer to her mother and stepfather, who abused and abandoned her. Currently she was emotionally and finically supported by a maternal aunt and her family, who retained custody of her children. The "good" relationship is of her daughter. This reference to mothers in a larger sense refers to her own lack of a protective and nurturing mother and her inability to care for her own children. Figure #27, titled "Bad-Mother-Good," was completed within the same week in the Deaf group, continues the same theme. It appears she is more comfortable visually confronting her issues in a Deaf predominately male group rather than a Hearing female group. Looking at this picture we see her internal struggle clearly. She now begins to discuss in-group another "mother" figure in her life. She stated when she was about 20; a Deaf woman unofficially adopted her. Later she reveals this woman was only a few years older than her and a drug user. She denied that it had been a sexual relationship. She discussed her concern for this woman, though she felt betrayed by her when she discovered she

was chemically dependent. Though she writes at the top "My children come first," they are not really a primary focus of this image. She appears unable to integrate these two parts of herself.

Figure #28, "Goodbye to My Old Life" was completed close to the end of her treatment and once again she splits the picture in two. The sun is extremely large, but generates no warmth. Overtly she stated she wanted to write down all of her negative experiences and throw them away into the sea. The hand throws away her past, which is another attempt to cut herself off from and destroy her past. There is no awareness or sense of integration of self.

In her last picture, Figure # 29, "Handle My New Feelings," she splits the image into two again. The left, her past, she labels anger. The figure, with a broken heart, continues to ask "why?" The hand coming at her clearly implies her history of childhood abuse. She discussed her father's suicide, and how she felt deprived of this relationship. She discussed her anger at her mother for keeping them separate, while allowing her stepfather to abuse her. T. in this image is more closely aligned with her father, who found suicide an acceptable alternative, rejoining her father is linked to a feeling of serenity. Treatment is ending during late spring and T. discusses the upcoming Father's Day in June. She states she will write a letter to father and throw it into the ocean. This is very similar to the previous image of her throwing her own history into the ocean. The image leaves one concerned that she too closely aligns herself with her mentally ill father, who was absent from most of her life and committed suicide after a brief reunion.
T. always stated that her goal was to complete inpatient, return to the metal health clinic for the Deaf in her home state, and complete the reunification of her family. She completed inpatient treatment and traveled by bus to her home. Within 24 hours she had relapsed with the women she called her "adoptive mother."

Discussion

Group art therapy in the inpatient program strives to support chemically dependent D/HH patients in their recovery process. In groups patients explore their resistance to treatment, defense mechanisms, interpersonal conflicts, use feedback, challenge old attitudes, and develop new coping skills through the artwork. The group provides a strong format to counter the patient's sense of isolation and to enhance self-acceptance and self-esteem. It is especially well suited to D/HH patients as unrecognized attitudes maybe brought into awareness through the art, a visual form of expression, more easily than with verbal language (Moore, 1983). S. in Figure #7 demonstrates this. He accepted feedback from group members who observed that he continued to isolate himself in treatment. In Figure # 20, which H. titled "Happy-Disgusted," she acknowledges her fears and sense of loss regarding her maternal role. We see her emerging sense of self in Figure # 22, Precious, and in T.'s Figure #24 titled "Do Not Enter." As Horovitz-Darby (1991, pp. 254) states, "the graphic component of the art mirrors the visual aspects of sign language and pictorially aid the deaf client's ability to bridge the gap between the deaf culture and hearing world."

The three case studies illustrated the strength of artwork, as a form of therapy and as a diagnostic tool for the therapist. Whether the artwork is spontaneous or structured, the experience is a major force in the movement towards emotional health and well being for the patient. The artwork also functions as a mechanism to assist the patient in the termination process by reviewing it in its totality. Many patients' title and give their works verbal comments to increase communication with others regarding their very personal struggles of addiction and

recovery. Group art therapy closely tied to the principles of the disease model of addiction and recovery, is an ideal modality to aid D/HH patients through a journey of self-expression, which leads to increased self-awareness.

Leslie Tabin is an addiction counselor at the John L. Norris Clinic in Rochester New York. She is also a clinical art therapist and leads weekly art therapy groups for deaf and hard of hearing clients in treatment. She is a field supervisor for Nazareth College in the Graduate Art Therapy Program.

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

Figure 6

Figure 7

Figure 8

Figure 9

Figure 10

Figure 11

Figure 12

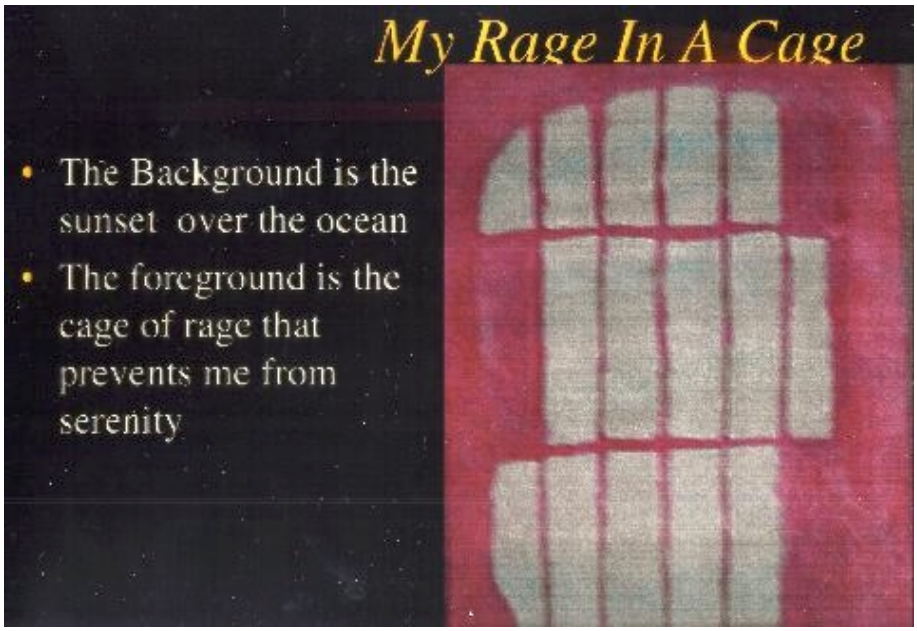

Figure 13

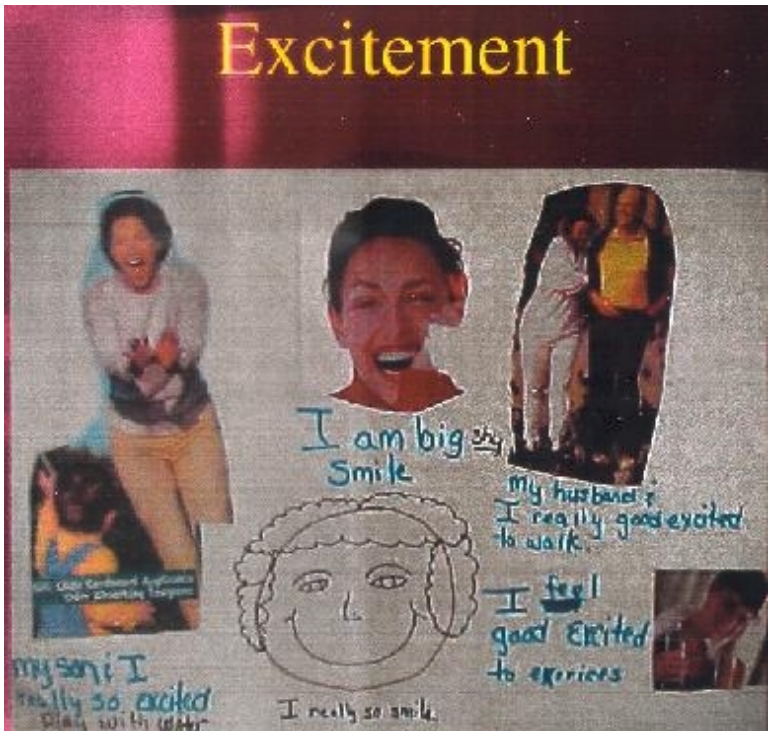

Figure 14

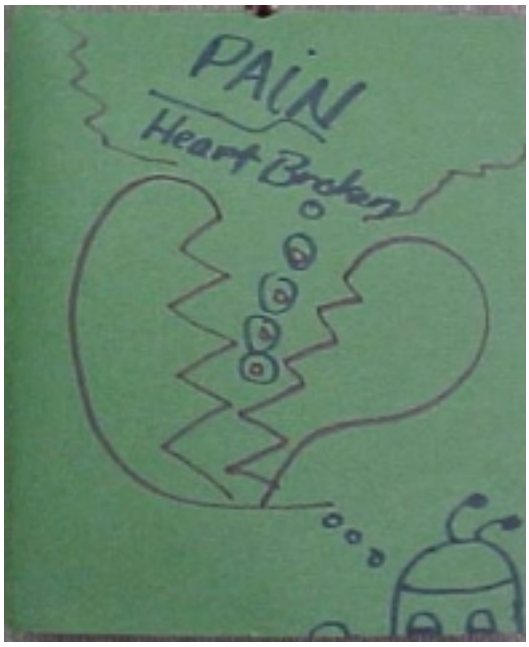

Figure 15

Figure 16

Figure 17

Figure 18

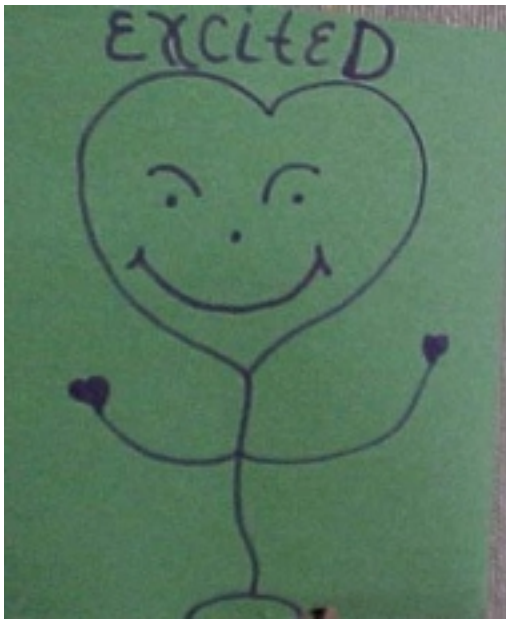

Figure 19

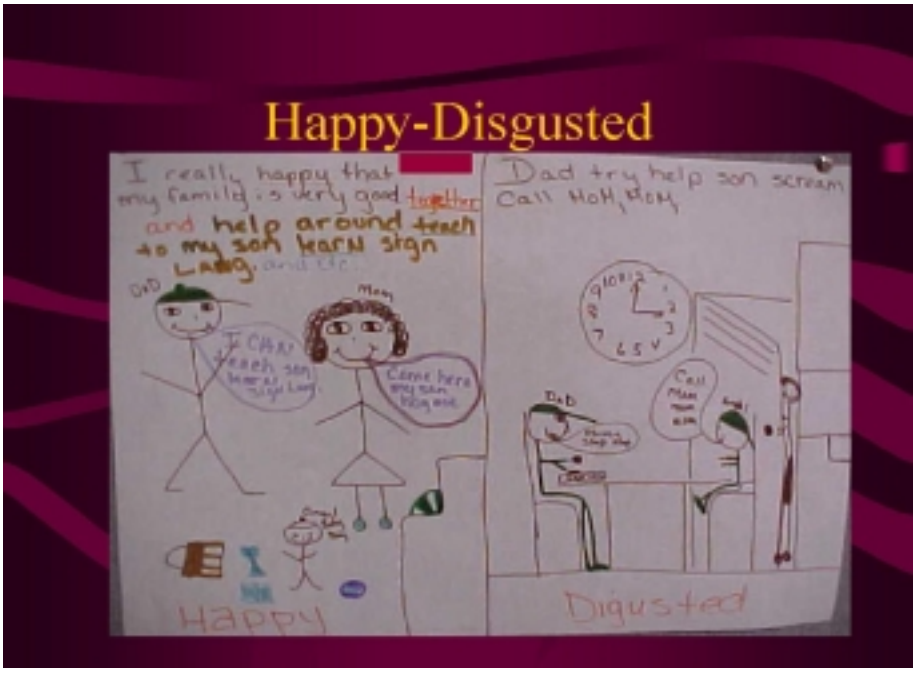

Figure 20

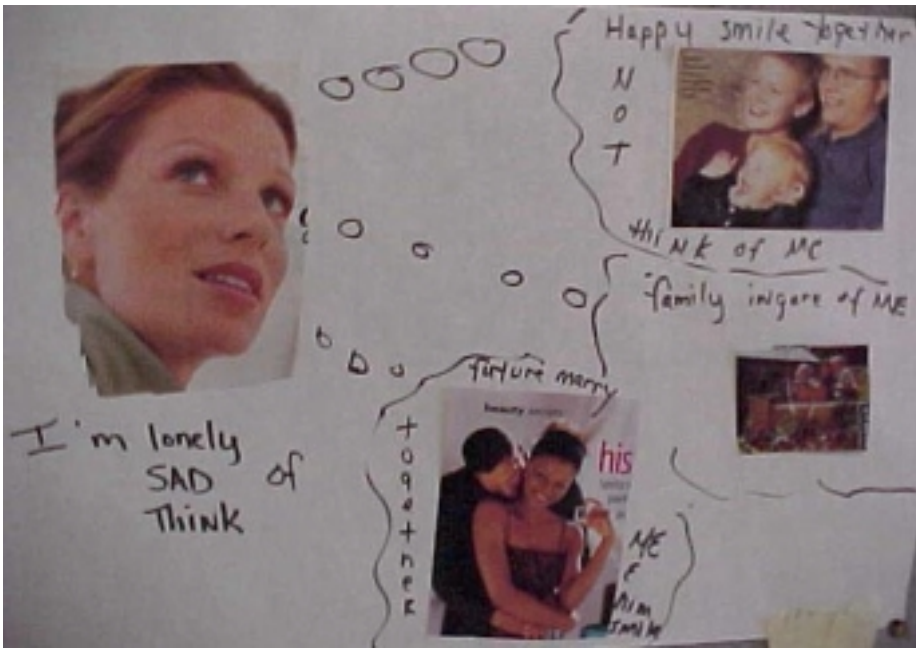

Figure 21

Figure 22

Figure 23

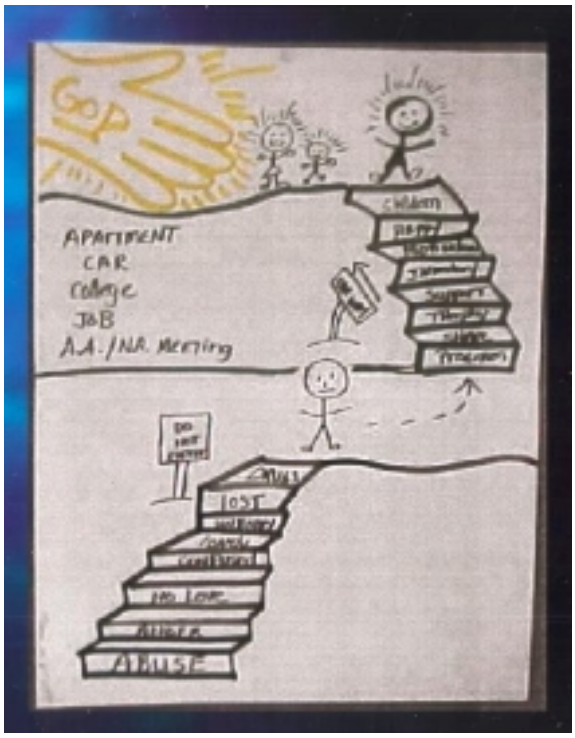

Figure 24

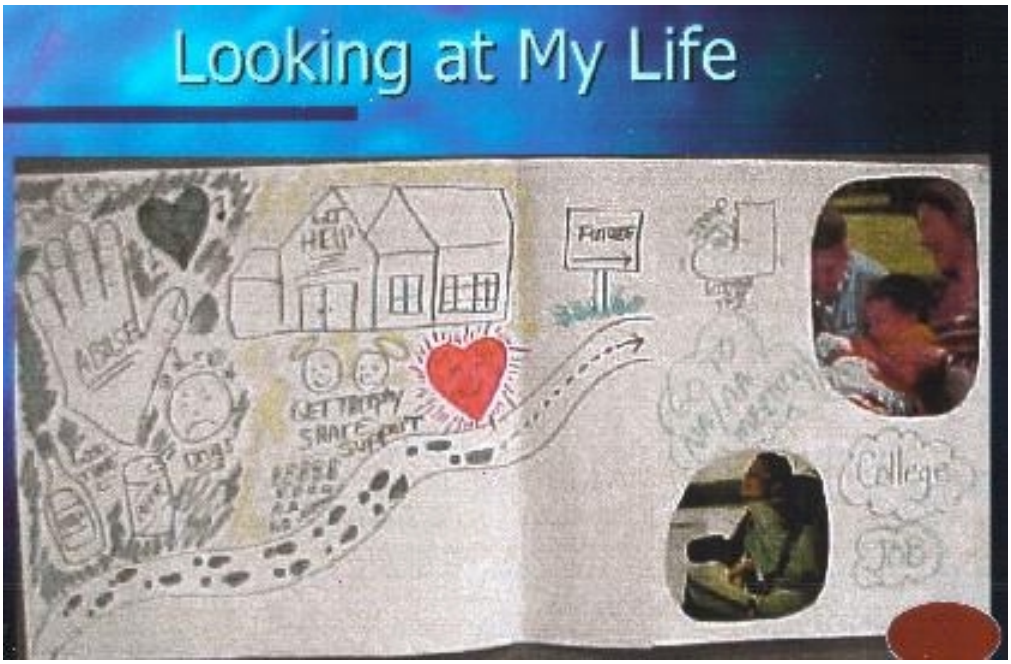

Figure 25

Figure 26

Figure 27

Figure 28

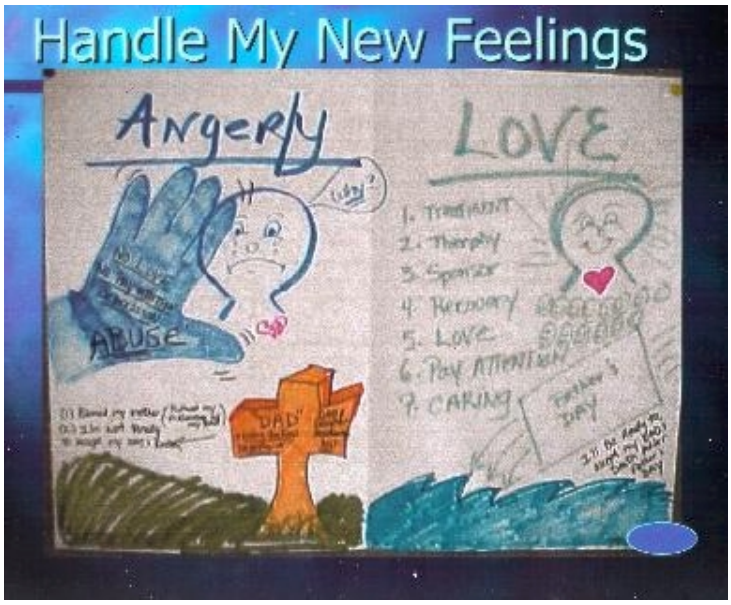
Handle My New Feelings
Angerly
LOVE
ABUSE
DAD
1. Treatment
2. Therapy
3. Support
4. Recovery
5. Love
6. Pay Attention
7. CARING

Figure 29

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Bridging the Gap between Hearing and Deaf Recovering Communities

Brandy Haddock, MS, CRC
David McDonald, MS

In October of 1998 the Deaf Outreach Center (DOC), a mental health program for the deaf and hard of hearing, and Deaf ACCESS, a vocational support program, began implementing a series of programs for substance abuse. These programs were aimed at providing support to individuals who are deaf and hard of hearing with substance abuse problems. There was a clear need in both communities for services addressing the issue of substance abuse. We took what we observed in our community and attempted to develop successful long running programs. Working with a small group of alcoholics, we have developed several programs, which we consider effective in assisting deaf1 people in recovery. To maintain these programs effectiveness, it was often necessary to change strategies; requiring flexibility on the part of the leaders and members of the groups. Each program we developed came with its own set of challenges: often they were unexpected.

In this paper, we will briefly discuss the programs we attempted and what we have observed, with an explanation as to why we altered the original idea. We do want to stress that we chose these programs and the changes we made due to our specific circumstances. What worked for us, may or may not work for you but this can provide a starting point for programs that you develop.

History. Until 1997, individuals with chemical dependency problems seeking services were referred to various community services in Little Rock (often times requiring an interpreter in sessions); however, it became clear this method did not promote improvement. The lack of support for this option encouraged us to look at alternatives for deaf addicts and alcoholics. In addition to these referrals, DOC would willingly supply interpreters to AA/NA/CA/Al-Anon meetings when one was requested. Unfortunately, without more support, the individual would either not attend or attend for a brief time and then halt his/her recovery. This put DOC in the role of a "police officer" – asking for a commitment from the individual to attend the requested meetings. The consequence of not attending the meeting was to no longer provide interpreting services for that individual. This put the individual at a disadvantage when s/he wanted recovery support in the future.

Individual Counseling. DOC decided to accept clients with substance abuse problems. This brought the deaf person into an environment where the counselor was able to communicate through sign language. The individual would attend one-on-one counseling sessions. The client

1 During this time, we were working primarily with the deaf. We did speak at Self-Help for Hard of Hearing (SHHH) meeting informing them of our programs and our willingness to try and accommodate the hard of hearing. Unfortunately, this avenue has not been pursued at this time by the hard of hearing community.

would discuss personal issues and/(or) problems with alcohol/drug abuse. The client would often get a "quick fix" with the personal problems during a session and not feel any need to continue the appointments or attend a 12 Step program. Even if the person worked on the personal problems, the primary problem, drugs/alcohol, were not being addressed. The conclusion reached in this instance was that we needed to develop programs that addressed the substance abuse. Emphasizing this alcohol/drug side of the person's problems placed recovery one step closer.

Mentor Program. We attempted to pair up a non-recovering non-addicted deaf person with a deaf person in recovery. The non-recovering person could provide support and guidance to the recovering individual. This is very similar to the idea of an AA sponsor, except instead of one addict helping another addict, one deaf person is helping another deaf person. We found that the small Deaf community hindered this process due to previous social relationships; therefore, we were unable to effectively match individuals with mentors.

1, 2, 3, Step Meetings. The next idea we tried was to gather a group of deaf addicts who were willing to commit to three consecutive meetings. In these meetings we discussed the Step One, Step Two and Step Three of the 12 Steps. This allowed a group to come together; in this group everyone used ASL to communicate. Our first actual meeting included 2 deaf recovering individuals and 2 group leaders. We borrowed the "first step drawing2" idea from The Minnesota Chemical Dependency Program and incorporated the activity into this part of our program. We requested that the individuals attend all three meetings. We eventually established a meeting that the only requirement to attend was a desire to stop drinking or using and no requirement for attendance.

Open AA Meetings. The leaders began attending Open AA Meetings with an interpreter. We invited any deaf person who wanted to attend, to meet us at these meetings. This was a very successful program for several reasons; (1) We were able to have an interpreter at a meeting one day a week without having to monitor the client's attendance; (2) it provided a "deaf friendly" environment (a deaf person could walk into the meetings and see a friendly face); (3) we, the leaders, increased our own knowledge of the AA "culture": i.e., the language, rituals, and humor that are inherent to the recovery community; (4) we made contacts with members of the hearing recovery community in Little Rock.

Recovery Groups. The Recovery Groups grew from the 1, 2, 3 Step meetings and also were conducted in sign language. We discussed addiction, the 12 Steps, personal problems and watched videotapes of other deaf people in recovery. This provided a setting that deaf individuals were treated like equals. Members were willing to confront and participate much more in these groups than in community AA groups.

2 The "first step drawing" is an assignment in which the person draws the feeling of powerlessness. This relates to Step One: "We admitted we were powerless over alcohol--that our lives had become unmanageable." This is a powerful.

Closed AA Meetings. We supplied an interpreter for a closed meeting once a week. Deaf individuals could make their own contacts and it provided the deaf with an opportunity to belong to a home group.

Slogans. Another positive outcome of attending Open AA Meetings was learning the slogans and the importance they have in the recovery. We were able to take these written and verbal sayings and interpret them into ASL; making what is linear into conceptual form. As we used the slogans in recovery meetings, we helped to increase the exposure that the group members had to them. In turn, helping them learn the slogan and the concept behind the slogan. With the understanding of the slogans, there were more shared experiences with the deaf and hearing recovering individuals.

Speaker Meetings. Through the contacts we made at Open AA Meetings, we were able to invite recovering members to our group and speak. They would tell us "What It Was Like," "What Happened" and "What It's Like Now." This added new faces to a very small group. One unfortunate outcome of small groups is the tendency to decrease in attendance due to "boredom." The Open and Closed AA meetings helped to add more options and faces to the group as did the Speaker Meetings.

One important point that needs to be made is that we are not an AA Meeting. It was important that we clearly define our role and set proper boundaries for both the deaf member and the AA community. We are a bridge to the hearing Recovery Community. By assisting the deaf group members in learning the 12 Steps, other recovery tools, and providing a safe, and ASL friendly environment, we tried to help make it possible for the deaf to join hearing recovery programs. Several times, we had to clarify this to the hearing recovery community; once we explained the differences between our groups and assured the person that we were NOT trying to be an AA Meeting, long lasting and friendly contacts were established.

12 Step Study. Although this program hasn't been actually tried, we feel it is a good idea that incorporates many of the positive aspects of the previous programs. Our first idea was to have a one-hour a week meeting for 12 weeks. Each week would focus on one step. We had asked several people in the recovery community to come and teach, lead and talk about the step of their choice. After more contemplation, we have decided that it may be better to work this idea in with the recovery group; set up weekly recovery group meetings and then use one week a month for the 12 Step study. A basic requirement of a 12 Step Study must be a large enough core group to accommodate the fluctuations in attendance. A group of five (5) or six (6) people is probably not a large enough group to maintain attendance for 12 consecutive meetings.

Teen Group. A group that has recently begun meeting at the Arkansas School for the Deaf is for students who have family or friends with substance abuse problems. We are early in the meeting program but several of the students have been attending and actively participating in the group. The one difficulty thus far is coordinating meeting times around the students' schedules.

General Disability Recovery Group. Our goal is to increase the number of people attending the recovery groups. We are considering opening up the recovery meetings to include all disabilities. This is still very much in the planning stage.

Tools

In addition to the adaptation required to fit the situation we faced with an appropriate program, we also had to alter some of the recovery tools we used. The slogans are one example of how we took what was used in the general recovery that didn't originally fit with the deaf. We changed the language of the slogans for the benefit of the deaf and to ease the learning of the concepts. Another tool we used was the "first step drawings" which were used in the beginning. These drawings allowed us to level the playing field of the group members. It does not matter what the education level of the person is s/he can still draw well enough to put the feeling of powerlessness onto paper.

Other Projects. We developed a series of videotapes of AA speakers telling the story of their addiction and recovery. The idea came from a deaf member who made the comment that hearing people in recovery can listen to audiotapes and he would like to have something comparable available to the deaf. We discussed the idea among ourselves and with a representative of the AA New York Central Office in New York City. We did not want a videotaping project to be affiliated with AA; however, we did not want to be in conflict with any of Traditions of Alcoholics Anonymous. After further discussion, we concluded our biggest dilemma was addressed in AA's 11th Tradition. "Our [AA] public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films." We decided to videotape the interpreter only. There was some disagreement from one AA member who felt that his physical appearance would add impact to the story. We created a policy of not showing any individuals face on the tape, if the speaker chose to have his/her face on the tape, we would respect their decision.
When a hearing person agreed to become a sponsor for a deaf person, we were looked upon as facilitators of communication. We would provide interpreters for AA group meetings and occasionally for individual meetings with his/her sponsor. Although we were not able to provide interpreters every time someone met with a sponsor one individual was particularly successful working with his sponsor. When a meeting took place the sponsor and sponsoree used the best available communication at the time. They sometimes used a computer, wrote notes to communicate, used a TTY (the sponsor was able to locate one) or found an interpreter in the building. We had the role of educators, as did the deaf member. Even though there was a fascination of the Deaf Culture by the sponsor, he did not loose sight of the relationship: Sponsor – Sponsoree.

The process is still growing. The numbers we have to work with are few. The problems we face will change with the day; the knowledge that there is someone to help carry the load through the slow times and the busy times is a great benefit. Having a co-leader was an asset in "reality checks": *"This is what I saw" "What did you see?"* We were able to keep up our motivation. If there was only one person working with the program, the lack of participation

may have hindered the continuation of the programs. Brainstorming was a lot easier with two people, as well.

"If you build it, they will come." We are not sure if the bridge is built to the right specifications yet, but we hope that with continued persistence we can bridge the gap one person at a time. Our goal is to be available for the deaf and hard of hearing community and to provide assistance in substance abuse issues; paving the way for a deaf and/or hard of hearing recovery group(s) to be established in the hearing recovery community. By continuing to bridge the gap between the two recovery communities, we will get there.

Making Connections: Creating Alliances for Prevention Programming

Cindi Sternfeld and Lisette Ortiz

In the current climate of funding cuts and doing more with less, collaboration is more important than ever. This workshop will address the pros of collaboration; provide strategies for starting partnerships and recommendations for easing the collaboration process.

Before deciding if collaboration is an appropriate avenue to pursue for your agency, it is imperative that you are clear about the goals and objectives of your workplace. The best place to find this information is in the mission statement of the agency. Just about every agency has a mission statement but most employees have never seen it. The mission statement condenses the goals and objectives of the agency into a one or two page document. The mission statement is an agreed upon set of goals which everyone in the organization ultimately works to uphold and attain. It will be useful in justifying and supporting you proposals to your superiors and their superiors

The mission statement is useful in collaborative work when directors are reluctant to take on big projects for fear that doing so will drain manpower and money. If two agencies share specific objectives in their mission statements and there is a project that would satisfy these objectives, the manpower and money challenge is a bit easier to overcome. The mission statement will serve as your primary tool in the work ahead of you. Familiarizing yourself with the mission statement and the staff of the participating agencies is a good place to start. The goal of this process is to take an inventory, which will later become a resource list for the proposed collaboration.

It is not unusual within an agency for various departments to have minimal inter-departmental contact. This reduces each employee's opportunity to understand the greater goals of the organization as well as limiting their ability to become aware of the individual strengths of other employees. On a day-to-day basis for the purposes of running an agency, this may be quite functional. For the purpose of interagency collaboration, it could create an insurmountable barrier.

Once familiarized with the goals and staff of agencies, the possibilities expand before us. For example, an agency, which provides comprehensive outpatient counseling and referral to Deaf individuals, may employ ten individuals, each with different job descriptions, each bringing a set of skills relating to their job. These skills may fit perfectly into a collaboration plan. The administrative assistant may be able to create PowerPoint documents or to submit orders for supplies needed for a collaboration project. More often then not, individuals also bring helpful resources to their workplaces from their personal connections; someone's husband works for a grocery store that would love to donate snacks and paper goods, another person's mother is a CEO of a corporation that will donate space for an event. All of these resources are ingredients for successful partnerships.

This seemingly simple process can be quite complex. Often people are afraid of change or added responsibilities to their already demanding workload. Further complicating this challenge is our desire for full inclusion of persons with disabilities. A clear example of this can be found in New Jersey where the teen institute desired to include deaf students in their program but had no experience in doing so. They were not initially aware of the expense and the cultural

accommodations that were required to appropriately serve the children. The idea of incorporating Deaf staff was completely novel to them and although they were open to some changes, in the early stages they expressed fear at sacrificing traditions of the camp to the needs of the deaf students. The barriers in this case were not communication related but rather attitudinal and required an approach that reflects an understanding of the issues at hand.

In an effort to ease the collaborative process we've created a list of possible concerns of the people involved. They are as follows; what is in it for us? What do we have to do? What is it going to cost? I never worked with deaf people before; it's too much trouble. Being ready to address these concerns will indicate to all involved that you've thoroughly researched the project and are ready for the challenges ahead.

Our primary goal today is to see increased interagency collaboration. This process is relatively easy; it just might not seem so at the project's outset. There will need to be a primary "mover and shaker" in each of the agencies involved who will make proposals and initial contacts. We presume by virtue of your attendance at this workshop that this person will be you. After completing the groundwork of studying the structure of your agency, familiarizing yourself with it's goals, and making initial contact with the agencies you wish to collaborate, you are on your way. This workshop will not deal with specific recommendations relating to event content rather to ease the collaboration.

Creating deaf friendly environs is perhaps the most important factor to consider. The needed accommodations vary in terms of difficulty. Here are a few tips. First, be sure that there is recognition that a deaf audience will be included. A brief statement about the interpreters, the use of assistive devises and any specific needs will reduce the level of distraction, which may exist in an audience not accustomed to these accommodations. We have created a brief delineation of ideas based on our experience, which may be useful. There are many ideas which can be done but we have attempted to list those which when addressed early on will significantly ease any last minute problems which might arise.

Presenters unaccustomed to working with a deaf group should be given information prior to the event. Such information should provide them with tips about working with interpreters and a deaf audience. Specifically, for the presenter that likes a high level of give and take with the audience, they will need to be sure that the interpreter has had an opportunity to sign the question before starting an exchange. Often times the question has been responded to before deaf participants know it has been asked. Presenters will also need to be cognizant of the turn taking that must exist with deaf participants and interpreters. Multiple layers of conversation serve to frustrate the process.

Presenters and activities, which tend to divide the audience into dyads or discussion groups will need to be sure that there are sufficient interpreters available to successfully integrate the deaf participants into a group. With willing participants an all-deaf group can be created but this somewhat defeats the initial intent of inclusion.

Lighting is an additional consideration. If there is a planned slide show or movie requiring lights to be dimmed, the interpreter must be lit through other means which will be sufficient for deaf participants to access signed information. Use of movies will also necessitate closed-captioned films and a monitor which has a closed captioned decoder. Open captioned films will automatically appear on the monitor without special technology. The size of the

monitor will be a factor and may require moving the deaf participants to move closer to the screen.

For groups attempting to find funding for interpreters and assistive technologies, it will be crucial to investigate current rates for interpreters, real time captioning services and rental fees for needed devises prior to writing a grant or conference proposal. Also, there will be a need to learn the level of expected accessibility. In some regions, real time captioning for example is expected and in others it is rarely provided. Government funded events are required to provide full accessibility and typically the state division dealing with ADA requirements will have funds set aside for such use.

Before, during and after the event there are a few items that are commonly forgotten. Prior to the event, establishment of a long-term calendar for meetings will be helpful in securing meeting places and any needed interpreters as well as insuring that everyone involved can attend. Press releases and advertising will need to be sent to appropriate media. It would be silly to pull an event together and not get any publicity or credit. Participant evaluations of the event will also be important for funding purposes and for feedback about the event overall.

After the event is over, it is also fairly common that we forget to thank all of the people and agencies involved. Having thank you notes ready for completion and distribution will assist in this process. The last and probably most important aspect of post-event planning is a meeting to de-brief about the event. For all involved to give their feedback in order to trouble shoot for future events.

Cynthia Sternfeld has been a Substance Abuse Coordinator for the Marie H. Katzenbach School for the Deaf for the past eight years and the HIV/STD Prevention Program Coordinator for three of those years. Currently, she is the acting Director of Residential Services at the Katzenbach School and an adjunct professor at the College of New Jersey. She holds a Master's degree in counseling with a Post-Master's certificate in Chemical Dependency counseling. She is currently working toward her Ed.S. in Marriage and Family Therapy. Cindi has presented at numerous professional conferences on topics related to substance abuse prevention, HIV/AIDS education and other topics as they relate to Deaf youth and the community at large.

Lisette Ortiz has worked for the past three years for Signs of Sobriety, Inc. She has collaborated with several different agencies such as NJAD, NJRID, Marie Katzenbach School for the Deaf and Teen Institute of the Garden State.

Let's Think Outside the Box!
New Approaches in Educating At-risk Deaf and Hard of Hearing Students

Linda M. Oberg, M.A.

Traditional ways of educating deaf and hard of hearing students might work for many but it does not work for all; students learn in different ways. This author proposes that a new model may be necessary to reach at-risk deaf and hard of hearing students. Educational programs with a non-traditional approach may best fit learners who need an experiential approach. Parents may need special training and exposure to the social emotional development of their deaf or hard of hearing child. The philosophy of developing everyday creativity to see opportunities instead of obstacles needs to be incorporated into programs whether they are for students or for parents at home.

Educational Programs

The education of deaf and hard of hearing students has incorporated many approaches and methodologies. Currently, deaf and hard of hearing students are educated in a variety of ways. Some attend residential schools for the deaf while others attend their local school with special education services from their home school district. Still, others are transported to programs that serve as a center for deaf and hard of hearing students in a particular area. At these programs students may be fully mainstreamed with little support or may attend special self-contained programs for deaf and hard of hearing students. All programs work reasonably well for some students. However, students who might be considered at -risk with social and emotional needs are often times forced to fit into a preexisting system that does not match their learning style nor their need for significant mental health services.

Alternative educational programs, such as the Intermediate School District #287's Options North Deaf and Hard of Hearing program in Plymouth, Minnesota can provide programs that might be a better match for some students. This program was developed since it was found that some at-risk students did not fit any of the traditional educational models. Program components that are successful at Options North Deaf and Hard of Hearing include:

- A small environment not included within a regular school
- Relationship building between staff and students as the key to success
- Continual connection with students to make sure they are not falling through the cracks during their school day
- Flexible schedule to allow for special activities or problem solving
- Continual connection with parents and/or guardians
- Highly innovative curriculum - specially designed for interests of each student
- On-going processing time with students to build coping skills
- Teachers, teaching assistants, educational interpreters and social workers that approach challenges as opportunities for growth; for themselves and for their students.
- Day to day progress reports to students
- Experiential learning incorporated into the curriculum

The author shared six beliefs that have become the shared values of the program at Options North. These beliefs are:

1. BELIEF in the good of all students
   "What we see depends mainly on what we look for"

2. BELIEF in chances
   "All students deserve a fresh start, a new hope that things can be better tomorrow"

3. BELIEF in a connection - a bonding.
   "A relationship can be the one thing, maybe the only thing that makes a difference"

4. BELIEF in patience
   "Results will happen but they may not be immediate and readily apparent"
   "A mind stretched by a new idea never retracts to the same place"

5. BELIEF in humor
   "Humor may be the way of survival"

6. BELIEF in a sense of belonging
   "First we trust ourselves, then another, then the larger system"
   "Trust leads to a sense of belonging to a larger group which is crucial for healthy self-esteem and relationship building"

Parent Education

Parent education has typically focused on which communication methodology to select and how to foster academic progress and success. Due to the enormity of these topics and their importance, the area of social emotional development of deaf and hard of hearing children often does not receive enough attention. Intermediate School District #287 took a new approach and presented three parent nights exclusively on this topic.

The following information was presented on the parent nights. Parents who's deaf and hard of hearing children were mainstreamed in their regular elementary, middle or high school attended these evenings.

FIRST PARENT NIGHT

- Understanding of family systems
- Misconceptions surrounding deaf and hard of hearing individual's mental health
- Developmental areas and how these can be different for deaf and hard of hearing children (physical, intellectual, emotional, social)
- Developmental tasks that need attention - how to foster social-emotional growth in their children.

SECOND PARENT NIGHT

- What is resiliency?
- Moving deaf and hard of hearing children from risk to resiliency
- Teaching decision-making to deaf and hard of hearing children

THIRD PARENT NIGHT

- How do I build a family with a deaf and/or hard of hearing member?
- What are the special considerations?
- Life as a sibling
- Ways to foster friendships
- How do I take care of me as the parent?
- The sharing of our gifts with others

Creativity

Creativity is something that we do not often think about in our everyday lives. However it is crucial if we are to change what we do as teachers and as parents to begin to meet the needs of deaf and hard of hearing children. The "Everyday Creativity" video, developed by Dewitt Jones - a National Geographic photographer, was used as a starting point for discussion. The key points were:

- Accept that creativity is not something magical and mystical
- Look at the ordinary - see the extraordinary
- Fall in love with the world
- Learn to change the lens - see a new perspective
- Accept that there is more that one right answer
- Find the 'next' right answer
- Reframe the problem as opportunity
- Don't be afraid to make mistakes
- Break the pattern
- Let the beauty of the change 'fill you up'
- Then the problem becomes opportunity

Having a vision, whether it is in the classroom or in the home, will put us in the place of most potential to influence change. Deaf and hard of hearing children who have significant social emotional needs require educational programming and parenting to be looked at in a new creative way. We all have that creativity within us.

> Creativity is not just about vision and passion. It's about technique and perseverance as well. It is a balance of emotion, of intellect - that springs forth from really caring about what we do. Really caring about the people that we work with and the projects we work on. When the people I photograph know that they are as important to me as my pictures - they open like flowers. And I find that the light that really lights my pictures is not the light from the outside. It's the light from within (Jones).

Linda Oberg has worked as a classroom teacher, an educational and freelance interpreter, and a research associate at Gallaudet University. She also worked at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals where she developed a curriculum and taught decision-making skills. She currently coordinates an educational program that serves deaf and hard of hearing students with significant mental health needs.

Please direct your correspondence to:
Linda Oberg:
Mental Health Therapist, Volunteers of America Mental Health Services
(612) 225-4053
E-mail linobrg@aol.com

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Alcohol and Drug Use by Deaf and Hard of Hearing Adolescents

Janet E. Dickinson, Ph.D.
Project Director
Drug Use and Violence Prevention Data Collection Study
With Deaf and Hard of Hearing Students

In 1997, the U.S. Department of Education Safe and Drug Free Schools Program awarded a grant to the Marie H. Katzenbach School for the Deaf to conduct the Drug Use and Violence Prevention Data Collection Study with Deaf and Hard of Hearing Students. The purpose of the project was to collect data on alcohol and other drug use by deaf and hard of hearing adolescents and to begin learning about issues of youth violence among this student population. The study was undertaken as a result of the realization that there was minimal data regarding substance use by deaf and hard of hearing adolescents and a data collection effort was needed in order to understand the extent of students' use and the effectiveness of prevention program.

A small statewide study had been conducted several years prior to this study (Dick, 1996); however, the sample size was very small and additional information was needed in order to confidently generalize the findings to all deaf and hard of hearing adolescents. Self-contained classes have not been included in the large studies, or have not been identified. It is possible that a few students with hearing loss who are mainstreamed in classes with hearing students did complete a questionnaire for one of these studies. However, they were not specifically identified, so it has never been possible to identify prevalence of alcohol and other drug use among deaf/hard of hearing students from these studies.

The study included students from middle school and high school programs for deaf and hard of hearing students in one state. This paper provides an overview of preliminary analyses conducted on the data collection from students in grades nine through twelve. Data collection is still being conducted; therefore the results presented are only the initial findings. Also, included is a description of the methodology, including some of the problems that occurred in the data collection effort. Individuals planning to do a similar study in their state should consider this information seriously and carefully review the methodology they use.

The study included all programs for deaf and hard of hearing students in the state. A program was defined as at least one class of deaf students. However, attempts were also made to include deaf and hard of hearing students attending "inclusion" programs in which they may be the only or one of a few deaf/hard of hearing students in their school. Although the data from the state education department showed that there were approximately 250 students in the state classified as auditorily handicapped-deaf and auditorily handicapped-hard of hearing between the ages of 14 and 21, it was not possible to locate all of them. Letters were sent to all of the school districts in which these students resided. However, it was only possible to locate approximately 71% of these students. A total of 177 students were interviewed and included in the data analysis. Aggregate findings are presented and not data related to either individual schools or individual students.

Consent letters were sent to parents of the deaf and hard of hearing students who were located. The parents or guardians were asked to return the consent forms only if they did not

want their child to participate in the study. Students' participation in the study was voluntary, so the use of passive consent was appropriate (according to federal confidentiality laws).

The development of the survey instrument and interview required an extensive process. The instrument from the earlier study (Dick, 1996) was used as the basis for the questionnaire for this study. That instrument had been adapted from the questionnaire used in the triennial survey conducted by the New Jersey Department of Law and Public Safety, which had been used and new questions field tested over a 10-year period.

After reviewing the questions to determine if any changes were needed and adding questions related to youth violence and violence prevention, the entire questionnaire (questions and answers) were translated into American Sign Language (ASL). The questionnaire included 149 questions.

A team of research assistants, who were native ASL users, translated the written English questions into ASL. A mock interview was videotaped and sent to a sign language interpreter who has certification from the Registry of Interpreters for the Deaf, is a native ASL user, and also has a degree in linguistics. She conducted a back-translation of the interview questions, and from that, staff identified questions for which the ASL translation did not match the meaning of the written English question. The translations were corrected and the interview was finalized.[1]

The interview was pretested at a school for the deaf in a neighboring state. Samples of students were interviewed, with each interviewer conducting at least six interviews. Students were chosen based on grade, gender, and reading level, and were assigned (matched) so that each interviewer's set of respondents were comparable. The pretest results were analyzed, no problems were identified, and there were no significant differences in the results obtained by each interviewer. The questionnaire and the interview process were finalized after the completion of the pretest.

Interviews were conducted at the schools attended by the participating students. Interviewers were sent to schools according to the communication needs of the students. If students to be interviewed were ASL users, an interviewer who is fluent in ASL conducted the interviews. A minimum of an advanced rating on the Sign Communication Proficiency Interview was the required level of proficiency for interviewer. If students were reported to use Signed English or another manual coding system, interviewers who are skilled in those modes of communication conducted the interviews. For oral students, the interviews were conducted verbally by hearing interviewers. All interviews were begun in ASL, and the interviewers had a written version of each question that they followed. If a student did not understand a question as signed, the interviewer could repeat the question in a different signing style in order to ensure that the respondent understood it. In studies of the general population, interviewers would not ordinarily change how a question has been asked. It was necessary in this study, because deaf students have varying signing styles and ability to understand ASL and/or signed English. If questions are signed only one way, the risk of losing many respondents (due to their lack of understanding) is high.

After 77 interviews were conducted, two problems in the interview process were identified. One of the problems was that interviewers had inadvertently signed a few questions in such as way that changed the meaning of the question. In these cases, the change was merely in one sign. However, that one sign resulted in the expression of a different concept than was intended in the original written English question. This happened even though the interview

training has emphasized the importance of signing questions exactly as were appeared on the questionnaire; however, this maxim was not always followed. This was not intentional on the part of the interviewers but was due to inexperience. Those considering replicating this study are cautioned to meet frequently with interviewers in order to review how questions are asked in order to avoid this mishap.

The second problem was the use of answer sheets. Dick (1996) found that information provided by student respondents via answer sheets were not reliable. Nevertheless, for this study, the advisory committee felt strongly that answer sheets should be used, in order to maximize confidentiality for students. The use of answer sheets were found to be problematic in that some students appeared to understand the questions when they were asked by the interviewers but provided inconsistent responses to drug use questions. For example, a student responded that he/she never used marijuana. Then, in a follow-up question asking the number of times he/she used marijuana in the past 30 days, he/she would provide a response showing that he/she had used in the past 30 days. The result was data that was neither valid nor reliable.

The initial 77 students whose interviews included the use of answer sheets were interviewed a second time without answer sheets in order to remediate the problem and obtain reliable data. Interviewers asked the questions in ASL to the students (changing to more English signing if needed by a student), and the students were instructed to tell their answers to the interviewer directly in sign language. This process allowed the interviewers to clarify any inconsistent responses during the interview process. This did reduce students' perceptions of confidentiality, but it was determined to be an important trade off in order to obtain valid data. The analysis of the data found that being interviewed twice had no significant effect on students' responses.

Description of the Sample

The sample included 177 deaf and hard of hearing students between the ages of 14 and 21. Most of the respondents were between the ages of 15 and 17. Fifty-nine percent (59%) of respondents were male, and 41% were female. Regarding the racial composition of respondents, 39% were Caucasian, 18.6% were African American, 6.4% reported being Asian, and 7.3% reported being other. In the area of religion, 43.7% of respondents reported that they were Catholic, 14.9% reported being Protestant, 3.4% said that they were Jewish, and 10.9% reported that they had some other type of religion.

Approximately 41% of respondents attended mainstreamed programs in public schools with interpreter services, 29.7% of respondents attended public school programs with no interpreter services, and 29.1% of respondent attended the residential school for the deaf. Respondents were asked if they had hearing and deaf friends, and then were asked if they felt closer to hearing friends, deaf friends, or both the same. Just under 40% of respondents said they felt closer to their deaf friends, 19.9% reported feeling closer to hearing friends, and 46.2% of respondents said they feel similarly close to both hearing and deaf friends. Sixty-four percent (64%) of respondents reported that their hearing friends rarely or never use sign language to communicate with them.

Frequency of Use

Four substances were used by respondents substantially more than others, cigarettes, alcohol, marijuana, and inhalants. 51%, 76.7%, 21.7%, and 16.1% of respondents used them, respectively. Respondents reported minimal use of cocaine, crack, pills, heroin, and hallucinogens, 2.3%, 1.7%, 1.1%, 1.7%, and 4%, respectively. The latter five substances were not included in any analyses as a result. The percentage of students reporting use of substances increased from the previous study. Cigarettes were used by 43% of respondents in the first study, 76% of respondents in the first study reported drinking alcohol, and use of marijuana was reported by 12% of respondents in the original study (Dick, 1996). While alcohol use remained consistent, the percentage of students reporting that they have smoked cigarettes and the percentage reporting that they have used marijuana both increased; there was an 8% increase in cigarette use and just under a 10% increase in the number of students reporting that they have used marijuana.

The use of these substances by respondents was compared to the percentage of students reporting use in a study of hearing high school students (Department of Law and Public Safety, 1999). The comparison is presented in table 1.

Table 1
Comparison of Use by Hearing and Deaf Students

Substance	Hearing	Deaf
Cigarettes	36.7%	51.1%
Alcohol	78.5%	76.7%
Marijuana	42.3%	21.7%
Inhalants	18.3%	16.1%

The hearing sample used alcohol, marijuana, and inhalants more than the deaf sample. However, there was only a 2% difference in the percentage of students reporting use of alcohol and inhalants, so the use patterns for those substances are very similar. Approximately 15% more deaf students reported having smoked cigarettes than hearing students.

Preliminary Analyses

A series of bivariate analyses were conducted in order to investigate the effect of a number of variables on respondents' use of alcohol and other drugs. The final result of the analyses is a profile of a deaf adolescent who uses alcohol and marijuana. The only substances that were included in the bivariate analyses were alcohol, cigarettes, and marijuana. The other substances (pills, hallucinogens, and cocaine) were used by only a small number of respondents, so they were not included in the bivariate analyses.

Parents' use of alcohol and drugs and friends' use of alcohol and drugs were included in the analyses, since they are considered to be important predictors of adolescents' use of alcohol and other drugs. Father's drinking was found to have a significant relationship to respondents' cigarette smoking ($p = .05$). More than half of the respondents (58.6%) who reported smoking reported that their fathers drink alcohol, and 78.3% of the respondents who reported that their

father never drank reported that they had never smoked cigarettes. The same relationship was found between mother's use of alcohol and respondents' cigarette smoking. Fifty-six percent (56%) of respondents reporting that their mother drinks alcohol said they have smoked cigarettes, and 58.5% of respondents who said that their mother never drank reported that they have never smoked cigarettes.

Friends' use of marijuana was found to have a significant relationship with respondents' use of marijuana and alcohol ($p<.001$). Almost 97% of respondents who reported that none of their friends use marijuana reported that they have never used marijuana. Friends' use of alcohol was also found to have a significant relationship with respondents' use of marijuana ($p<.05$). Close to 80% of respondents who reported that few or none of their friends smoked marijuana reported that they have never used marijuana.

The same relationship was found regarding friends' cigarette smoking. A significant number of respondents who reported that few or many of their friends smoke cigarettes said that they had smoked cigarettes. A significant number of those who reported having no friends who smoke cigarettes reported that they have never smoked cigarettes. Similarly, a significant number of those who said that none of their friends used inhalants reported that they have never used inhalants.

Parents' use of sign language was found to be related to respondents' use, of cigarettes and marijuana. Significantly more respondents who said that their fathers use sign language reported smoking cigarettes than respondents who said that their fathers do not use sign language to communicate with them. For mothers, 85.5% of respondents who reported that their mother does not use sign language reported that they have never used marijuana while only 14.5% who said that their mothers do not sign reported that they have used marijuana.

Church attendance and academic achievement were found as being related to respondents' use of substances. A significant number of respondents who reported regular attendance at church (90.9%) reported that they had never used marijuana ($p=.01$). Regarding academic achievement, significantly more respondents reporting good grades (A's and B's) reported less use of marijuana than those with lower grades in school ($p=.001$).

Interaction with peers was also related to respondents' use of marijuana. A significant number of respondents who reported having hearing friends (81.7%, $p<.05$) and who reported attending mainstreamed classes (83.8%, $p=.005$) reported never having used marijuana. A significant number of respondents who reported having deaf friends reported that they have used marijuana.

What the preliminary analysis of the data found is that the factors most strongly related to deaf adolescents' use of cigarettes, alcohol, and marijuana are similar to those that are influential factors for adolescents who can hear. Including parents' use of substances, friends' use of substances, academic achievement, and involvement in traditional institutions of society such as church and school (Jessor & Jessor, 1984; Jessor, 1987). The profile of the user from this study is: a deaf student who has parents who drink, friends who use, does not attend church, has poor grades in school, has parents who use sign language to communicate with them, and has deaf friends and attends school with deaf students.

The relationship between the deaf culture/socialization variables and respondents' use of substances is unexpected and difficult to explain. It would be expected that if a deaf adolescent is able to communicate with one or both parents in sign language, and therefore has

communication at home, his/her use of alcohol and other drugs would be less than if there was no communication due to the parent not signing. The frustration and distress at not being able to communicate with parents would not be present and thus could not serve as a factor placing the adolescent at risk for alcohol and other drug use. Since this was only a preliminary analysis, it was not possible to conduct multivariate analyses in which other problems between the parents and respondents were investigated. Furthermore, questions were not included in the study to adequately conduct such an investigation. Further studies should continue the analysis of this finding.

The other surprising finding is the relationship between having deaf friends and use of substances. It is possible that if a deaf adolescent has deaf friends, and communication is completely accessible and natural, that activities such as experimenting with and using alcohol and drugs occurs just as it does with adolescents who can hear. Jessor (1987) explains deviant (problem) behavior by adolescents (such as using alcohol and other drugs) as a normal transition from adolescence to young adulthood. If a deaf student has only hearing friends who do not use sign language, such transgressions may not take place as normally expected, because the free flow of communication among peers is thwarted. This could explain the finding that use was lower for respondents who had more hearing friends than deaf friends and who attended mainstreamed classes with hearing students than for respondents with more deaf friends and who did not attend classes with hearing students. With the popularity of inclusion programs for all children within the special education system, including deaf and hard of hearing students, the effect of interactions with peers on students is of particular importance. Further study of these effects is needed.

Janet Dickinson is the Director of Community and Transition Services for the Austine School for the Deaf in Vermont. She is also Principle Investigator for the Drug Use and Violence Prevention Data Collection Study with Deaf and Hard of Hearing Students, a project administered by the Marie H. Katzenbach School for the Deaf, where she was formerly the Director of Community Affairs.

[1]For a videotaped copy of the survey questionnaire, contact K. Noble at the Marie H. Katzenbach School for the Deaf, PO Box 535, Trenton, NJ 08625-0535.

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TREATMENT STRATEGIES FOR DUALLY DIAGNOSED CLIENTS

Kristen Swan, M.A., L.P.
Regions Hospital, St. Paul, Minnesota

The purpose of this paper is to share some considerations in working with dually disordered clients (i.e. persons who are mentally ill **and** substance abusers). The disorders specifically discussed will be Major Depression, Bipolar, Anxiety, Antisocial Personality, Borderline Personality, Schizophrenia and some types of Organic Brain Disorder. It is critical that before a clinician can be effective working with deaf dually diagnosed clients he/she must have a solid understanding or foundation in the basic principles of working with other dually diagnosed persons. This paper will be a general overview of these principles since the similarities between deaf and hearing clients, in this regard, outweighs the differences. The focus will be primarily on counseling considerations and approaches and not how to make the actual diagnosis. I would refer you to the resources cited in this paper for more specifics. Much of the information shared in this paper was gleaned from the two books listed in the reference section.

INTRODUCTION

One issue, which complicates treatment progress and the use of conventional treatment approaches, relates to the presence of dual or multiple diagnoses. Individuals with dual disorders experience a greater amount of "distress and disability...where the whole problem is greater than the sum of the parts" and where the "two disorders inevitably exacerbate each other" (Evans & Sullivan, 1990). These are individuals who, because of their multiple disabilities, will be in crisis more often and will use hospitals and emergency rooms more frequently.

At the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing People the vast majority (75%) of clients served have, in addition to their Axis I diagnosis of chemical dependency and Axis III diagnosis of deafness, either an additional Axis I (affective) diagnosis or an Axis II (personality disorder) diagnosis, or show characteristics akin to these disorders.

Recent research cited by Daley, Moss and Campbell (1987) in their book, *Dual Disorders: Counseling Clients with Chemical Dependency and Mental Illness*, says that possibly 70% of hospitalized alcoholics have experienced one or more episodes of another substance abuse or psychiatric diagnosis in their lifetimes" (Daley, Moss & Campbell, 1987).

GENERAL TREATMENT CONSIDERATIONS

There are several general treatment considerations that are of particular importance when dealing with clients who are identified as dual disorders. Accurate assessment of these individuals presents a big challenge since there seems to surface an argument related to which is "**primary**" or "**secondary**;" did one disorder cause the other; and which should be treated first. Some chemically abusive or dependent individuals "can develop symptoms similar to those seen in many psychiatric disorders such as: psychotic symptoms, depression, anxiety, mood swings, isolation and social withdrawal, as well as erratic, hostile or criminal behavior (Evans & Sullivan, 1990). Other symptoms that are similar in both disorders include blaming, denial, rationalizing, and minimizing, to name a few. Sometimes one disorder masks the other and its

only when the person experiences a "drying out" that the symptoms of their mental illness actually surface.

This may be especially true with long-term addictions or with elderly people. Forty or more years ago there was limited understanding of psychiatric disorders, a lot more stigmatization than even today, and very few appropriate treatments. Chemical dependency found fertile ground in which to develop in these people due to untreated psychiatric illnesses such as affective and anxiety disorders. From the other direction, prolonged chemical dependency can produce depression or other forms of affective disorder based on the many losses experienced from ones use and consequences. Sometimes it is even hard to get an accurate early picture of a person's life or psychiatric history because their use had been so intrusive and long-standing – they really cannot remember, "how it was before."

The primary/secondary issue, however, becomes a "moot" point -both have to be treated. As to which is best to treat first, ideally treatment should be flexible enough to happen **simultaneously**, rather than sequentially.

There is also the danger of **misdiagnosing** a deaf person as mentally ill or psychotic when in reality the problem is related to a chemically induced psychosis, language/communication deficits, or cultural deprivation.

With this in mind, it is critical on intake to get a **comprehensive social and medical history** in order to uncover underlying psychiatric illness and/or hereditary connections. During the "drying out" period the staff can then be on the alert for any underlying psychiatric illness that may surface.

Providing proper and ongoing assessment to determine a client's readiness for group and their ability to actually benefit is critical. This may be especially true for schizophrenic or highly anxious people. In a treatment setting where there is a larger census it may be helpful to separate people into groups with a more equal level of functioning and as their psychiatric concerns become less intrusive they would move up to higher level of group interaction. This is not usually an option for deaf programs since the numbers are usually too low to "split up". But it may be a factor to consider if time allows a person to move more slowly.

Both chemically dependent people and persons with psychiatric disorders engage in denial, blaming, rationalizing, and minimizing which makes compliance for treatment a difficult task. When a person has both conditions they may be doubly hard to convince of the need for help. On the other hand, due to the fact that they may be **more severely disabled in their level of functioning** they may not as easily escape intervention from outside sources and thus may end up in treatment sooner than someone with a single diagnosis.

A person may **oscillate between various presenting problems**. For example he/she during the course of CD treatment may have severe emotional reactions to traumatic events in their life and need to be temporarily transferred to a psychiatric unit. Or the person may need to

be medically stabilized first on such a unit if they have had a psychiatric crisis. Once that happens the person could be transferred to a CD program.

Another consideration is that successful treatment will **undoubtedly take longer, be more intensive and require more staff involvement.** This has a myriad of implications for payors and clients alike. More often than not staff has to "make do" with the days allotted from the payor source.

Co-facilitation is really required if the CD group has dual disordered clients. There are usually so many issues surfacing that it is hard to attend to everything if one is trying to run the group alone. This is especially important when these clients have personality disorders, which have the dubious distinction of masterfully "hooking" a therapist/counselor's own issues and creating power struggles.

Most professionals writing on this topic agree that the "state of the art" treatment would treat both disorders concomitantly as previously stated. This is often difficult due to a limited number of **professionals trained and experienced in both chemical dependency and mental health**. Within the deaf community we are still in the pioneering stages of providing appropriate chemical dependency treatment for clients with hearing loss. It is a big enough challenge to find people with expertise in deafness and train them in chemical dependency counseling and especially vice versa. With the addition of a psychiatric diagnosis, clinicians will need to add a third area of expertise to be able to adequately treat these individuals.

This emphasizes the need for **team approaches and consultation from other professionals** since the availability of individuals with training in all three skills is usually limited. It is crucial to have a psychiatrist working closely with the CD program, preferably on site, and readily available for medical consultation or one-to-ones. Ideally, it would be helpful to have psychologist trained and cognizant of CD issues available to provide either training/consultation for the staff or actual sessions with clients while on the unit or in outpatient programming.

Expectations should be kept tied to the client's ability and based on reality. Determine and understand what "being well" or "being recovered" means to each person. Be sure you know where you are going with the client and that he/she is "on board." It is important to assist them in developing their own treatment plan based on the variety of symptoms they may have. Often counselors waste a lot of time and energy trying to impose their worthy and well-intentioned agendas on their clients.

The heart of any treatment program for chemical dependency or mental health is **education.** Clients need sufficient knowledge related to symptoms, diagnoses and medication which they can get through lectures and one-to-ones. There should be openness on the part of the staff and other clients to discuss the additional illness and how the symptoms of the psychiatric diagnosis impact their life. When one relates the symptoms of the particular mental illness to the behaviors and consequences related to the chemical dependency, this may help the client make a

more realistic assessment of which issues they may have power to change and of which they need to let go. Ultimately our clients need to learn how to live on a daily basis with their diagnoses and manage them without relapsing into chemical abuse.

Medication is a dilemma for many treatment professionals as well as clients. I am a strong believer in the benefits of medication to help with many psychiatric disorders. There are some AA/NA groups that do not support the idea of medication for addicted people despite the official endorsement by the national office. However, there is a valid concern about the need to develop alternative ways of coping with life situations rather than the mind-set that pills will always solve ones problems. Significant education is needed for staff and clients regarding the manner in which psychotropic medications work on the brain and what they do and do not do. Medication should never be touted as "the answer" to a person's problems. It can and does assist a person to function at a level where they are more able to benefit from treatment or therapy. Research has shown, for example, that in the treatment of depression far more people get well or show improvement if there is a combination of medication **and** psychotherapy than those who just take medications. It is true that many addicts inappropriately seek medication and that some medications – anti-anxiety medications especially – are more prone to abuse and thus need to be used with a lot more caution, if at all. Antidepressants, on the other hand, take so long to "kick in" that would be unusual to hear of people seeking a high from this class of medications. It is ironic that the clients who seem most opposed to taking doctor prescribed; "safe" medications are chemically dependent people who thought nothing of using street drugs or sharing needles. The concern often heard from deaf and hard of hearing clients is that these "drugs" are for "crazy people" or will "make a person crazy." A helpful response to this may be to explain that different kinds of medications are used for different types of illnesses and use visual aids to show the actual way in which the medications act on the brain.

AFFECTIVE DISORDERS

Major Depressive Disorder

This is perhaps one of the most prevalent diagnoses for chemically dependent persons; most have experienced depressive symptoms at some point in their life, especially while abusing substances. The main feature of this disorder is a [persistent] depressed mood or loss of interest in most usual activities [for a period of at least 2 weeks] (Daley, Moss & Campbell, 1987).

Assessment considerations: Questions should be ask related to their family history, whether the symptoms were present prior to the chemical problems or during times of abstinence, suicidal ideation or attempts. Some people are glad to get a diagnosis of depression and to understand that they may have been medicating their depression; the more they understand the more they feel that there may be a way out and to once again take charge of their life and recovery.

Counseling considerations: Once the client is safely detoxified (on a psychiatric ward if there has been suicidal gestures) and the mood has stabilized or improved somewhat, then they can begin treatment.

In general, the most effective approach is a supportive one that instills hope in one's abilities to feel and "do" better. In working through the 12 steps it is useful to put a greater emphasis on assets and strengths and avoid any tendency to "beat themselves up." The counselor can be firm but kind, using gentle confrontations to point out negative patterns of thinking. Teaching and encouraging them to express feelings in a direct and honest way can be quite empowering and successful.

Daley, Moss and Campbell outline 3 general counseling approaches they have found to be helpful with this type of client:

1) Emotional release or ventilation of feelings;
2) Changing thoughts and beliefs; and
3) Changing behaviors

The ventilation of feelings provides relief and helps to foster trust between the client and the professional working with him/her. A goal of treatment is to help the client tolerate dysphoric feelings...and establish connections between unpleasant emotions and the thoughts and attitudes that precede the emotional state (Daley, Moss & Campbell, 1987). Sometimes clients will perseverate on certain negative feelings. The counselor may need to set time and place limits on when and for how long they can emote or "feel bad." Anger management techniques are helpful since it is a common belief that depression is anger turned inward and at some point the client will need to get in touch with this feeling. Grief work is often relevant for these clients since they may have experienced many losses that are unresolved. The 12-step program offers a helpful framework to begin working through this grief. A word of caution: the depression a client feels as a result of the losses from his/her use is often therapeutic in helping them to realistically see what their use has done to them so it is important not to attempt to relieve this depression too quickly. It is important to be aware that some may use their depression as a way for them to avoid the pain of dealing with their addiction.

Education related to understanding chemical dependency and acceptance of it as a disease may relieve some of their guilt and shame. At the same time they need to also accept that the responsibility is now theirs to make the changes necessary to improve their life and deal with their addiction. A cognitive-behavioral approach seems to be successful in helping to change thoughts and beliefs. In this approach one attempts "to identify and change distorted thoughts styles of thinking or the premises or assumptions underlying thoughts" (Daley, Moss & Campbell, 1987). It is beyond the scope of this presentation to expound on cognitive-behavioral therapy but a basic premise involves the process of "countering" where logic is used to develop a positive self-statement to counteract and decrease the negative one. Since these clients tend to be overly critical and harsh with themselves this can be a successful technique to break through their self-defeating patterns. These statements should be created by the client (with help from the counselor if necessary), be concise, believable, stated assertively, and be opposite to the negative thoughts. Clients also need to be encouraged to see the positive progress they are making and give themselves positive reinforcement and meaningful rewards. Making lists of their assets and strengths is helpful but may be difficult for them too early on in treatment.

Clients should be encouraged to increase their level of activity and identify pleasant leisure activities. Contracts or behavioral assignments may be helpful to begin taking some

small steps toward more activity and changing ones perceptions. Weekly, daily or even hourly schedules can be drawn up to keep things more success oriented. Behavior expectations need to be concrete and manageable. Sometimes it may be helpful to prepare them for some new task or behavior by role playing or imagining it. Assertiveness and social skills training can provide good specific tools for helping clients to change behaviors.

Rebuilding their social support system is also important as well as increasing their interactions with others. This helps to decrease the focus inward and the sense of isolation that is so characteristic of depressed individuals. Family involvement and their feedback are also critical here and may provide a catalyst for the client to improve and make changes.

As mentioned above, it is very important not to rule out the use of anti-depressants with this population because of an attitude or belief you might hold that states that total abstinence from all mood altering chemicals is the only way to a clean and sober life. For some individuals with severe endogenous depressions and suicidal ideation, medication (and concurrent psychotherapy) is their only hope to a clean and sober life. These [discriminatory] attitudes must change if dual diagnosed patients are to receive the best care currently available (Shnaps, 1991).

Bipolar Disorder

This disease, formerly called manic-depressive illness, is a cyclic mood disorder with its main feature being "a distinct period of extreme mood and behavior ranging from manic euphoria and hyperactivity to depressed sadness and immobility" (Evans & Sullivan, 1990). People are sometimes misdiagnosed as schizophrenic because they can behave psychotically during the manic phases. It is thought that some "acting out" adolescents may have undiagnosed bipolar disorder.

Individuals with this disorder are especially prone to chemical abuse. The alcohol abuse can be heightened during a manic phase in an effort to slow themselves down. This gives rise to the belief that they may be attempting to self-medicate at these times. Stimulants have also been used, however, to maintain an euphoric state. It also can be the particular "impulsive behavior" that they are compelled to engage in when in their manic state.

Assessment Consideration: These persons might appear initially in psychiatric hospitals - not in treatment centers - so they most likely will have been stabilized on lithium carbonate. But chemical dependency counselors should be alert to a person's rate of speech/signs, production of ideas or flight of ideas, evidence of grandiose mood or excess elatedness, and their sleep patterns and energy level. Investigation into the family psychiatric history is critical too, as this tends to be a familial disease

Counseling considerations: Sullivan and Evans (1990) outline 3 key treatment issues:

1) Medication compliance
2) Need for grief work
3) Need for a balanced lifestyle

Related to medication compliance, these patients typically enjoy the high, euphoric times so will discontinue their medication because it serves to level them out. Also since their "lows"

are not as low they start feeling better and decide they no longer need the medication. Once they discontinue their medication regime they are at an increased risk for mental illness relapse and the abuse of alcohol. Education is crucial for these patients to understand their disease as a disorder of their brain chemistry and the need for probably a long-term medication regime to manage it. They need to realize the importance of frequent blood level checks and regular visits to their psychiatrist.

Grief work may be necessary due to the process of coming to grips with some of the behaviors they engaged in while in their manic phases. They will require supportive therapy that does not further shame them but helps them face the realities of what they did, take responsibility for whatever they need to and then "let go" and move on. Pointing out their manic behaviors at appropriate times can help them see and accept the necessity for medication and the reality that they are suffering from two illnesses.

Third, since stress can trigger manic episodes, the need to learn to develop a balance in their activities and lifestyle. Learning specific techniques in stress and time management, relaxation, and redirecting their energy can give them a sense of mastery and control that they need for continued recovery.

As a general rule it is best if the person not start chemical dependency treatment until the manic symptoms have stabilized as these clients tend to be monopolizing, and disruptive to the group process, albeit amusing and enjoyable at times. Counselors should beware of being enticed or encouraged by their energy level, wit and/or creativity, as it can tend to shift the focus from the seriousness of their chemical issues.

Other suggestions which Sullivan and Evans (1990) present for dealing with a person in the manic state are to "avoid any attempt to stop the manic behaviors...[but] instead...redirect the energy." They suggest limiting their time in-group for speaking, staying seated and taking time outs to assist in lowering stimulation levels. Establishing some kind of signaling cue (hand or verbal) might help client monitor his/her need to slow down or stop talking. This signal or cue should be jointly determined and be discreet enough to avoid extra embarrassment or shame. However, since the mental health disorder is integral to recovery from chemical dependency, the impact of ones symptoms can and should be dealt with directly in-group and by the group members as well as the counselor. Other kinds of "gentle but firm limit setting" are helpful related to written assignments or verbal responses during lectures. There is always the tendency for them to try to do "too much too soon." The need for education and awareness of interpersonal boundaries is important as the client begins his/her involvement with a sponsor and in AA/NA groups. It is helpful to find an understanding and perceptive sponsor who is able to take the additional disability in stride.

ANXIETY DISORDERS

Anxiety disorder can best be understood as a disturbance in the normal way in which the body responds to danger or the threat of danger (Daley, Moss & Campbell, 1987). They involve both "anxious arousal and avoidance of the anxiety provoking situation" (Evans & Sullivan, 1990). There are phobic disorders (i.e. simple, social, agoraphobia), as well as anxiety states, such as panic disorder, obsessive-compulsive (OCD) disorder, post-traumatic stress disorder (PTSD), and generalized anxiety disorder. Alcohol and other sedative-hypnotics are often

associated with these disorders as a form of self-medication. Individuals with these disorders should be educated with the information that their anxious symptoms are never truly relieved by alcohol and may in fact be exacerbated.

Assessment Considerations: Inquiries should be made concerning avoidance of situations or places that may be a problem for the client (Daley, Moss & Campbell, 1987). It is also helpful to determine how they "cope" with their fears. Because the term "panic attack" may have a different meaning for the deaf or hard of hearing client, it's best to ask about episodes that "come out of the blue" and consist of heart palpitations, sweating, rapid breathing, and an intense feeling of fear (Daley, Moss & Campbell, 1987).

Counseling Considerations: The approach should be firm but not confrontative. A kind, supportive approach is more successful in encouraging clients to progress at their own pace. It is important that the treatment milieu be safe and supportive. For example, phobic clients may not feel safe and thus not do well in a locked ward. In general, the intense social expectations that occur in residential or inpatient settings may be difficult for persons with one of these disorders, especially social anxiety. Care and concern should be taken to assure that clients are not put in anxiety producing situations prematurely. Persons with panic disorder should really be treated with medication prior to their involvement in the treatment program. There are some special concerns when considering anti-anxiety medications for these patients. Xanax, one of the primary anti-anxiety medications, is highly addictive and may in fact be another patient's drug of choice. Staff needs to closely monitor the administration of this type of medication. Sometimes persons with panic disorder can be treated with anti-depressants or Buspar, which has no abuse potential. Whenever possible the focus should be on psychotherapeutic strategies.

Staff needs to understand the acute and actual fear that is present for these individuals. Outside consultation and a team approach will be helpful for staff working with this population. Phobic clients may need additional support from staff to actually go out to attend AA or support meetings. It must be communicated that abstinence is a must, but for this population the reality is that there is a high risk of relapse with chemicals or involvement with other compulsive behaviors.

Some techniques that have proven helpful for these patients are anxiety management skills such as relaxation, biofeedback, meditation, positive self-talk and imagery. Standard step work is also useful for these people. Sullivan and Evans state that the paradox of powerlessness in the first step needs to be emphasized. By accepting that they are not in control of their drug or alcohol abuse and by accepting that their attempts are to control the uncontrollable, these individuals can begin to make progress (Evans & Sullivan, 1990). The second and third steps provide a mechanism for them to develop a level of trust and a framework by which they can begin to maintain a level of calm and let things happen as they will.

PTSD is a condition that is the result of exposure to an unusual, highly stressful, psychologically traumatic event (Daley, Moss & Campbell, 1987). It is characterized by a re-experiencing of the stressful event through intrusive and painful images, memories, dreams or nightmares; a withdrawal from or reduction in responsiveness to the external world; and symptoms such as an exaggeration of the normal startle response, hyper-alertness and sleep disturbances (Daley, Moss & Campbell, 1987). Sometimes dissociative features may also

surface. At intake they may feel distrustful and be experiencing a lot of confusion so that their level of disclosure is limited. They also tend to show higher rates of alcoholism and cocaine addiction.

The first counseling task would be to develop a trusting relationship. Counselors may find it helpful to learn as much as they can about the traumatic events (i.e. war or sexual abuse) that their clients have experienced so that they can be more aware and sensitive and thus more effective in dealing with these issues with their clients. It is important to immediately deal with the alcohol or substance abuse issue but be much less aggressive about dealing with the trauma issue. This may need to unfold more slowly. Outside or adjunct support groups are helpful for addressing PTSD issues so that the focus in treatment groups can remain on the chemical issues. Counselors must beware of a tendency or desire to "be nice" or overly sympathetic to these clients and thus be less direct about the chemical dependency.

PERSONALITY DISORDERS

Personality is defined as enduring patterns of perceiving, relating to, and thinking about oneself and the world that manifest themselves in a wide range of important situations (Evans & Sullivan, 1990). A personality pattern becomes "disordered" only when the pattern is inflexible and maladaptive, leads to substantial subjective distress or functional impairment, and characterizes the person's long-term functioning in a variety of situations (American Psychiatric Association, 1987).

Some features that the personality disorders have in common as listed by Daley, Moss, and Campbell are:

1) Pattern of problematic relationships;
2) Tendency to blame difficulties on others or bad fortune;
3) Lack of responsibility;
4) Learning little from previous experience;
5) Lacking specific behavioral skills (occupational or social);
6) Inadequate control over their emotions;
7) Distorted thinking;
8) Self-defeating sequences of events, which aggravate their difficulties.

Of the several personality disorders the two that seem to be most prevalent, both in hearing alcoholics and the deaf clients served at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing People, are **anti-social** and **borderline personality disorders.** This paper will focus on these two disorders. The acting out behaviors characteristic of these disorders make them more likely to be in mental health or chemical dependency programs, or involved with the law.

Anger is a key affect for these individuals and tends to characterize many of their important interactions (Evans & Sullivan, 1990). There are also strong patterns of denial, lying, thrill seeking, conflicts with authority and family, control issues and feelings of alienation and unhappiness (often due to getting caught!).

It is important to acknowledge that persons, while they may be exhibiting behaviors or traits associated with these personality disorders, may not actually BE personality disordered. In the case of some deaf individuals, they may instead be highly under-socialized and need education related to social skills such as respect and listening to other people's problems and feelings.

Anti-social Personality Disorder (ASP)

The anti-social individual shows "a pattern of irresponsible behavior and behavior that consistently violates the rights of others social norms and laws" (American Psychiatric Association, 1987). In addition to the features and characteristics already listed, "these individuals have an extremely inflated sense of their own worth and prerogatives with little capacity for a genuine empathetic relationship with other persons" (Evans & Sullivan, 1990). They are "thrill-seekers" who feel little remorse for their behaviors; In fact they often see nothing wrong with what they have done, have incredible rationalization skills and see "life as a game...to be won." Their image is of prime importance.

Assessment Considerations: When assessing a person with ASP, collateral data from the family, legal personnel, or other professionals involved is critical since any data collected from the individual is most likely inaccurate, minimized or incomplete. Sometimes the client has alienated his family and thus they will most likely not be involved but discussing "family experiences and issues...may increase the client's understanding and provide insight into current patterns of behavior" (Daley, Moss & Campbell, 1987).

Counseling Considerations: Sullivan and Evans suggest that when working with an individual with ASP it is important to avoid discussion of "why" they are the way they are. This provides an easy excuse for them not to take responsibility for themselves and their behaviors.

The goal [of therapy] is to adapt the sociopath so that antisocial clients come to believe that playing by the rules of society can actually make them look better in the long run, giving them greater success and helping them stay out of trouble (Evans & Sullivan, 1990). A helpful question is to ask them if their drug use or behavior is actually "getting them what they want." It is unrealistic to assume that a person who is classically ASP will develop an altruistic, empathic, or remorseful nature.

This type of client creates a challenging dilemma for the counselor. As alluded to above, clients may be misdiagnosed as ASP. Once that label is attached, however, it tends to raise "red flags" for the counselor who may then decide that the person is basically untreatable - a "chronic" - and give up on them. Because of the negativity of the behaviors, counselors may blame the client and let themselves off the hook for not trying to help them. Counselors must try to contain any hostile reactions towards these clients and "must learn to tolerate the less attractive traits...in order to gain the trust needed in a helping relationship" (Daley, Moss & Campbell, 1987). It is easy to get hooked by the charm and manipulation of these individuals. It is imperative that the counselors maintain emotional distance, appropriate boundaries and a clear, honest and realistic perspective. The client, who thrives on angry, conflictual relationships, may try to engage staff in angry power struggles, which the counselor must learn to defuse. Close

collaboration with other staff and outside supervision is helpful in working more effectively with these clients and developing appropriate treatment goals. In some cases it may be helpful to develop or at least discuss these individual goals in the group setting. This may assist in setting up more accountability for the client.

Sullivan and Evans describe R.R. Rada's "three C's" which outline treatment strategies useful for working with ASP clients:

1) The need to "corral" them. This type of client does better in a residential setting or inpatient program where external controls and firmer limits can be established. They often need external mandates (i.e. court orders) or they will not stay in treatment. These clients are often the ones who go "AWOL" or leave AMA.

2) "Confronting" the anti-social personality. It is important to help these clients identify "thinking errors" in an effort to help him/her get what he/she wants in a more socially appropriate way. Some of these "thinking errors" include making excuses, blaming, lying, minimizing, super-optimism, anger, grandiosity, intellectualizing, vagueness, and ingratiating themselves. Also, directly confronting the addiction as a primary problem is critical. Setting oneself up as the "helper," the counselor should attempt to come up with some mutual, tangible goals, which they can work together to achieve. A contract or agreement should be made which allows the counselor to provide feedback about their behavior patterns or errors in thinking which are interfering with the client's ability to reach his/her goal. The counselor's strategy should be one of an ally who is there to remind and guide. A reality-oriented approach focusing on exploring the client's current behaviors and feelings is useful (Daley, Moss & Campbell, 1987). Homework assignments can be helpful, concrete tools to help them begin to change behaviors.

3) Use of "consequences" for inappropriate behavior. The manipulative power struggle noted above can be best avoided by having clearly defined rules or expectations in the form of contingency contracts. If these are concrete and explicit, in writing and readily available, outlining the consequences for non-compliance, this will better enable some accountability on the client's part for the own treatment progress and success. The consequences need to be immediate, concrete and to make use of the clients need to look good and feel excited (Evans & Sullivan, 1990). Peer pressure in the form of group consequences can be helpful. Sometimes repetition is necessary due to learning problems. Therapeutic discharge may be necessary at times and the best choice of action especially if the person's behavior has become so disruptive that the entire treatment milieu is suffering.

Borderline Personality Disorder

Borderline personality disorder is characterized by instability in a variety of areas of the person's life including interpersonal behavior, impulse control, mood and self-image (Daley, Moss & Campbell, 1987). At the core level the borderline client is a deprived, damaged, fragile child who was typically traumatized by a very dysfunctional family situation (Evans & Sullivan, 1990). It is helpful to see these individuals as having deficits in the skills necessary for dealing

with their environment instead of "personality deficits." When one considers the abuse, neglect, trauma or general invalidation these individuals most likely received growing up, it is easier to be compassionate and effective in helping them. This disorder is more prevalent with women, is fairly severe and presents some of the greatest challenges to professionals. These individuals are very susceptible to all kinds of chemical abuse. Abstinence is clearly imperative for these clients but may not always be a realistically attainable goal.

Other characteristics and/or problems include: continual crisis orientation, self-identity issues, dependency, poor boundaries, suicidal gestures and other self-harm behaviors such as cutting or burning, intense anger/hostility and acting out, ambivalence, variability in moods, manipulation, self-centeredness and sometimes psychotic episodes.

Assessment Considerations: This disorder is a difficult one "to make as clients often present themselves with depression, suicidal behaviors, and relationship crises" (Daley, Moss & Campbell, 1987). Consultation and more intense psychiatric care may be necessary before determining if they are stable enough to benefit from a treatment program.

Counseling Considerations: The approach that seems most effective with these clients is a "matter-of-fact," "here-and-now" attitude. Intense confrontation is not helpful as it revictimizes them. When they experience negative feedback in-group it may be helpful for the counselor to reframe this into a more positive manner so as to minimize feelings of rejection. A gentle, non-threatening style that helps remind them of their "errors in thinking" and the ways they fall into a "victim" role can be productive.

Limit setting is by far the most important task of the treatment staff. These limits need to be set related to such things as which staff they can talk to, when, where, and for how long; which topics they can talk about in group and for how long. Also limits may need to be established related to phone calls or visitors. Since sexual boundaries are often a problem, some strict limits as to with whom they can have contact on the unit may be therapeutic. The limit setting is ultimately helpful to the client for it allows them to develop skills to increase their tolerance for frustration and delayed gratification. It also help keep the focus on the chemical dependency instead of getting waylaid into the quagmire of other issues, which is one of the borderline individuals special trademarks. It is also crucial with this population that the staff continually collaborate with one another due to the tendency of the client to "split staff" or play one against the other and sabotage the treatment efforts.

Some techniques to consider teaching would be specific anger management skills since a primary goal is to help them understand their anger and "tolerate emotions and conflicts without the use of mood altering chemicals" (Daley, Moss & Campbell, 1987). A more recently developed and highly effective approach to treating people with borderline personality disorder is Dialectical Behavior Therapy (DBT). The emphasis is on skill building related to: 1) mindfulness, 2) interpersonal skills, 3) emotional regulation and 4) distress tolerance. Care needs to be exercised when having them "tell their story" as they can be revictimized by the traumatic feelings and end up acting out. For this reason grief group is not always as effective with these clients as with others.

Sullivan and Evans postulate the "3 S's" to "guide [their] therapeutic strategies with borderline clients" (Evans & Sullivan, 1990):

1) Safety - since these clients are prone to self-harm it needs to be communicated to them that staff will help them stay safe and that limits will need to be set to assure this safety. The use of no-harm contract is useful. Educating them in identifying other safe sources of social support to utilize is also a good idea. Since safety and vulnerability are issues for this client, an emphasis on powerlessness too early in recovery can be counterproductive except perhaps as it relates only to their addiction. Unmanageability may be a better concept to focus on.

2) Strengths - It is important to emphasize accomplishments in order to boost their self-esteem. Providing some concrete education related to learning basic self-care, assertiveness, or time management skills would be of benefit so that they can experience some tangible success or progress. The use of positive self-talk and affirmations can also be helpful with this population. Developing some recreational outlets will be another important piece of this client's recovery. When working on steps 2 and 3, they may experience difficulty with the abstract concepts put forth and it may have to be more simplified, individualized and tangible. For example, list three positive things that have happened since you have been abstinent. Steps 4 and 5 should emphasize an equal balance of assets and deficits.

3) Survivor work - The goal is to move the client from their identity as a "victim" to that of a "survivor". This can begin to happen only after they have acquired a feeling of safety and have developed some ego strength and a sense of hopefulness. The counselor should "start at a very intellectual level and avoid expressive, feeling oriented approaches" (Evans & Sullivan, 1990). This can be done through classes, lectures, reading, and videotapes related to survivor issues, secrets, or dysfunctional families. The client should be given a sense of being able to "control their exposure to these reminders of trauma by, [for example], closing the book, leaving the class or switching the topic" (Evans & Sullivan, 1990)

Staff people need to be clear about their own boundaries and aware of their own vulnerabilities from their families of origin since these clients are especially masterful at finding our "buttons" and "pushing them". An especially common tendency is for the client to "perceive others in terms of all good or bad...[rapidly switching from]...idealizing and devaluing the counselor" (Evans & Sullivan, 1990). This can hook the counselor who has poor ego strength. A counselor with a propensity to rescue or enable will be ineffective with a borderline client. If the counselor also has a lot of their own ego invested in their client "getting well", they will be setting themselves up for disappointment and their client for failure or dependency.

SCHIZOPHRENIA

The cardinal features of schizophrenia are substantial impairment of the client's thought processes and the bizarre content of the thought (Evans & Sullivan, 1990). It is a condition that "tends to be chronic, with flare-ups in response to stress, failure to take medications, or chemical use" (Evans & Sullivan, 1990). During the active stage of this disorder, psychotic features such as delusions (false beliefs), hallucinations (visual or auditory) or a formal thought disorder may be present. If a client comes to you with this diagnosis it is always best to reevaluate for a couple of reasons. First of all the client may be experiencing an acute psychotic episode related

to his or her drug use. This is especially the case with cocaine addicts and with individuals where there has been extensive and chronic cannabis use. Secondly, in the case of a deaf individual, you may be again facing the possibility of misdiagnosis due to the examiner's ignorance about deafness and the deaf person's language and cultural deprivation.

The 3 key issues which Sullivan and Evans list as helpful for these clients to best be able to manage life include:

1) Taking medication regularly;
2) Performing activities of daily living;
3) Maintaining abstinence.

In order for these clients to function appropriately at all in the treatment setting they should be on some form of neuroleptic or anti-psychotic medication such as Haldol™, Navane™, Prolixin™, Stelazine™, Thorazine™, Loxitane™, or Trilafon™. Medication compliance is sometimes difficult because they may not be convinced that they have a problem. Or they may have paranoia and thus be suspicious of medications. Sometimes their thinking is so disorganized that they are not able to handle the self-administration. Keeping this client from being isolated is very important. Socialization activities and having a daily schedule, which includes learning how to take care of their personal needs, is helpful in keeping them oriented and organized. Related to the importance of abstinence, the client needs to understand that "the combination of alcohol and neuroleptics is potentially lethal" (Daley, Moss & Campbell, 1987).

Assessment considerations: With these clients it is most helpful to interview the significant people involved in their life. Collaborative information will be crucial to insure that an adequate history of the problem is attained, as these clients are poor historians. Marijuana tends to exacerbate and bring on psychotic episodes for these individuals even if they are taking the appropriate medications and they will "sometimes abuse their side-effect medication because of the 'buzz' that...[it] can deliver (Evans & Sullivan, 1990).

Counseling considerations: While such an individual is in treatment the counseling personnel need to continually assess their symptomatology and be alert for any decompensation in their behavior, interactions with others, speech or level of comfort. The suggestion is to use a passive, friendly, and low-key approach, minimizing high levels of confrontation, challenge and criticism, and give feedback in a matter-of-fact style (Evans & Sullivan, 1990). Strong confrontation tends to exacerbate their psychotic symptoms. It would be unwise to push them towards the kind of self-disclosure one might expect from other clients, but their participation and responses should still be elicited. When there is a lot of intensity in affect, these patients may feel overwhelmed, withdraw, and become more disorganized, even if they are on medication. It is better to focus in the present with attention to specific issues of everyday living than to explore unconscious reasons for past behavior (Daley, Moss & Campbell, 1987). Keep in mind that there may be times when they do better on a 1:1 basis.

The important thing to remember with schizophrenic clients is **STRUCTURE.** They respond well to different kinds of prompts and a reliable routine but may need reminders from staff. Visual aids, simplicity of concepts, and repetition are most helpful. They often find it

difficult to apply the new information they may be learning and translate it into a change in behaviors. They tend to learn at a slower pace and thus treatment goals need to be adapted and flexible. They respond well to "positive reinforcement, encouragement, and support."

The socialization emphasis helps them receive the support that they need to deal with their dual illnesses. The counselor must also establish a norm of tolerance for unusual behavior in the group, especially a mixed group of people with different diagnoses, but also be ready to set limits and keep stimulation levels low (Evans & Sullivan, 1990).

Since this group of individuals "often have strong denial about the effects of alcohol and drugs on their lives," and since they do not respond well to heavy confrontational approaches, the counselor must find a different way to slowly and gently assist the person in accepting the fact that drugs and alcohol are causing major problems in their life. This can be partly accomplished by education related to the disease concept of chemical dependency and how it effects their body, their thinking, and their relationships. These clients, whether they are hearing or deaf, will require significantly more time to complete a treatment program.

Step work is a little trickier with this population. With Step 1, the concept of "unmanageability" can be stressed using "clear and concrete" methods. This concept is more useful than "powerlessness as this can lead to further disorganization in the thinking of this population" (Evans & Sullivan, 1990). An example suggested by Sullivan and Evans to address this concept is to have them write out on cue cards three (3) reasons why they need to take their medication and three (3) reasons why they cannot use drugs and carry these around with them as reminders. There is a danger with the concept of "Higher Power" in Steps 2 and 3 because of their tendency for religious delusions. Clients may tend to decompensate at this point in their treatment and need an increase of medications and a decrease in expectations. It is best instead to keep Steps 2 and 3 concrete and based on helping them identify the people that they can depend on for assistance and support as well as how their life has changed or improved as a result of being abstinent.

ORGANIC BRAIN DISORDER

The essential feature of an organic mental disorder is a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain and judged to be caused by a specific organic factor (Evans & Sullivan, 1990). Clients with Organic Brain Disorder or with some kind of brain damage or retardation, require a lot of 1:1 staff time. Treatment plans and expectations need to be severely altered and modified to be of any value to these clients. This can be done through the use of pictures, role-play - any creative ways that simplify and concretize concepts.

Persons, who are victims of Maternal Rubella, especially when the disease was contracted early on in the pregnancy, will have more severe impairments, which tend to mirror other kinds of brain disorders or mental illnesses. Some examples of these impairments are memory problems, anxiety, sleep problems, hyperactivity (ADD or ADHD), immediate gratification needs, destructiveness, impulse control problems, learning and processing difficulties, poor generalization skills, decreased abilities in academics, depression and acting out. These persons may experience some remorse or regret for their behaviors but be unable to consistently control their impulses and overcome their difficulties. With these individuals the

incidence rate of mental retardation is 3 to 4 times as high as in the general population. Their cognitive and academic failures often "result in depression, acting out behaviors, and membership in socially deviant groups" (Evans & Sullivan, 1990). Psychological testing can help determine strengths and deficits that the client has in the various modalities.

Because of all these difficulties and frustrations in living, these clients are at high risk for substance abuse and dependency, especially those with ADD. Behavioral interventions are a preferred course of action for clients with ADD, but some to respond favorably to medications such as Ritalin, Lithium or an anti-depressant. Similar interventions are used with ADD clients as with Schizophrenic individuals, such as prompts, cueing devices, praise, repetition, relaxation, and practicing new material or behaviors on a situation-by-situation basis. There is always the concern that the behavior will become the primary focus, not the addiction. Because of this it is sometimes difficult to manage them on a unit where most individuals are adults. Thus, when the behavior becomes so disruptive the decision may need to be made to medicate and get them stabilized or remove them from the treatment setting until they are able to participate more appropriately and benefit from the experience.

SUMMARY

Individuals suffering from the dual disorders of chemical dependency and mental illness face incredible challenges in the course of their treatment and recovery. For deaf and hard of hearing clients the challenges and roadblocks are even greater. This is due in part to the lack of qualified service providers and professionals who have skills in all three areas: chemical dependency, psychiatric disorders and deafness, as well as the language difficulties and cultural deprivation that deaf persons often have experienced.

While no hard research data is available on the incidence of concomitant chemical dependency and mental illness within the deaf community, it has been the experience of the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Persons that a high percentage of their patients have either bona fide additional diagnoses or several characteristics in common with these diagnoses. As with the hearing population the most frequent diagnoses seen are major depression, antisocial and borderline personality disorder. Since an extremely high percentage of the deaf and hard of hearing clients served in Minnesota are also survivors of sexual and other forms of abuse or neglect, many symptoms of PTSD or other anxiety disorders are seen. This clinical picture also paves the way for the development of the personality disorders listed above. Proportionately, there may also be a higher percentage of deaf or hard of hearing persons exhibiting characteristics of organic brain disorder than with hearing individuals. This could be due in part to whatever the etiology of the deafness had been and the exacerbating difficulties (i.e. meningitis, maternal rubella or other brain trauma at birth).

It is imperative that counselors/therapists model good psychological health, emotional maturity, and solid boundaries when dealing the dually disordered client. The risks for countertransference seem to increase the more dysfunctional or challenging the person is. In addition, the need for more trained personnel has never been greater. It behooves any professional working within this field to have a solid understanding and working knowledge of the most common mental disorders. From this general knowledge, professionals in deafness can make the appropriate adaptations in their treatment approaches and counseling with their deaf and hard of hearing clients to best address their recovery needs.

Kristen Swan is a licensed psychologist working at Regions Hospital (St. Paul, MN) with the Health and Wellness Program Serving Deaf and Hard of Hearing People. She provides counseling and therapy to deaf and hard of hearing people of all ages and with a wide range of mental health or adjustment problems.

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Motivational Enhancement: Counseling that Works

Rosemary L. McGinn, J.D., C.A.S.A.C., Program Director;
Hugh Young, M.D., Medical Director; New York Society for the Deaf Substance Abuse Treatment Program, New York, NY.

Introduction:

Motivational enhancement (ME) is a research-based counseling technique for invoking change in people with alcohol and other drug abuse problems (3). Unlike some traditional treatment approaches, it does not attempt to guide or force the client through recovery, but focuses on identifying the client's current motivation and then employing specific strategies to help the client move through the continuum of change to goals that the client articulates. The counseling strategies of ME are guided by a principle that could be stated as "the customer is always right:" the client's perception of the nature of the presenting problem is not challenged or corrected but accepted as the appropriate starting point for treatment. We have seen many times that if there is a drug or alcohol problem attacking the presenting problem will invariably lead us there.

Treatment of problems related to AODA has long relied heavily on confrontation and pressure, with the counselor seen as the expert who issues orders and ultimately humbles the client. Treatment programs specially designed for individuals who are deaf or hard of hearing are no exception to this pattern. In fact, such programs may rely even more on confrontational techniques, because they often must choose between counselors skilled in ASL and those skilled in addictions. Unfortunately, all too often the program chooses the candidate with ASL skills, to the detriment of clinical skills. These inexperienced counselors are more likely to rely on the common lay perception of addictions counseling as confrontation.

Despite the public's widespread image of the addictions counselor as someone who "breaks down" denial that the client brings into the treatment, research has demonstrated that counselor style is a powerful determinant of client resistance and change, and that confrontational technique is a predictor of continued drinking. When resistance is evoked, clients tend not to change.

ME acknowledge that the responsibility for change lies with the client, and that *the client always has a choice*, even when the options are distasteful or not readily apparent to either counselor or client. Clients are free to do whatever they want -- it is not the counselor's job to convince them otherwise. Thus, ME counseling strives to communicate respect and acceptance for the client and the choices the client has made thus far in life, along with insight into the consequences of those choices. It is thought that failure to respect these realities and acknowledge the client's autonomy is a fundamental cause of client resistance to change. The

(3) For the sake of brevity, throughout this paper we will use the term alcohol and other drug abuse and its abbreviation AODA to refer to the DSM-IV clinical definitions of substance abuse and dependence OFFICIAL CITE FOR DSM. Furthermore, we will use the term addictions counselor to refer to all those who have the opportunity to provide any type or degree of counseling about AODA issues, ranging from primary care physicians to social workers to school-based prevention workers.

counselor using ME techniques seeks to build a sense of self-efficacy rather than "break down" or confront denial.

This paper provides an overview of this scientifically based technique. It examines the theoretical basis for ME, including the stages-of-change model and specific clinical interventions for each stage. It is not necessary to adopt the therapeutic model in its entirety in order to be effective; integrating only one or two of the techniques can provide a reasonable introduction. Our paper also provides a very basic overview of a treatment philosophy that we feel embodies the ME approach: harm reduction. We review the current literature on integrating harm reduction and ME, with emphasis on pharmacology. When appropriate, we will note special issues of interest to those who work in addictions counseling of individuals who are deaf or hard of hearing. However, this is an overview only. Interested readers are encouraged to seek further training and clinical supervision, and to review the "recommended reading" list below. We especially recommend the seminal book *Motivational Interviewing: Preparing People to Change Addictive Behavior*, by William R. Miller and Stephen Rollnick (New York, Guilford Press: 1991), and "Motivational Enhancement Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals with Alcohol Abuse and Dependence," from the *Project MATCH Monograph Series, Vol. 2* (Rockville, Md.: U.S. Department of Health and Human Services, 1995), available at no charge from the National Institute on Alcohol Abuse and Alcoholism (800-729-6686 voice, 800-487-4889 TTY). Much of the material in this paper is drawn from these two volumes. Furthermore, please feel free to contact us for further comment and discussion.

A note on self-awareness:

Motivational Enhancement is an approach and a mindset: non-confrontational albeit directive. It is not ideal for every client or every counselor, but most counselors can benefit from at least considering the underlying principles. Motivational Enhancement assumes that resistance is a counselor problem, not a personality trait that the client brings into treatment. While some counselors find this approach off-putting and disorienting at first, ultimately it can generate a greater sense of counselor competence and skill, because of the assumption that the counselor *can* affect the outcome by changing approaches. Since ME views resistance as a sign to change strategies, the counselor always has the opportunity for creativity and trying new ideas rather than being "stuck" with a resistant client. Finally, as we progress through our study of the underlying principles and techniques of ME, we encourage readers who find themselves resistant to consider their willingness and openness to self-examination and change.

What is motivation?

Traditionally, motivation has been seen as a personality trait or condition that the client brings into the counseling situation. Clients whose motivation is deemed inadequate are labeled as "not ready" or "not yet hitting their bottom."

In this traditional model, a motivated client

- Agrees with the counselor;
- Accepts the counselor's diagnosis and/or accepts the label of alcoholic or addict;
- Expresses a need or desire for help;

- Appears to be distressed about her/his condition; and
- Follows the counselor's advice.

On the other hand, an unmotivated client traditionally

- Disagrees with the counselor;
- Refuses to accept the counselor's diagnosis or judgment;
- Expresses no desire or need for help;
- Appears undistressed about his/her current condition; and
- Does not follow the counselor's advice.

This attitude can be summarized as "Disagreeing with your counselor is called 'denial;' "agreeing is called 'insight'"(Miller & Rollnick, 1991).

In the ME model, however, motivation is seen not as a personality trait but as a state that fluctuates: an internal state of readiness that is influenced by external factors, *including* counseling. This view is reinforced by extensive research that demonstrates conclusively that there is no such thing as the "alcoholic (or addict) personality" abusers of alcohol and other drugs are no more likely to suffer from excessive levels of denial than those who do not have these problems are.

Stages of change:

Given that this state of readiness can be influenced by external factors such as counselor style, how can we determine the appropriate techniques for exerting this influence in the desired direction? The first step in this process is to determine the client's current status in the process of change. The psychologists James Prochaska and Carlo DiClemente developed one helpful model for how change occurs, when they were examining the experience of smokers attempting to quit. They first described this model in a 1982 article entitled "Transtheoretical therapy: Toward a more integrative model of change," in the journal *Psychotherapy: Theory, Research, and Practice* (vol. 19, pp. 276-288). They later expanded their studies, and noted that regardless of whether they obtain help from a therapist or elsewhere, all people seem to go through similar stages of change and must complete the same tasks in order to move along in the process. (See *Motivational Interviewing* for a detailed discussion of how this model applies to addictions.)

Prochaska and DiClemente formulated this process in the form of a wheel with four, five, or six stages. We will use the five-stage wheel favored by Miller and Rollnick in *Motivational Interviewing*.

Motivational Enhancement posit that at any given moment, each client is at a particular stage of change (represented by a point on the wheel) and must complete particular tasks in order to move on to the next stage. The counselor's task is to match counseling strategy to the client's current stage in order to facilitate the client's progress through the process. Thus, another way to state the fundamental premise of this model is that counseling strategy is adjusted to accommodate the client's readiness for change. The client is not forced into a one-size-fits-all counseling process regardless of motivational status. The following constitutes a brief exploration of each stage of change.

1) Pre-contemplation: From a counseling perspective, clients in this stage are the most difficult to work with: they have not even thought about having a problem or needing to change. If approached at this stage, they are likely to be surprised rather than defensive. By definition, pre-contemplators seldom present for treatment. Even the most reluctant court-mandated client knows s/he has a problem -- a "judge problem" or a "P.O. problem" -- that a counselor can start to work with.

2) Contemplation: The individual has some awareness of a problem: s/he both considers change and rejects it, seesawing back and forth between reasons to change and reasons to stay the same. This is the hallmark of contemplation: ambivalence, a state of mind in which a person has co-existing but conflicting feelings about the same thing, also known as "mixed emotions." The classic ambivalent statements include "I need help, but it's not that serious" and "Yes but...." It is a fundamental premise of ME that *ambivalence is normal*, not pathological. Indeed, a total lack of ambivalence, feeling 100% one way about something important, can be seen as pathological. The counseling task in this stage of change is to "tip the scales:" develop motivation to change. The individual will experience as premature any attempt to force action at this point, possibly leading to a power struggle.

The counseling task in this stage of change is to provide information and feedback in order to raise awareness of the need for change. The counselor should encourage the client to articulate both sides of the argument about change, and then listen, rather than assuming s/he knows the benefits and drawbacks of the behavior under discussion. Contemplation is not the time to begin "skill-building," a common error that generates much of the resistance seen in counseling. Treatment planning goals for clients in the contemplation stage can include completing a decisional balance sheet; talking with veteran clients about their struggles and successes with changing addictive behavior and discussing responses to the stories they hear; and "observing" AA / NA meetings and discussing impressions in group.

3) Determination/decision: The individual decides to make a change. This stage can be seen as a window of opportunity: the individual is ready to change and needs a menu of options; s/he can slip back into contemplation if the opportunity is not seized. The outward signs of this stage are "What to do?" and "I must do something!" Here, the power struggle can be about *what* to do rather than whether to do *any*thing. The counseling task: strengthen commitment to change.

During this phase, it is essential that the counselor frequently help the client to recapitulate the reasons for change as well as provide information and advice on options. It is also important that the client and counselor negotiate an action plan. Here it is important the counselor not assume what the client's goals are, but ask and listen. For example, some parents may not want to regain custody of their children. The client should be encouraged to express concerns about goals as well as the benefits of the goals. The counselor should help the client to consider options for action, by creating a "menu" and by building in "Plan B," in case the client does not succeed on the first try (a common occurrence).

4) Action: The individual engages in particular actions intended to bring about change. This stage is what most people think of as counseling. Many counselors expect and/or hope for our clients to come to us in this stage, where they share our goals and we merely present them with a menu of options. Unfortunately, this is often not the case!

5) Maintenance: The individual develops new behaviors to maintain changes and prevent relapse. It is important to note that maintaining a change may require a different set of skills and strategies than were needed to accomplish the change in the first place -- for example, maintaining weight loss or sobriety are very different challenges than achieving those goals initially.

6) Relapse: The individual takes a step backward in the change process. The ME model regards relapses (or "slips") as normal, expected occurrences as the individual seeks to change a long-standing pattern. The counseling tasks: help the individual avoid discouragement, continue to plan on changing, and start around the wheel again. This repeat trip around the wheel can be relatively short.

Resistance is a counseling problem:

A basic premise of the Motivational Enhancement approach to counseling is that resistance is generated by the *counselor's* use of an inappropriate strategy for the client's stage of change. Even a cursory review of the stages of change, as above, demonstrates the validity of this idea: a client in the contemplation stage needs information to help make the decision to change -- for example, education on the long-term physiological effects of alcohol and other drugs, or on legal consequences of dropping out of treatment. If offered options (such as inpatient versus outpatient treatment), the client will "resist." But here it is obvious that the "resistance" is generated by the counselor's use of an inappropriate strategy: a parolee who does not understand his/her legal status may reject treatment without a second thought. In other words, the counselor is not answering the questions in the client's head, but replying to the questions that the counselor thinks the client *should* be asking.

This point is especially important for counselors working with individuals who are deaf or hard of hearing and have not had the life experience, education, or access to information necessary to understand factual issues related to treatment. For example, we as counselors may be baffled by a client who continues to drink despite extensive liver damage, or a parolee who repeatedly misses appointments despite the strong likelihood of reincarceration. In the past, we have labeled this behavior as "resistance" resulting from "poor judgment." Using the ME model, we can see that it often results from our own errors in strategy: we have offered action options to individuals who do not see the need for action! Another example: too often, we start our counseling relationship with a client by explaining the program's rules, negotiating a treatment contract, assigning "homework," etc. Later, we are genuinely surprised when the client does not comply with our recommendations and his/her own promises, ignoring consequences that are obvious to us. We need to respect the client's stage of change: "back up," meet the client where s/he is, explain everything, and assume nothing.

To get a sense of the client's experience in this matter, counselors should try this brief exercise of the imagination:

> Think of an important decision you have been trying to make -- something that is hanging over your head right now. Choose a situation that really matters to you. Imagine that you must decide, right now, what you are going to do. Note how long you have been trying to make this decision. Your decision to change must be definite and permanent; not only must you stick to it, but also you must actively work to realize it. And, no matter how hard the decision is or how many obstacles you encounter in carrying it out, you may not have any second thoughts about it. Uncertainty will be judged as evidence that you are not serious about your decision or that you are planning to go back on it, in direct violation of your agreement.

Note your reactions to all these demands; there is usually a wide variety. Some individuals seem to instantaneously make a decision. However, either they have not really made the decision, and do whatever they want anyway as soon as out of eyeshot, or they become anxious and later blame the demanding counselor if they come to feel they made the wrong decision. Others feel rebellious and reactive, demonstrating that the best way to generate resistance to change is to insist on change. Why? Clients feel, and perhaps rightly so, that we do not know them nor they us. Our values, assumptions, and ways of dealing with problems are all unfamiliar. They may feel that our understanding of their problem is limited.

To summarize, Counselor style is a powerful determinant of client resistance and change. To truly internalize this idea, to the point of changing counseling style from confrontation to respect, is very difficult for some counselors. They resist giving up control of the treatment situation. They fear that when they strive to truly meet the client where s/he is, they will become as out of control as the client. These counselors may find it helpful to consider that, in fact, they never really "had control" of the client and the treatment; they merely had an illusion of control. Because, as we have all seen demonstrated countless times, the client always has a choice and only the client controls his/her behavior -- even if the client does not understand and accept this!

Harm reduction:

The Harm Reduction Model of treatment of AODA problems follows logically from Prochaska and DiClemente's formulation of the stages of change. Just as relapse is a normal and expectable stage in the wheel of the process of change, this variation on the Medical Model of treatment of chronic diseases (such as hypertension, diabetes mellitus or cancer) makes room for relapses, poor patient compliance and modest goals. This model accepts the ideas of "meeting the client where s/he is," and "the customer is always right." It will rarely be the only model in a counseling program, except for mandated clients who may still be in pre-contemplation. This model fits well into the medical practice of physicians or emergency rooms, and can prove quite valuable in the treatment of the many alcohol/substance dependent people who never find their way into a formal treatment program, or as a first step in treating people who will finally accept a formal treatment program.

The Public Health Model, which integrates the Medical Model, looks at the treatment of addiction as a chronic disease. Characteristics and expectations of this perspective include:

1) Expect many remissions and relapses.
2) The course of the disease is highly variable, from mild/transient to severe/persistent.
3) Different types and/or severity of the condition respond to different interventions.
4) Cure is not always possible.
5) Reduction of symptoms and/or severity is worthy of pursuit.
6) The goals of the model: minimize harm and improve health and well being.

The Harm Reduction Model (a variation on the Medical and Public Health Models) thus focuses on *reducing* rather than *eliminating* the negative consequences of drinking (or smoking, or overweight, or tumor growth, or...). This mindset is reflected in an approach that we have found tremendously helpful in our outpatient treatment program: focus on consequences. Basing on assessment on the quantity of substances used, or arguing with a client about "how much is too much," are no-win situations, whether it be about beer, crack, debt, or sex. We all engage in self-destructive behaviors but monitor ourselves as well as our situations to avoid excess negative consequences. Why should we treat our clients with less respect, and lower expectations, than we demand for and of ourselves?

Harm reduction can be a valid treatment goal for AODA problems, just as it is for hypertension, diabetes mellitus, or asthma. In this model, goals may be more modest: drinking less, longer cycles between relapses, less drinking during a relapse, or shorter relapses. We can also adopt principles that are used in the Public Health Model of goals for palliative care (for instance, as used in the treatment of cancer), which include:

1) Induce remission, complete or partial when possible.
2) Limit relapses when possible.
3) Prevent and treat complications.
4) Educate and support the patient and significant others.
5) Slow the rate of deterioration.
6) Reduce suffering (Willenbring, ML, 1999).

Although medications (such as methadone or Revia) may be the first tools of palliation that come to mind, there are other "palliative" techniques in the area of alcohol/substance dependence, such as needle exchange, avoiding specific and serious legal or financial consequences or even overdoses, developing other and better health habits, for example by drinking less during a binge or by smoking less.

The basic principles of Motivational Enhancement:

A basic goal of ME counseling is to elicit from the ambivalent client the reasons for concern and the arguments for change. However, this strategy is not as simple as it may seem at first glance. It requires true respect for the client and the ability to convey that respect. ME uses five basic principles to achieve this:

1) Express Empathy: “Empathy” is identification with, or acceptance or understanding of, another individual. Empathy has been considered by some scholars of counseling to be the primary, most important tool of a counselor. It is important to note, however, that acceptance does not equal approval but is all-important because it facilitates change. The primary skill in expressing empathy is reflective listening, which is described in detail below.

2) Develop Discrepancy: The counselor helps the client to see the gap between stated goals and behavior, or create cognitive dissonance. The counselor asks, “How is that going to get you what you want?” One perspective on this tool is “Counselor as Columbo,” the television detective who innocently questioned inconsistencies. Here, the client becomes helpful to the counselor, explaining ideas and behavior. This can be especially meaningful when a deaf client explains for the hearing counselor, a rare experience for many of our clients. Also, teaching is often an important part of this strategy. As noted above, many of our clients are genuinely ignorant of consequences, through absolutely no fault of their own. Pointing out discrepancies in behavior and goals, and listening to the client’s response, may help the counselor pinpoint where additional education is needed. Furthermore, this strategy supports ME’s goal that the client should present the reasons for change.

3) Avoid Arguing: While the temptation may sometimes be almost irresistible, the research leaves no doubt that arguments are counterproductive. As discussed above, confrontation is clinically proven to be an unsuccessful treatment strategy; similarly, defending breeds defensiveness. A corollary: labeling is unnecessary. A beginning counselor may spend hours trying to convince a client to admit that s/he is an ‘alcoholic or addict;’ but what has that achieved? Where does that take the client? There is rarely any benefit to the client from being forced to accept such a label. As discussed in detail above, resistance is a sign to change strategies. As the reader may have experienced during the exercise above, when an individual’s freedom is threatened, s/he will assert freedom to the extreme

4) Roll with Resistance: In some martial arts, students are trained to use the weight of an opponent against the opponent. Similarly, ME encourages the counselor faced with a ‘resistant’ client to acknowledge the truth of the client’s position -- thereby allowing the client to voice the opposite side. For example, if the counselor constantly points out the harms associated with AOD use, the client may feel obliged to defend his/her behavior and articulate the benefits of using. When the counselor respects the client’s decisions, and acknowledges that there are some benefits to AOD use (which must be true or the client would not use), the client may feel inclined to articulate the opposite side of the argument: the harms of using. This strategy respects the reasons that the client uses in the first place, which we often neglect to acknowledge, reducing our credibility.

5) Support Self-Efficacy: The client is responsible for choosing and carrying out personal change, but the counselor can play a valuable role as a kind of cheerleader, assuring the

client that 'You can do it!' For many of our clients, this may be the first time they receive this message directly and clearly. Once again, counselors should not assume that clients 'know they can do it.' The counselor can give up the "habit of expertise," emphasizing the client's ability to accomplish the stated goals.

Strategies and Skills based on the principles of Motivational Enhancement:

The primary skill of ME counseling is reflective (or empathic or active) listening. This requires that the counselor listens to what the client says and reflects it back in a slightly modified form. Of course, the counselor is selective about exactly what and how it is mirrored back, with emphasis on self-motivational statements.

This skill is very important but difficult to master, as it often requires that the counselor guesses at what the client means and be willing to be wrong. It is well worth the practice and supervision that is required to master this skill, however, as reflective listening is unlikely to evoke resistance. It also keeps the client talking, exploring the topic. It communicates respect and caring and builds the therapeutic alliance. More concretely, it helps the counselor clarify exactly what the client means, providing another opportunity for clarification of consequences and choices. Again, the goal is always for the client to express the concerns and reasons for change.

Some 'roadblocks' to reflective listening have been identified in *Motivational Interviewing*. They include ordering; warning or threatening; preaching; providing solutions; labeling; analyzing; consoling; and persuading. What these all have in common is that they interfere with reflective listening because they imply an unequal relationship. The counselor who hears herself offer one of these responses can regard it as a warning that she is not listening, but merely keeping quiet just long enough to think of an answer. (See *Motivational Interviewing* for more details and some wonderful examples.)

Good reflective listening questions actually make a hypothesis. Some 'stems' or starting phrases for reflective listening statements include:

- It sounds like you...
- You're feeling...
- It seems to you that...
- So you...

Reflective listening can also demonstrate the ME principle of "Roll with resistance," as briefly explored above. Again, this requires acknowledging the validity of the client's viewpoint and stepping away from opportunities for confrontation and argument. Some examples:

- Simple reflection: *Sounds like you're angry with me; You don't think that would work for you*
- Reflection with amplification or exaggeration: *You think there's no problem with that...*
- Shift the focus: if the client says he *cannot quit drinking, all my friends drink*, etc., The counselor protests, *We're not up to that yet!*
- Agree with a twist: *You have a good point there; You may decide not to quit drinking....*
- Emphasize personal choice and control: *Nobody can force you, it's really your decision*.
- Reframe: The counselor invites the client to see his/her perceptions in a new light or

reorganized form; *Maybe your brother said that because he's concerned about your health.*

Conclusion:

Motivational Interviewing is an effective way to acknowledge the truth of the counseling setting: the client always has a choice. The counselor's job is to help the client recognize the options and make an informed decision, then to help implement the decision. Confrontation is counterproductive, ambivalence is normal, and incremental achievement of goals is valuable.

In closing, we emphasize that this is a major change in attitude for most of us. Thus, we strongly urge the reader interested in this approach to seek out and absorb as much information as possible, then to secure good, regular clinical supervision. This is not work that is easily undertaken alone. However, once embarked upon, with the proper support, this journey can be tremendously successful and rewarding.

Rosemary McGinn is the director of the Substance Abuse Program at New York Society for the Deaf, the only outpatient treatment program in the Northeast. Ms. McGinn designed and implemented the treatment component of the agency's substance abuse services. Ms. McGinn is fluent in American Sign Language and has been working with deaf substance abusers for 10 year.

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Mentorship in Sobriety: An Alternative to Twelve-Step Support

Ron Lybarger, Ph.D., ICADC
Katherine A. Sandberg, LADC

For individuals seeking recovery from alcohol and other drug addiction/dependence, the most common source of support is Twelve Step programs. Some people who experience problems as the result of alcohol or other drug use seek help directly from these programs. Others turn to Twelve Step programs as a source of ongoing support after having completed chemical dependency treatment. For years, deaf recovering people, like their hearing counterparts have been referred to Twelve Step meetings. Frequently, Twelve Step meetings, related literature, and sponsorship are not accessible to Deaf individuals pursuing recovery. The authors suggest there may be alternatives to traditional Twelve Step groups that would provide Deaf recovering people with fellowship, information, and support. This paper proposes an alternative model of support for deaf people using mentors who are members of the Deaf Community.

Background Information

Twelve Step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have effectively helped millions of individuals establish and maintain lifestyles that are free of the use of mood altering chemicals. Many addicts who were once hopeless have been given a new life as a result of the information and ongoing support offered by these fellowships. Twelve Step programs operate on the premise that addicts cannot control their use of alcohol or other mood altering drugs, and they are unable to stop using on their own. The Twelve Steps teach that the addict needs the help and support of other recovering people to maintain sobriety. Two of the main components of Twelve Step recovery programs are regular attendance at meetings and frequent contact with a sponsor. These two activities are the foundation of ongoing support for many recovering people.

Regular attendance at meetings allows individuals to maintain their sobriety through sharing common experiences with others who suffer from the same problem. The only requirement for membership in AA or other Twelve Step groups is a desire to stop using alcohol or other drugs. Although meetings have many different formats, the general concept is to offer the participant support while educating them as to how to effectively apply the principles of the program to their individual lives. Open meetings can be attended by anyone who has an interest. Open meetings usually involve talks by a facilitator and two or three speakers who share their experiences of addiction and recovery. Closed meetings are designed to include only the recovering alcoholic or addict and typically involve a small group discussion format.

Alcoholics and drug addicts seeking support from Twelve Step meetings are encouraged to get a sponsor. A sponsor, an individual with experience in recovery, serves as a mentor and tutor to the less experienced person. The sponsor relationship is one that is meant to be continuous and occurs on a one-to-one basis. The newly recovering person seeks out an experienced group member with whom he/she feels comfortable to talk freely and confidentially. The relationship is designed to strengthen the sobriety of both individuals. Although

sponsorship responsibility is unwritten and informal, it is viewed as an essential component of recovery through the Twelve Steps.

Just as the sponsor arrangement is informal, so is the process of matching sponsor and newcomer. Often, the new member will seek out an experienced member with whom he/she feels comfortable and asks that person to be his/her sponsor. A sponsor can help the new member to meet other recovering people.

While this paradigm of recovery has been largely successful for groups of individuals who share a common culture and language, it can be very difficult to access for those who are culturally or linguistically different. For example, consider the case of a Deaf person who does not have available interpreting services to regularly attend meetings and who may not be able to find a sponsor who is deaf or even one who is hearing and fluent in sign language. Deaf people in this situation are, in effect, cut off from the opportunity to access Twelve Step groups as a source of support in recovery.

Twelve Step groups are a well-established resource for many recovering individuals and should be utilized whenever possible. In our combined experience, which includes nearly 20 years of providing chemical dependency services to deaf individuals, we have consistently found that culturally and linguistically accessible Twelve Step meetings are frequently nonexistent for deaf people seeking recovery from addiction. Even when sign language interpreters are provided for Twelve Step meetings, many deaf people feel cut off culturally from hearing members of the Twelve Step group.

Many chemical dependency treatment programs rely on the principles of Twelve Step programs for their therapeutic orientation, and frequently they emphasize attending Twelve Step meetings and finding a sponsor as a part of aftercare. It is common for the overt message offered by many programs to be that ongoing sobriety is unlikely or impossible if Twelve Step attendance and sponsorship is not a part of the individual's aftercare plans.

Research supports the importance of Twelve-Step participation. In a recent issue of NIDA Notes (a publication of the National Institute on Drug Abuse), Robert Mathias reports on a study conducted by Dr. Robert Fiorentine showing that patients who attend Twelve Step meetings regularly before entering treatment stayed in treatment longer and were more likely to complete treatment. Further, the study's findings suggest that Twelve Step programs can serve as a useful and inexpensive aftercare resource that can assist patients in maintaining abstinence.

In a study conducted with former clients of the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, Debra Guthmann (1996) found attendance at AA/NA meetings was a factor in overall improvement in the person's life.

Although participation in 12 step meetings has been documented to be effective, it is not the only way to obtain social support in the pursuit of recovery. In a recent study, Beattie and Longabaugh (1999) examined the role of general versus specific social support in those attempting to remain abstinent from alcohol use following treatment. They found that both alcohol specific and general social support improved outcomes. Alcohol specific support was superior to general support in short-term outcomes, but both forms of support were beneficial in determining long-term abstinence. These authors recommended that treatment programs should attend to building both general and alcohol specific support systems as a part of the treatment and aftercare process.

Accessibility Issues

In the case of the deaf individual who does not have access to meetings or potential sponsors, the message is often clear. The road to recovery is blocked by the lack of accessibility. We suggest that this problem is one of the main barriers to ongoing recovery for deaf alcoholics and drug addicts. In her book, *Deaf and Sober: Journeys Through Recovery* (1998), Betty Miller emphasizes the problem of a lack of role models within the Deaf recovering community. Miller also comments that some recovering deaf people find support for their recovery in their involvement in various activities of the Deaf Community.

In many communities, a solution that has been attempted has involved trying to provide interpreters for several meetings a week, thus creating an opportunity for deaf recovering people to access Twelve Step meetings. Sometimes, this issue is addressed by securing funding for interpreters from state alcohol and drug agencies. Other times, large Twelve Step meetings generate sufficient funding by "passing the hat" thereby financially supporting accessibility from among those (deaf and hearing) who attend the meeting. Occasionally, vocational rehabilitation or other agencies handle the cost of an interpreter so that a client can attend the meeting thus allowing other deaf people to access the meeting, too. Funding for interpreters is not the only issue related to accessibility. Even when funding is available, sign language interpreters who are qualified to interpret in these settings are frequently difficult to find. While an interpreter may be fully trained and certified, he/she may be not qualified to interpret in a Twelve Step setting if he/she is not familiar with the terminology and concepts of addiction.

We believe the solution to this problem may lie within the Deaf community. It is our opinion that the Deaf community has been a tremendously underused resource in the recovery of alcoholics and drug addicts who themselves are Deaf. We propose establishing a mentorship program within the Deaf community in which non-recovering Deaf role-models would receive training and support to help them co-facilitate ongoing recovery for Deaf addicts.

Given the lack of access to traditional avenues of support for many Deaf individuals and the importance of support for ongoing recovery, perhaps it is time to explore other solutions. Social support in the form of mentorship is suggested as an alternative to Twelve Step involvement in situations where deaf individuals find themselves excluded from currently established paradigms of recovery or when they would prefer an option to available recovery related resources. Mentorship may also serve as an adjunct to support gained through traditional Twelve Step programs.

Community Partnerships

Marie Egbert Rendon (1992) points to the fact that the problem of alcohol and substance abuse in the deaf community is a reality. She suggests that the culture (of the deaf) often provides a shelter and a barrier to recovery by facilitating isolation and denial. However, as information and education has come into the community, the situation is improving. Rendon emphasizes that "this breaking down of the isolation and denial barriers requires continued efforts on behalf of a community already stretched to its limits. The deaf alcohol or drug-addicted individuals can achieve recovery only when advocacy promoting and achieving accessibility is the reality and not the rarity."

The concept of this approach to post-treatment support would involve a partnership between the professional community and the Deaf community. Professionals in the field of

chemical dependency and deafness would reach out to the Deaf community and request assistance in the process of supporting those who are attempting to maintain sobriety and pursue recovery. The professionals would offer education about addiction, training related to the needs of newly recovering individuals, as well as information and skills development necessary to provide ongoing support to recovering addicts. Simultaneously, this interaction would offer the Deaf community a more active role in treatment issues specific to Deaf individuals. Professionals would benefit from the opportunity to tap into the vast resources available within the Deaf community.

The Deaf mentor would function as a guide, support, and role model for the recovering alcoholic or drug addict in a similar fashion as a sponsor might if one were available and accessible. The role of the sponsor in a Twelve-Step group involves sharing experience, strength, and hope, with sponsorees. Deaf mentors could also share experience, strength, and hope although it might not include shared experience with addiction. Mentor candidates would be expected to meet certain criteria that include such things as stable mental health, good boundaries, appropriate coping skills, fluency in communication and the willingness to learn about and work with recovering addicts.

One of the things that greatly contributes to the success of Twelve Step programs is the fact that the sponsor and the sponsoree have their addiction in common. Under usual circumstances, this approach is preferred because it addresses one of the hallmarks of addiction, the feeling of being unique or alone. Again, we remind the reader that the circumstances with persons who are deaf often involve individuals who are excluded from the opportunity to participate in mainstream recovery groups as a result of linguistic and cultural barriers. Furthermore, deaf people have no control over these situations, and as indicated before, attempts to remove these obstacles have often been ineffective.

While a Deaf mentor may not share the common experience of addiction and recovery from addiction with their mentoree, they could communicate effectively and could relate on the basis of the cultural needs of the recovering individual. The Deaf mentor would be in a unique position to understand the needs of the mentoree in a way that no hearing person could. With the professional community and the Deaf community working together in partnership, the road to recovery could be opened to many more Deaf alcoholics and addicts who so desperately want to find their way into recovery.

While in theory this approach seems to hold much promise for improving the recovery environment for Deaf people, it remains largely untested. The effectiveness of this mentorship idea can be better measured only when communities try it and see if it results in the anticipated benefits.

Recommendations

The creation of a training curriculum would be an essential component for preparing mentors for this project. Following are some of the concepts to be included. Training for mentors would focus on education specific to the principles of addiction and the behaviors commonly associated with chemical dependency. Professionals in the fields of chemical dependency and mental health would be able to supply this information.

Mentors will also be provided information describing the treatment process and the nature of support that would be most helpful to a newly recovering Deaf person. Mentors would

be provided with detailed information about the process of relapse, and they would be given training regarding effective intervention before the recovering person returns to his/her use of mood altering chemicals.

Mentors would be given information about where to seek help if they are struggling in their relationship with the recovering person. They would also be taught to recognize when they need help. A support group for mentors, facilitated by professionals, could be developed to address some of these issues.

In addition to the concepts mentioned above, mentors would be provided with a general overview of issues that Deaf addicts who also experience mental illness may encounter. Education related to the unique needs of individuals with chemical dependency and co-occurring mental illness will be provided including the role of psychotropic medication in recovery.

Although some of the material incorporated in the curriculum would be generic regardless of the location of the community, some other information such as available resources and specifics of the treatment process will vary by location.

As we work to continue the development of this project and prepare to implement pilot trials based on this model in communities, we are interested in opinions, concerns, and feedback regarding how we might expand on the ideas presented and improve on the concept. All feedback will be seriously considered and greatly appreciated.

Katherine A. Sandberg is program manager of the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, located in Minneapolis, Minnesota. Ms. Sandberg was also involved in the development of a specialized version of the Drug Abuse Resistance Education (D.A.R.E.) Curriculum and has published articles and presented at conferences and workshops.

Ron Lybarger has worked at the Kansas School for the Deaf, Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals, Research Medical Center-Deaf Services, and is currently employed by the Missouri Department of Mental Health and has a Private Practice in the Kansas City Metropolitan area. Dr. Lybarger holds degrees in Sign Language Interpreting, Addiction Studies, and Counseling Psychology.

Please direct your correspondence to:
Katherine Sandberg: Program Manager, Minn.Chemical Dependency Program for Deaf & Hard of Hearing Individuals
(800) 282-3323 V/TTY,
E-mail kasandberg@aol.com

Ron Lybarger Ph.D., Private Practice, Kansas City Metropolitan Area
(816) 228-3217 v, (816) 228-6545 TTY, (816) 228-6825 fax
E-mail lybarger@sound.net

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Deaf Recovery Group

Conchetta LoPresti, OSF, M.Ed., AAC II

Abstract

There are very few deaf recovering alcoholics/addicts available to serve as role models for others. In an effort to encourage deaf leadership in recovery, the author has used several methods with an outpatient deaf recovery group to develop leadership. The three areas presented deal with; expressing feelings, understanding the 12 Steps, and deaf issues in recovery.

Introduction

For the last three years, I have been the chemical addiction counselor for the Deaf in western Pennsylvania. Our program began about twelve years ago. It is collaboration between Saint Francis Chemical Dependency Program and Pittsburgh Hearing, Speech, and Deaf Services, Inc. We bring together the expertise of an established (100+ years) psychiatric/addictions program and an agency that has served the Deaf in western PA for over 75 years. We attempt to respond to a great need outpatient-care for hearing impaired persons in recovery. Research indicates there is a relationship between abstinence and access to a friend with whom clients can talk about sobriety (Guthmann, 1998).

My work with the Deaf began in 1980. My ministry included religious education for the Deaf in the Pittsburgh Diocese; coordinator/counselor for deaf students at a Catholic college in western Pennsylvania; mission work with the Deaf in west Texas; freelance interpreting in the Pittsburgh area.

In my most recent ministry of chemical addiction counselor I have been able to use some of the suggestions from the DeSales Project (Key, et al, 1992). Among the suggestions implemented were the need for socializing, importance of community/group support; and the use of storytelling and celebrating. Blending my understanding of psychosocial aspects of deafness with the skills I have learned about addictions counseling, I have found several techniques that I use with my outpatient recovery group composed of deaf clients. The topics I would like to focus on and give the participants an opportunity to experience are expressing feelings, discussions of the Twelve Steps, and discussions of problems specific to deaf persons in recovery.

Expressing Feelings

Expressing feelings is difficult for patients in recovery. However, for the Deaf who have seldom been asked their opinion or feelings about anything, an additional problem is that of not having the vocabulary to name the feelings. Two techniques I use in our group are “What color are you today?” and “What animal are you today?” The first question is simple. The explanation gives the client an opportunity to share (to the level they choose) what is happening in their life in the present and how that makes them feel. The second question ads the element of attitude as the description of the animal usually involves its motion and often how it relates with others.

Understanding the Twelve Steps

The Twelve-Steps are the keys to recovery versus being dry and clean but in misery. Hearing members of AA or NA usually learn how the Steps work in beginner meetings and discussion groups. However these are difficult for the Deaf person in recovery because of difficulty with English and the problem of lag time when participating with an interpreter.

We use the videotape "Clinical approaches: An American Sign Language Interpretation of the Twelve-Step Program." This tape is open captioned and signed in ASL. This combination makes it excellent for a wider range of members in the group. In the early stages, I play the tape for one of the steps. Then after stopping it, I would explain new vocabulary/concepts. I ask key questions to help the members to share their own experiences. Later, as the group matures, the leader for the week stops the tape at any point he/she felt discussion is helpful.

Deaf Issues in Recovery

Persons in recovery often blame others and deny their responsibility in the recovery process. Deaf clients will often blame the obstacles presented by their deafness as a reason to excuse themselves from making progress. Miller's book Deaf And Sober: Journeys Through Recovery (1998), offers many stories of how persons in recovery solve deaf issues. Among the issues we discussed were: what to do when you need to go to rehab and must wait two days to two weeks while they arrange for an interpreter; how to handle when you have relapsed and are embarrassed to see other deaf persons in recovery at the interpreted meeting; how to handle when you are angry at another deaf person in recovery, yet to go to an interpreted meeting you will need to be in the same room with them, etc. At the clinic, we provide members with an opportunity to share solutions that they have used or seen other deaf persons use successfully.

Hopes for the Future

In this day of managed care, the number of group sessions a client will have covered by their insurance is often limited. I run the Deaf Recovery Group for two hours once a week for three months with a 'break' month in between. When a client is completing their third set, I begin to let them be the leader. The role is rotated among the clients. This gives them the experience in keeping the group moving and on task. I am hoping soon that the 'graduates' of the group will develop their own recovery group. They may choose to rotate between members' homes or meet in the park on a beautiful spring day. They may choose to share present successes and problems in a discussion, or have a family outing. Perhaps, they will plan to sit together at other deaf gatherings where alcohol is served, to support each other (and give a powerful witness) that people can have fun when they are sober.

Conchetta LoPresti, OSF, M.Ed., AAC II is a Franciscan Sister who is currently a chemical addictions counselor in Pittsburgh, PA. She has a background in education for the multi-handicapped; 20 years experience in work with the Deaf; and 8 years experience in counseling.

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The Halfway Home Project: How it fits in the continuum of care for deaf and hard of hearing individuals in recovery from chemical dependency.

Keven Poore, MA, CADC, Program Coordinator

When the term "halfway house" is mentioned, most people envision a setting that serves as a halfway point between two extreme environments, namely early chemical dependency treatment or incarceration and community based living. According to Hitchcock, Roque, and Stainback (1995), a substance abuse halfway house is a residential setting that meets various needs of clients and has the potential of increasing chances that clients will continue with aftercare upon discharge or completion of halfway house programming. Halfway houses typically accommodate individuals who are chemically dependent, individuals transitioning from prisons into independent living, or individuals who are suffering from some type of mental illness. For the purposes of this paper, we will focus on halfway houses for individuals who are chemically dependent.

Halfway houses are part of the family of long term residential treatment approaches including, but not limited to therapeutic communities (TC), and social model programs. Generally, what differentiates halfway houses from other programs in the family of residential treatment programs is that halfway houses usually have more programming. Counseling, groups, psychoeducation, attendance at Alcoholics Anonymous/Narcotics Anonymous (AA/NA) meetings, Independent Living Skills instruction, and other programs are available in halfway houses to assist in the transition back to independent sober living. The other models such as Three-quarter houses, sober houses, and Oxford Houses generally do not incorporate as much, if any, therapy in the programming. These programs are focused more on support from peers and some psychoeducation they also have basic rules of conduct in the house.

Generally the continuum of care begins with detoxification, inpatient, intensive outpatient, and outpatient treatment. Upon further assessment while at these other modalities, referrals may be made to halfway houses. Halfway houses typically have an average length of stay between three months and a year or even longer. During an individual's stay, programming occurs to prepare each person for independent sober living in ways that are achievable, individualized, and realistic. Also, halfway houses attempt to prepare individuals for jobs by expecting clients to work or obtain some type of vocational training while in the program. Another way halfway houses accomplish their purpose is by the continuous exposure to Twelve Step programs, to the AA slogans, to feedback from peers and staff, to self-exploration and behavioral change. The structure provided by the house enables individuals to make conscious changes in their behavior and lives. Such structure includes, but is not limited to, rules, schedules, and treatment plans.

Sometimes individuals may require additional support upon completion of programming due to history of relapse or need for housing. Transition can occur towards three-quarter houses, sober houses, or Oxford houses where the individual rooms with other recovering individuals for a certain amount of time. After discharge from halfway houses clients can continue to obtain support in the form of support groups, outpatient counseling, and other avenues as a way to continue to assist in the transition.

Occasionally, there are individuals with various issues in addition to chemical dependency, such as mental illness, poor parenting skills, or other concerns that challenge their ability to participate fully in chemical dependency treatment. Additional services may be provided or included in the treatment plan that specifically targets these other concerns such as medication and additional counseling. Some halfway houses are specific to dual-diagnosed clients.

For halfway houses to successfully meet the needs of and to enhance progress of the residents residing at the houses, continuous teamwork with staff and residents is a crucial factor. The individual resident and the program as a whole progress must be continuously assessed and evaluated to allow for intervention and change as appropriate.

Now that a description of a typical halfway house model has been given, discussion will now shift to The Halfway Home Project, a program specifically designed for individuals who are deaf or hard of hearing and chemically dependent.

The Halfway Home Project is located in Belle Mead, NJ on the campus of Carrier Foundation. Carrier Foundation is a chemical dependency/mental health facility for hearing individuals. The Project is a program of the Marie H. Katzenbach School for the Deaf although it leases a building on the campus of Carrier Foundation 22 miles away. Carrier Foundation allows the program to use some of its facilities such as the gym and library as well as rooms for meetings.

The Project is a ten-bed co-ed program with an average length of stay from six to twelve months. Residents, as they are called in the program, are over the age of eighteen and are deaf or hard of hearing and use American Sign Language. The program staff at this time consists of a program coordinator, counselor, several counselor aides, a part time secretary and a part time staff interpreter.

The Project is funded by two grants: one from the State of New Jersey – Department of Health and Senior Services – Division of Addiction Services, and the other from a private foundation, The Robert Wood Johnson Foundation. The process of setting up this program began several years ago and the program originally was to be housed at a State facility in Secaucus, NJ, near New York City. The target opening date of the Project was the summer of 1997. The State facility idea fell through and the project director, Dr. Janet Dickinson, found the current location after some searching.

The Project, after additional delays, opened its doors and accepted the first resident on November 2, 1998 and has admitted a total of 22 individuals since then (as of March 24, 2000). The program received over 50 referrals and conducted 38 intake interviews. The majority of the referrals, interviews, and admissions have been males, 70%, 71% and 77%, respectively.

Residents are primarily referred from other drug and alcohol programs including the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. Families who have either contacted Signs of Sobriety in Trenton, NJ, the Katzenbach School, or the program itself refer other individuals. The court system or the social services system refers others as well.

At the present time, the program's admissions are limited to residents of the State of New Jersey. The program has received at least eighteen referrals from out of state and unfortunately has had to refer them elsewhere.

The program has discharged sixteen individuals with one "successful" completion. The majority of the discharges have been of a behavioral nature or against staff advice. The program will be graduating its next resident two weeks from today after thirteen and a half months in the program. The program is currently looking into early discharge and looking to find ways to change the program to a more favorable percentage if a concern is found. The program is currently discharging an average of one resident per month.

There are four phases of the program at the Halfway Home Project. The first phase is orientation where the resident learns about the premise of the program and has limited privileges. This is an opportunity for the staff to learn about the resident as well. The first treatment plan is established with the resident's involvement. The next phase consists of work readiness, involvement in all aspects of programming, and continued work on issues identified and implemented in the treatment plan. The third phase consists of the work experience and continued counseling and psychoeducation on a less frequent basis. The final phase deals with preparing for discharge and continued development of aftercare resources that begin in the early part of the program.

A typical day at The Halfway Home Project begins at 7 a.m. with exercise and ends at 10 p.m. with "Goodnight Group." Weekdays are more structured and therapeutically oriented than weeknights and weekends primarily due to staffing. Residents typically participate in a variety of activities: study time, groups, addiction education, current events, house meetings, Independent Living Skills instruction, lectures, and other structured activities. Evenings are primarily devoted to attendance at AA or NA meetings in the community. Chores and sober fun activities take up much of the weekend.

What has been discussed thus far is a fairly general overview of the program. It is anticipated that in the next year or two, there will be many changes, as the staff at the program learns what works and what does not work.

Some changes have already been made. The staff members at the program created a curriculum prior to admitting the first resident and with experience over the past sixteen months, the program has modified the curriculum a few times. The curriculum will continue to be modified as time progresses. Examples of changes include: the addition of "Goodnight Group," feelings group, process group, biweekly feelings bulletin board, and monthly 12 Steps bulletin board. The staff members also have added more activities that focus on good use of down time or things to do when bored. Some of the challenges with curriculum changes include the current staffing pattern. The program currently has only one counselor on staff and when residents are working, the counselor's schedule needs to be changed to meet the needs of the residents who return from work. The counselor aides are very instrumental in taking responsibility for the activities that are appropriate for them to handle.

Presently, the program is also looking at the number of early discharges to determine whether the number should be a concern or whether it is within normal expectations. The counseling staff members have started to re-evaluate the interview process to determine appropriateness for admission into the program. A review committee is currently in the process of assisting with analyzing the admissions process and also the remainder of the program to look at retention. Factors that may impact on the early discharges include, but are not limited to, staff skill levels, resident readiness, and length of stay. The current average length of stay of the residents who have been discharged is four months.

Part-time work for the residents has proven to be quite a challenge in that many of the residents have struggled with gaining employment for various reasons. The program is looking to establish a relationship with Division of Vocational Rehabilitation and job development specialists to explore this area. We expect residents to be working up to 25 hours a week by the time they reach their third month in the program, and to utilize counseling services to address work related concerns.

Another area the staff members are looking at is our practice of giving out weekend passes. At this time, weekend passes are given to residents who request them in a reasonable time frame and the staff members decide whether to approve the passes or modify them. This process is not followed up thoroughly as we do not administer urine screens at this time.

As previously mentioned, the rate of successful discharges is a concern. At this time, the program has successfully discharged only one resident. The program is currently in the process with our next graduate. Clearly, more attention will be focused on the termination process such as developing a discharge oriented treatment plan or including discharge in the treatment plan from day one to assist in the transition to community based living or the next level of service needed by the resident.

In summary, The Halfway Home Project has come a long way to provide an option for deaf and hard of hearing individuals in recovery to lengthen their sobriety upon completion of other forms of treatment. From experience, it is not just lengthening the sobriety of the individuals that is the biggest need, but offering alternative ways to lengthen sobriety and helping residents see sobriety as a positive alternative to their using lives. For many of the residents, overcoming boredom, conflicts with peers and staff, struggling with concomitant issues, and being in a place that is very structured is extremely challenging in itself. For a resident to see this as a beneficial alternative to being carefree and under the influence of drugs or alcohol, the staff must work together as a team to show the residents they can eventually become more comfortable with being sober One Day at a Time. Feedback from the residents is crucial in helping the staffs identify weak areas and strengths and making the changes as appropriate. Halfway houses are intended to serve as halfway points between two extreme parts of life and to help individuals in their transition from chaotic living to more stable community based living. Perhaps the Halfway Home Project should be considered to be in transition from a chaotic beginning towards a more stable existence.

Keven Poore is the program coordinator for The Halfway Home Project in Belle Mead, NJ. He is a former Senior Counselor at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. He has a Master's Degree in Mental Health Counseling from Gallaudet University and also holds the credential of Certified Alcohol and Drug Counselor.

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CHILDREN OF SUBSTANCE ABUSERS: REVIEW OF RESEARCH & IMPLICATIONS

Ann W. Moxley, Ph.D.
Northern California Assessment Center for the Deaf and Hard of Hearing
California School for the Deaf, Fremont

Abstract

There is a documented relationship between maternal substance abuse during pregnancy and subsequent problems in their children. Current research on the physical, cognitive and behavioral effects of prenatal drug use will be summarized. Prenatal alcohol exposure, in particular, can have devastating effects on cognitive and adaptive functioning. Effects of other substances have been less well documented. A large number of factors influence the outcome making it more difficult to isolate the effects of the substances used during pregnancy on children. Suggestions for prevention and treatment will also be highlighted.

Introduction

Substance abuse is a major public health problem. The number of pregnant women abusing substances has increased with an estimated 100,000 to 375,000 children born each year exposed in utero to illicit drugs according to the U.S. General Accounting Office 1990 report to Congress. The figures are much higher when the number of children exposed to alcohol and nicotine are also included. National Institute on Drug Abuse statistics from 1985 noted that 8-14% of women of childbearing age were "chemically" dependent; of these, 5-8% were alcohol dependent, 2-3% were cocaine dependent, 0.5% were dependent on narcotics, while another 2-3% were dependent on mood altering prescription drugs. Exposure to drugs in newborns resulted in total hospital charges almost double those of non-exposed newborns with longer lengths of stay and higher intensity care per day (Norton, Zarkin, Calingaert, & Bradley, 1996). Not only does maternal substance use have severe consequences for the child's health and well being, but the costs for these consequences are often borne by others.

Research on the prevalence of substance abuse in the Deaf culture is meager (Guthmann & Sandberg, 1997) but from the few studies that exist we know that substance abuse is also a problem in the Deaf community compounded by cultural factors, communication barriers, and under utilization of treatment services. McCrone (1994) projected the following approximations for deaf individuals: 98,000 using marijuana, 32,000 using cocaine, 5000 using crack, and 3500 using heroin. Kearns (1989) cited information from the National Council on Alcoholism that 600,000 or more individuals experience both alcoholism and hearing loss. Poor parent-child communication has been related to later substance abuse (Babst, Miran, & Koval, 1976; Carter, 1983).

The effects of prenatal exposure to these substances include facial anomalies and other physical defects including: intrauterine growth retardation, smaller head circumference, and behavioral dysfunction. Research indicates that pregnant drug users are at increased risk for

miscarriage, ectopic (tubal) pregnancy, stillbirth, low weight gain, anemia, hypertension, and other medical problems. Of particular concern is that HIV can cross the placental barrier; in fact, among the total cases of pediatric AIDS in the United States, about half are related to either maternal injection drug use or maternal sex with an injecting drug user. New data from a study of pregnant drug users suggest that a mother can also transmit Hepatitis C virus to her unborn child and that this also increases the risk of maternal transmission of HIV to the fetus (Hershow, Riester, Lew, et al., 1997). In this study, drug use during pregnancy was highly correlated with Hepatitis C infection, and the data suggest that maternal Hepatitis C infection either enhances HIV transmission directly or is a marker for another cofactor, such as maternal drug use. Further study is needed to confirm the findings of this study and to determine whether the association represents a biologic effect of Hepatitis C infection or results from a confounding interaction with drug use or other factors. However, specific insults and effects have not been consistently found in the research for most substances. That is, there is no "typical profile" for a prenatally drug exposed child.

A primary difficulty in research on the effects of prenatal substance abuse and use is the large number of variables that impact the outcome. Many women use more than one substance and poor nutrition is common, making it difficult to isolate the effects of one drug. In fact, the more common pattern is one of poly-drug use. Individuals using "uppers" such as amphetamines and/or cocaine frequently use a "downer" such as alcohol to come down from their high. Cigarette smoking is common among drug-dependent individuals as well and drug dealers may cut one drug with other drugs. Because of the risk of legal consequences, women may not seek prenatal care. With some drugs such as cocaine, fetal metabolism may break the drug down into a more potent and long lasting substance, exposing the fetus to higher levels of the drug and for a longer time than the mother's exposure. The fetal liver is not fully developed and cannot excrete and break down drugs quickly. Drugs as well as the HIV virus can pass through breast milk to the infant. For example, cocaine and its metabolites can persist in breast milk for 48 hours after the mother's last use.

Poor environments postnatally further complicate the picture such that it is hard to discern whether the effects are due to the drug exposure or to poor parenting, continued substance abuse problems in the environment, etc. We do know that prenatal drug exposure creates a biological vulnerability making children more susceptible to poor environments. When the mother is hearing and the child deaf, communication problems may have a significant impact on future outcome and development in addition to the effects of prenatal drug and alcohol exposure.

The potential for positive outcomes is increased with a favorable care-taking environment. Some effects observed early on may disappear later. For example, methadone-exposed infants had poor motor coordination at 4 months of age in comparison to non-exposed infants (Marcus, Hans, & Jermey, 1982). Yet, by one year of age this difference had almost completely disappeared unless the child was in a family at risk for social problems (Hans, 1989). The quality of the postnatal environment appeared more important than the amount of substance abused.

Finally, many women who abuse substances may have other problems such as depression, post-traumatic stress disorder, or other mental health problems that affect their ability to care for themselves and their children. Children of depressed mothers are often more irritable

at birth (Zuckerman, Bauchner, Parker & Cabral, 1990), have more behavior and learning problems, accidents, or affective disorders themselves. A mother involved in continued drug use may be unable to respond to her infant's signals for stimulation or nutrition. Insufficient care and nutrition can lead to failure to thrive. The child's biological vulnerability from drug exposure is compounded by the mother's inability to provide appropriate care taking. Children born into families that abuse substances are at higher risk for other problems associated with drug and alcohol use such as child abuse, violence, and depression. The mother may be a victim of violence during the pregnancy or after, the child may witness violence in the home or be a victim of abuse.

A prenatally exposed child may display behaviors that interfere with the development of normal and positive parent-child interactions. Specifically, these children often have difficulty in regulating arousal or their own behaviors as well as difficulties eliciting appropriate care giving from their mothers. Normally, a mother who responds to the child's needs in an appropriate manner provides stimulation when a child is under-aroused or reduces the amount of stimulation when the child is overexcited; this helps her child to develop self-regulation. Jacobvitz & Sroufe (1987) found that if mothers were intrusive with their infants at 6 months of age and over stimulating when the children were 3½, the children were more likely to be hyperactive. When mothers disrupt their child's activity, such as by tickling the child, or are intrusive, such as trying to get the child's attention when the child is turning away, the child may have more difficulty learning to regulate arousal and his/her own behavior. Children who cannot regulate their own behavior are more impulsive, less attentive, more distractible, and more restless. The Maternal Lifestyles Study has shown subtle but significant deficits in behaviors critical for success in the classroom such as blocking out distractions and concentrating for long periods.

There is a great deal of research on children of alcoholics (COAs) but minimal research on children of other drug abusers such as children of heroin addicts, cocaine abusers, or poly-drug abusers (Johnson & Leff, 1999). COAs are at high risk to become alcoholics themselves and to develop other maladaptive behaviors. The single risk factor of parental substance abuse places their children at biological, psychological, and environmental risk.

COCAINE AND OTHER STIMULANTS

Stimulants readily cross the blood-brain barrier as well as the placenta. Cocaine and other amphetamines affect several neurotransmitter systems: Dopamine (DA) and Norepinephrine (NE). Neurotransmitters not only influence neuronal migration and differentiation of nerves, but also the proliferation of nerve synapses and receptor sites. The drugs block reuptake of these neurotransmitters, resulting in an excess amount of the neurotransmitter in the synapse and an exaggerated signal. Cocaine magnifies the pleasure response, which leads to very persistent drug-seeking behavior.

With continued cocaine use DA is depleted in the central nervous system (CNS) and depression ensues. If DA is decreased prenatally, postnatally there will be a decrease in the number of receptors in the brain for DA. This apparent degeneration of DA neurons is irreversible. The DA cells of prenatally exposed adults fire less. Behavioral symptoms of DA neuron disruption include vulnerability to mood disorders and an inability to experience positive feelings (Gawin & Ellinwood, 1988). Norepinephrine is involved in alertness, vigilance, heart

rate, blood pressure, muscle contractions and glucose levels. It stimulates the "fight-or-flight" response necessary for survival in dangerous situations. Cocaine increases the amount of NE in nerve synapses and leads to increased arousal.

When taken during pregnancy, cocaine can cause a variety of complications (Zuckerman & Brown, 1993): premature detachment of the placenta, premature labor or delivery, intrauterine growth retardation, decreased birth weight, microcephaly and other congenital anomalies. CNS lesions and vascular injury, vascular constriction, which leads to, decreased oxygen, reduced transfer of nutrients to the fetus, and possible neurobehavioral problems also may occur. In the early months of pregnancy, the drug can cause miscarriage; late in pregnancy it can induce uterine contractions leading to labor or even death of the baby. Cocaine produces extreme fluctuations in both maternal and fetal heart rate and blood pressure. Cocaine constricts the blood vessels leading to the placenta, thereby reducing the fetal oxygen supply. Or, tiny blood vessels in the fetal brain can rupture resulting in a stroke, which can cause irreversible brain damage. The damage may be subtler if the constriction of blood vessels leading to the placenta is intermittent. The mother herself can also suffer a stroke or fatal heart-rhythm changes. Another effect of cocaine use is *abruptio placenta* where the placenta pulls away from the wall of the uterus causing extensive bleeding or death to the mother and/or the baby.

Women who use cocaine during pregnancy may reduce the nutrition their babies receive because the drug tends to reduce food intake or because of the constricted placenta reducing the flow of oxygen and nutrients needed for optimal growth. Women who use cocaine during pregnancy are three times more likely to have a premature baby; even the babies born at term are more likely to be of low birth weight (less than 5.5 pounds). And low-birth weight babies are 40 times more likely to die in the first month of life than are babies of normal weight. There is an increased risk of the infant dying suddenly from SIDS (Sudden Infant Death Syndrome).

At birth, infants exposed to cocaine are usually sleepy, withdrawn or unresponsive. They may show signs of withdrawal such as being irritable, jittery, or startling at the gentlest touch and softest sound. When not asleep they can be easily over stimulated and difficult to comfort. Maternal bonding may be impaired because of these characteristics of the infant along with the mother's continued dependence on the drug. When the baby cries, is fussy or irritable, the mother may have trouble coping. These children are at increased risk for child abuse and neglect. Other observations include increased lability, tremulousness, and startles along with decreased interaction. Poor habituation, impaired orientation, motor problems, abnormal reflexes have been noted as well. There is an increased risk of birth defects, specifically malformations of the urinary tract and genitals.

Because regulation of activity, emotional responsivity, and attention are affected, the infant's ability to maintain homeostasis in the face of stressors, may also be impaired. Cocaine use in the third trimester has been negatively associated with alertness and the ability of the infant to orient to the environment (Eyler, Behnke, Conlon, et al., 1998). When children had to initiate, set goals for their behavior, and follow through during unstructured tasks, drug-exposed toddlers had significantly more difficulty than non-exposed children. The behavioral disorganization and learning problems seen in these children may go unrecognized early on. Using cocaine even once can have tragic consequences.

However, cocaine may have less impact on neonatal behavior than do alcohol, nicotine, and/or marijuana according to Claire Coles, a psychologist at Emory University in Atlanta

(1992). She did find that cocaine use could interfere with the mother's ability to carry the fetus to term and the effects of prematurity itself cause significant problems. It is still unclear the extent to which cocaine's effects are separate and distinct from those associated with poly-drug use, the lifestyle associated with the mother's drug use, and other environmental and medical factors. Yet, factors other than the drugs themselves may account for some variability of findings. The mothers may have used several different substances, there may have been complications of labor and delivery, the child may be undernourished, withdrawal rather than the drug itself may all play a role in the symptoms observed.

OPIATES

Opiates are a group of drugs derived from the poppy plant indigenous to Asia Minor. Some natural opiates are morphine, codeine, and opium. Modification of morphine yields heroin, Dilaudid, and other forms found in Percocet, Percodan, and Vicodin. Completely synthetic narcotics with chemical structures unrelated to morphine include methadone, fentanyl, Demerol, and Darvon. The naturally occurring compounds are called "opiates" while the semisynthetic and synthetic forms are called "opioids" (Zuckerman & Brown, 1993). The effects of opioids include analgesia, reduced anxiety, heightened mood, sleepiness, clouded consciousness dilation of peripheral blood vessels, and respiratory depression. Each year 2 or 3 per 1000 infants were prenatally exposed to narcotics.

The main effects of *in utero* narcotic exposure are intrauterine growth retardation and neurobehavioral dysfunction (Zuckerman & Brown, 1993). Even though methadone maintenance during pregnancy improves growth, infants of these mothers are still much smaller than drug-free controls (Kandall et al., 1976; Wilson, Desmond, & Wait, 1981). Also, there appears to be an increased risk of seizures in methadone-exposed infants in comparison to heroin-exposed infants (7.8% vs. 1.2%). Over time the neurological exams of these children became normal. While there is no consistent, direct evidence of congenital malformation in infants exposed to narcotics prenatally, there is some preliminary data that narcotics may alter fetal brain structure and organization. For example, morphine reduces the density of neurons in parts of the hypothalamus and layers of the cerebral cortex.

The fetus exposed to narcotics develops dependency and tolerance for the drug; after delivery withdrawal leads to neonatal abstinence syndrome (Zuckerman & Brown, 1993) with irritability, sweating, tremors, a high-pitched cry, increased muscle tone, stuffy nose, feeding difficulties from abnormal rooting and suck-swallow patterns, diarrhea, and vomiting. These withdrawal symptoms appear at different times depending on the drug. Because heroin has a short half-life (4 hours) the symptoms appear the first day of life, while methadone-exposed infants may not show symptoms until one or two days, or as late as a week or more, because of its long half-life (32 hours) and the fact that the drug remains in the infant's system for days. A subacute withdrawal syndrome may last up to 3 to 6 months and include restlessness, agitation, tremors, and sleep disturbance. Withdrawal severity is related to maternal dose: infants exposed to less than 20 mg/day can be managed with TLC (swaddling, pacifier, and demand feeding with high calorie formula, decreased stimulation). If the infant does not respond medications may be indicated; about 60% of narcotic-exposed infants (40-50% of heroin-exposed; 70-90% of methadone-exposed) will require pharmacotherapy.

Behavioral abnormalities seen in these children include reduced responsiveness to visual stimuli, inattention, poor self-discipline, and more difficulty being consoled. Cognitive effects are inconclusive as poor child rearing practices may also affect learning and behavior.

MARIJUANA

While marijuana crosses the placenta early on in the pregnancy, transfer diminishes as pregnancy progresses (Indanpaan-Heikkila et al., 1969). The primary effects are on fetal oxygenation. When a pregnant woman smokes marijuana, fetal hypoxia from inhaled carbon monoxide lasts about an hour (Clapp, Wesley, & Cooke, 1986). The active ingredient in marijuana, THC, is stored in the body's fatty tissues. It may take up to a month for a single dose of cannabis to be completely excreted from the body (Nahas, 1976).

Outcome studies with marijuana are very limited. According to the National Institutes of Health, some studies have found decreased birth weight, shorter length, smaller head sizes, reduced muscle mass, decreased body fat, nervous system problems and even features resembling Fetal Alcohol Syndrome (FAS) in babies born to mothers who tested positive for marijuana use. Smoking during pregnancy causes similar effects some of, which are consistent with imapired fetal growth due to hypoxia. There are no consistent long-term outcome studies for children prenatally exposed to marijuana, although in one study (Fried & Watkinson, 1988) children whose mothers smoked more than six joints weekly, had poor scores on the memory and verbal sections of an intelligence test. Another study at Boston City Hospital evaluated the effects of maternal drinking and marijuana use on fetal development and growth. Factors other than Prenatal Alcohol Exposure (PAE), which adversely affected fetal growth and development, included lower weight gain during pregnancy, maternal illness during gestation, cigarette smoking, and marijuana use. Marijuana use was found to negatively affect fetal growth. Women who smoked marijuana and drank alcohol during pregnancy showed a five-fold increase in infants whose features were consistent with FAS (Hingson, R., et al., 1982).

ALCOHOL

History:

Knowledge of the devastating effects of alcohol on a fetus is not a new phenomenon. There has been some awareness of the connection between drinking during pregnancy and fetal development for at least 2000 years. The Ancient Greeks had laws prohibiting alcohol use by married couples to prevent conception during drunkenness. In Judges 13:7, Sampson's mother was told, "Behold thou shalt conceive, and bear a son: and now drink no wine or strong drink." In the Middle Ages, Sir Francis Bacon warned women about using alcohol during pregnancy. A painting depicting the ravages of the Gin Epidemic in England in the 1700s by William Hogarth shows a child with FAS facial features. In modern time in the United States, a law was passed requiring all alcoholic beverages to provide a warning label about the risk of birth defects from consuming alcohol during pregnancy.

Physical effects:

An agent or factor that causes physical defects in the developing embryo is called a **teratogen**. The four possible outcomes from a teratogen are death, malformation, growth deficiency, and functional deficits. Not all teratogens cause all four outcomes but alcohol does,

resulting in organic brain damage as well as behavior and learning problems. Alcohol reaches the fetus through the maternal blood supply passing through the placenta into the embryo's blood stream, and from there to all developing tissues. The amount of alcohol in the fetal blood is the same or higher than in the mother's. There is also evidence that alcohol can be transmitted through breast milk during breast-feeding. This is important because an infant's central nervous system is still developing and some organs are not fully developed at birth, including the brain.

Alcohol is the only "proven" teratogen among all these substances. In fact, it is the most common teratogen to which a developing fetus will be exposed. Prenatal Alcohol Exposure (PAE) can result in lifelong disabilities and is one of the leading preventable causes of birth defects and disabilities. Negative effects on the brain are the most serious consequence of prenatal alcohol exposure. There is evidence that consumption of alcohol during pregnancy is increasing. In a national survey, half of women aged 18 to 34 reported using alcohol during the previous month; 13-17% of these same women reported binge drinking (4 or more drinks on one occasion); half of all women aged 15 to 44 drank while pregnant (U.S. Department of Health of Human Services, 1998).

The outcomes of PAE are (1) Prenatal and/or postnatal growth retardation; (2) Central Nervous System (CNS) dysfunction; and (3) Altered physical development and facial dysmorphology (short palpebral fissures, maxillary hypoplasia, short nose, smooth philtrum, thin upper lip). Fetal Alcohol Syndrome (FAS) constitutes the full syndrome with symptoms in all three of these areas plus an established positive history of maternal alcohol use during pregnancy. Without the physical characteristics of FAS, but with confirmed alcohol consumption during pregnancy, the terms Fetal Alcohol Effect (FAE) or Fetal Alcohol Related Conditions (FARC) are used. Brain damage can occur without accompanying physical manifestations and from lower doses and frequency of exposure to alcohol. In some ways, children without the facial features but with brain damage from exposure to alcohol may have more difficulty receiving appropriate services because their handicap is not as visible. While the national incidence of FAS is 1 to 3 per 1000 live births in the United States, the incidence of FARC is thought to far exceed this number; FAE occurs in 3-5 out of 1000 live births (Abel, 1983). The lifetime cost per child with FAS is estimated to be $1.4 million (Centers for disease Control, 1998). Not only a childhood disorder, PAE can result in lifelong physical and mental disabilities and may increase the risk for later drug, tobacco, and alcohol dependence and abuse.

No amount of alcohol has been established as "safe." Zero risk comes only from zero exposure. And the more the mother drinks the more at risk she places her unborn child. The type of alcohol makes no difference, either. An ounce of alcohol is an ounce of alcohol whether it is beer, wine, or hard liquor. Alcohol is toxic to cells and can lead to cell death, such that certain areas of the brain may contain fewer than normal cells. Particularly susceptible areas of the brain include the cortex, cerebellum, corpus callosum, and hippocampus. Alcohol has chemical effects such as interrupting amino acid (building blocks of proteins) and glucose (the main energy source of cells) transport. Alcohol can interfere with regulatory systems that control the maturation and migration of nerve cells in the brain. Finally, alcohol can reduce the amount of oxygen cells receive by impairing placental-fetal blood flow.

A variety of factors make it impossible to determine the exact outcome of timing and amounts of alcohol exposure. The mother's metabolism and genetic susceptibility along with amount of alcohol consumed, duration of alcohol consumption, and when the alcohol was consumed all impact the effect on the fetus. For example, fraternal twins exposed to the same about of alcohol can be differentially affected at birth. Because the face is fully developed by the 10^{th} week, abstinence during the first ten weeks of gestation followed by alcohol consumption after this time period will not produce a child with FAS because facial features are one of the three criteria necessary for this diagnosis. Growth of the fetus is more affected during the last trimester. The CNS can be damaged at any time during pregnancy but there is no way to tell which part of the nervous system is damaged. The brain is the most vulnerable organ in the body to effects of prenatal alcohol exposure.

Central Nervous System Abnormalities:

Many areas of the brain can be affected by intrauterine exposure to alcohol. The hippocampus, a structure critical in memory, is particularly vulnerable. Deficits of impulsivity and preservation have been related to frontal areas of the brain and neuronal connections to this area. Autopsies of children with documented FAS have shown disrupted migration of nerve cells, microcephaly, incomplete development of brain structures (cortex, corpus callosum, cerebellum and brain stem) and enlarged ventricles with hydrocephaly.

Imaging studies suggest differences in brain volume and size in both FAS and FAE individuals in comparison to normal children. Other findings include loss of cells, reduced glucose metabolism, abnormal cysts or cavities (holes) in the brain or absence of parts of the brain (anencephaly). Chemical and microcellular damage can also occur that is not visible with current imaging techniques. Individuals with more severe facial dysmorphology were likely to have more midline brain pathology (Swayze et al., 1997).

Neurons in the brain communicate with each other at the synapse, or connection between neurons, via chemical messengers called *neurotransmitters*. Fetal alcohol exposure affects the brain's neurotransmitter system, particularly dopamine (DA) neurons by decreasing the number of active DA neurons in certain brain areas. When more of these neurons are active the brain seems to focus better. Reduced levels of activity may impair the individual's ability to focus and may increase his/her activity level. In addition to attention, DA is also associated with the motor system, pleasure and reward, and craving.

Effects on the Sensory System:

Hearing disorders may go unrecognized in FAS children. In one small study (Church and Gerkin, 1988) 93% (13 of 14) of the PAE children studied had some type of hearing disorder including a history of chronic serous otitis media; many required repeated placement of ventilation tubes. About a third also required amplification for bilateral sensorineural hearing loss.

Because there is a high frequency of eye involvement in children with FAS, it is important for these children to have a complete ophthalmologic exam. In Sweden, a study of 25 FAS children found some type of ocular abnormality in all but one child, including fundus anomalies (23), underdevelopment of the optic nerve (19), strabismus (13) and other abnormalities such as cataracts, nystagmus, congenital glaucoma, abnormally small corneas and eyeballs (Stromland & Hellstrom, 1996). In over half (17) their visual acuity was equal to or worse than 20/70.

Cognitive and Behavioral Abnormalities:

Some of the most devastating effects of PAE are on intellectual and adaptive functioning; FAS is one of the leading causes of mental retardation in the Western world. Greater dysmorphology may be associated with lower IQ although growth deficiency and dysmorphic features may lessen with age (Streissguth, Clarren, & Jones, 1985). Children with FAS have lower IQ scores than those with FAE or FARC with verbal IQs higher than performance IQ (Streissguth, Aase, et al., 1991). The adverse effects on IQ appear to be greater in children of less educated parents or those from larger families.

Streissguth, Aase, et al. (1991) found average adaptive level was about 7 years. Even those with a normal IQ could not live independently; they still failed to consider consequences of their actions, lacked appropriate initiative and were unresponsive to subtle social cues. Maladaptive behaviors included poor concentration, short attention, and impulsivity. A group of adolescents and adults with FAS attained only a second to fourth grade academic level, demonstrated poor judgment, had difficulty perceiving social cues and were distractible.

Conry (1990) felt that for the FAE children, alcohol had a relatively greater effect on their visual-spatial problem solving ability while the FAS children had a more generalized depression of intellectual ability. There was definite involvement of the motor system with lower performance IQ, poor visual-motor integration, impaired motor strength and weak grasp, psychomotor retardation, eye-hand coordination difficulties, and tremors.

One of the first behaviors to be investigated was hyperactivity. Animal studies found poor **response inhibition** in prenatally exposed animals who did not learn as quickly to avoid a noxious stimulus, as did non-exposed animals. More perseverative behaviors were also seen. Furthermore, these neurobehavioral effects of alcohol did not diminish with age. Nanson & Hissock (1990) noted behavioral similarities between children with FAS/FAE and children with ADHD: hyperactivity, impulsivity, and distractibility. In comparison to ADHD children, the FAS/FAE group had slower reaction times. Poor attention and impulsivity have been documented. The most consistent developmental outcomes for FAS children are developmental delay, hyperactivity, and motor problems. Although some studies have found improvement among FAS individuals as they got older in cognitive and mental health functioning while hyperactivity did not improve (Steinhausen, Gobel, & Nestler, 1984), most studies find neurobehavioral effects of PAE still evident after many years; attention and memory deficits were dose-dependent (Streissguth, Barr, et al., 1994); and growth effects appeared more transient (Sampson, et al., 1994).

Studies have found difficulties with complex attention, verbal learning, and executive functioning in PAE individuals greater than expected for their IQ. Adults with FAS have demonstrated memory problems. Both animals and humans have shown preservation and failure to inhibit with prenatal alcohol exposure. Diminished habituation is another effect. Habituation is the decrease in a person's response to a repeated stimulus, which correlates with intelligence. The inability to habituate may reflect a failure or inability to shift attention or inhibit responses. Yet, the studies of attention have had mixed outcomes.

Many caregivers feel that providing a good home and love will "cure" their child. But the permanent nature of the brain damage must be appreciated to ensure that appropriate expectations and services are established for these children. Surprisingly, children placed in foster care early did not show better growth or performance than those raised by their chronically alcoholic mothers (Hanson, Jones & Smith, 1976) nor were the harmful effects of prenatal

alcohol exposure eliminated (Aronson, 1984). An improved environment has not improved the cognitive or intellectual level of FAS children, although psychosocial functioning may improve (Aronson, 1984). Yet, living in a stable and nurturing environment is an important protective factor in terms of school adjustment, future drug and alcohol problems, inappropriate sexual behavior, and trouble with the law.

OTHER DRUGS

Little is known about the prenatal effects of **barbiturates** especially of specific drugs. However, as with opiates, the infant may experience a similar withdrawal pattern of irritability, nervousness, high-pitched cry, tremors, restlessness, abnormal reflexes, weakness, disturbed sleep, vomiting, and/or diarrhea. Birth defects are possible but not specifically associated with barbiturates.

PCP and **LSD** are used much less frequently than the above substances, so there is little research on their prenatal effects. Sorting out effects due specifically to these drugs is difficult, as they are likely to be used in combination with other harmful substances. Women who use PCP during pregnancy are at risk for injuries secondary to its use. Infants prenatally exposed to PCP have shown abnormal reflexes, vomiting, diarrhea, nystagmus, and may be jittery or tense. Again, birth defects are possible and a poor attention span is common. There is even less knowledge about LSD's effects on the fetus, but possible chromosomal changes and abnormalities leading to an increased rate of birth defects have been suggested.

Nicotine from cigarettes can cause several complications during pregnancy: miscarriage, toxemia, placental abruption and previa, intrauterine-growth retardation and prematurity. Mothers who smoke may also have more difficulty conceiving. At birth infants born to mothers who smoke have low birth weight, increased mortality and an increased risk of SIDS. Later problems seen in children of mothers who smoke have included slow growth, respiratory disease (from second-hand smoke), learning disabilities and behavioral problems.

PREVENTION & TREATMENT

There are three levels of prevention. Primary prevention would focus on preventing mothers from using drugs and alcohol during pregnancy and encouraging family planning for women who abuse substances and are of childbearing age. About half of all pregnancies and births are unintended–either unwanted or unplanned. Women should have access to counseling services, be educated about the harmful effects of using drugs and alcohol, even occasionally during pregnancy.

The next level of prevention is secondary prevention, which focuses on early identification, intervention, and treatment to prevent further health problems and minimize the effects of prenatal drug exposure. That is, secondary prevention tries to lessen the impact of the primary disability. Tertiary prevention aims to minimize the long-term disability and reduce the negative effects. This may involve helping the prenatally exposed individual to understand his or her problems, seeking services, and providing advocacy. It is important to identify safe, accepting and culturally appropriate environments in which parents can explore and grieve their roles in often unknowingly creating a child with problems related to their use of drugs and alcohol.

One reason the issue of drug and alcohol use during pregnancy is an even bigger problem for the Deaf is that they may not have access to services and treatment. Since programs typically serve hearing individuals there is the issue of communication. Substance abuse is often very

isolating. Because many treatment programs rely on a social interactive therapeutic process, the Deaf individual needs Deaf peers for fellowship and support that cannot be provided through an interpreter (Guthmann, 1999). Guthmann (1999) emphasizes several obstacles to treatment and recovery for Deaf individuals: the Deaf community's negative view of substance abuse; the stigma as well as shame attached to chemically dependent individuals within the Deaf community; confidentiality issues for those in treatment; finding a sponsor with whom one can easily communicate, especially when tempted to use; and the issue of avoiding old acquaintances and other reminders that reinforce a previous life of chemical dependence.

Specific treatment approaches vary depending on the age of the child. In general, children who were prenatally exposed to drugs and alcohol need consistent, stable environments. They need predictability or continuity through routines and rituals; this can be accomplished through schedules of activities. Set limits and follow them consistently; a secure environment is important and predictability makes children feel safer. Responses to behavior need to be consistent across caretakers and teachers as well as across environments; there should be agreement on consequences for positive and negative behaviors. Make sure to reward appropriate behavior. It may be necessary to change rewards often to maintain the child's interest. When inappropriate behaviors arise, it is important to redirect behavior while modeling alternative behaviors and strategies. Environmental structure helps mitigate the impulsivity and attentional problems common to these children. Reduce distractions, avoid over-stimulation, alert the child before transitions or change, and allow the child sufficient time to adjust.

Infants and toddlers need appropriate handling and even swaddling. A consistent and loving primary caregiver is crucial. The parent should be aware of and respond to the child's muted signals and indications of distress. Individuals must be careful not to over-stimulate the child. Rituals and language can organize the child's experience. Early childhood interventions can reduce problems at later stages. For the preschooler, consider the child's developmental level. Decreased attention and concentration may be problematic so reduce distractions and avoid interruptions as much as possible. Use physical prompts, concrete visual and verbal cues to redirect the child and to ease transitions. Positively reward appropriate behavior. Use a hands-on approach with manipulatives and direct experience to engage the child.

The elementary school setting can provide a fairly consistent environment for the school-aged child. In fact, the classroom teacher may be one of the most important individuals in the child's life, particularly with regard to developing that child's self-esteem (Streissguth, 1999). Continue to use "rituals" of daily living even for the school age child. These children will benefit from firm, consistent limits on inappropriate behaviors. Model appropriate play and conflict resolution strategies. Continue to prepare the child for transitions or changes in routine and protect him/her from an over-stimulating environment that can exacerbate distractibility, anxiety or disruptive behavior. By middle school the child may be over-stimulated or overwhelmed by changing teachers, classrooms, classmates and subjects. Intervene before negative behaviors arise or behavior escalates.

As at younger ages, the most optimum learning setting for adolescents is a structured, safe environment. It may be necessary to shift the educational focus from academic skills to vocational and daily living skills to assure successful experiences in adulthood. Begin career education and plan for vocational training and residential placement as needed.

CONCLUSIONS

The impact of drug abuse and addiction on children can be devastating and often lifelong. While we do not know the full extent of the effects of prenatal drug exposure, babies born to mothers who use drugs during pregnancy suffer complications of pregnancy, may not grow properly, have both physical and central nervous system abnormalities, and most significant of all, experience cognitive, adaptive and behavioral problems. Because the substance abuse is generally not reported by the mother, the cause of the child's problems goes unrecognized, making it harder to remediate them.

The most definitive research has been done on the effects of alcohol on the developing fetus with specific diagnostic categories identified. In Fetal Alcohol Syndrome (FAS) there is documented use of alcohol during pregnancy along with facial dysmorphology, central nervous system dysfunction, and growth retardation. With only subsets of these symptoms and a history of prenatal alcohol exposure, a diagnosis of Fetal Alcohol Effects is made. In fact, alcohol is the primary preventable cause of mental retardation in the Western world. Poly-substance abuse is common with negative effects documented for cocaine and other stimulants, opiates, barbiturates, marijuana, PCP, LSD, and even nicotine.

Yet, a primary difficulty in establishing specific effects from these substances is the number of other variables that may affect outcome such as poor maternal nutrition during pregnancy; poor postnatal environments including poor parenting, continued substance abuse problems, violence in the home, or abuse; mental health problems in the mother that negatively influence her child; and characteristics of the child that interfere with normal and positive parent-child interactions, bonding, and attachment. It is clear that prenatal drug exposure creates a biological vulnerability rendering children more susceptible to poor environments.

Many of the effects of prenatal drug exposure will not disappear even with a favorable postnatal environment. The cognitive and behavioral problems are often lifelong. Providing consistent, stable and structured environments both at home and school is necessary to mitigate the negative effects of the prenatal drug exposure. Problem identification and a life-span approach to treatment can do much to help these children. Parents also need support and help in developing appropriate parenting skills and in treating their substance abuse problems.

It appears that substance abuse is just as prevalent in the Deaf population despite a lack of research. Yet there are factors that interfere with effective treatment of Deaf individuals: a negative view of substance abuse in the Deaf community at large, fear of stigmatization, privacy issues, mistrust of the hearing population, and communication barriers to existing treatment programs. Further, most children who are deaf have hearing parents, which also leads to communication problems. More research is needed among Deaf individuals to determine the true magnitude of the problem and attitudes toward treatment so that programs can be developed to meet the needs of this population.

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Substance Abuse and Sexual Abuse: How they are Related, How We Can Help

By Susan M. Lemere, LICSW

"Most of the clients on my substance abuse treatment caseload have a history of being sexually abused. Should I be addressing this in treatment, and if so, how?"

"I'm working with a sex offender who says he only tried to molest children when he'd been drinking too much. Now that he's sober, does he still need sex offender treatment?"

"Each time my client talks in counseling about having been sexually abused by her father, she goes back to drinking and drugging. Should I encourage her not to talk about it?"

These are comments I have heard from my colleagues who work in the substance abuse and mental health treatment fields, as well as in schools and rehabilitation programs. They are also questions I have had to address in my own work during the past four years working with Deaf and hard-of-hearing clients on both an inpatient and outpatient basis. They are the questions that arise when we work with clients whose problems include both substance abuse AND sexual abuse.

Historically, problems related to substance abuse were categorized in the realm of addiction treatment, and problems related to sexual abuse were categorized in the realm of mental health treatment, without much attention to the interaction between the two problems. Yet, a number of studies have shown a correlation between substance abuse and sexual abuse, and there is strong evidence that each problem can contribute to or exacerbate the other one. The following are examples of some of the ways in which substance abuse and sexual abuse can be related:

1) <u>Substance abuse can lead to aggression.</u>

Abusing substances is thought to increase the chance that a person may be aggressive in any number of ways, including sexually. For example, alcohol is a disinhibitor which can interfere with judgment and impulse control; cocaine use can cause a person to be paranoid and reactive, and therefore more prone to aggression.

Within the sex offender treatment literature, there is ample evidence of the correlation between sexual aggression and substance abuse, particularly alcohol abuse. In 1974, research by Virkunen claimed alcoholism rates of 50 to 60 percent among sexual offenders. A 1976 study by Peters and Rada showed that approximately half of their samples of convicted sex offenders were drinking when they committed their offense. In 1985, Gene Abel and colleagues found that 30% of a sample of child molesters reported that drinking increased their attraction to children, and 45% of rapists said that alcohol increased their desire to rape. In light of these findings, psychologist Anna Salter (1998), an expert in the sexual offending assessment and treatment field, recommends that a substance abuse assessment should always be a component of a sexual offender assessment.

While substance abuse is clearly a risk factor for violence, including sexual violence, it should never be accepted as the excuse for sexual offending, or as the primary area of focus of

treatment (above sex offender treatment). What is needed when someone shows both problems is a treatment approach that takes both problems into account. An integrated approach to the treatment of these problems will be further explained in the next part of this article.

2) Some youth are "at-risk" for a variety of problems.

For children and adolescents, certain risk factors may increase their chances of *both* sexual victimization *and* substance abuse. For example, parental substance abuse has been correlated with both increased rates of child substance abuse and increased rates of child sexual abuse (research shows that usually, non-family members commit the sexual abuse). Although we do not know for sure why parental substance abuse increases the risk for child sexual abuse, we can speculate about a number of factors, which commonly accompany parental substance abuse, including insufficient parental supervision, poor boundaries, and exposure to other substance abusers.

3) Substance abuse may lead to someone being sexually victimized.

Abusing substances may increase a person's risk of being victimized in general, including sexually. Examples would include a date rape situation in which the perpetrator encourages the victim to drink or use to intoxication and then takes advantage of the person's impaired ability to think clearly and/or defend oneself. In a survey of 6,159 college students in 32 institutions across the country, it was found that when date rape occurred, 73% of the assailants and 55% of the victims had used alcohol and other drugs prior to the assault (White, 1991).

4) Sexual abuse my lead to substance abuse.

A person who is sexually abused is at increased risk for abusing substances, perhaps as a way of managing the emotional and psychological aftermath. This maladaptive way of trying to cope with sexual abuse can impede the person's emotional and psychological recovery, as well as lead to a variety of substance abuse-related problems, which can include additional victimization.

In other words, substance abuse and sexual abuse are two problems, which can lead to the other one happening, recurring, or becoming worse. This is true with regards to the general population. However, in working with the Deaf and hard-of-hearing population, we must also be aware of population-specific risk factors, treatment needs, and service barriers.

According to Marie Egbert Rendon, PhD, of the University of California Center on Deafness (1992), substance abuse rates among Deaf and hard-of-hearing are considered at least equal to, if not greater than, rates in the general population. She cited isolation, communication barriers, lack of accessible and appropriate services for the deaf, and cross-cultural family problems in many mixed deaf-hearing families as potential contributors to substance abuse among deaf people. Program Director Katherine Sandberg (1996) of the Minnesota Chemical Dependency Program for Deaf and Hard-of-hearing Individuals discusses the stigma of substance abuse in the Deaf community and the tendency for systems (including families, school, work, the criminal justice system) to enable Deaf substance abusers as significant contributors to the problem.

There are also population-specific risk factors for sexual abuse in the Deaf community, which, as with substance abuse, is thought to occur with at least the same prevalence as among the general population, and possibly with increased prevalence (though there are no available statistics with which to measure this at present). Mary Bauer (1999), a program planner with the

Deaf and hard-of-hearing services division of the Minnesota Department of Human Services, states that the Deaf community has not been given equal access to information about violence and violence prevention, including sexual violence. Lance Egley of Wisconsin wrote in 1983 that the Deaf community, as a sub-culture stigmatized by non-members, might experience more stress in everyday life than the general population, and therefore be at greater risk for violence (similarly, one study showed that racial minorities had a higher domestic abuse rate than the general population (Straus et al, 1980). Others have speculated that the extremely close, insular characteristic of the Deaf community makes some members reluctant to share secrets, including those related to sexual abuse, outside of the community (Melling, 1984).

We have just explored the correlation between substance abuse and sexual abuse, with consideration of some issues and concerns that are specific to the Deaf community. In order to effectively approach the assessment and treatment of Deaf and hard-of-hearing clients who present with both substance abuse and sexual abuse problems, a clinician must have basic knowledge about deafness and Deaf culture, substance abuse assessment and treatment, the problem and impact of sexual assault, and the assessment and treatment of sexual offending. It is most helpful for professionals to work collaboratively on addressing these complex issues, considering the many facets of assessment and treatment. Another important aspect is to provide integrated treatment addressing both disorders.

I. Integrated Treatment of Sexual Abuse-Related Trauma Symptoms and Substance Use Disorders

Individuals who have both post-trauma symptoms and substance use disorders are often challenging to treat, given the variety of their symptoms and their increased risk of relapse (Najavits et al, 1998; Trotter, 1992). The traditional addictions treatment model urged clinicians to help their client postpone addressing issues of childhood abuse until the client was at least one year in recovery; the idea was to delay the overwhelming feelings that can accompany remembering sexual abuse until a time when the client had sufficient recovery experience and skills to cope with the strong emotions he or she might experience. However, for a vast number of clients, post-trauma symptoms such as intrusive memories, flashbacks, and nightmares were not experiences that could be "put off," and many of these clients often relapsed (Evans, Sullivan, 1995; Najavits et al, 1998; Trotter, 1992).

A Massachusetts psychologist, Lisa Najavits (1998), developed an alternative approach to treatment. In working with clients who struggled with both Post Traumatic Stress Disorder (PTSD) symptoms and substance abuse issues, she found that an integrated approach to treatment was useful. The approach, "Seeking Safety," is a 25-session cognitive-behavioral approach in which treatment for both substance abuse and PTSD happen simultaneously, with an emphasis on safety, education about both disorders, and skills training for symptom management and relapse prevention.

During a recent outcome study of outpatient clients who had participated in at least six sessions of this treatment significant improvement were found from pre- to post-treatment in the following areas: substance use, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to treatment (Najavits, et al., 1998). Dr. Najavits' (1998) approach also adheres to the following principles: 1) clients with substance abuse disorders and PTSD

need help identifying the meaning of substance use as it relates to their PTSD (i.e. drinking or drugging to numb out; reenactment of abuse toward self), 2) clients with PTSD and substance abuse disorders often need assistance with daily life issues, such as housing, financial or employment issues, and family problems, and 3) 12-step participation is encouraged but not required, and harm reduction, rather than total and ongoing abstinence, is the goal. Dr. Najavits (1998) explains her approach in detail in a book called "Seeking Safety: Cognitive-Behavioral Therapy for PTSD and Substance Abuse", soon-to-be-published by Guilford Press.

II. Integrated Treatment of Sexual Offending and Substance Abuse Disorders

Sex offender treatment is a specialized field, which differs in many ways from traditional therapy. The goal of sex offender treatment, stated simply, is no more victims, and toward that end, confidentiality is very limited, and the therapist's approach with the client is directive, often confrontational. While some modern concepts from the addictions field are being applied to sex offender treatment, such as the use of motivational enhancement strategies to engage and treat sexual offenders, the bottom line that public safety is the priority cannot be over-emphasized. Therefore, harm prevention, rather than harm reduction, is the only goal when the issue is sexual aggression. This had led to the increased use of measures which some consider invasive, such as the penile plethysomograph, a device which a client attaches to his penis in order to measure his level of arousal to different subject matter (i.e. Is the client sexually attracted to young children, teens, adults, or a combination? To scenarios involving consent or scenarios involving force?), and the polygraph or lie detector test. Most often, treatment is part of collaboration between the mental health system and the criminal justice system.

During the past two decades, researchers concerned with sexual offender risk, treatment, and recidivism have worked to understand whether treatment is effective with this population and, if so, what kind. Of particular significance is a study by Karl Hanson in which the meta-analysis of numerous smaller studies, combined to achieve an enormous sample size, yielded information about factors, which seem to be correlated with sex offender recidivism. This study and others like it have aided in the development of actuarial risk assessment measures, which are empirically proven to have some predictive reliability when used to determine someone's likelihood to re-offend.

With regards to treatment, while much is still unknown about what methods work, with whom, and why, the research to date indicates that the following methods appear most effective with sex offenders in general: cognitive-behavioral treatment with a relapse prevention focus provided in the context of group treatment, with monitoring by the criminal justice system. The central feature of the relapse prevention model with sexual offenders is the concept of the sexual offending cycle; in other words, the idea that sexual offending is actually the latter part of a series of thoughts, feelings, and behaviors which can be interrupted as a means of preventing sexual re-offending. Sex offenders are taught to recognize their cycle, identify high-risk emotions, behaviors, and thoughts, and intervene when these occur. Examples of interventions include asking for help, removing yourself from a high-risk situation, recognizing and disputing a thinking error (also known as cognitive distortion), or replacing maladaptive behavioral responses to healthier behavioral responses, such as exercising to alleviate stress. The premise is that sexual offending is avoidable.

It should be noted that two groups of sexual offenders are considered poor candidates for sex offender treatment: psychopaths, as defined by Robert Hare (1991), and sadists, who derive

pleasure from terrorizing and/or hurting others (DSM-IV). At present, there are no treatment approaches empirically proven to reduce the risk of re-offending for these two groups. In fact, recent research has suggested that these clients may in fact become more dangerous when involved in standard sex offender treatment. For this reason, the presence of psychopathy and/or sadism is considered to be a reason to exclude someone from traditional sex offender treatment.

Regarding the integration of substance abuse treatment and sexual offender treatment, it is important to note first that a person does not become a sex offender because they are a substance abuser, though it is not uncommon for a sex offender to try to explain or excuse their sexual offending as resulting from their substance abuse. In a 1978 study by Groth, Burgess, Birnbaum, and Gary, it was noted that 70 percent of sex offenders in their study had never abused alcohol. At the same time, there are cast numbers of addicts and alcoholics who never commit sexual violence. While it's clear that substance abuse *by itself* does not cause sexual offending, it can be a significant contributing factor for some sex offenders, especially when the substance abuse is a part of the individual's sex offending cycle. The substance abusing sex offender has two serious pathologies, substance abuse and sexual offending, and both need treatment.

As stated before, a comprehensive sexual offender assessment should always include an assessment of the person's substance use history. This is the starting point of the work. If a substance abuse history is present, the clinician should try to learn whether and how the substance abuse is part of the sex offender's cycle of offending. Does the person drink or do drugs in order to work up the courage to commit a sex crime? (A client of mine described drinking until the "don't care attitude" set in, making it easier for him to sexually assault his victims). Do they drink to excess before offending in a pre-meditated plan to use their intoxication as an excuse if they are caught? Do they drink or do drugs after sexually offending, as a means of coping with the transitory guilt many offenders experience after committing a sexual offense? Regardless of the function the substance abuse, whenever substance abuse has been part of a person's sex offending cycle, their relapse prevention plan should always include abstinence from non-prescribed substances and a program of substance abuse recovery, such as Alcoholics Anonymous or Rational Recovery.

Although there are significant differences between substance abuse treatment and sex offender treatment, there are also many parallels, which should be emphasized as part of an integrated treatment approach. For example, both substance abuse and sexual offending are considered lifelong problems for which there are no cures, but which can be effectively managed. Both are seen as the end result of a pattern of problematic thoughts and behaviors; this pattern, or cycle, can be learned and therefore can be part of a relapse prevention plan. Isolation and secrecy are considered to be risk factors for both disorders, whereas involvement with groups of people who are also in treatment for these problems is considered helpful for promoting positive change.

There is a stereotype that sexual abuse survivors are female and sexual offenders are male. While statistics support the stereotype, it is also important to note that male sexual abuse survivors are often reluctant to seek treatment for what has been traditionally addressed as a "women's problem," and the societal view that women are incapable of sexual offending is thought to have resulted in significant under-reporting of female sexual offending. As clinicians, we must be aware of such biases and be open to the idea that some of our clients will not fit the stereotype.

Finally, with regards to working with Deaf and hard-of-hearing clients, there is tremendous need for research regarding the assessment and treatment needs of this population. There is also tremendous need for accessible services. Both the substance abuse field and the sex offender field have a significant amount of jargon, which needs to be taught to our clients in a communication-accessible way. And in the prison setting, where an inmate might be the only Deaf person in substance abuse and/or sex offender treatment programs, much attention must be paid to communication issues. For example, I have worked with a Deaf inmate in prison setting who, with minimal access to sign language interpreting, was expected to pass a number of "classes" regarding sexual offending. The system needed education about the degree to which this person's treatment was inaccessible.

To summarize, substance abuse and sexual abuse are two problems that often occur together. They may happen independently of one another, but there are also a number of ways in which the two can be related, and in fact, the research shows that they often co-occur. Deaf clients may be at higher risk for both sexual abuse and substance abuse than the general population. When a client has both problems, it is important to provide an integrated treatment in which both problems are simultaneously addressed. For trauma survivors who are not sexual offenders, a harm reduction model of substance abuse recovery seems effective. However, with sex offenders who are also substance abusers, since the bottom line is public safety, abstinence and a substance abuse recovery program must be the expectation. Sex offender treatment is most effective when it happens in collaboration with the criminal justice system. At present, there are few accessible sex offender treatment options for Deaf and hard-of-hearing clients. There is tremendous need for research, material development, and program development in this area.

Substance abuse and sexual abuse are serious problems that require skillful and knowledgeable intervention. As more human service providers and clinicians who work with Deaf and hard-of-hearing clients become educated about these problems and how to provide integrated treatment when the problems co-occur, our services will improve and expand. Gatherings like this "Stepping Forward" conference are important opportunities for us to get together and share what we are learning. Let's keep learning from each other.

Susan Lemere, LICSW, is a clinical social worker specializing in deafness and mental health. She obtained her Masters in Social Work at the Smith College School for Social Work in Northampton, MA, and has completed a certificate program in Chemical Dependency Rehabilitation with Deaf and H.H. through the University of Minnesota/the Minnesota Chemical Dependency Program for Deaf and H.H. She is a social worker and substance abuse treatment coordinator at the Mental Health Unit for Deaf People in Westborough, MA, and is developing expertise in the assessment and treatment of deaf sex offenders.

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FAMILY ISSUES FOR DEAF INDIVIDUALS IN RECOVERY

Betty Ann Rave, CCDC II
LeRoy H. Eagle Bear, Six Years in Recovery

The purpose of our discussion here today is to look at five issues that affect deaf substance abusers during their ongoing recovery process. We will name these issues and look at how they can be integrated within the person's ongoing treatment plan.

The topics will include five main ideas or areas related to the family. These are 1) separation, 2) isolation, 3) re-integration, 4) alcoholic family systems, and 5) sharing the recovery message. We will do this by sharing case studies and personal experiences, as well as doing some interactive audience participation activities.

1) <u>SEPARATION:</u>

Often it happens that a deaf individual is separated from their family due to outside circumstances. Frequently, this happens because the residential school for the deaf is many miles across the state. Some families may be able to move closer to the school, while others may not have the desire or the means to do so. Sometimes, family circumstances do no allow for frequent visits and interaction with the deaf child who has been separated from the family. These circumstances might include poverty, lack of transportation, unhealthy family systems, etc.

For the deaf child, separation from the family is a traumatic experience. If this happens at a young age, often times the child does not understand what is happening and will conclude that the family no longer wants them around. If the child is in an alcoholic family system, emotional separation occurs at an early age also. The child may learn that to cope he must separate himself from the adults in his life who are behaving erratically due to alcoholism. In order to deal with the chaos of his environment, the child will take on a role that prevents the emotional developmental cycle from taking place in a healthy progression. Even in the best of separation circumstances, a feeling of abandonment strongly affects the emotional well being of the child. The resulting shaming symptoms are like the symptoms of post-traumatic stress as the child reaches adulthood.

A) Lack of bonding, separation from persons to whom child has bonded or, no bonding due to communication problems
B) Lack of trust, broken when separation occurs
C) Lack of emotional development, individual is stuck in that emotional trauma

Erickson and others who have studied the process of emotional development see very early childhood as the period of life in which the major emotional tasks center on developing a sense of security and an ability to trust the environment. At the same time a sense of one's ability to interact with others to have basic needs met should also be learned. For the deaf child, these basic conditions may not be met due to a lack of communication with those who are responsible for these needs of the child. Maybe the child is being isolated because he is deaf. The family may not have knowledge of how to educate the child, especially if the school system has no resources available which is the case in many rural areas. Legally, the caretakers are responsible to educate the child. When forced to do so, it becomes a traumatic situation.

Here we may find the beginning of pain in our client's life. They may have experienced chronic, severe loss of attachment to the family. They often felt abandoned, therefore unlovable and unworthy. This belief (whether it is based on the truth of the situation or not) may lead to shame, guilt, sadness and/or anger. The inability to cope with strong emotions often leads to another method used to control the pain, dependence on alcohol and/or a mood-altering chemical. Another strong feeling is one of fear and this is the feeling that may be triggered under stress at the present time. Some of the personality characteristics that may need to be dealt with as an adult as a result of these early losses in life are being rigid, controlling and dependent. These characteristics are the same ones that we need to help the individual to confront during the treatment and recovery process.

2) <u>ISOLATION:</u>

Isolation from the family is frequently a result of being a deaf child. Deaf children are often "left out" of family communication and knowledge of daily life activities within the family, as well as within the wider circle of the extended family.

Each of us has a variety of cultural identities. They tell us who we are, where we are from, and where we are going. They are an outgrowth of our roots, our ancestry, our religious beliefs, our families, and our upbringing. Our cultural identity gives us values. They reflect the things we cherish. For the deaf child, these family and cultural values are often unlearned or misunderstood.

I am from an Irish, Catholic family, any of you in here today? There was definitely a certain set of rules for behavior, and my five siblings and myself came to know what were acceptable behaviors and attitude and what was not within our family. For instance, you did not show up late for dinner, period. No excuse for being late was good enough, and there was no tolerance for anyone who showed up late for dinner. Probably the reason was that my Dad expected us to show respect for our Mother at all times. Also, as children we were sent off to confession every two weeks on Saturday afternoon, whether we needed it or not. And beer drinking was an acceptable part of every special occasion and definitely a part of everyday life in my house. This was my family culture.

Many of you can identify with your background and family of origin, whether it is Italian, Native American, Norwegian or Scottish. You know the special days to celebrate the special foods that are a part of celebration and the hero's of your culture: this is our ethnic culture. We also may identify with being Catholic, Jewish, Methodist, Traditional Native American and so forth: this is our religious culture. To repeat, our cultural identity gives us values. It reflects the things we cherish. Cultural identity tells us who we are, where we are from, and where we are going.

For deaf children with hearing parents there commonly is no knowledge of a "Deaf culture." Most likely, there were no deaf role models around for either the parents or the deaf child to look to for guidance or assistance. The deaf child then pick up as well as they are able the cultural identity of their family.

When a child is physically separated from their family, and placed in an unknown environment, as in the case of a deaf child who is moved to the state's residential school for the deaf, feelings of isolation begin to deepen. For the child who has experienced language difficulties, the feelings of isolation are increased. A new environment to learn to adapt to, new peers, as well as new caretakers promote feelings of isolation. We have seen that each of us has many cultural identities. When our cultural identity is "pulled out from under us," we lose that

sense of who we are, where we are from, and where we are going. We may be learning that we have another cultural identity, but to have lost all that we know is a traumatic experience that can prevent integration within that new culture from being a happy and beneficial experience.

For preadolescent children, Erickson and others discovered that a major emotional task is developing a sense of autonomy and the ability to use rules to cope with life events. If these tasks have been learned in a specific environment and suddenly the child is separated from the environment and culture, a break in the learning process of these emotional tasks occurs. The former sense of autonomy becomes confused. The rules of the new environment are different and not understood. When the child eventually becomes more adept in their new environment, it is often painful to rejoin the family system, usually due to communication problems. This causes feelings of isolation when the child is with their family during holidays and summer vacations.

Other kinds of isolation may be experienced today in the mainstream educational system. The social and emotional needs of the mainstreamed student with a hearing loss are often not satisfied in this environment. Family separation is still experienced due to misunderstanding on the part of the family that all of the child's emotional and psychological needs are being met just because they have an interpreter everyday in school. The family may not realize that the child is only receiving the academic focus in most cases. There is little understanding of the lack of peer groups, sports or other extra-curricular activities.

As audience members shared major loss experienced in their life prior to age 13 they were asked to consider the following questions.

1) How did you handle the loss at the time?
2) What belief and behaviors interfered with your ability to move through the grief process?
3) How did you care for yourself when these past losses occurred?

As the individual in treatment, or as the treatment provider, it is important that we gather this background information during the assessment, and follow along in the treatment and recovery process so that the depth of isolation can be understood and addressed in order to interrupt the pain cycle. When the person who has experienced these deep feelings of isolation feels pain in the present time, the consequences of their persistent loss, the deep-seated feeling of abandonment, may lead to continuing to be the victim, exhibiting rage, or being constantly depressed. When we look at the way the substance abuser chooses to control the pain, we see a combination of addiction and compulsion. Or the person may be trying to control the source of the pain, resulting in perfectionism and procrastination.

The result of behaviors which stem from this feeling of abandonment often include an inability to make decisions, great dependency on others, the inability to make or keep emotional attachments with friends or relationships, and the abandonment of self.

3) <u>RE-INTEGRATION:</u>

When the person who is recovering has begun to cope with their daily life on a more consistent, regular basis, as counselors we need to become interested in the resiliency of that person and their ability to bounce back from all the previous painful memories. It has not been just a matter of naming the past hurts, but of searching for the strengths that helped the substance abuser to recover despite them. According to Wolin and Wolin in their book <u>THE RESILIENT SELF, *How Survivors of Troubled Families Rise Above Adversity*</u>, there are seven resilience

factors: insight, independence, relationships, initiative, creativity, humor and morality. Few people will claim all seven of these factors. For the majority of people, resilience and vulnerability are in steady opposition; one holding you up while the other threatens to pull you down.

As counselors we are trained to be careful of becoming involved with our client's personal lives. The idea of setting up relationships with our Deaf clients may not occur to us. It didn't occur to me either, but being willing to listen may help you identify that this unconditional acceptance is the resilience factor that your client instinctively knows would make a difference in his recovery. Proceed with caution, but do proceed.

It is necessary for the helper to have ***EMPATHY*** for the pain and wounds of the past, yet at some point in the therapeutic relationship, we need to help the client hold out for the possibility that they survived the adversity. This will empower the client with a "survivor" view of self instead of a "victim" view of self and their situation.

As Wolin states, "I have seen that many survivors are like desert flowers that grow healthy and strong in an emotional wasteland. In barren and angry terrain they find nourishment, and frequently their will to prevail becomes the foundation for a decent, caring, and productive adult life." The one thing that your client may be searching for to continue their recovery journey is a relationship of unconditional acceptance.

We know all problems are not resolved when the alcoholic stops drinking. Health problems may occur after sobriety has been ongoing, but connected with the previous alcohol abuse. Establishing a connection with the family may require the use of an interpreter. The opening of memories can be the spark that keeps the individual interested in their family. Establishing trust will be an important part of this process. Accessibility to ongoing counseling and support groups is often limited. As counselors with Deaf and HH individuals, we may be required to go the extra step in making these arrangements.

For the recovering deaf individual, this is the time they begin to wonder what happened in their family. A group that they had only interacted with during drinking or using periods, or that was avoided for long periods, begins to spark their interest. They would like to get to know the family history, customs and values. They may question who they are and what has influenced their life. At the time of recovery, family re-integration may be easier or more difficult depending on the client's age, the length of time detached from the family, the client's need to know and the families need to reconnect with the client. We see many adult deaf clients who are 40 years old or older and they have lost many family memories, or the memory is not complete. Re-integration is a slow process as the family learns to trust the recovering person again, and the recovering person gains new understanding and perspective on events and relationships in the family.

4) <u>ALCOHOLIC FAMILY SYSTEM</u>:

Often, the recovering deaf person will begin to recognize that their family of origin is enmeshed into an alcoholic system of family relationships. A parent and/or siblings may be strongly co-alcoholic. This means that they have supported or enabled the alcoholic patterns in the family to continue. This could be done out of fear of causing more disruption in the family, it could be done due to a cultural belief, it could be done out of a lack of education and prevention services, or it could be done because it is easier than "changing." The alcoholic continues to drink without consequences in many cases, thus contributing to the ongoing pattern of alcoholism in the family. When dealing with families of deaf persons in the treatment process, there are many unique issues to consider. There may be extra baggage due to unresolved issues

surrounding the deafness; lack of acceptance, guilt or doubts about decisions that were made, and isolation from the "child's world." (The child may be an adult by this time.) Communication is most likely impaired and inadequate for the development of true family intimacy. In recovery, your client may begin to recognize the enabling behaviors in their family that were part of a significant family member's way of dealing with alcoholism. They also begin to learn of the co-alcoholic factors that show the pain that family members may experience in response to problems in their midst, the sense of frustration these can evoke, and the family's need for assistance in making changes.

The research on families wounded by substance abuse is growing. We are learning that all families are not affected by alcohol dependence in a uniform manner. More attention is being directed to the family's protective factors, those family attributes that seem to reduce the disruption that can accompany substance abuse. Unfortunately, with the attention directed to the problems that the alcoholic family pose, what was too long overlooked was the fact that these coping strategies may become resiliency factors. Research by Emily Werner, begun in 1955 in Hawaii with newborn children and continuing until they reached age 18, has shown that those who were raised in an alcoholic family and did not develop serious problems themselves had several traits in common. These include a belief in taking care of ones self, an orientation toward achievement, a positive self-concept, and behavior that was prompted more by the person's own feelings and beliefs than behavior that was a response to others.

Dr. Larry Brendtro, Ph.D., author and president of *RECLAIMING YOUTH INTERNATIONAL*, a nonprofit and charitable organization that operates programs that focus on reclaiming troubled youth has focused his studies on resilience factors. He sites them as 1) connectedness, 2) continuity, 3) dignity, and 4) opportunity. Among the therapeutic means of teaching these is recasting all problems as opportunities, providing fail-safe relationships, meaning unconditional acceptance (which is what LeRoy was looking for at the beginning of our counseling relationship) and focusing on building strengths. In other words, conducting a "talent search" rather than a deficit search. Brendtro also stresses the importance of giving seeds time to grow, remembering the developmental continuum. We need to keep positive expectations alive, providing a sense of optimism.

5) <u>SHARING THE RECOVERY MESSAGE:</u>

As the deaf person is re-integrated into the family becoming a trusted family member again, it is possible for the person to begin sharing their experience, strength and hope with other family members. The recovering person must be able to accept the fact that they can only share their own experience. They cannot "take on" or accept the responsibility to change the family system. At the same time, it is important to be able to go ahead and share their experiences so that the family may have the opportunity to learn from them.

Claudia Black points out that the turning point in recovery is in the way the alcoholic chooses to respond to their pain. The pain lessens as it heals and pain control behaviors modify or end. The person in recovery leads a progressively pain-free, spiritual life. Factors involved in this recovery pattern include attending to loss so as not to continue to feel abandoned, feeling unconditional love and establishing and maintaining boundaries. The reality of the person's family condition is faced without denial. The person becomes more flexible with a behavior of interdependence rather than dependence. And that person can begin to live shame free. With this recovery the person begins to feel connected to others, to feel loved and worthy, and to have a feeling of serenity.

In recovery, the alcoholic begins to believe that people can benefit from friendship with him. He can share his accomplishments with humility and welcome continuing successes. He now accepts the way he looks to others. He can trust himself, accept his mistakes and forgive himself. Dreams and goals begin to be revived and there is a feeling of looking forward to each day. Sharing the beauty of his new life with his family is a new and welcome priority.

Your client may begin within their "Deaf family," working as a peer mentor to others in the Deaf community who are still suffering, or have begun the process of recovery. They may continue to carry the message by their example to their family of origin.

In closing, as you continue working with your Deaf clients, I encourage you to focus on strengths and resiliency that you find in them. Do your "talent search." Even the most chronic alcoholic has some strength if we but focus on finding it. Remember what this means. Recovery is achieved on a developmental continuum. As professionals working with Deaf clients, we need to remember that we are not only a necessary part of the referral and treatment plan in the beginning, but we counselors continue to be an important factor in this continuum of sobriety and achieving a new, fulfilling life.

As we have looked at these five family issues involving the Deaf alcoholic in recovery, separation, isolation, re-integration, alcoholic family systems and sharing the recovery message, we have seen that our Deaf client may be involved in several cultures, several family situations and several communication modes. It takes a variety of services to touch all these parts of the unique individual. There is no specified time frame to accomplish this change. Just be there and be aware, empowering your clients to believe in their worth and to reclaim the ***power*** that allows them to find value in life.

Betty Ann Rave, BA, CCDC II, Interpreter, Level IV, is the Coordinator of the Alcohol and Drug Abuse Program at Communication Service for the Deaf (CSD). CSD, a private non-profit organization, governed by and for the Deaf, provides a broad base of direct services to people who are deaf, hard of hearing, deaf-blind, and blind in South Dakota, North Dakota, Iowa, Minnesota, Georgia and Texas. The headquarters are located in Sioux Falls, SD, and serve as a model program for deaf groups throughout the country. Ms. Rave has given presentation on substance abuse and deafness for universities, prisons, and treatment providers including the Native American Communities, and the National Association of Alcohol and Drug Abuse Counselors national convention in San Francisco, CA in 1997.

LeRoy H. Eagle Bear is a deaf recovering alcoholic who was born on the Rosebud Indian Reservation in SD and is a member of the Sicangu Lakota Sioux Tribe. He is a 1993 graduate of MCDPDHHI who has six continuous years in Recovery. LeRoy is a graduate of the SD School for the Deaf and he is from a family of six brothers and sisters, one of his brothers is also deaf. LeRoy has lost his Father and a sister to the disease of alcoholism. He works full time at John Morrell and Co. meat packing plant in Sioux Falls, SD. LeRoy has been serving as a Peer Mentor to other deaf people in SD who are in the process of treatment and recovery. He will represent Communication Service for the Deaf at the National Substance Abuse Conference for Deaf Native Americans in Alaska in July 2000.

The Deaf Community and Recovering Deaf People: Involving Friends and Family Members

Betty G. Miller, D.Ed., C.A.D.C.

Today, many inpatient treatment programs for recovering addicts/alcoholics have been greatly reduced from thirty days to as little as seven due to limited financial support by health insurance companies. Now, what will be the future of deaf people in need of assistance in recovery? Family members, friends and service providers of these people can no longer deny, or look away from, this problem and "leave it to others to take care of them." It is time for them to provide more support.

Recovery for addict is a long-term process. There are many challenges to make changes with their lives. The recovering process cannot succeed without help from everyone involved. Treatment programs may initiate support and understanding of what happens during recovery, but only for a short while. Then, the recovering deaf people are on their own during aftercare. The members of the deaf community and recovering deaf people need to get together, and find ways to provide continued support to addicted deaf people in recovery.

Deaf and hearing family members, interested friends, professional helpers, and co-workers who are involved with the recovery of addicted deaf persons are encouraged to learn how to provide support to deaf people who are trying to achieve and maintain sobriety from the disease of alcohol and substance abuse.

Workshops can be provided and should take at least one full day and be open to all deaf and non-deaf people interested in providing support. Participants may be involved in sharing what their expectations are; learning what it means to provide support, and learning how they can provide support without patronizing.

The Deaf people in the Community

In a deaf community there is often a denial of the problem among many deaf people. Many are not aware of the seriousness of alcohol problems or drug addiction. They either consider it a shame so they avoid the problem, or they think the addict is just being a lot of fun, or that it is a temporary problem.

Shame and embarrassment are common feelings among the members of the deaf community towards the disease of addiction. These feelings are often barriers to recovery among the addicts. Many friends and family members, even if they are knowledgeable about alcoholism and addictions, would not recognize them as having a disease. They think that is not something to worry about and it will go away in time. They think that once the personal problems that caused using or drinking are resolved, addiction will disappear.

Confidentiality is another barrier to recovery. Many deaf people in recovery try to keep their recovering process a secret from the deaf community. They are fearful that they will be rejected. They may stop going to some club activities. They are ashamed of their past behavior, and sometimes they do not even think that recovery itself is positive. At the same time, their friends avoid talking about the disease, or they deny the seriousness of the disease.

Deaf People in Recovery

Most of recovering deaf people are referred to treatment programs by force. When they are confronted and required to attend educational facilities or program treatment, they may

continue to be in denial long after they fulfill the requirements. The resources that refer them include court orders, employment assistance programs (EAP), job supervisors, and family members. These referred deaf people may be sent to inpatient treatment programs, DUI education facilities or counselors. Most of these referring resources do not provide interpreters for deaf people to attend such programs. For example, at a DUI (or DWI) educational facility, a deaf person may pay for his/her own sign language interpreter, plus the cost of education itself. There are very few programs in this country, which can help educate recovering deaf people to receive important education through American Sign Language.

In the book, *Deaf and Sober* (1998), in chapter four, the author stated:

> "…Supportive AA sponsors and friends, who are making efforts to improve their own behavior and come with their own feelings, often try to assist other members who are struggling with their emotional situation by simply talking with them, sharing their own experiences, trying to be present for them, and accepting them as they are. …In this respect, recovering deaf alcoholics are no different from hearing addicts. They may be subjected to more criticism from other deaf members who did not fully understand that coping is a new skill to be developed."

These deaf members may or may not be in recovery.

Deaf/hearing relationships in AA are often difficult due to several barriers. The barriers may include the fact that there are not enough interpreters available to communicate with the hearing members. Or that both deaf and hearing members are not willing to keep their minds open towards the differences in cultural behaviors. Sometimes the deaf AA group may not exist long enough due to issues such as diversity of the members past backgrounds, identity, and confidentiality.

There are some deaf groups that include hearing members (interpreters may be provided) or that the groups have a facilitator such as a counselor or social worker familiar with addiction and recovery issues.

<u>Support within the Deaf community</u>

Deaf community members often hear comments that confidentiality in a small deaf community is extremely important. Trust and confidentiality are important to many deaf members to protect themselves and other members in the small deaf community. However, recovering deaf addicts or alcoholics may abuse the concept of confidentiality to avoid taking responsibilities or making necessary changes in the process of recovery.

The word "anonymous" has been used in sign language similarly to the English word "secret." Actually anonymous in AA means that it does not matter who you work for, or what your profession is, or who you really are in AA. The primary purpose of being at AA meetings is dealing with the disease of alcoholism or drug addiction, and being able to provide support and understanding to another with the disease. It is a way members help each other to maintain sobriety and overcome the disease as long as one is sober. However, using the same sign for both words encourages misunderstanding and denial among the deaf members in the recovery community.

To keep this disease of alcoholism and drug addiction in the deaf community a secret encourages the denial the disease exists. Addiction is not seen as a disease that is similar to other diseases. For example, for people with cancer, members of the community offer prayers and

support without feeling shame or embarrassment. It is time now to be open about the disease of alcoholism. There is no cure for this disease. There should be no shame or embarrassment about having this disease. The more the community becomes open about his, the more they can provide support. The more knowledge and understanding abut this disease, the better we can give the support.

Deaf Community Involvement

Once recovering deaf persons leave a treatment program, they are basically on their own using outside resources to provide support. They are now responsible for their own action and behavior. Usually they are able to find help such as counseling, with interpreters provided, or counselors who can use American Sign Language and interpreted AA/NA meetings.

In the early process of recovery, they often need to find housing similar to halfway houses or an Oxford house which provides a drug free room with rules that help with structured living and safety to maintain sobriety. There are few facilities that provide such support for recovering deaf people. These houses are usually not able to provide special needs for deaf persons such as interpreters for the house meetings, and their own AA/NA meetings.

But there are some facilities such as a deaf program, which provide activities and education on Saturdays (such as Deaf Reach Alcohol/Drug Program, Washington, DC) that bring together several recovering deaf people. A counselor is available at this facility and provides support when needed. Another facility is a halfway house in New Jersey, for recovering deaf residents of the state. Most of these people remain in this house of at least six months before they go on with their new sober lives. Most of them are referred to this program immediately after they spent time at the inpatient alcohol and drug treatment programs.

Because of limited professional facilities for recovering deaf people, it may be now essential to involve some other help within the deaf community. Many deaf members of the community are not aware of or do not understand the importance of support for recovering deaf people. There are members of the communities who would be interested in providing support but do not know the process.

Workshops on substance abuse and recover can be offered to all deaf and non-deaf participants in the community. Workshops may be offered by substance abuse counselors (deaf and/or non-deaf professionals who work with the deaf), or treatment program educators to help them learn how to deal with challenges in working with recovering deaf people. It is possible to do such presentations at the deaf cultural or deaf awareness events. They need to be able to do presentations and workshops showing positive approaches, and help the community become familiar with resources where recovering deaf people can get help without shame and embarrassment. The presentation may include one or two recovering deaf persons sharing his or her story on what it was like before (drinking and using) and what it is like now (clean and sober).

The activities may include what roles they can play, how substance abuse and alcohol problems affect addicts and their health and life-style, tough-love tactics, intervention, and a reality-based recovery process. Steve Shevlin, executive director of Signs of Sobriety, shared at his presentation various activities provided for recovering deaf people. In Trenton, New Jersey, there is a regular deaf 12-step meeting where there are experienced recovering deaf persons providing support and education. Also, there are yearly activities that take place at a summer camp retreat for sober deaf people, which is sponsored by Signs of Sobriety. This retreat

includes family members, volunteer workers, and recovering persons working and playing together for one full week, learning at the same time.

Kathy Sandberg and Ron Lybarger provided a workshop to discuss how and where we can have mentors for recovering deaf persons. The mentor concept is to provide support and understanding to recovering deaf persons (not replacing AA sponsors). The mentors may include members of the deaf community who may not necessarily be in recovery. This may help with what is now lacking in many recovering deaf communities: AA sponsorship for recovering deaf people.

At the conference, there was a panel of four recovering deaf persons sharing their stories to participants who are mostly friends of recovering people. This sharing had a tremendous impact on the audience. They claimed that they learned a lot, several people from the audience told me that here should be a traveling tour of such panelist to share their stories throughout the country in deaf communities. This is another idea of means to provide education and prevention.

Finally, on a personal note, conference like this one, Stepping Forward: Creative Approaches in Prevention, Treatment and Recovery for Deaf People, in Minnesota (2000), are definitely Meccas for many of us recovering deaf and hard of hearing people. We appreciate these conferences not only because we can learn more about recovery, treatment, and prevention, but because we get to meet and associate with so many recovering people, which rubs off wonderful spiritual and supportive experiences that a lot of us can not get from our hometowns. Yes, there is support in our hometowns, but there are usually only a few, often only one or two persons who understand our recovery. We hope for more conferences like these, where we can get some shots of inspiration and hold this in our memories long enough until the next conference.

Betty Miller is a deaf certified alcohol and drug counselor. Dr. Miller has worked with deaf persons with alcohol and drug abuse problems for the past 25 years. She worked at Deafpride, Inc. in Washington, D.C. for several years and has recently written and illustrated a book, “Deaf and Sober: Journeys through Recovery.

Keynote Presenters

Conference Welcome: Senator Larry Pogemiller

Conference Opening: Dr. Tom Humphries

Panel of deaf and recovering people: Betty G. Miller

Luncheon Keynote: William Cope Moyers

Concurrent/Training Sessions – Thursday

The Deaf Community and Recovering People: Betty G. Miller and Steve Shelvin

Deafness 101: Deb Guthmann and Lynn Bloom

The Use of Art Therapy with Chemical Addicted Deaf Adults: Leslie Tabin and Lisa Butler

Making Connections: Crating Alliances for Prevention Planning: Cindi Sternfeld and Lisette Ortiz

It Works If You Work It: Steve Shevlin and Julie Doermann

What Do Porcupines and Pennies have to do With Recovery?: Barry Blood

The Role of the Interpreter: Mark Alan English

Deaf Recovery Group: Sr. Conchetta LoPresti

Bridging the Gap: Integration Recovering Deaf into the Hearing Recovering Community: David McDonald and Brandy Haddock

Clinical Approaches in Treating Chemical Dependency: Kathy Sandberg and Elly Carpenter

Concurrent/Training Sessions – Friday

Motivational Enhancement: Counseling that Works: Rosemary McGinn and Hugh Young

The Halfway Home Project: How it fits in the Continuum of Care for Deaf & Hard of Hearing Individuals in Recovery from Chemical Dependency: Keven Poore

Alcohol and Other Drug Programs at Gallaudet University: Education, Prevention, Intervention and Treatment: Susan Hanrahan, Jennifer Joseph and Emily Smith Rappold.

Treatment Considerations for Dually Disordered Patients: Kristen Swan

Holding Patterns: One Look at Violence in the Home: Bev Hull

Children of Substance Abusers: Review of Research & Implications: Ann Moxley

Cultural Competency for Deaf within an Outpatient Treatment Program: Georgia Lynn Ortiz

Substance Abuse and Sexual Abuse: How They're Related, How We Can Help: Susan Lemere

Deaf Community STI/HIV Prevention Education: Risk Reduction and Assessment in Substance Abuse Programs: Denise Anderson and Nancy Emery

Models of Alcohol and Other Drug Treatment: Deb Guthmann, Ron Lybarger, Georgia Lynn Ortiz and Kathy Sandberg

Living Your Dying: Letting Go of What no Longer Serves You: Suzann Bedrosian

Concurrent Sessions – Saturday

"Are You Sober Yourself?": Self-disclosure as a Treatment Tool: Rosemary McGinn

Mentorship in Sobriety: An Alternative to Twelve Step Support: Ron Lybarger and Kathy Sandberg

Alcohol and Other Drug Use by Deaf and Hard of Hearing Adolescents: What do We Know?: Janet Dickinson

Let's Think Outside the Box! New Approaches in Educating At-risk Deaf & Hard of Hearing Students: Linda Oberg

Relapse Prevention: Tools, Tools and More Tools!: Erika Lohmiller

Family Issues in Recovery: Betty Ann Rave and LeRoy Eagle Bear