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## Alcoholism Treatment For The Deaf: Specialized Services For Special People\*

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## ALCOHOLISM TREATMENT FOR THE DEAF: SPECIALIZED SERVICES FOR SPECIAL PEOPLE\*

Paul Rothfeld

### An Underserved Population

During the past decade, alcoholism treatment services in the United States have experienced a period of unprecedented growth. The federal government, local municipalities, and the general population have become increasingly aware of the devastating impact of alcohol abuse and alcoholism upon people's health and welfare and upon the overall economy. As a result of this growing awareness, diversified alcoholism services are now available in communities throughout the country providing acute, intermediate, and long term care for alcoholics and their families.

Although it would appear that all segments of the alcoholic population should be reached by this preponderance of treatment programs, there is at least one segment which remains overlooked and virtually unserved. This is the deaf alcoholic.

### First Contact with Deafness and Alcoholism

My first experience with deafness and alcoholism occurred in the summer of 1975 when a frustrated, distraught mother contacted me for assistance. Her thirty-year-old, prelingually deaf son had developed a serious drinking problem accompanied by severe bouts of depression. He had just completed a three-week voluntary commitment at a state mental hospital and his mother felt that his "treatment during that time consisted only of heavy sedation and locked wards". Apparently, as is so often the case, the hospital

staff had little knowledge or understanding of deafness and no specialized resources for the deaf were utilized.

At the mother's request, I met with the young man to see if I could provide some help. My perceptions of deafness at that time were probably representative of a majority of the hearing population. I did not consider deafness one of the most debilitating handicaps; I felt sure that I could somehow communicate with the client; and, as a recovered alcoholic myself, I felt sure there would be an immediate bond between us which would transcend all other barriers and allow meaningful and effective therapeutic process to occur.

### Barriers to Therapy

To some degree, all of the above conditions were true and some positive interaction did occur at that first and subsequent meetings between myself and Steve. There definitely was some empathetic understanding on both our parts and to some degree a trust relationship did develop. But, always and ever the barrier of our inability to communicate freely and easily blocked the path to a meaningful therapeutic process. The barrier became even more obvious to me when Steve and I attended an AA discussion meeting. A sign language interpreter was utilized and translated for Steve as each person in the group participated in the discussion. It was impossible for Steve to keep up with the dialogue, let alone to benefit from the often

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moving and personal testimony presented. I then began to understand and believe that, if therapy was to be effective for the deaf, it should occur between peers. Deaf alcoholics should be in group process with other deaf alcoholics and therapeutic dialogue should be direct from one group participant to another. I began to realize that a specialized program, uniquely designed to meet the needs of deaf alcoholics, was needed if people like Steve were to have a fighting chance to recover.

### **A Tragic Ending**

During the next two years, I met with Steve on an on-and-off basis, more as a friend than as a therapist. He continually sought help through AA, mental health services, and private practitioners, but all to no avail. Sadly and tragically, he ended his life on November 21, 1977. It is ironic that just twenty-one days earlier I had completed and submitted an application to the NIAAA to fund a comprehensive program for deaf alcoholics. Although too late to help Steve, perhaps this new program would prevent a recurrence of so wasteful a loss of human life.

### **CCAIRU Project for the Deaf Becomes**

#### **A Reality**

On November 1, 1979, two years after the initial submission date to the NIAA, the CCAIRU Project for the Deaf became a reality and the task at hand was to implement as quickly as possible the first comprehensive program for deaf alcoholics in the United States.

#### **Project Staffing**

The initial months of the first year grant period were spent in recruiting staff with special skills in alcoholism and deafness. It became quickly evident that persons with knowledge and expertise in both areas were virtually non-existent. In fact, skilled therapists for non-alcoholic deaf persons exist in limited numbers only and are at a high premium in the job market. Once again, the underserved nature of the "hidden" deaf population is highlighted by the scarcity of skilled therapists available for a project of

this type. The complex problems associated with deafness mandate that therapists have special knowledge and sensitivity in areas of deaf development and functioning, communication skills, linguistic retardation, and intellectual, vocational, and psychiatric aspects of deafness.

As of early summer 1980, fourteen staff positions have been filled by persons with diversified backgrounds which support CCAIRU's multi-disciplinary approach to alcoholism treatment. Six of the fourteen persons are deaf themselves and two are recovering alcoholics. One of the recovering alcoholic counselors is the child of deaf parents and the other recovering alcoholic is herself deaf.

An additional aspect of staff requirements not experienced in the "hearing" world is the need for interpreters. In the original grant application, only one interpreter was included in the staffing pattern. It was naively believed that with all persons on staff being proficient in sign language, one interpreter would be sufficient. It became glaringly obvious that, if the Project for the Deaf is to relate to the outside hearing world, interpreters are needed not only for clients, but also for deaf staff members. This very real problem besets most treatment programs for the deaf, both economically and in the availability of qualified personnel. By the summer of 1980, the CCAIRU Project for the Deaf had three permanent and three temporary interpreters working at its residential facility in West Falmouth, Massachusetts.

With a full complement of qualified staff, the CCAIRU Project for the Deaf was ready to accept clients in its residential facility on May 1, 1980. The facility has been named the Stephen Miller House in recognition of the young deaf alcoholic whose tragic quest for recovery was so instrumental in this, the development of the Project. An Open House and dedication program was planned for October 4, 1980 and all persons interested in treatment for deaf alcoholics were welcome to attend.

#### **Widely Distributed Client Population**

Recognizing that the incidence of alcoholism amongst the deaf will be widely

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distributed, it is essential that an effective outreach and referral network be established both on a statewide and on a national basis so that accessibility for those in need of treatment is assured.

During the first three months that the residential facility has been operational, approximately fifty percent of admissions have come from out-of-state, including Ohio, Michigan, Tennessee, and New Hampshire. To insure that an efficient referral network is established on a nationwide basis, a National Advisory Board with broad geographical representation is being developed. It is hoped that this board will be instrumental not only in developing working referral affiliations nationwide, but also in documenting new knowledge gained in working with deaf alcoholics so that it may be shared with others who follow this first venture.

On a statewide basis in Massachusetts, a broad outreach and referral system is being developed with involvement by state agencies and consumer organizations which serve the deaf. Affiliation agreements have been entered into throughout the State with offices of the Department of Mental Health, the Massachusetts Rehabilitation Commission, and almost every alcoholism program in existence. As clients present themselves throughout Massachusetts, the CCAIRU Project for the Deaf, in close collaboration with affiliated agencies, will provide evaluation and placement in the residential program or in an outpatient service. It is planned that ultimately an outpatient/aftercare system will be operational so that residents leaving the Stephen Miller House may continue in outpatient treatment upon return to their local communities. A comprehensive follow-up and program of continuing support is deemed essential for the deaf alcoholic returning to self-sustaining status as a member of the community at large.

### Telephone Communications

It appears appropriate at this time to point out the very obvious, but often overlooked, fact that deaf people cannot communicate by ear or voice via the telephone. Hence, a deaf alcoholic has great difficulty in complying

with that wonderful AA suggestion to "call before you pick up the first drink". There is a device which enables deaf people to communicate by telephone. It is known as a TTY (telephone typewriter) or, more currently, as a TDD (Telecommunication Device for the Deaf). As part of the CCAIRU treatment program, participants will be trained in the use of these devices (typing skills) and upon return to their homes will be assisted and encouraged to obtain a device through whatever sources are available. On a local level, the CCAIRU Project for the Deaf has installed a TDD at the county emergency medical center and the number is being publicized so that all deaf people on Cape Cod may benefit from this service. For the first time on Cape Cod, a deaf person in need of police, fire department, or emergency medical assistance, can communicate directly with the emergency service center . . . if the deaf person has a TDD himself.

### Treatment Program Content

The Project treatment program consists of residential and outpatient components. Program content will be similar to other traditional alcoholism programs and include group and individual therapy, participation in AA meetings, vocational and educational planning, alcohol information, and general participation in the peer milieu.

There are significant differences, however, between a program for the hearing and a program for the deaf. These must be given careful recognition and attention if the program is to have positive results. The most significant area that needs to be continually addressed and worked on is that of communication skills. A deaf person has grown up in a world where language is totally visual and vocabulary is frequently, if not invariably, at a much different level than that of a hearing person with comparable intelligence. Staff must be continually aware that the meaning of many, many words may not be evident to deaf people. In using written subject matter such as the AA books and pamphlets, much of the language is frequently not understood by deaf clients. Efforts have already been made to translate

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the 12 steps of AA into language that is more meaningful and more readily understood by the deaf.

A similar and equally complex problem is that of varying levels of sign language proficiency by clients. In an early group of clients, one individual had no sign language skills whatsoever and could only read lips; his oral verbal skills were very good. As a consequence his early participation in group process was minimal. This was further complicated by a resistance on his part to learn sign language, although this appeared to change gradually as he became more comfortable at the Stephen Miller House.

Another client had extremely low level signing skills, could not read lips at all, and had no oral verbal skills. He, too, was unable to participate effectively in group process and counselors and/or interpreters had to be exceptionally proficient in order to communicate at a meaningful level with him. Related problems for staff with a client of this type are inability to accurately assess intelligence, aptitude, or possible psychiatric problems.

It is obvious that varying levels of lan-

guage proficiency are a complex problem in the treatment of deaf clients. Effective ways of dealing with this problem must be developed if the treatment is to be viable and successful.

The CCAIRU Project for the Deaf is now fully operational and accepting clients for its residential program from all over the United States. The Stephen Miller House is a lovely, nineteen-room Victorian manse on four acres of land overlooking the waters surrounding Cape Cod. It provides a place where deaf alcoholics can participate in a program with peers and come to grips with their alcoholism and with the problems associated with deafness.

There is much to be learned about helping deaf alcoholics to recover from alcoholism. I am hopeful that the CCAIRU Project for the Deaf will make a significant contribution in pioneering the accumulation of this needed information while simultaneously providing help for those who enter its treatment program. Let the tragedy of Steve Miller be the catalyst which moves us forward to prevent such an event from happening again.