

THE ROLE OF ACTION RESEARCH IN SERVICES FOR DEAF ALCOHOLICS*

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HIDDEN DEAF ALCOHOLICS

Seclusion of the Deaf Drinker

The extent of alcoholism among deaf and hearing impaired persons is one of the most controversial and difficult issues that the deaf communities must confront. It is a sensitive issue that they don't feel comfortable talking about. For years they have denied the problem of pathological drinking among them in order to protect their public image.

Attitudes of deaf people tend to seclude the deaf alcoholics within the confines of the deaf community. That is, alcoholism is defined as a shameful sin and a sign of moral weakness. Knowledge about alcoholism as a treatable illness is generally lacking. A very effective gossip network discourages any public admission of drinking problems. Hence, social control forces within the deaf community tend to maintain the secretive seclusion of deaf alcoholics in an untreatable condition (Boros, 1977).

Unresponsive Alcoholism Programs

If by chance, a deaf alcoholic overcomes the vicious stigma of his/her own deaf community, he/she encounters complex barriers of another kind from any alcoholism program that he/she approached for help. As presently designed, alcoholism programs are unrespon-

sive to deaf people for a number of reasons. Their counselors are ignorant of the psychosocial aspects of deafness. They cannot communicate in manual language when some deaf persons require it. These agencies are reluctant to get involved in an effective outreach effort that would liberate deaf alcoholics from a provincial world of ignorance, fear, and superstition. They are hesitant to include deaf clients in their caseloads on the basis that they don't have expertise in the field of deafness. On the other hand, counselors of the deaf shirk working with deaf alcoholics on the grounds that they don't have the expertise in the field of alcoholism.

The Extent of Untreated Deaf Alcoholics

The combination of the barriers of fear operating within the deaf community and ignorance operating in the agency world results in the deaf alcoholic being undiagnosed, untreated and uncounted. Subsequently, it is difficult at this point in time to correctly estimate the numbers of deaf alcoholics in any geographical area. Many alcoholism experts use the formula of *one of every ten adult drinkers is in some phase of alcoholism*. If a similar incidence rate applies to deaf people,

*This study was made possible, in part, by a grant from Cleveland Foundation.

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for example, then an area where there are about 18,000 drinking deaf adults, then there should be about 1800 deaf alcoholics present there, also. Since large numbers of deaf alcoholics are not reported to be in treatment, one can conclude one of two possibilities: (1) the rate of alcoholism among deaf people is non-existent or (2) large numbers of deaf alcoholics are struggling without the help of community agencies. The assumption of this paper follows the second deduction, pointing to the tragedy of undiscovered and untreated deaf alcoholics. The following discussion is aimed at showing how action research can improve services for deaf alcoholics through a special need assessment study design.

INNOVATING SERVICES WITH ACTION RESEARCH

Since both the deaf community and agencies are hesitant to assume responsibility for helping the deaf alcoholic, a strategy that necessarily involves them in the assessment process has the best chance of arriving at a permanent solution. Action research was derived principally from the work of Kurt Lewin. This technique provides an orderly framework for problem-solving that relies upon actual observations (Isaac, 1971). It is flexible and adaptive, allowing for changes during the trial period. Its objective is situational and its sample is restricted and unrepresentative. Reliability and validity measures are difficult to obtain; however, it does involve a self-study procedure. People who are to take action participate in the research process. That is, the action-research group diagnoses its own difficulties, collects information to help make necessary changes, and after the changes have been made, evaluates their effectiveness. (Weiss, 1972).

Currently, this action research model is being used in a study of Northeast Ohio by Project AID. Prior to implementing an action research design, a number of assumptions were made (1) that agency personnel require valid and comprehensive information about the need for new services to deaf clients (2) that practitioners will cooperate with this need-assessment action research effort (3) that

agency personnel will accept help in communicating with deaf clients when it was deemed necessary (4) that agency personnel will reallocate their resources to improve programming of deaf alcoholics once they are convinced that there is a dire need to do so.

The goals of this action study, then are:

- (1) Determine the need assessment: (a) to services of alcoholism treatment programs (b) to discover the numbers of untreated deaf clients.
- (2) Provide data to alcoholism agency personnel in order that any needed new programs can be designed to be more responsive to the verified problems of unserved deaf alcoholics.

Next, the six basic parts of this action research design are presented as an overall intervention strategy to bring about community based services for the deaf alcoholic. It is the design now being used in Cleveland, Ohio by *Project AID*. As much as is possible, references will be made to actual experiences of AID. The later parts of this model have not yet been tested; sections are based on the ideal model only.

THE INTERVENTION STRATEGY

I. Community Awareness Workshop

The first stage involves the creation of community awareness. In order to penetrate denial and ignorance of alcoholism among deaf people, an all day workshop was conducted on a Saturday, when both deaf people and agency personnel could attend. There were several planning sessions with agency representatives and deaf leaders. Using mostly local resource people, the workshop was conducted around the following topics:

1. Defining the Problem of Untreated Deaf Alcoholics
2. Building Blocks for Alcoholism Treatment
3. Nature of Deafness Related to Alcoholism
4. Rehabilitating the Deaf Alcoholic
5. Facing the Challenge (small group discussions on what could be done to help the deaf alcoholic)

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6. Commitments for Future Action (over twenty alcoholism and deafness agencies made commitments to offer new services for deaf alcoholic clients)

The proceedings of that workshop were recorded and published as a monograph *Dimensions in the Treatment of the Deaf Alcoholic*.^{*} Later, the monographs were distributed to deaf leaders and all the agencies which were represented at the workshop.

II. Seeking Financial Support for Outreach Project

When both influential deaf and agency leaders recognized the problem of the hidden deaf alcoholic as revealed during the workshop sessions, they lended their support to a proposal for conducting an extensive outreach search for deaf persons who needed service. Section 504 of the 1973 Rehabilitation Act stressed the penalties for agencies whose services were not accessible to the handicapped. A Federal expert had told a local conference that the alcoholism agencies, not the deafness agencies, were responsible for treating the alcoholism of deaf clients. Around the same time, a deaf alcoholic leaped to his death from a treatment facility, leaving a suicide note in which he complained that no one could communicate with him. Letters of support for the new project came in from all over the State of Ohio and the country. Project AID was finally funded by the Cleveland Foundation.

III. The Need Assessment Methodology

1. *Staff*. Persons were selected who had a working knowledge of both deafness and manual language. In addition they had to be willing to be trained in basics in the field of alcoholism. They had to be willing to do outreach work in the evenings and weekends and establish rapport with deaf people.

2. *Baseline for Data*. Agencies were asked to report any deaf alcoholics that they were treating in the last six months. All new cases during the project year would be compared with this baseline. A dramatic increase in the

caseload would most likely be due to Project AID and support the contention that deaf alcoholics were hidden and untreated.

3. *Advisory Committee*. To select an advisory committee for Project AID, the director accepted representatives from the deaf community as well as those agencies which were actually going to be involved in the referral process. The committee participates in the ongoing evaluation of the action-research findings and recommends changes to improve Project AID. This committee will also help in the designing and implementation of the year-end workshop where all the findings will be discussed by all workshop participants.

4. *Deaf Awareness*. In order to prepare alcoholism agencies for receiving deaf clients from Project AID, a number of informal sessions were held with key agency personnel on what to expect in counseling relationships with deaf people. Without an exception, these professionals became enthusiastic in efforts to bring deaf alcoholics into treatment.

5. *Alcoholism Awareness*. By far, the greatest obstacle was overcoming a strong resistance by some leaders from the deaf community to any discussion about the extent of alcoholism among deaf people. Outreach activities shifted to a deaf community educational program on the general custom and possible dangers of drinking experienced throughout American society. Upon concluding these basic talks to small groups of deaf people, an invitation was always offered to anyone who would like more help in understanding some specific aspect of alcoholism. This indirect approach was slower, but more effective in eliciting self-referrals.

6. *Referral Orientations*. When clients did come to Project AID for help regarding some aspect of alcoholism, the formal record-keeping intake procedures were kept simple. Clients answered questions of a demographic kind, reacted to pictorial test pictures in the life of a typical problem drinker, and filled out a form on their own drinking activities. Much of the intake process was devoted to building

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rapport with the deaf client and his family. Specific education on necessary alcoholism topics was also provided. If referral for treatment was required, an in-depth orientation to the receiving agency was given in terms that the deaf person could understand. If at all possible, the staff person accompanied the client to the agency to continue the orientation process.

7. *Facilitating Service.* If needed, Project AID furnishes an interpreter in the counseling provided by the alcoholism therapist to the deaf client. Any other supportive services required for the client's problems attributed to deafness (e.g., hearing aids, manual language instruction, etc.) is sought from existing agencies. At any time, alcoholism therapists can obtain general and background information on questions about the nature of deafness as a bio-psycho-social disability from Project AID staff.

8. *Collecting Data.* In order to facilitate the goals of this action research program, all AID staff keep field notes on client and agency contacts. A log is kept of each encounter by recording: the *situation* (date, place, time, type of encounter); *description* of the events; *new client insights* (from either the client or the AID worker) that help to explain the drinking problem; *barriers* to the helping process (e.g., communication, finances, prejudice, lack of interpreters, etc.); and any *other* information that will help in the development of an improved service for deaf clients. The project director will analyze all field notes and write the final report on the findings.

9. *Workshop Presentation.* Towards the end of the project year, a workshop of the findings will be presented to all agencies, organizations, and persons who were involved in this action research. Workshop participants will evaluate the findings and make recommendations on how to improve services for deaf clients in the following year.

10. *Distributing the Monograph.* In order to publicize and share the findings and the recommendations, the proceedings of the workshop will be printed and distributed to all participating agencies, organizations, and

groups who were involved in the effort to make programs more responsive to the deaf clients.

IV. Revised Programming for Deaf Alcoholics

Program ideas stemming from commitments at the workshop will be implemented. If finances allow, the action research model can be undertaken again during this second year.

V. Follow-up Evaluation of Second Year Modifications

A planning committee from the first workshop could be formed to evaluate the progress of the second year activities. It may not be necessary to organize another workshop. An evaluation report, however, should be sent to all participating agencies and organizations. Suggestions for improving programming for deaf alcoholics during the third year should also be contained in this report that is being circulated.

Implications

This paper analyzed the unique problem of unserved deaf alcoholics. Because of the complexities involved, this writer has suggested using an action research model which involves practitioners and applied researchers on the same team. The six basic stages of this action research intervention strategy were presented and discussed. The joint effort is expected to culminate in a widely supported program that has an excellent chance of permanency.

The ideas presented in this paper are only to be considered as guidelines. Each community will have to adapt this model to fit its own situation and resources. After Project AID has finished its first year, it might be possible to address the model treatment plan for deaf alcoholics in a future paper. Lack of experience and knowledge prevented any meaningful discussion of different therapies to be used with deaf clients at this time. Only the strategy for starting a community-based system for delivering responsive services to deaf alcoholics was discussed in the present paper.

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