WORKING WITH DEAF ALCOHOLICS IN A VOCATIONAL TRAINING PROGRAM

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There are over 10 million alcoholics in America (Cohen, 1976), which is approximately one out of every ten adults. Boros (1979) generalizes to the deaf community and points out that while approximately 10% of the deaf community may be alcoholic, there is a lack of deaf alcoholics in terms of treatment programs. By alcoholism we mean four factors being present in the drinking history, namely: excessive intake of alcohol, loss of control over drinking, mental disturbance due to drinking, and a disturbed social and economic lifestyle caused by drinking. In addition, there are 7 million Americans who are considered heavy drinkers in the sense that they may abstain 3-4 months at a time and then spend a weekend drinking during which they have accidents, traumatic experiences, and/or behave in a socially irresponsible manner. The importance of this 'heavy drinker' category is that approximately 70% become alcoholic. Medical problems with alcoholics involve cirrhosis of the liver, pneumonia, heart disease, and susceptibility to tuberculosis. The psychosocial aspects involve loss of job, marriage ending in divorce, and, frequently, loss of contact with the family. According to Forrest (1975), an alcoholic may lose 10-12 years in his/her lifespan as a result of drinking.

The above profile also applies to deaf alcoholics in that the same pattern is evident with the alcoholism, but is complicated further by the effects of deafness. As Boros (1979) indicated, alcoholism is one of the most controversial and difficult problems the deaf community must confront because the attitudes of deaf people tend to seclude deaf alcoholics within the confines of the deaf community. As a consequence, "the combination of the values of fear operating within the deaf community and ignorance operating in the agency world result in the deaf alcoholic being *undiagnosed, untreated,* and *uncounted*" (Boros, 1979, p.1). To illustrate the complexity of working with the deaf alcoholic, a case history will be presented in an attempt to elucidate the vocational and therapeutic issues that arose during treatment. The treatment team consisted of a clinical physchologist, social worker, and vocational counselor at the Rochester Rehabilitation Center. The social worker and vocational counselor were fluent in American Sign Language and knowledgeable about the psychosocial aspects of deafness, while the clinical psychologist was knowledgeable about alcoholism counseling. The counseling sessions were conducted jointly by the vocational counselor and clinical psychologist in the vocational workshop with the vocational counselor acting as co-therapist and interpreter in the sessions. The social worker was the case coordinator of services within RRC; coordinator of information between various outside agencies involved with the client; and a supportive counseling source for the client during crises when the vocational counselor and clinical psychologist were unavailable. The following case material was submitted to our team prior to the client's entry.

Case History: Client was a 30-year-old divorced male with three children in foster placement. His divorce had occurred after nine years of marriage to an alcoholic spouse. Client had been profoundly deaf since age one, had weak lip reading skills, but communicated effectively

medical damage due to alcoholism. However, with the communication breakdown, i.e., a hospital staff member inexperienced with deafness and sign language with no interpreter, medical testing was changed into a brief physical exam which entailed checking his pulse rate and listening to his heart beat. It also become evident that there was a reluctance by some staff at other agencies to deal with the client's alcoholism since he had shown tremendous improvement over the course of his contact with them during the past five years. They expressed fears that by focusing on the alcoholism they might frighten the client away and push him back into his former problem-ridden level of adjustment. Unfortunately, the client interpreted this sympathetic avoidance as proof that he did not have a drinking problem and therefore would return to our agency quite happy that he was "healthy" and did not need further medical evaluation. These misunderstandings fostered the client's tendency to fluctuate between facing his problems and being somewhat negative in denying the serious consequences of his drinking. After the communications between the various agencies had been corrected the major concern was maintaining the client in the program at RRS until the detoxification program with an interpreter was available. Terminating the client from RRC without the detoxification program available would have dangerously isolated him in both a physical and emotional sense. Again, one is reminded that "information is more difficult to come by for the deaf; experiences and opportunities for social intercourse are more limited; the attitudes needed for gaining a foothold in hearing society require more intensive cultivation; and the developing psychic structure is subject to greater hazards when one is deaf" (Levine, 1980, pp.41-42). The dilemma facing our team was whether we were helping or hindering the client by maintaining the program for him at RRC in spite of the absenteeism and tendency to drink on weekends.

Personality Traits of the Deaf Alcoholic: We are in agreement with Forrest (1975) that there is not an "alcoholic personality", per se, but certain personality traits frequently occur in alcoholics and in deaf alcoholics. The following traits are the most common ones that we encountered in our treatment contacts.

1. *Denial:* The alcoholic is the last to know that he has a drinking problem and typically will respond, "No one ever told me". Another aspect is his reluctance to admit the control alcohol has over his daily life. For the deaf alcoholic, he is restricted to other deaf persons and they frequently drink as well and add to the client's sense of isolation from deaf non-drinkers.
2. *Anxiety:* The alcoholic typically has been uncomfortable interpersonally for years and has relied on alcohol to reduce the discomfort. The alcohol which served to reduce this anxiety, after a few years becomes a source of anxiety in and of itself. This insight is harsh for the alcoholic to cope with and accept.
3. *Depression:* This trait is much more evident among alcoholics. In counseling there are persistent feelings of worthlessness, inadequacy, sadness, and profound pessimism with their abstinence. The depression may turn to anger which in turn frightens the alcoholic.
4. *Anger:* Alcoholics frequently feel that they have not measured up to family expectations and may become frightened when they become aware of their anger.
5. *Immaturity:* Alcoholics typically have an intensive need for approval and acceptance; e.g., being the life of the party. This social image may be hard for them to forsake for sobriety since it takes time for the alcoholic to realize that he can socialize effectively and relate to people while sober.
6. *Dependency:* Invariably the alcoholic depends on well-intentioned people who try to help but basically allow him to drink, fostering dependency, and frequently aid in making the drinking problem.
7. *Sexuality:* There are often questions

concerning sexuality and promiscuous behavior when drunk. When drinking, a blackout can occur in that behavior occurs in a reflex manner without being recalled the next day. One consequence is the alcoholic's need to fabricate for such blanks in an attempt to explain what has happened and to conceal the memory gap from others.

8. *Inferiority:* Alcoholics typically have a very poor image of themselves, closely tied in with their feelings of never having been able to measure up to expectations.
9. *Interpersonal behavior:* Alcoholics tend to be 'loners' even when married and typically see themselves as physical providers for their family. This loner syndrome is in all likelihood intensified for the deaf client who has already experienced isolation due to deafness and restricted social experiences. Possibly, the deaf client is as isolated as an alcoholic *prior* to alcoholism. Again, the attitudes of the deaf community (Boros, 1979) do not always provide a supportive setting whereby the deaf alcoholic can acknowledge or cope with the drinking problem.

Counseling Strategies: There are certain strategies we have found helpful in dealing with the deaf alcoholic, namely:

1. The diagnosis of alcoholism must be conveyed to the client. This requires dealing with the tendency of the deaf client to comply passively with the opinions of professionals and agreeing without evaluating or questioning. For example, when we sent this particular deaf client to a hospital for medical testing regarding alcoholism, he was quick to agree to a routine physical examination. He then returned feeling relieved and concluded that he must not have an alcoholism problem. Such miscommunication and misunderstanding can aid and abet the alcoholic's tremendous ambivalence about treatment. The well-intentioned professional who is not knowledgeable about deafness as well as alcoholism may reassure the deaf client and ignore the alcoholism so as not to cause upset. This particular client had been in and out of emergency rooms in hospitals for over eighteen years with various symptoms highly suggestive of a drinking problem. One is reminded of Chafetz's (1970) contention that medical practitioners are reluctant to diagnose alcoholism in patients who do not fit the "skid-row stereotype" of the alcoholic.
2. Another strategy involves helping the alcoholic remember the unpleasant experiences of drinking since alcoholics like to remember the "good times". The counselor needs to focus on the negative aspects and underline the price that the client pays for continued use of alcohol.
3. A major focus of the counseling sessions needs to be on the day-to-day living of the client: whom he talks with; what activities he has on that particular day; any difficulties he may have encountered and how he has coped with them; whether he has maintained a balanced diet; etc. These day-to-day problems are crucial since alcoholics have avoided them through continuous drinking for years.
4. After his day-to-day living is controlled, the counselor needs to focus on other reality issues such as responsibility, thinking about counterproductive behaviors and generating healthy behavioral alternatives. Reality issues become easier to deal with after a sense of trust has developed. With the deaf alcoholic, a problem from the deafness, per se, is lack of trust. Deaf clients have difficulty trusting the hearing community, especially hearing professionals. In view of this, the counselor has to expect the counseling relationship to progress at a slower, more cautious rate for the deaf alcoholic. Focusing on behaviors and everyday problem situations can be less threatening for the deaf alcoholic and may be instructive. The goal is to

in American Sign Language. He lived alone, was highly dependent on his parents, had few friends, had stopped attending church, and frequently went to bars for recreational drinking" with friends. Client worked briefly in a factory doing light assembly work. However, physical symptoms involving tremulousness, sweatiness, and complaints of lightheadedness had caused problems in attendance. In addition, client had fallen a number of times at home resulting in damage to ribs and back. Consequently, work tolerance limitations due to pain contraindicated any prolonged standing, sitting, or movement. The psychological evaluation had indicated superior intelligence in visual-manual tasks, visual-spatial orientation, fine-motor coordination, and perceptual organization with personality traits of deeply ingrained dependency and inadequacy.

Client entered our Vocational Evaluation Unit for the first five weeks. Observation indicated an eager, cooperative client with good work habits, not requiring constant supervision. His strengths were good dexterity, aptitude for machine operating, and quickness in understanding instructions demonstrated visually and with the use of sign language. Two problem areas were physical tolerance and attendance. For example, client was unable to stand while working for long periods of time and missed 4 out of 17 days due to illness. He was referred to our workshop for vocational and personal adjustment training. However, client's start date was delayed two weeks because of a hip injury due to a fall. When client started in the workshop, his work habits were excellent with good concentration, good production rate, consistently high quality work, and good relationships with supervisors and co-workers. However, attendance became a problem with absenteeism 30% of the time due to a variety of physical illnesses, e.g., infections, upset stomach, and feeling weak. He did not report these illnesses, although his parents had agreed to call for him since he did not own a TTY. During the first six months of program, the attendance problem had been attributed to various medical problems for which he was receiving treatment at outside clinics. However, after self-disclosures with the social worker and vocational counselor, we confronted him with the possibility of a drinking problem, carefully explaining how excessive drink could be affecting his physical health and attendance. He agreed to follow through on medical testing to assess any physical damage due to drinking and expressed surprise at the time of confrontation that he might have a drinking problem, responding: "In 18 years of drinking, no one ever told me I had a drinking problem".

The attendance problem continued after this meeting, but the excuses began to include oversleeping due to hangovers. His physical symptoms were inconsistent in the workshop; e.g., one day he would be unable to tolerate standing more than a few hours whereas at other times he was able to stand for 2-3 consecutive days at a particular job. At this point client was maintained in workshop for the express purpose of structuring his life and providing an emotional support system while waiting for admission to a full-time detoxification program for alcoholics. The complication was the lack of such a program in the Rochester area for deaf clients. It took approximately 4½ months to arrange for changes which would enable an alcoholic detoxification unit to serve our client.

Once the diagnosis of alcoholism had been brought to the client's awareness, the clinical psychologist and vocational counselor, in joint counseling sessions, attempted supportive counseling in the workshop setting to help him cope with his alcoholism. An important advantage was that most of the staff members with whom the client had to work were capable of signing and providing positive reinforcement for his work behaviors. Consequently, a combination of professional skills were utilized in the rehabilitation team including experience with deafness, fluent ASL skills, and experience with alcohol counseling. During the joint counseling sessions, the client openly shared aspects of his drinking problem in regard to guilt and embarrassment about drinking, anger towards parents, dependency, and need to drink when feeling angry, anxious, or depressed. He also reported extreme loneliness since his few friends were other deaf clients who were "recreational drinkers". This concurs with Hetherington's (1979) suggestion that the deaf alcoholic is not only isolated from society because of his alcoholism, but the deaf community itself is normally a group of isolated people with painful awareness of the isolation. As such, alcohol becomes a relief from this emotional discomfort due to the person's inability to communicate like the majority of the hearing community around him. Although our client was able to develop these insights, absenteeism in the workshop did not allow him to follow through with these insights or develop a consistent enough counseling relationship. It was also frustrating for the co-therapists not to be able to deal more effectively with these problems and help the client with various behavioral strategies discussed in the sessions. At times the co-therapists felt like disciplinarians rather than counselors since the attendance problem had to be addressed whenever client returned to the workshop after an absence. In the later stages of his program at RRC, the importance of attendance was stressed with the client for his own physical health and emotional safety, not just program requirements. As his drinking became less controlled he was encouraged to

come to program even when he had a hangover or was primarily in need of a counseling session after a few days, or a weekend, of drinking. Our primary concern became maintenance of contact with a severely isolated deaf alcoholic who could only communicate with a small number of professionals experienced in deafness and alcoholism. It was evident that this client had been "bounced from agency to agency and given all kinds of help for everything but his alcoholism" (Hetherington, 1979, p. 9). Eventually the client's absences increased to the extent that the program had to be terminated due to his inability to utilize the support services available to him. Fortunately, he entered the detoxification program approximately three weeks after this occurred.

A number of problems had to be dealt with by the team to maintain the client until the appropriate detoxification program was available. Continued communication with our administration ensured understanding of the complexity and difficulty in treating the deaf alcoholic within a vocational setting. If the client had not been alcoholic or had not been willing to seek help, services would have been terminated early in the program due to high absenteeism. Continuation in the program presented problems in enforcing a consistent attendance policy with some other deaf clients who questioned the special consideration for this particular client. Although the client admitted serious problems from the drinking, he preferred to avoid such problems, e.g., in the workshop he would not admit physical tolerance problems even when in pain. However, he then would be absent the following day. Since he was deaf and did not have a TTY, it was difficult to determine if unreported absences were due to his avoidance, being in an alcoholic stupor, or having asked a family member to call who had failed to do so. This complicated setting limits when dealing with dependency on his family, and raised the issue of accountability for our team. After a total of nine months in the program, during which considerable energy had been expended by the team to help the client cope with his deafness and alcoholism, we were uncertain if he would follow through with detoxification, maintain sobriety, and successfully continue vocational training.

Other complications became evident in terms of mismanagement between the various agencies involved. From first contact with the client there had been a lack of background information and no focus on his most important problem, alcoholism. This client had been known to a number of hospitals, a venereal disease clinic, and various other agencies, none of whom had ever focused on the drinking. There were a number of staff changes at the various agencies serving him, including our own, thereby reducing continuity and effectiveness of services. When we confronted the client with the drinking problem our team was relatively new to him and his situation. In ensuing discussions with various RRC staff who signed, the client had expressed fears regarding his isolation, sexuality, and sexual behavior when under the influence of alcohol, e.g., he had VD on a number of occasions and was extremely embarrassed when he obtained treatment which included being interviewed about the names of recent partners. The client's maturity did not foster introspection or a realization that he had lost control over his drinking. Another aspect was the fear of changing his behavior since he did not know many people and felt the need to maintain contact with his deaf drinking buddies. This highlights the social isolation which Mindel and Vernon (1971) labeled as a major consequence of deafness.

There were three other agencies involved with this client when he started the program at RRC. Consequently, a considerable amount of communication had to be maintained with various professionals in the agencies through our social worker to minimize duplication of services. There was also a problem with the client's selectivity (perhaps manipulation) in terms of whom he would share information with in various agencies. As a result, different professionals had different information at different points in time. One serious example of this occurred when he had been referred by our team for medical testing to assess possible

delay impulsive behavior and develop practical judgment in choosing appropriate behavioral alternatives.

6. It is helpful to indicate to the client that relapses may and can occur with alcoholism and do not necessarily indicate failure or hopelessness. Alcoholics can become very depressed and discouraged with a relapse. With the deaf alcoholic this is more complicated due to the restrictive social circle which may well include other deaf alcoholics or heavy drinkers. It is important to encourage the client to attend the counseling sessions even after a weekend of drinking. This allows him to reflect on what led to the drinking situation and generate coping mechanisms that might be used in the future in dealing with the pressures and anxieties that were experienced.
7. Confrontations have to be made in a caring, firm, practical manner. One can not afford to be paternalistic or patronizing, which may well be the experience of many deaf clients in general.
8. A final crucial strategy involves use of support services in the community, such as Alcohol Anonymous. These services are available to hearing persons but frequently are not available to deaf persons. Consequently, the deaf alcoholic tends to become even more isolated in his struggle with alcoholism by not being able to utilize AA. They are deprived of social contacts with other recovering deaf alcoholics, of having phone numbers of people they can call at any time when anxious or struggling with the desire to drink, or of transportation to AA meetings for companionship. Telephone contacts are an important support vehicle for beginning AA members and is virtually non-existent for most deaf clients. Consequently, there is a tremendous amount of emotional support and restructuring in the environment available for the hearing alcoholic that has limited accessibility for the deaf alcoholic.

In our experience, the counseling relationship itself is a crucial ingredient in treatment. The counselor can provide a role model for the client with whom he can identify and imitate. In the beginning, one must convey a sympathetic, honest, non-critical concern for the deaf alcoholic as a person. This means treating the client with dignity and not mistakenly giving the client the impression of being judgmental or patronizing if a relapse occurs. Honest, concerned confrontation is necessary, not a punitive disciplinary reaction. Basically, the counselor tries to convey a sense of trust and self worth which alcoholics typically do not have (Forrest, 1975).

In summary, our involvement with deaf alcoholics indicated a number of obstacles to providing effective treatment. Being aware of these difficulties and complexities hopefully will prepare the professionl working with the deaf alcoholic for minimizing some of the frustrations and being realistic about the many obstacles involved in treatment. It takes time, patience, continuous follow-through with various agencies, and a firm resolve not to let the team's own frustrations and annoyances foster dismissal or neglect of the deaf client in a patronizing manner. Interestingly, Chafetz (1970) recommends a team approach in which the emotional burden the alcoholic patient presents can be spread out, as it were, over more than one caretaker. It is crucial for staff to be experienced with deafness, fluent in manual communication, and experienced with alcoholism. Our respective professional roles, i.e., clinical psychologist, social worker, and vocational counselor were defined more by the needs of the client than by any strict professional role definition. Thus, a flexible comfortable working relationship among the team members is crucial to accomplish what is best for the deaf alcoholic. A major concern throughout most of the treatment was the danger of miscommunication within the team as well as among the various agencies. As final note, we would like to emphasize Armor, Polich and Stambul's (1978) suggestion that we might well view alcoholism as

a process evolved from a complex developmental source involving a great range of sociological, cultural, and psychological variables and their possible interactive effects with one another. With the deaf alcoholic, one must add to this definition of alcoholism the developmental complexities of deafness which impairs language development, results in gaps in socialization and information, frequently entails restrictive educational experiences, and fosters limited life experiences frequently encouraged by well-intentioned, overprotective families.

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