Relapse Prevention with Deaf and Hard of Hearing Persons

Debra Guthmann, Program Director
Katherine A. Sandberg, Outreach/Development Counselor
Minnesota Chemical Dependency Program for
Deaf and Hard of Hearing Individuals
2450 Riverside Avenue
Minneapolis, MN 55454
(800) 282-3323 (V/TTY) - (612) 672-4402 (V/TTY)
(612)672-4114 Fax

Kristen Swan, M.A., L.P., Psychotherapist
Health and Wellness Program
Regions Medical Center
640 Jackson Street
St. Paul, MN 55101
(651) 221-2742(V)

Abstract: *This paper discusses the process of relapse and factors in preventing relapse with deaf and hard of hearing persons. Barriers to recovery are examined as well as factors that contribute to recovery. Relapse prevention materials and services are discussed. Results of a follow up study of deaf and hard of hearing individuals who completed treatment at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals are also shared. Recommendations fro promoting recovery are offered.*

Introduction

Service providers need to learn about relapse and its prevention as more options become available for deaf people who recognize a problem and seek treatment for addiction to alcohol and other drugs. Individuals who complete treatment are only beginning the road to recovery. Recovery entails a great deal of work after treatment and show be encouraged by ongoing support and education. Hearing people often have many options for getting this kind of support including counseling and self help groups like Alcoholics Anonymous as well as a large recovering community. Def people, on the other hand, often find local sources of support to be inaccessible due to communication barriers and the small number of recovering deaf people.

Families, friends and service providers are better able to provide support to recovering deaf and hard of hearing persons if they understand the processes of addiction, recovery and relapse. This paper will focus on the process of relapse and how it related to the process of recovery. By knowing the process of relapse, concerned persons may be able to detect warning signs and intervene in this process. It is important to have the recovering individual understand the process of relapse and to be actively involved in prevention efforts on his or her own behalf.

In addition to the process and the warning signs, we will look at factors which seem to contribute to ongoing recovery in the cases of deaf and hard of hearing clients who have completed treatment at the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. We will identify those variables which seem to be present in individuals who achieve longer periods of sobriety or abstinence and absent in those individuals who have been unable to continue a recovering lifestyle.

Relapse Definition

Gorski and Miller (1986) describe the evolution of the current understanding of relapse. In the 1930"s relapse was thought to be simply the resumed use of alcohol. But, as alcoholics began substituting the use of other sedative drugs for alcohol, there was a recognition that an alcoholic cannot safely use any sedative drug. Relapse was thought of in terms of the resumption of any sedative use, including but not limited to alcohol. As the use of a variety of drugs became more

common in the □60's, there was an awareness of the ability of any mood altering chemical to trigger relapse. The effects of LSD, marijuana, cocaine and other drugs may differ from alcohol and other sedatives. However, they have the same behavioral effect in that they relieve pain now but cause pain later, and result in loss of control. By recognizing that recovery requires more than just abstinence from alcohol and other sedatives. However, they have the same behavioral effect in that they relieve pain now but cause pain later, and result in loss of control. By recognizing that recovery requires more than just abstinence from alcohol and other drugs, we were able to recognize that relapse also is more complex than the simple act of taking a drink or a drug. Now, it has become clear to the recovering community and to treatment providers that relapse is not defined by the single event of using a chemical but may more properly be thought of as the process of becoming dysfunctional in one□s sobriety. In other words, the process of relapse begins before the actual addictive use and the dysfunction will likely involve one□s physical, emotional, psychological or social health (Gorski and Miller, 1986).

Relapse is more than just the return to drinking or other drug use. It is no longer accurate to think of relapse as the return to □loss of control drinking□, triggered by the ingestion of the first one or two drinks. The acceptance of psychological and social factors are important in precipitating the first use but also in maintaining the pattern of use after this point (Marlatt, 1978).

The Relapse Process

Gorski and Miller (1986, pp. 139-156) describe the relapse syndrome as a series of phases and warning signs that ultimately lead to the resumed use of mood altering chemicals. This syndrome begins with a phase of Internal Dysfunction involving thought impairment, emotional impairment, memory problems, high stress, sleep problems and coordination problems. The alcoholic or addict experiences shame and guilt as a result of the inability to manager these warning signs and develops a sense of hopelessness. The second phase is External Dysfunction involving a return to denial, avoidance and defensiveness, crisis building with personal problems, a stage of immobilization and finally confusion and overreaction. Next comes the loss of control phase involving depression, loss of behavioral control, recognition of the loss of control, and a

feeling of being trapped with the only alternatives seeming to be insanity, suicide or addictive use. The actual return to addictive use often follows closely on the heels of these phases and signs.

With the identification of these phases and signs of the relapse process comes the opportunity to intervene in the process prior to the actual resumed use of mood altering chemicals. As with the addiction, the recovering person is often not able to detect the various signs of relapse. It is especially important that there be supportive individuals who can point out various warning signs to the recovering person. With deaf and hard of hearing persons, such support persons may be fewer because of the communication issues. Instead of the vast number of choices of Twelve Step meetings and members, the recovering deaf person may have only one or two interpreted meetings and a smaller number of AA or NA members with whom he or she can communicate. Wentzer and Dhir (1986) refer to the recovering group within the Deaf Community as □microscopic□ in size. Whitehouse (1991) suggests that there are few professionals nationally in helping roles who are versed in chemical dependency as well as the communication, psychological, social and cultural dimensions of deafness. Professionals providing services, family, friends and members of the Deaf Community can all provide helpful feedback that can help the recovering deaf or hard of hearing individual prevent or arrest a relapse.

Factors in Preventing Relapse

In the field of chemical dependency, many ideas have been put forth as to indicators of long term sobriety success and the prevention of relapse. One study suggests that patients at a higher risk of relapse request more medication for subjective symptoms during treatment than do their peers who are more likely to remain abstinent (Heer and Marshall, 1993). A report of the Maudsley Relapse Study of 1978 identifies the following more prominent relapse factors: negative mood states such as boredom and anxiety; cognitive factors including deliberate decisions to use again; and a range of environmental factors including unsatisfactory home environment (Gossop, 1992). Likewise, Mudsley (1978) identified a number of protective factors including persons, activities and social structures which were identified by the recovering person as being helpful to them. It has been suggested that routine follow up by Employee Assistance program staff can result in

reduced frequency of relapse (Foote and Erfurt, 1991). Even the use of codeine for relief of non-life threatening conditions may pose an unacceptable risk to the addict□s recovery (Stock, 1991).

Treatment Follow up with Deaf and Hard of Hearing Persons

A study done with deaf and hard of hearing clients from the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals (MCDPDHHI) looks at some factors which may contribute to successful treatment and recovery for deaf and hard of hearing persons (Guthmann, Hall and Meyer, 1994). The Program is an inpatient treatment program which is hospital based and follows a Twelve Step philosophy. The MCDPDHHI works with deaf and hard of hearing persons from across the United States and Canada in an environment that is sensitive to the communication and cultural needs of this population. The study was done as a follow up to treatment services received at the Minnesota Program. A total of 112 contacts and interview were conducted with former clients of the Program. (A few of the survey times were conducted with 90 clients.) The survey was designed to include emphasis of the following areas: length of sobriety, current use of alcohol/other drugs, use of self-help groups, client satisfaction with the Program and quality of life since treatment.

At the time of the survey, 58% of the clients reported being sober; 8% were not sure of their status (some information comes from referral sources, family and other persons involved with the client) and 34% indicated that they had relapsed. [Figure 1]. The last reported use of mood altering chemicals ranged from one week to six months. Related specifically to alcohol use, 48% of individuals reported no use, 15% reported weekly use; daily use was reported by 10%. But related to the use of marijuana, 69% of the individuals contacted reported no use. [Figure 2]

When former clients were asked about support for their recovery, 34% of the clients reported some contact with a sponsor from a Twelve Step program. Many also reported getting support in their recovery from family and from friends. However, 57% of clients reported some attendance at AA/NA meetings ranging from daily to monthly. Fifty percent of the respondents indicated participation in individual counseling and only 17% were involved in some kind of family counseling. [Figure 3] These responses may be indicative of the difficulty still being faced by deaf and hard of hearing persons in accessing traditional support fro recovery. Sponsors who are

deaf, hard of hearing or who can communicate in sign language continue to be difficult to find. Accessible Twelve Step meetings have become more available in large metropolitan communities but continue to be seriously lacking or nonexistent in other communities. The situation seems to be similar related to agencies or individuals who are able to provide accessible counseling services.

Eighty-seven of the individuals reported that they perceived their treatment at the MCDPDHHI as having contributed to their success in achieving sobriety. Seventy-nine percent also reported the belief that their problems prior to treatment were related to their use of alcohol/drugs. [Figure 4] After treatment, most of the respondents indicated a general improvement with specific improvement in various life areas: 67% reported improvement in home/school/work; 71% reported improvement related to family/friends; 58% reported financial improvements; 74% reported improvements in the area of health. [Figures 5 & 6] Forty-nine percent of clients indicated that they have changed friends since treatment. [Figure 7]

In the areas of employment, responses were largely negative with the majority of the former clients (57%) continuing to be unemployed. Most were also not in school. [Figure 8] A number of these former clients (25%) continued to live at home with their parents or other relatives even though all were adults. [Figure 9] Even when the client had relapsed and returned to negative behaviors such as abuse, theft and lack of respect, he/she was allowed to continue to remain in a family member□s home. As previously stated, there appears top be only minimal use of family therapy in these situations. This information seems to point to the need for ongoing sharing of information with family members, friends and professionals who work with deaf and hard of hearing people who are chemically dependent. Changes in these systems (family, school, work, social services) could help to encourage clients to utilize the information and skills learned in treatment.

This study seems to reinforce the idea that traditional sources of support and encouragement for hearing people working on recovery are seriously lacking for deaf and hard of hearing persons. Lack of accessible AA/NA meetings, difficulty in obtaining a sponsor, lack of accessible

communication with sponsors and limited choices for socializing within the Deaf Community point to the shortage of traditionally perceive supports. The study also points out the apparent tendency of these clients to be unemployed following treatment. Several explanations can be proposed including a lack of adequate training on the part of the individual, lack of motivation for working (as opposed to being supported by SSI or other forms of public assistance), lack of available jobs, or some form of discrimination based on the deafness and/or the addiction. It is beyond the scope of this study to predict employment activity in a longer period after treatment. However, it seems that a connection with vocational rehabilitation services would be helpful, particularly if the individual has access to a rehabilitation counselor with some understanding of the disease of chemical dependency.

Relapse Prevention Groups

Just as group work can be very therapeutic in the treatment setting, it can also provide ongoing support and education related to relapse prevention. St. Paul Regions Medical Center□s Health and Wellness Program runs a relapse prevention group for persons who are deaf or hard of hearing. Kristen Swan, L.P., facilitates the group and offers suggestions for ways in which such a group can be successful. She feels that firm rules and boundaries about gossip, confidentiality and chemical use should be in place. Education in this area is especially important as the expectation of confidentiality runs counter to the cultural grapevine in the Deaf Community. Confidentiality, however, is essential in building trust. Recovering persons in this kind of group should be encouraged to have several sponsors, possibly including some individuals who are hearing. The tendency to get on deaf sponsor often results in the person having no backup in a crisis. In these groups, co-facilitators may serve more in an advisory role and be less directive toward individual members. However, individuals therapy outside of the group setting should be encouraged when indicated. Education about the content and nature of feedback is also often necessary. Feedback in this kind of group should include affirmations and comment about individual strengths as well as areas that may be relapse warning signs.

The relapse prevention group leader should also have a clear idea about the topic or goal for each group session. Continued work based on the Twelve Steps of Alcoholics Anonymous helps them

continue to access Twelve Step meetings. In addition, the group should provide education about the relapse process, myths about relapse, progression of the disease (chemical dependency), consequences of use, and substitute addictions or compulsions. Group members can be helped to recognize patterns in their behavior, both positive and negative. Identification and utilization of safe places and sober social activities can also happen in the group context. Additional related topics may also be addressed in the group such as: social skills, relationship building, assertiveness skills, decision making/problem solving skills, conflict resolution skills, help seeking skills, independent living skills services and recreational skill development. (Swan, 1992).

Relapse Prevention Materials

The Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals consistently recommends a strong aftercare program as part of the recovery process. Twelve Step meetings, counseling, obtaining a sponsor, aftercare meetings and other support groups are a part of the aftercare recommendations. However, many deaf and hard of hearing clients return to home areas where there are few if any recovering deaf people and few if any service providers who are knowledgeable and skilled in working with the assistance of a counselor or therapist. Program staff also continue to develop modified versions of this relapse work to accommodate clients with varying language levels. (Some examples of modifications are shown after the standard example from the Manual.) Part I of the manual identifies the process of relapse and discusses common warning signs. The list of warning signs includes signs described by common AA saying such as □Stinkin□ thinkin□□. Various warning signs are explained and the client is given an opportunity to write or draw examples of times he/she has experienced these signs. Part I also discusses disappointments, feeling, urges and thankfulness.

Example Task from Part I:

TREATMENT HIGH means□feeling very good when I leave treatment□

Many times people leave treatment feeling very good. This is called a treatment high. People are excited about being sober and new behaviors. We want to help other deaf people. We want to save the world. Later, this feeling may go away. Regular life can make sobriety very hard.

Sometimes, after treatment, being sober doesn□t feel good. Sometimes, we feel sad, lonely, disappointed, depressed, scared or angry.

NOW IT□S YOUR TURN!

Draw or write about how it feels to be sober. Tell about now and before. Tell about positive and negative feelings.

Negative *Positive*

Modified task from Part I:

Draw, I feel good about sober, why? (Draw 5 whys)

Draw, I feel bad about sober, why? (Draw 5 whys)

Part II of the Relapse Prevention Manual deals with feelings and healthy vs. unhealthy ways of dealing with feelings. This section covers resentments, anger, hurt, loneliness, grief, shame, jealousy and feeling good in recovery. The client is assisted in identifying feelings triggers that could lead to relapse.

Example from Part II:

LONELINESS means feeling like you are by yourself.

Being lonely means feeling left out. Being lonely means being isolated. Being lonely means being alone and unhappy about it. Sometimes recovering people feel alone with their problems. We think no one understands how we feel. We forget to talk to other people. We forget to ask for help. We begin to stay away from other people.

NOW IT□S YOUR TURN!

Draw about times you felt lonely. Show what you did.

Name people who can help you when you feel lonely.

Modified task from Part II:

The people who can help me sober at home, who?

Draw five people and live where?

Part III focuses on beliefs about self. It explains how we develop feelings and beliefs about ourselves. It assists clients in examining what triggers various negative thought and how behavior is connected to negative thinking. Clients then work with positive thinking in a similar manner.

Example from Part III:

Negative beliefs and behaviors can be a sign of relapse. Look at the sentences and then add your own.

I think I am a bad person----------so I break the low.

I feel jealous of my brother-----so I steal his shirt.

I□m afraid to meet new people---so I stay home and drink.

Now add your examples:

I _____ so I _____.

Modified Task from Part III:

Finish this sentence and say it every day!

I am good at _____.

Draw a picture of yourself. Show good thing about you!

Part IV encourages clients to explore various ways of having fun as a sober person. Clients are invited to recall instances of sober fun and to identify some new activities they would like to try by examining skills and interests. This section talks about boredom as a trigger for relapse and helps clients identify those times when boredom is likely to set in.

Example form Part IV:

Being bored can be a dangerous time. When we are bored, we begin to think

about our favorite using times. We know those memories can be from a long time ago. Those memories can be very powerful. It is important to think of things we enjoy doing sober. It is important to have ideas about what to do before we become bored.

NOW IT□S YOUR TURN!

Draw or write about things you like to do in your free time.

Tell about skills you have.

Part V discusses the importance of establishing and maintaining good health as a part of the recovery process. It examines the H.A.L.T. (Hungry, angry, lonely, tired) concept and ties those factors to sobriety. It encourages examination of eating and sleeping patterns and invites clients to set goals for changes they would like to make.

Example from Part V:

Chemicals in some foods can change our moods. Caffeine is a chemical is coffee, chocolate, tea and pop. Nicotine is a chemical in tobacco. Sugar is in many foods we eat. Caffeine, nicotine and sugar can change how we feel. It is important to know how much of these chemicals we use. It is important to know how they affect us. Write about how much of these chemical you take when you are using and when you are sober.

	USING	*SOBER*
Caffeine		
Nicotine		
Sugar		

The final section helps clients develop a prevention plan for relapse summarizing personal

relapse warning signs and identifying sources of support for when these triggers emerge. A relapse prevention contract form offers the opportunity for clients to contract with someone they trust, asking for feedback about relapse warning signs.

Encouraging Recovery

Recovery is a lifetime task and, while each individual must attend to his/her own recovery, concerned persons can make a contribution to encouraging recovery. The provision of specialized services across the continuum of prevention/education, intervention, treatment and aftercare is an important step. The slowly growing number of accessible AA meetings is also cause for hope. The following proactive suggestions by Kristen Swan, L.P., a counselor at St. Paul Regions Hospital□s Health and Wellness Program, can help to promote recovery as a healthy option.

*Encourage deaf and hard of hearing people to go to general AA area service meetings and be Group Service Representatives as a way of becoming more involved in the structure of AA.

*Provide inservice sessions for hearing leaders in AA to help them understand issues that deaf and hard of hearing people face.

*Encourage deaf people to go to their area deaf clubs and organize a □sober night□ on a regular basis.

*Assist in setting up interpreters for special interest support groups such as for gay/lesbian people, Native persons, African American persons, survivors and so on.

*Advocate for sober living environments such as sober houses or halfway houses.

Conclusion

While treatment is important in intervening in substance abuse, real recovery work begins after treatment. A part of that work involves the recognition and prevention of relapse. Many variables can influence relapse but the lack of accessible resources can be a major factor for deaf and hard of hearing people. Specialized materials which take into account the communication and cultural needs of deaf and hard of hearing persons can positively contribute to the process of recovery. Support services such as aftercare, vocational rehabilitation and self help groups can help to encourage ongoing pursuit of a recovering lifestyle but only if they can be accessed by the deaf or hard of hearing person. Substance abuse treatment services that meet the communication

and cultural needs of deaf and hard of hearing individuals are not enough. A continuum of education, prevention, treatment and aftercare services can help to ensure deaf and hard of hearing people the opportunity for recovery.

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