Are We Prepared to Hear Them All? Examining the Relationship Between Substance Abuse Counselors' Knowledge of the Models of Disability and the Self-Assessment of Their Cultural Competance Working with Deaf Sign-Language Users

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Abstract
This study examined the relationship between four specific models of disability and the substance abuse counselor’s (SAC) self-assessment of cultural competency when working with deaf sign-language users. Given the exploratory nature of the study, the researcher chose an interview strategy to collect qualitative data. The research question informing the study is: What is the relationship between SACs’ knowledge of the four models of disability and their self-assessment of cultural competency when working with deaf sign-language users? Qualitative data was collected from interviewing 10 substance abuse counselors. A particular effort was made to interview both hearing and deaf SACs, with varying experience working with deaf sign-language users. The researcher’s intent was to not test the effectiveness of therapeutic treatment. Analysis of the qualitative data utilized a content analysis approach that developed categorical dimensions to code the data. The researcher’s goal was to generate plausible hypotheses regarding the relationship between the SACs’ knowledge of the four models of disability and their self-assessment of cultural competence. A secondary purpose of this study was to enable the researcher to offer evidence-based recommendations for professional development for substance abuse counselors.

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Are We Prepared to Hear Them All?
Examining the Relationship Between Substance Abuse Counselors’ Knowledge of the Models of Disability and the Self-Assessment of Their Cultural Competence Working with Deaf Sign-Language Users

By
Angelia Smith Wilson

Submitted in partial fulfillment of the requirements for the degree Ed.D. in Executive Leadership

Supervised by
Dr. Jason Berman
Committee Member
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St. John Fisher College

August 2014
Dedication

I dedicate this body of work to my children, to show them to always dream BIG…

This research study has been a transformational endeavor for me, and I am truly grateful for almost every moment. There are so many to thank, but first and foremost, this has been a lesson of faith. So I give honor to God, who has provided me with insurmountable courage and staying power.

Now, to those earthly angels, and to one who has left this earth. Thank you, Dr. Karel, I miss your smile, your ease, and your laugh that feels like a hug. Thank you, Dr. Berman, for being the best Chair in the world. Dr. Carpino, thank you for stepping in and bringing such value and expertise.

Next in line, my children: Kalen, Nya, and Taylor. Kalen, thank you for your silent praise; thank you, Nya, for giving me a distraction when I needed one; and thank you, Taylor, for always being excited to go to the library.

For the one who saw the doubtful and fearful Angelia, but never allowed me to stay in those places, Charles (Mr. Kenny), thank you for being my backbone when times were rough. I love you.

For my girlfriends, Rochelle, Tara, and Dr. Tracey, thank you all for the sister-girl power. Rochelle and Tara, I know you didn’t understand the journey at times, but thank you for encouraging me in your own unique ways.

Last, but certainly not least, a special thanks to my family, Mother, Berince, Sharon, Van, Greg, and Ken. Thank you all for your cheerleading. My DEXL family,
Unity, thank you all for being some of the smartest people I know and for sharing this journey with me.
Biographical Sketch

Angelia Smith is currently a full-time faculty member at Monroe Community College in the Human Services/Addictions Department. Ms. Smith attended the State University of New York at Brockport from 1989 to 1993 and graduated with a Bachelor of Science degree in Psychology in 1993. She attended Roberts Wesleyan College from 2002 to 2005 and graduated with a Master’s degree in Social Work in 2005. She came to St. John Fisher College in the summer of 2012 and began doctoral studies in the Ed.D. program in Executive Leadership. Ms. Smith pursued her research in Examining the Relationship Between Substance Abuse Counselors’ Knowledge of the Models of Disability and the Self-Assessment of Their Cultural Competence Working with Deaf Sign-Language Users under the direction of Dr. Jason Berman and Dr. Peter Carpino and received the Ed.D. degree in 2014.
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Qualitative data was collected from interviewing 10 substance abuse counselors. A particular effort was made to interview both hearing and deaf SACs, with varying experience working with deaf sign-language users. The researcher’s intent was to not test the effectiveness of therapeutic treatment. Analysis of the qualitative data utilized a content analysis approach that developed categorical dimensions to code the data. The researcher’s goal was to generate plausible hypotheses regarding the relationship between the SACs’ knowledge of the four models of disability and their self-assessment of cultural competence. A secondary purpose of this study was to enable the researcher to offer evidence-based recommendations for professional development for substance abuse counselors.
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Chapter 1: Introduction

Drug and alcohol dependence have long been major public health concerns for society as a whole. Substance use remains one of the greatest challenges facing any established nation. National inquiry on the treatment for drug abuse, dependence, and related problems dates back to the 1920s when, in the aftermath of the Harrison Anti-Narcotic Act, researchers were searching for more information on good medical practices for drug treatment. In 1915, in the political and social throes of the Progressive movement, Congress passed the Harrison Anti-Narcotic Act that imposed a tax on the sale and use of opium and opium derivatives and required physicians and pharmacists to register and report their prescriptions to the Department of the Treasury. Initially, the Harrison Act was designed as a taxing measure, but soon it introduced a secondary purpose of medical practices regulation. This regulation of physicians’ medical practices was highly controversial, but it did allow for drug addiction to be seen as an ailment that needed to be treated. As a result of the regulation, physicians had the authority to, in their own judgment, attempt to cure the patient’s habit or do what was necessary to break the habit. The Harrison Act marked the origin of a new United States policy that set out to control nonmedical use of narcotics, and that act evolved into the prohibition of nonmedical substance use and the regulation and control of medical substance use.

In the 21st century, the World Health Organization has estimated the attributable burden of disease from substance abuse in established market economies, like the U.S., conservatively at greater than 23% from tobacco, alcohol, and illicit drugs. The report did
not mention prescription drug abuse (World Health Report, 2002). Drug and alcohol dependence continues to be a major public health concern for society as a whole. Conservative estimates by the Alcohol, Drug Abuse and Mental Health Administration are that more than 10 million adult Americans, or about 5% of the population, are alcoholics, and another seven million have alcohol-abuse problems (Guthmann, 1996).

**Defining substance abuse.** The *Diagnostic and Statistical Manual of Mental Disorders* (4th edition) (DSM IV TR, 1994) defines substance dependence as “a maladaptive pattern of substance abuse, leading to clinically significant impairment or distress, as manifested by three (or more) of the . . . [criteria], occurring at any time in the same 12-month period” (DSM IV TR, 1994). The current *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) (DSM V TR, 2013) defines substance abuse as a maladaptive pattern of substance use with the elimination of the dependence criterion. The clinical threshold to be able to diagnosis dependency has been lowered to two of the now 11 criteria, which is up from the nine criteria previously listed in the DSM IV TR. The DSM V TR further delineates substance abuse by severity, rendering a mild (two to three criteria), moderate (four to five criteria), and severe (more than six criteria being met).

**Substance abuse economic implications on society.** Treating substance abuse disorders reaches beyond a specific definition and a code-able diagnostic system. Drug addiction is a complex disorder that can involve virtually every aspect of an individual’s functioning—in the family, at work and school, and in the community (National Institute on Drug Abuse, 2010). Substance abuse is a serious public health problem that imposes substantial economic costs on society (Wickizer, 2013). A number of studies specifically
outlined the “societal costs” attributed to substance abuse and addiction. A search of the literature reports the cost of substance abuse and addiction in the following categories:

- Premature mortality
- Crime costs, including police-protection costs, court costs, and incarceration
- Morbidity costs (decreased earnings or reduced housekeeping values)
- Health care costs
- Substance abuse treatment costs
- Other related costs, including nonmedical costs arising from motor vehicle accidents.

Cartwright (2007) explored the societal costs of drug abuse by using an economic lens to evaluate the societal factors of drug abuse. He grouped the societal costs in three ways: actuarial costs and health plans, social costs and cost-of-illness approaches, and service research costs. One approach to understanding the impact of the disease is to estimate its economic cost through cost-of-illness (COI) studies. The COI approach measures the economic burden of a disease and estimates the maximum amount that could potentially be saved or gained if the disease were eradicated (Wickizer, 2013). Rice (1990) conducted an early national COI study on substance abuse, which was followed by a more comprehensive national COI study jointly sponsored by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The NIDA/NIAAA study estimated the cost of alcohol abuse, alone, at $148 billion and drug abuse at $98 billion for 1992. Updated analyses estimated the 1998 cost of alcohol abuse and the 2002 cost of drug abuse, at $186 billion and $181 billion, respectively, on a national basis (NIDA/NIAAA, 2000, 2004). The economic cost to treat
substance abuse is enormous and continues to grow. The treatment of substance abuse is necessary. It helps individuals to stop using drugs; maintain a drug-free lifestyle; and achieves productive functioning in the family, at work, and in society (Volkow, NIDA, 2010). Treatment is also much less expensive than incarceration. For example, the average cost for one full year of a methadone-maintenance treatment is approximately $4,700 per patient, whereas one full year of imprisonment costs approximately $24,000 per person (NIDA, 2010).

**Elements of effective substance abuse treatment.** In 1999, the NIDA issued its “principles of effective treatment” in a series of documents that drew upon the nearly three decades of research funded by NIDA. These documents included research from previous NIDA studies, including NIDA-sponsored studies such as the Drug Abuse Reporting Program (1979–1981), the Treatment Outcome Prospective Study (1986–1988), and the Drug Abuse Treatment Outcome Studies (DATOS, 1990–1993); all of these studies have provided a comprehensive foundation for effective treatment (Taxman & Bouffard, 2003).

Effective treatment practices have also been consolidated in the form of clinical practice guidelines (Field & Lohr, 1990; Peters & Peyton, 1998), the most detailed of which is in the drug treatment field by the American Society of Addiction Medicine’s (ASAM) Principles of Addiction Medicine (American Society of Addiction Medicine, 1991; Lamb, Greenlick, & McCarty, 1998). The National Institute on Drug Abuse’s 13 principles of effective treatment for substance abuse is adapted from the American Society of Addiction Medicine (ASAM). The NIDA principles act as a guide and provide best practices that ensure a successful treatment setting and approach. Treatment for
substance abuse is delivered in many different settings using a variety of behavioral and pharmacological approaches. In the United States, more than 14,500 specialized drug-treatment facilities provide counseling, behavioral therapy, medication, case management, and other types of services to persons with substance abuse disorders (NIDA, 2010). Effective treatment programs typically incorporate NIDA principles in their treatment program and procedures.

The NIDA’s 13 effective principles address every aspect of substance abuse and its consequence; however, three principles directly address therapeutic practice of substance abuse treatment. Principle two, “no single treatment is appropriate for everyone”; principle four, “effective treatment attends to multiple needs of the individual, not just his or her drug abuse”; and principle six, “behavioral therapies including individual, family, or group counseling are the most commonly used forms of drug abuse,” assist in creating the therapeutic experience needed to engage an individual in treatment (NIDA, 2010). These principles help ensure that a successful therapeutic environment is created for the individual being treated for a substance abuse disorder. The principles further provide a foundation, along with the counselor’s training, for a successful counseling experience. The literature supports the notion of the principles as evidenced by recent studies that measured substance abuse counselors’ beliefs, philosophies, and knowledge (Taxman & Bouffard, 2003), counselors’ theoretical perspectives to application of service delivery (Poznanski & Mc Lennan, 1999), and the impact of demographic factors on variations of counselors’ treatment philosophy (Thombs & Osborn, 2001). All of these studies sought to add to the literature, with regard to the counseling experience, by attempting to link counselors’ perspectives,
philosophies, and application of a specific theory to the counselors’ effectiveness. Some of the initial research on the possibility of a relationship between counselor characteristics (including theoretical orientation) and counselor effectiveness dates back to the early 1960s, when Combs and Soper (1963) suggested that the “perceptual organization” of the counselors might influence their overall effectiveness (Taxman & Bouffard, 2003). The relationship between counselor characteristics, particularly treatment orientation, is critical to understanding the development and delivery of effective treatment services (Taxman & Bouffard, 2003). This fundamental concept is what helps to ensure that NIDA principle two, that “no single treatment approach is appropriate for all,” is achieved when counselors seek to understand this critical relationship.

**Substance abuse and the general population.** In 2012, an estimated 22.2 million Americans aged 12 or older were classified with a dependence on, or abuse of, either alcohol or illicit drugs (8.5% of the total population). Of these, 2.8 million were classified with dependence or abuse of alcohol and illicit drugs; 4.5 million had dependence or abuse of illicit drugs but not alcohol; and 14.9 million had dependence or abuse of alcohol but not illicit drugs. Overall, 17.7 million people had alcohol dependence or abuse and 7.3 million had illicit drug dependence or abuse (SAMHSA, 2013). In 2012, an estimated 2.5 million people aged 12 or older received some kind of treatment for a problem related to the use of alcohol or illicit drugs in the 12 months prior to being interviewed in 2011 (SAMHSA, 2013). In 2012, an estimated 20.6 million people aged 12 or older (7.9 % of the total population) needed treatment for illicit drug abuse problems (SAMHSA, 2013).
**Substance abuse and the deaf and hard-of-hearing population.** Empirical research regarding substance abuse and the deaf and hard-of-hearing population began to surface in the literature around 1930–1940, with the bulk of the studies starting in the late 1950s. In its infancy, research in this area focused on defining substance abuse in the deaf population in three areas: unveiling the hidden problem of substance abuse in the deaf and hard-of-hearing population; the collection of demographics of the deaf substance abuser; and identifying some initial variables that may impact substance abuse treatment for the deaf and hard-of-hearing client.

The literature reveals that little research has been done to accurately identify the level of substance abuse among deaf people (Guthmann, 2006). Research methods developed to gather this information in hearing communities are often ineffective among deaf people for a variety of reasons including distrust of predominantly hearing researchers, fear of ostracism and labeling, and the inaccessibility of assessment instruments due to language limitations (Guthmann, 2006).

Steitler (1984) estimated more than one million deaf Americans need substance abuse counseling, while other investigators report incidence levels ranging from seven to 20. Many think that the true extent of alcohol and drug abuse in this population is underestimated; however, most writers believe that the prevalence of abuse in the deaf population is at least as high as the prevalence in the hearing population (Boros, 1981; Dixon, 1987; Ferrell & George, 1984; Guthmann, 1996; McCrone, 1982). Hearing researchers, often unaware of the Deaf community, overlook it in their research efforts (Guthmann, Sanberg, & Dickinson, 2010).
Substance abuse addiction professionals who work with people with disabilities, where the deaf and hard-of-hearing population is often grouped, continue to face a number of unique issues. To engage effectively in a counseling relationship with a client who is deaf, it is necessary to examine the counselors’ views and biases related to groups that are different from his or her own (Sue & Sue, 2003).

Several authors reported that the best way to become aware of, appreciate, and accept the Deaf culture, as with all cultures, is through exposure (Lane et al., 1996; Scheetz, 2004; Williams & Abeles, 2004). As a profession grows and evolves, so do many of its practices and standards. Professionals who work with deaf and hard-of-hearing individuals have grown from being a relatively small group of service providers to a full complement of specialists in a wide range of human services areas. There is more demand than ever for specialized programs related to mental health, addiction treatment, independent living, education, and recreation for the deaf and hard-of-hearing population (Guthmann, 2006). Cooper et al. (2004), in their survey of mental health professionals’ attitudes toward deaf clients, found that the professionals who were comfortable working with these clients had received some training in issues related to individuals who were deaf. As the service provider continuum of services continues to expand for the deaf population, it is anticipated that the number of professionals who serve this population will need to become more knowledge rich about the disability community in general. The effectiveness of treatment depends, to a large extent, on the staff providing the services (Taxman & Bouffard, 2003). Based upon the current state of addiction literature regarding the deaf and hard-of-hearing population, addiction
professionals who provide treatment services to the deaf and hard-of-hearing population will need to develop additional skills to become competent in serving this population.

**Problem Statement**

Substance abuse continues to impact millions of people each year, with the number continuing to grow. Several researchers have reported that the prevalence in the deaf and hard-of-hearing population is similar to the hearing population. Substance abuse (dependency) can be a devastating yet treatable condition, where livable recovery is possible. The field of addiction needs to address the disparities that exist in the delivery of services to the deaf and hard-of-hearing substance abusing population.

The issue of substance abuse within the Deaf and hard-of-hearing community and the need for appropriate treatment surfaced in the literature more than 30 years ago (Guthmann & Titus, 2010). Despite the initial interest, the past three decades have witnessed very little progress made in addressing substance abuse and treatment for deaf and hard-of-hearing people (Guthmann & Titus, 2010). In addition to the insufficient data on the drug abuse problem among deaf and hard-of-hearing persons, typical treatment and recovery resources pose barriers to these individuals. The evidence supports the need for substance abuse treatment in the deaf population. One could purport a variety of reasons as to why there is sparse information related to deaf and hard-of-hearing population. The problem is there are no studies that examine the relationship between the substance abuse therapists’ knowledge of the models of disability and their self-assessment of cultural competency working with deaf sign-language users. Further examination of this area might explain the lack of literature and generate more research. Individuals who are deaf can experience their first barrier to treatment when they go to
have an assessment for a potential substance abuse problem. Many hearing substance abuse counselors are not proficient in sign language and thereby unable to communicate effectively with the deaf substance abuser. A 1996 study conducted by the Minnesota Chemical Dependency Program for the Deaf and Hard of Hearing, concluded that training programs need to be established for vocational rehabilitation counselors, social workers, chemical health assessors, teachers, administrators, psychologists, and mental health counselors serving the deaf and hearing individuals. This training should focus on the unique considerations related to this population (Guthmann, 2006).

**Americans with Disabilities Act.** The Americans with Disabilities Act (1990, revision, 2008), a critical piece of civil rights legislation, continues to be a driving force behind improving the lives of individuals who have disabilities. The research that has been conducted over the past 35 years continues to support continued research in the area of health care delivery in general to the deaf population. All Americans continue to face access and other barrier issues with regard to health care, but service delivery to the deaf population (part of the disabled population) has not shown a marked improvement since the passage of ADA.

The ADA guarantees that all individuals with disabilities receive the same level of care as able individuals. Harmer (1999) analyzed health care delivery and deaf people with regard to physician attitude and awareness of the Disabilities Act. She found that practicing physicians demonstrated an extraordinary level of ignorance about the doctor’s obligation under the legislation. Harmer further explored the initial research proposed by Lane (1988) who reviewed the literature between 1967 and 1987 that was written by perceived experts on deafness, which helped to shape the minds and train future doctors,
teachers, and others working with the deaf population. The previous reviews by Lane supported the notion that doctors presented with a paternalistic attitude toward the deaf patient.

During their medical education, physicians typically receive training on the pathology of hearing loss and, as a result, tend to treat deaf patients in a way that can be interpreted as paternalistic (Harmer, 1999). Research reviewed by Pollard (1996) contended that, as a result of trying to normalize the patient, these efforts affected the accessibility, quality and ethics of care, and the patient’s opportunity to participate in and consent to appropriate health services (Harmer, 1999).

Medical professionals attend academic institutions to receive training that will provide them with the skills necessary to work with a diverse group of people and cultures. The literature supports the notion of a lack of clarity in the general population with regard to a definition of the Deaf culture, and this is illustrated in the medical training of physicians as well. Harmer postulated that if the health care provider continues to fail to recognize that some of the norms in the Deaf culture are different from those held by the hearing community, inaccurate assumptions about the deaf patient will continue to happen (Harmer, 1999). These assumptions only add to the stigmatization of drug addiction. It is imperative that substance abuse counselors have foundational knowledge about the deaf or the Deaf community as well as the levels of diversity within that community.

**Deafness and Deaf culture.** Practitioners who provide services to the deaf often are unaware of Deaf culture and the Deaf community. To engage effectively in a counseling relationship with a client who is deaf, it is necessary to examine the
counselor’s views and biases related to the groups that are different from the counselor (Peters, 2010). Several authors reported that the best way to become aware of, appreciate, and accept the Deaf culture, as with all cultures, is through exposure (Lane et al., 1996; Scheetz, 2004; Williams & Ables, 2004). It is critical that those who work with the deaf not only have exposure to Deaf culture but have an understanding of their perception of defining deafness. Cooper, Rose, & Mason (2004), in their survey of mental health professionals’ attitudes toward deaf clients, found that the professionals who were comfortable working with these clients had received some training in issues related to individuals who were deaf.

**Theoretical Rationale**

The Americans with Disabilities Act (1990, 2008) defines and categorizes deafness as a disability. According to the ADA, with respect to an individual, the term disability means: (a) a physical or mental impairment that substantially limits one or more major life activities of such individual, (b) a record of such impairment, and (c) being regarded as having such an impairment (ADA, 2008).

Deafness is not merely the absence of hearing (Peters, 2010). Until 25 years ago, academic literature addressing deafness typically described deafness as pathology, focusing on cures or mitigation of the perceived handicap (Peters, 2010). In order to provide ethical and effective services to clients with disabilities (including deafness), substance abuse counseling professionals need to be aware of how they conceptualize the experience of disability. The literature currently supports four models of disability: biomedical, functional, environmental, and the sociopolitical. These four models of
disability will provide the conceptual framework for this research study, as they offer insight on the experience and culture of disability.

**Biomedical model.** The biomedical model of disability is a long-standing, well-established medical model supported by the medical profession. This model is rooted in the scientific model and has very much shaped the public views on disability. The strength of the biomedical model lies in its strong explanatory power, which far exceeds any other model. This model defines disability in the language of medicine, lending scientific credibility to the idea that disabilities are wholly an individual experience (Smart & Smart, 2006). There is no mention of social justice within this model due to the “individualization,” “privatization,” and “medicalization” of the word disability. The biomedical model is categorized as being a non-interactional model, because the nature of the “problem” or disability lies within the individual with the disability (Smart & Smart, 2006).

The underlying assumption in the biomedical model is that pathology is present and disabilities are objective conditions that exist in and of themselves (Smart & Smart, 2006). This conceptualization of pathology being connected to the disability opens the door to the possibility of dehumanizing the disabled person because attention is focused on the supposed pathology (Albrecht, 1992; Longmore, 1995). The model considers a disability to produce biological inferiority, malfunction, pathology, and deviance when compared with individuals without disabilities (McCarthy, 1993).

This extreme lends itself to medical professionals categorizing deafness as a pathology and interacting with deaf patients in a paternalistic manner. The biomedical model places people with disabilities in stigmatizing categories, therefore allowing the
“general public” to view them as their category: “blind,” “quads” (individuals with quadriplegia), and “the mentally ill” (Nagi, 1969). One can easily add the category of “deaf people” as another category. Once categorized, people are seen as their category and not as individuals. Schur (1971) described the effects of categorization as devalued and stigmatized people, where individual qualities and actions become secondary. This categorization by disability type has had many pervasive, institutional, and systematic consequences, some of which have resulted in inferior services or lack of services from counseling professions. In addition, this categorization has fragmented people with disabilities from their own community and robbed them of a collective history (Hahn, 1985, 1988, 1993).

The categorization of persons with disabilities has taught and continues to teach society to focus on the disability category rather than the universal problems and challenges faced by people with all types of disabilities. In this model, the disability exists totally within the individual and, accordingly, the individual who is responsible for the “problem” should also be totally responsible for the solution (Kiesler, 1999). Not only does the biomedical model legitimize prejudice and discrimination but, to the general public, its treatment of people with disabilities often does not appear to be prejudicial and stigmatizing (Smart & Smart, 2006).

Functional model of disability. Unlike the biomedical model of disability, the functional model of disability is an interactional model that considers the function of the individual (Smart & Smart, 2006). In this model, biology becomes less important and the individuals’ “functional” abilities are highlighted. Disability is defined in relation to the skills, abilities, and achievements of the individual in addition to the biological/organic
factors (Smart & Smart, 2006). This model underscores some of the basic tenets of counseling such as focusing on an individual’s strength.

The functional model defines disability, the causal attribution, and the solution attribution, which is not found wholly within the individual (or his or her disability). Therefore, the “problem” is not the disability, but it suggests that many of the difficulties are located outside the individual, especially within the environment and its functional requirements (Wolfensberger, 1972). This interactional premise is the foundation of the functional model and is closely related to the theoretical assumption and practice orientations of most counselors (Smart & Smart, 2006).

While the biomedical model “categorizes” individuals with disabilities and does not allow for individual qualities to be valued, the functional model views the client as a complete person. Seeing the client as a complete person with individual skills and abilities and allows the counselor to see the client as more than a disability. Because an individual’s cultural identification defines his or her functions, roles, and environment to a great extent, the functional model provides a better basis from which to understand and respond to the disabilities experienced by individuals who are not white, middle-class, heterosexual, male, or Euro-American (D.W. Smart & Smart, 1997b; J. F. Smart & Smart, 1997). The functional model allows for a broader, multicultural approach to counseling diverse persons with disabilities.

Environmental model of disability. The environmental model of disability addresses the very nature of the environment that surrounds a person with a disability. Disadvantages or limitations, such as poverty or lack of education, has an influence on the persons with disabilities. This model is an interactive model because the disability (of
the individual) interacts with functions and environment (Dembo, 1982; Tanebaum, 1986; Thomason, Burton, & Hyatt, 1998).

The environmental model of disability posits that society can cause disabilities, exaggerate disabilities and, in the words of some disability scholars, “make disabilities” (Higgins, 1992). Itzhak Perlman, the world-famous violinist and polio survivor, said that people with disabilities experience two problems: (a) the physical inaccessibility of the environment, and (b) the attitudes of the people with disabilities toward a disability and the people with disabilities (Smart, 2004). If the location of the problem shifts, the onus for the solution of the problem also shifts. By viewing the definition, the cause, and the difficulties of disability as interactional, helping professionals can aim interventions at adapting the environment and functional demands to the needs of the individual with a disability in addition to “rehabilitating” the individual.

There is a tendency to think that each individual’s environment and functions are exclusively unique to that individual. However, broad, general changes in both environment and function can affect the daily life of an individual with a disability. Thus, by viewing individuals as more than their disability and conceptualizing the environment and the functional requirements as major determinants of the difficulties experienced by people with disabilities, the fear of acquiring a disability will be greatly reduced.

**Sociopolitical model of disability.** The sociopolitical model (in contrast to the biomedical, environmental, and functional models) describes more of the day-to-day lives of people with disabilities. This model is the most recently developed and, more importantly, is a fundamental and radical change from the previous models. In this model, people with disabilities view themselves as members of a U.S. minority group.
The hallmarks of this model include self-definition, self-determination, the elimination (or reduction) of the prejudice, discrimination (sometimes referred to as “handicaps”), rejection of medical diagnoses and categories, and the drive to achieve full equality and civil rights under the U.S. law (Smart & Smart, 2006).

The sociopolitical model does not accept the inferiority, categorizing, or stigmatization of disability. Disability in this model is defined as a social construction of society’s view of disability and has nothing to do with the disability itself. Stigmatization, prejudice, discrimination, inferiority, and not being handicapped are not inevitable, natural, or unavoidable consequences of disabilities. The sociopolitical models have three aspects that are included in conceptualizing disability: (a) people with disabilities must define disability; (b) people with disabilities must refuse to allow “experts” or “professionals” to define the disability, determine the outcomes of their lives, or judge the quality of their lives; and (c) people with disabilities must refuse the “disabled role” of deviance and pathology (Smart & Smart, 2006).

The sociopolitical model purports that disabled individuals, in the past, were forced to accept their disabled role. The new model refuses to accept the categorization of disability, which is the source of much prejudice and discrimination. According to the sociopolitical model, the categorization has resulted in: (a) teaching individuals who bear diagnoses to accept the meanings of these labels as their self-identity, (b) allowing the general public to avoid focusing on the universal problems of people with all types of disabilities, (c) fragmenting the disabled community so that it cannot form broad coalitions with which to effect sociopolitical changes (d) leading “society” to believe that
disability is inferiority and that prejudice and discrimination toward people with disabilities are inevitable consequences of the inferiority (Smart & Smart, 2006).

Individuals who support the sociopolitical model suggest that the discrimination and prejudice that individuals with disabilities face is ingrained into the American way of life. The ADA (1990) further asserts that “unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress discrimination” (p. 5).

**Statement of Purpose**

This study seeks to examine the relationship between four specific models of disability and the substance abuse counselor’s (SAC) self-assessment of cultural competency working with deaf sign-language users. As mentioned earlier, that the best way to become aware of, appreciate, and accept the Deaf culture, as with all cultures, is through exposure. The National Association of Social Worker’s (NASW) (2008) *Code of Ethics* regards cultural competence as a fundamental ethical standard for social work in all settings. The current health literature indicates that there is ambiguity regarding cultural competence as a construct, how it is operationalized in health interventions, and whether it improves health outcomes (Horevitz, Lawson, & Chow, 2013). Cultural competence has emerged, though, as a strategy to deal with these individual differences and reduce misunderstandings and impactfully affect the treatment and outcomes of diverse patients (Horevitz et al., 2013).

This research study is warranted because it is the responsibility of the field of substance abuse counseling to produce culturally competent counselors. The current
literature supports that there is no set way of doing this. This researcher believes that the introduction of the models of disability to the counselors’ knowledge base will enhance their preparation and training. In addition, due to the ambiguity in the field of health care in general as to what constitutes cultural competency, the researcher believes the models of disability can add clarity in helping substance abuse counselors examine cultural competency. The researcher further believes that the models may affect the substance abuse counselors’ self-assessment of cultural competence as the models would provide the lens or theoretical frame through which the counselors can examine their current conceptualization of cultural competence pertaining to counseling the Deaf. The researcher does not intend to prove whether therapy is effective, but rather to offer future opportunities for professional development for substance abuse counselors. These future professional development opportunities may include, but not be limited to, cultural competence training in providing culturally competent services to the deaf substance abuser.

Research Questions

The research question that has informed the study is “What is the relationship between substance abuse counselors’ knowledge of the four models of disability and their self-assessment of cultural competence working with the deaf sign-language user?”

Potential Significance of the Study

There is a gap in the literature with respect to the models of disability and the substance abuse counselor’s self-assessment of cultural competence working with deaf sign-language users. Much of the literature supports the notion that substance abuse in the Deaf community is close to that of the general population, but very little is known about
the treatment experience of the deaf substance abuser. Even less information is presented in the literature with regard to the substance abuse counselors who are charged with counselling the deaf. The researcher hopes to generate plausible hypotheses regarding the relationship between the SACs’ knowledge of the four models of disability and their self-assessment of cultural competence. A secondary purpose of this study is to enable the researcher to offer evidence-based recommendations for substance abuse counseling professional development.

A limitation of the study is that the researcher is only seeking to better understand intended practices of the substance abuse counselor; the researcher is not looking to prove whether therapy is effective. A further limitation acknowledges that, in examining the assessment of cultural competence working with the deaf population, the researcher should consider the deaf client perspective and perceptions, which is only presented in this study through the literature, not personal accounts from deaf clients. This is an area that can be explored in future research studies.

Definitions of Terms

*Americans with Disability Act* – An act designed to provide rights to those citizens classified as disabled. The Act further provides legal protection for those individuals deemed disabled for any form of discrimination. (ADA, 1980, 2008).

*Cultural Awareness* – Developing sensitivity and understanding of another ethnic group. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness must be supplemented with cultural knowledge (Adams, 1995).
**Cultural Competence** – A set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations (NASW, 2008).

**Cultural Humility** – A construct for understanding and developing a process-oriented approach to competency (APA, CFY News, August 2013).

**Cultural Sensitivity** – Knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong to those cultural differences (National Maternal and Child Health Resource Center on Cultural Competency, 1997).

**Drug Dependence** – a means that a person needs a drug to function normally. (National Institute of Health, 2006).

**Drug Abuse** – Used interchangeably with the term addiction. A chronic, relapsing disease characterized by compulsive drug seeking and use and by long-lasting changes in the brain. (National Institute of Drug Abuse, 2013).

**Hard of Hearing** – Persons who either have no difficulty hearing normal conversation but do wear a hearing aid or have some difficulty hearing normal conversation (regardless of hearing aid) (Mitchell, 2005).

**Substance abuse** – A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one or more of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance...
related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired)
- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
- Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

(Diagnostic and Statistical Manual, 4th edition)

Substance abuse treatment – Treatment intended to help individuals stop compulsive drug seeking and use.

Substance Abuse and Mental Health Services (SAMHSA) – Branch of the United States Department of Health and Human Services that works to improve the quality and availability of substance abuse prevention, alcohol and drug addiction treatment, and mental health services (SAMHSA, 1970).

World Health Organization (WHO) – the directing and coordinating authority for health within the United Nations system. It provides global direction in combatting disease and issues that impact overall health (World Health Organization).

Chapter Summary

This chapter provided an overview of the problem, purpose, research questions, and study significance. The chapter closed with a definition of terms for review and facilitating clarification of the topic. Subsequent chapters provide a review of literature
(Chapter 2), research design and methodology (Chapter 3), and a discussion of the findings (Chapter 4). The dissertation concludes with a discussion of the implications as well as recommendations for future practice (Chapter 5).
Chapter 2: Review of the Literature

Introduction and Purpose

This chapter addresses the current literature on substance abuse and the deaf and hard-of-hearing population. The examination of the literature will be presented in three sections. The first section discusses substance abuse and the deaf/hard-of-hearing population. The next section addresses the various perspectives that define deafness, frameworks to examine deafness (disability models), and barriers that the Deaf community face. The final section discusses literature on counselors’ perceptions, beliefs and attitudes towards working with persons with disabilities, including deaf people.

Substance abuse and the deaf and hard of hearing. Empirical research regarding substance abuse and the deaf and hard-of-hearing population began to surface in the literature around 1930-1940. In its infancy, research in this area focused on defining substance abuse in the deaf population. The research has since evolved to unveiling the hidden problem of substance abuse in the deaf and hard-of-hearing population, and the lack of the collection of demographics of the deaf substance abuser as well as identifying some initial variables that may impact substance abuse treatment for the deaf and hard-of-hearing client. Guthmann (2001) reports that there have been few attempts to conduct prevalence studies to determine the incidence of substance abuse in the Deaf community. McCrone (1994) projected the presence of approximately 3,505 deaf heroin users, 31,915 deaf cocaine users, 5,105 deaf crack users, and 97,745 deaf marijuana users in the United States. These figures, collected in 1992, may not represent
the enormity of substance abuse and the deaf population because they are based on data collected by the U.S. Department of Justice overall illicit drug use with the assumption that deaf people represent 0.5% of the general population (Guthmann, 2001). The issue that consistently impedes the reporting of the accuracy of deaf substance abuse statistics is the collection of deaf substance abuse data. Deaf people present a challenge in terms of the provision of alcohol and other drug treatment services due to their unique cultural profile and numerous communication accessibility issues (Sandberg, 1998). The review of the literature does support advances in the field with regards to the collection of deaf and hard-of-hearing data using new technology; however, it does not totally eliminate the confounding variables in a manner that would enrich the credibility of the deaf/hard of hearing substance abuse data. The literature revealed that little research has been done to accurately identify the level of substance abuse among deaf people (Guthmann, 2006). Research methods developed to gather this information in hearing communities are often ineffective among deaf people for a variety of reasons which include distrust of predominantly hearing researchers, fear of ostracism and labeling, and the inaccessibility of assessment instruments due to language limitations (Guthmann, 2006). Most professionals familiar with substance abuse and deafness identify a level of substance abuse within Deaf communities that is equal to that of the rest of the population (Sanberg, 1998). The impact of substance abuse in the deaf and hard of hearing is apparent and those impacted are just as in need of treatment as the hearing population.

Guthmann (2006) examined a variety of demographic, attitudinal, and other background variables that predict an impact on the treatment outcomes of the deaf and hard-of-hearing substance abuser. At the time of the study, there was no other program
similar to The Minnesota Chemical Dependency Program for the Deaf and Hard of Hearing Individuals (MCDPDHHI); the research consisted of a formative evaluation study.

The MCDPDHHI, a model hospital-based inpatient treatment program, receives funding from the Center for Substance Abuse Treatment and the Office for Special Education and Rehabilitation Services (Guthmann, 2006). Since its opening in March 1989, until August 1996, 516 clients have been served (Guthmann, 2006). The sample size consisted of less than 400 who had been admitted to the program since 1989, which proved to be a limitation of the study because the results could not be generalized across the deaf population. The MCDPDHHI study supports the current state of literature by confirming that minimal research exists related to the incidence of substance abuse within the deaf and hard-of-hearing communities. The study further supports that substance abuse is apparent in the deaf and hard-of-hearing community and that treatment options need to be further explored as well as the many variables that impact treatment outcomes for this underserved population.

**Defining deafness.** Deafness has multiple definitions and multiple meanings. The many definitions and meanings reveal various ideological, disciplinary, and cultural understandings of deafness. The distinction of the capital “D” (Deaf) versus the lowercase “d” (deaf) differentiates the cultural identity (D) from the physiological meaning (d) of deafness. This separation of audiological issues (measuring hearing levels, deaf, and hearing) from socialization, acculturation, and identity helps one to better understand the confusing issues of “Deaf or deaf.” This distinction has formed the foundation of the cultural definition of deafness, as well as informing the medical model
of deafness. Pre-lingual deafness refers to deafness that occurs prior to the individual’s acquisition of a first language and includes deafness at birth through 3 years old. Prevocational deafness, as used by Schein (1992), refers to deafness prior to the age of 19 and occurs at roughly twice the rate of pre-lingual deafness. These specialized definitions help one to understand why someone who loses his/her hearing later in life, might be considered “deaf” but not “Deaf.” It is important to understand these definitions because the various definitions assist in discussing the Deaf community.

The Survey of Income and Program (SIPP) is a national survey that regularly collects data identifying the American population of persons with hearing loss or deafness. The latest SIPP estimates are that 10 million people are hard of hearing and close to one million are functionally deaf. From the SIPP perspective, persons who are hard of hearing are those who have the ability to hear but require hearing aid devices.

**Deaf community.** The Survey of Income and Program (SIPP) illustrates that there is a sizable Deaf community. Community is the cornerstone of an individual’s life; it helps in forming the basis of an individual’s identity. The “representation of the self” is the classical way of describing identity (Baumeister, 1997); being a member of a community solidifies an individual’s identity. It is difficult to get an accurate estimate of the Deaf community (Padden & Humphries, 1988; Steinberg, 1991) as one does not have to be deaf in order to be deaf (Padden & Humphries). An individual can be “deaf,” meaning having an audiological impairment, or “Deaf,” meaning a person who identifies as being a member of a cultural group (Padden & Humphries, 1988).

Culture is an element of any community. A group of people is considered to have a culture if they have four attributes: a language that is unique to that group, learned rules
for behavior, values, and traditions (Padden, 1980). Deaf people have a culture; they have a language, exclusive behaviors, and values as well as traditions (Annual Deaf Awareness Week). While deafness historically has been labeled a disability, most deaf adults see themselves as members of a unique, non-disabled culture. The Deaf culture does not consider deafness as a handicap (Lane et al., 1996; Padden & Humphries, 1988).

**Deafhood.** Further infusing Deaf culture and Deaf community is the concept of Deafhood. Deafhood is a concept that aims to disrupt medically oriented and oppressive discourses by offering a deaf-constructed model that grows out of deaf people’s own ontologies (i.e., deaf ways of being in the world), emphasizing positive, experience-oriented views of deaf people (Ladd, 2003). Paddy Ladd’s book *Understanding Deaf Culture: In Search of Deafhood*, was to the Deaf community what feminism brought to the Women’s Movement. Kusters and Meulder (2013) discusses that “deafhood, feminist theories, and ontologies have been powerful toward self-exploration and activism.” The Deafhood concept is used as a “deconstructive tool for a more efficient analysis of oppression.”

**Being deaf.** Deafness has for decades been described and understood as a major human deficit, and deaf persons have therefore been subjected to different medical-technical interventions and special treatment (Breivik, 2005). Being deaf is a biological characteristic, just like being Black or White, female or male. It is not a condition, it is a way of being (Whyte et al., 2012). Deaf people want to be acknowledged as belonging to a community and not necessarily the disabled community. Whyte et al. (2012) reports that it is living in a non-signing world that can be disabbling, not the experience of being deaf.
**Treatment access.** Access is an important factor in determining the effectiveness of health service delivery in that it represents the ease with which health services are initiated and sustained (McCaughrin & Howard, 1996). Accessing chemical dependency treatment and beginning a program of recovery presents many problems for any individual, but those who are chemically dependent, deaf, and hard of hearing face additional barriers to treatment and recovery (Lybarger, 2006). Research in the field of substance abuse has demonstrated that persons with disabilities (PWDs) are at substantially higher risk for substance abuse than persons without disabilities (Glazier & Kling, 2006; Krahan et al., 2004). Successful completion from substance abuse treatment for the general population has proved to be challenging. Attrition from treatment for substance abuse disorders is a persistent challenge that severely limits the effectiveness of service (Laudet, Stanick, & Sands, 2008). Examining the access barriers to treatment is a large part of the literature regarding persons with disabilities, including the Deaf and hard of hearing.

Krahan et al. (2004) examined access barriers to substance abuse treatment for persons with disabilities. This study explored the low rate of admittance to substance abuse program for persons with disabilities (Krahan et al., 2004). The study results were consistent with trends with regard to access to health care in general as it relates to persons with disabilities, which supports consistently and sustained low rates of admission to substance abuse treatment programs.

The study explored the potential reasons for the lower rate of SA treatment access by PWDs as compared with other Medicaid sub-populations and identified numerous potential barriers to treatment (Krahan et al., 2004). Variations in individual
characteristics, referral patterns, and treatment barriers of PWDs were all evident. Specific vulnerabilities and barriers of PWDs included lack of support from their social environment, lack of accommodations by treatment centers, agency limitations, inadequate reimbursement rates, dual-diagnosis demands, policies regarding psychoactive drug use, and stigmatization by clinicians and agency personnel (Krahan et al., 2004). Many factors listed are similar and can be generalized to the deaf and hard-of-hearing population.

Krahan et al. (2004) reported through a multiple perspective approach numerous potential barriers to treatment for persons with disabilities. Specific vulnerabilities and barriers of treatment prove to be consistent with the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health best-practice guide. The guide provides comprehensive standards for programs to use to provide the best treatment to persons with disabilities. Krahan et al. (2004) identified access barriers such as lack of accommodations by treatment centers and agency limitations among others. The study reports that substance abuse treatment professionals must pay close attention to the unique aspects of the lifestyle of PWDs, which may affect the outcomes of substance abuse treatment (Krahan et al., 2004). The literature suggests examining substance abuse treatment facilities in regards to providing services or access to services for persons with disabilities for which the deaf and hard-of-hearing population are categorized. The study supports the notion that it is important even for a substance abuse facility to consider the systemic culture of persons with disabilities.

West (2004) explored the accessibility of substance abuse treatment facilities in the United States for persons with disabilities. A stratified random sampling technique
was used for participant selection. Stratification was based on the 2000 U.S. census and was generated by region (i.e., Northeast, South, Midwest, and West) and the states within those regions to ensure representation within the sampling frame of facilities from all states regardless of total population or number of treatment providers (West, 2004). A total of 525 facilities from all 50 states and the District of Columbia make up the sample. A 105-item questionnaire regarding the accessibility of substance abuse treatment facilities; the utilization of policies, procedures, and personnel to facilitate the recovery of PWDs; and the number of PWDs receiving treatment services is used as the instrument. West’s (2004) findings reported that, with regard to accessibility standards mandated by the Federal statues, of the responding facilities (N = 134), 35 (20%) indicated that they did not have accessible parking spaces, 32 (20%) did not have accessible restrooms facilities, 38 (24%) indicated that their facilities did not meet guidelines for accessible hallways or doors, and 38 (24%) did not have fire alarms with both auditory and vision alerts. Most of the facilities (84%) did not have anyone on staff who knew how to use ASL or signed English (West, 2004).

Although the West study included relatively low 30% response rate, it highlighted a common limitation of persons with disabilities studies: access. Issues regarding accessibility that prevent PWDs from reaching treatment in the first place may be present not only in treatment but also in other domains (West, 2004). The literature suggests further consideration needs to be given to how individuals in general engage and remain engaged in substance abuse treatment.

Laudet et al. (2008) examined factors that may have an impact on an individual staying engaged in substance abuse treatment. Laudet et al. (2008) explored attrition from
treatment services which they conclude was a persistent challenge that severely limits the effectiveness of services. The purpose of the study examined the clients’ reasons for leaving treatment as well as what, if anything, could be done to retain those services. The study was conducted in the context of a prospective investigation of 12-step group participant after outpatient treatment (Laudet et al., 2008). Participants were recruited at two publicly funded, state licensed intensive outpatient treatment programs in New York City between September 2003 and December 2004 (Laudet et al., 2008).

The Laudet et al. (2008) study instrument consisted of standardized scales and open ended questions, collected through semi-structured interviews designed to obtain information about participants’ experiences and beliefs in their own words with regards to perception of effective treatment. The collective experience of the person in treatment predicts how engaged the person was in treatment and generally how long the person will remain in treatment. Longer participation in treatment was associated with stabilization and/or improvement in protective resources that, in turn, bolster the long-term effects of treatment and mediate part of its influence on remission from substance abuse up to 15 years later (Laudet et al., 2008).

The Laudet et al. (2008) study reported reasons why persons with disabilities leave treatment, including disliking the program, interference with other activities, substance use, practical considerations, not wanting help, personal issues, finances, and not finding the services helpful. Among the 33% of dropouts who said something could have been done differently to retain them in services, unmet social service needs was cited most (54.2%) followed by wanting more supportive staff and greater flexibility.
Key barriers to retention in this sample can be categorized into program- and client-related factors (Laudet et al., 2008).

It can be argued that clients who were treatment resistant or in denial may look for external reasons to drop out of services they do not really want, do not intend to complete, or from which they expected an immediate magical cure and were not willing to take responsibility for their actions. The previous study discussed why individuals leave treatment prior to the completion of treatment. The findings illustrated two distinctive patterns: individuals leave because of treatment-level program barriers or individual-level barriers. Pringle, Emptage, & Hubbard (2006) further explored unmet needs for comprehensive services in outpatient addiction treatment. Data for their study came from the Wrap-Around Services Impact Research Group (WASIS) that examined the use of appropriate wrap-around services. The literature regarding substance abuse and the deaf and hard-of-hearing population supported the inclusion of added support to the deaf/hard of hearing recovery process. The Pringle et al. (2006) study collected data between 1996 and 1999 from patients in nine outpatient addiction treatment programs in western Pennsylvania. The study observed a cohort of treatment patients prospectively through a specific episode of care. Assessments were conducted with participants shortly after their entry into treatment and at three months after their baseline assessment. There were 1,709 patients included in the WASIS baseline sample, with 1,003 patients followed up at the three-month assessment. Findings report that subjects needing services for psychosocial troubles (i.e., advisory legal, basic needs, and family services) were more often reported as needing health services (i.e., medical and mental health services), which provided support for a comprehensive service provision. McCaughrin and Howard (1996)
explored the area of access to treatment by examining how the aspects of the multidimensional concept of access influence the ease of initiating and sustaining treatment. Their study examined 326 non-methadone outpatient substance abuse treatment organizations. The conceptual domains of affordability and availability significantly predicted access to substance abuse treatment. They concluded that various factors play a significant role in predicting access to outpatient substance abuse treatment programs. The literature supports that access is certainly an issue that persons with disabilities face; a closer examination of the special populations reveals inconsistent data with regard to the true nature of the prevalence of substance abuse in the deaf and hard-of-hearing population.

Communication. The most common complaint of deaf people either in treatment or seeking treatment is problems with communication (Corker, 1994; Dickert, 1988; Freeman & Conoley, 1998; Lane, 1993; Roe & Roe, 1991; Vernon & Miller, 2001). Steinberg, Sullivan, and Loew (1998) conducted a study of deaf mental health participants and found the reported chief barrier to mental health therapeutic services was communication. Whyte et al. (2012) discussed that deaf people share a common experience called the “dinner table syndrome”: hearing individuals can converse freely at the dinner table about their day at work, school, or simple issues, while deaf people miss out on these exchanges. The story of poor communication at the dinner table is so widely told that it becomes a metaphor for the whole deaf experience.

Language is the pathway for therapy and miscommunication produces dangerous consequences (Glickman, 1996, Steinberg, 1991; Vernon & Miller, 2001). Without clear communication, the untrained hearing professional risks misdiagnosis (Dickert, 1988;
Misdiagnosis of a mental health illness may result in treatment with a variety of, or even harmful, medications (Dickert, 1998).

Patterson & Stewart posit that “the nature and principles of counseling with deaf people are no different than those that characterize counseling with other people. Rather, it is their implementation that differs.” They argued that for counseling to be successful with deaf people, the counselor must:

(a) understand certain facts about deaf people;
(b) be aware of the special problems experienced by the deaf;
(c) know the impact of these problems so their impact on the counseling relationship is minimized;
(d) be able to communicate with deaf people in their language;
(e) be aware of ways that deaf clients can be helped to better express themselves.

(p. 56)

Miscommunication often occurs in the context of translation of English Spoken Language to American Sign Language (ASL). Although sign-language interpreters continue to be an option for making counseling services accessible to the Deaf community, in combination with non-signing hearing professionals who may or not be knowledgeable about this population, this is not comparable to direct communication (Whyte et al., 2012).

Freeman and Conoley (1986) examined deaf students’ counselor preferences using the independent variable of manual communication versus use of an interpreter, type of counseling degree, and years of experience. Participants viewed counselors who
had the ability to sign more favorably over those counselors that used an interpreter. Freeman and Conoley (1986) link the ability to communicate with the deaf client a possible indicator of more effective treatment. Whyte et al. (2012) contends that a culturally-competent counselor uses American Sign Language (ASL) and communication that matches clients’ preferences.

Lipton and Goldstein (1997) proposed nine communication barriers in the research of deaf, but stated the communication barrier was a limitation of the researcher and not of the deaf person. Simply stated:

For the hearing researcher it has been a discovery of a parallel universe – a distinct culture with its own very different language, adjacent to the hearing world, but in many fascinating ways, quite different and a demand – of a cultural competence level we did not anticipate. (p. 738)

One can compare the emergence of the Deaf community and culture as the “finding of the Americas”; it is imperative that in counseling the Deaf, the professional must understand the Deaf.

Kirston, Fernando, and Douglas (2000) discussed transference dynamics that can occur between deaf and hearing persons. They reported that a hearing therapist can become a transference object and that it helps for the clinician to be familiar with common life experiences of deaf people. With this knowledge and the needed communication skills, the process of treatment becomes similar to the treatment of the hearing. Fernando (2004) found that the anger that deaf patients feel because of feeling misunderstood has an overall impact on the therapeutic interaction between the therapist
and the deaf patient. The current research illustrates a need for future studies examining
the deaf and hard-of-hearing population (Guthman, 2006).

Counseling the deaf. One of the main principles cross-cutting the priorities of the
Substance Abuse and Mental Health Services Administration (SAMHSA) is developing
an addiction treatment workforce capable of providing high quality services to the
millions of individuals in the country who need treatment for alcohol and drug abuse or
coa-occurring mental health disorders (SAMHSA, 2000). This addiction workforce needs
to be aware of some of the variables that will impact working with the deaf substance
abuser. One counselor variable that can have an impact on deaf and hard-of-hearing
treatment outcomes is counselor self-efficacy beliefs that may or may not be informed by
the counselors’ theoretical orientation. It is apparent that counselors’ theoretical
orientation is at least partly influenced by individual factors such as education, recovery
status (if the counselor is in recovery him/herself), and program type (Taxman et al.,
2002).

Some researchers have postulated that counselor preparation influences counselor
attitudes towards empirically supported treatment (Fals-Stewart & Birchler, 2001) and
that more formal education is needed within the addiction field (Rawson et al., 2002).
The current literature reports, health care professionals often have negative attitudes
towards patients with substance abuse use disorders and perceive treatment of these
patients as challenging, stressful, and difficult. Van Boekel et al. (2013b) examined
health care professionals’ attitudes with respect to working with patients with different
medical diagnoses, such as diabetes or depression. They found that health care
professionals had lower regard for working with patients with substance use disorders.
Regard was defined as biases, emotions, and expectations that a medical condition generates among professionals (Boekel et al., 2013).

Research has illustrated that only a small proportion of people with substance abuse problems seek treatment. In the United States only a quarter of people with lifetime alcohol dependence sought treatment (Substance Abuse and Mental Health Services Administration, 2011). Grant (1997) proposed that one of the explanations for why people do not seek treatment may be denial and concealment of substance use problems and lack of confidence that treatment is effective. Additionally, negative attitudes of health care professionals may increase the chance of dropout or relapse during treatment (Ball et al., 2006; Eaton, 2004). Evidence suggests that several factors may contribute to low regard among health care professionals working with patients with substance use disorders. There are no studies that explicitly extrapolate these factors that may better inform research as to why and how these negative attitudes of health care professionals are formed. Taxman et al. (2002) examined a potential link between the counselor’s beliefs, philosophies and knowledge and the services that were offered in treatment sessions. Their findings indicated that more training and guidance are needed to help counselors understand the differences among therapeutic models. In general, the study findings implied that there may be mixed messages delivered to clients as a result of the counselors’ multiple messages. This nature of mixed messaging service delivery can prove to be a hindrance to any individual in need of substance abuse but may be easier to mitigate for the hearing client over the deaf client.
Whitehouse et al. (1991) illustrated that working with the deaf is laborious. The researchers expose this in a list of comments about how providers served deaf substance abusers:

- We refer them out.
- (When asked where…) We don’t know.
- (How did you communicate with these clients?) We spoke louder.
- We gave them hearing aid batteries and wrote.
- One counselor fumbled with sign language.
- They could write, so the staff did not have to change their communication mode.
- The process of working with these people was laborious for both clients and staff. (p. 109)

The effectiveness of treatment depends, to a large extent, on the staff providing the services (Taxman et al., 2002). Staff providing services to individuals who are deaf and hard of hearing need to be knowledgeable about disability and the models of disability. In the past, clients with disabilities were served by rehabilitation counselors probably because of the misconception that a client’s disability was the sole or, at a minimum, the most important concern (Smart & Smart, 2002). However because disability is a natural fact of life and because individuals with disabilities have multiple identities, roles, functions, and environments, they will require counselors in all specialty areas (including substance abuse) to be informed about the nature of disability (Smart & Smart, 2002). To meet minimum standards of practice, counselors will be required to become proficient in disability issues (Hayes, 2001; Hulnick & Hulnick, 1989). Humes,
Symanski, and Hohensil (1989) suggested that counselors have not facilitated the personal growth and development of their clients with disabilities: “The literature includes many testimonies of persons with disabilities . . . who have achieved successful careers despite roadblocks they have perceived to have been imposed by counselors” (p. 45). However, in spite of this need, which continues to grow, very few university counseling programs provide adequate training about disability issues (Kemp & Mallinckrodt, 1996; Olkin, 1999; Pledger, 2003). This lack of training around the models of disability and whether or not this impacts the counselor’s service delivery needs to be examined further.

Disability studies. Disability is a natural part of human existence and is growing more common as a larger proportion of the U.S. population experiences some type of disability (ADA, 1990; Bowe, 1980; Employment and Disability Institute, 1996; Pope & Tarlov, 1991; Triscgmann, 1987; U.S. Department of Education, Special Education and Rehabilitation Services, National Institute on Disability and Rehabilitation Research, 2000). As early as the 1960s, sociologists such as Erving Goffman (1961, 1963) and anthropologists such as Robert Edgerton (1967) were using the social construct of stigma to explore the phenomenological and cultural experience of disability. Over the last decade or so, the term “disability studies” has become a familiar usage throughout all areas of inquiry and scholarship involved in the study of issues affecting people with disabilities (Fergueson & Nusbaum, 2012). Disability studies offer models of disability in an attempt to define “disability” in a holistic manner. The United States legislation and policy has created upwards of 67 definitions of “disability,” including variations in the term such as “handicap,” “disabled person,” and “individual with a disability.” There are
overlaps among definitions and some legislation uses more than one definition. The literature supports cultural, environmental, biomedical, sociopolitical, and functional. These various definitions of disability are adapted from the various models of disability.

**Models of disability.** In order to be effective with counseling any group of individuals, counseling professionals must have a good understanding of the group’s cultural features (Pinderhug, 1989). This would include how the group views itself as well as how the group views the helping professional. The stigma, denial, and enabling associated with substance abuse or mental health disorders are only a few of the barriers that prevent deaf and hard-of-hearing people from accessing treatment. Mistrust of providers, concern about communication difficulties, fears about losing confidentiality and lack of information about available services also dissuade deaf and hard-of-hearing people from accessing treatment (Steinberg, Sullivan, & Loew, 1998). There are studies regarding how substance abuse professionals and other health care professionals view substance abusers but none that discuss implicitly the nature of the counselor’s understanding of the models of disability and the therapeutic relationship between counselors and the deaf substance abuser. The nature of psychotherapy with deaf persons is dependent upon the model of deafness that one adopts (Glickman, 1996). Glickman (1996) argued that shifting from the medical-pathological model of deafness (the most prevalent model of disability used) to the cultural model resulted in a radically different set of concerns.

A growing interest in models of disability has emerged in recent years, led by a variety of counseling practitioners, educators, and policy makers (Bickenbach, Somnath, Badley, & Ustan, 1999; Humes et al., 1989; Melia, Pledger, & Wilson, 2003; Olkin &
Pledger, 2003; J. F. Smart, 2001, 2004; Tate & Pledger, 2003). Smart & Smart (2002) suggested that examining these changing models of disability can help counselors reorient service provision and further broaden their understanding of disability. They suggested counselors recognize that disability is never entirely a personal, subjective, and idiosyncratic experience, nor is disability a completely objective, standardized, and universal experience (Smart & Smart, 2002). The conceptualization of disability as an attribute located solely within an individual is changing to a paradigm in which disability is thought to be an interaction among the individual, the disability, and the environment (both social and physical) (Dembo, 1992; Higgins, 1992).

**Cultural vs. biomedical.** The cultural model of disability defines disability from a cultural identity perspective. One does not have to be “disabled” to be a part of the “disabled community.” The cultural model of disability with regard to deafness recognizes that one does not to be “deaf” in order to be part of the Deaf community. The use of “deaf” with a lower case “d” refers to an individual who has the audiological condition of not being able to hear; “Deaf” with a capital “D” refers to a person who belongs to a certain cultural group (Paden & Humphries, 1988). The recognition of American Sign Language, Garretson (1989) purported that it “... created a renaissance among deaf persons. It has caused a rebirth of hope, pride, and confidence in ourselves as we take a more active role in the modern role” (p. vi.)

In their survey of mental health professionals’ attitudes toward deaf clients, Cooper, Rose, and Melon (2004) found that the professionals who were comfortable working with these clients had received some training in issues related to individuals who were deaf. The study supports the cultural model of disability because the view of
disability encompasses the cultural environment of the persons with disabilities and calls for professionals who work with this group to acknowledge more than the disability.

The biomedical model considers disability a problem of the individual that is directly caused by the disease. This definition makes the point that the disability is unwanted and places the individual in the “sick role” (Parsons, 1975). The medical model of disability addresses deafness as pathology, one in need of being corrected. Prior to the 1970s, the small amount of literature that existed on mental health care of deaf people worked exclusively from the medical-pathological model of deafness. Deafness was understood only as a medical disability (Glickman & Harvey, 2008). The paternalistic belief that hearing people need to rescue deaf people from their affliction, a term known as “audism,” is the basis of the medical model versus the cultural model debate (Lane, 1993; Padden & Humphries, 1988). In his study of 80 mental health professionals, Dickert randomly assigned the word “deaf” to about half of the cases, and then asked for treatment recommendations, the need for supervisory care and attitudes towards the patient, from the mental health professional. Dickert’s 1998 study illustrated that the mental health professionals who were not knowledgeable or familiar with deaf clients were more likely to restrict, misdiagnose, and overmedicate deaf clients.

**Functional model of disability.** There are variations in the literature with regard to defining the functional model of disability, with the convergent point being that “disability” has an impact on a person’s performance of his/her ascribed societal role. This pertains to the level of functioning that an individual has in performing the tasks of that ascribed role. Similar to the cultural model, the functional model goes beyond the “disability” of an individual. The functional model views the person with disabilities as
having a disability that varies with the roles expected of the individual (Smart & Smart, 2002). Larry Stewart was the first person to demonstrate that non-directive counseling could be done with “traditionally underserved” deaf clients; he argued that “many deaf clients experience no difficulty participating in the counseling process exactly as a hearing client of comparable abilities would, provided the counselor possesses the communication skills and empathy level necessary for effective interaction with the client” (p. 136). Stewart provided transcripts of sessions demonstrating counseling with different language and functional abilities.

**Environmental model.** The environmental model of disability removes the dehumanizing effect that the biomedical model brings. In the environmental model, it is more difficult to dehumanize individuals with disabilities partly because partial responsibility for the response to the disability devolves upon “society” to provide a physically accessible and non-prejudiced environment (Smart & Smart, 2002). In a position statement from the National Association of the Deaf (2003) “accessible treatment” is defined as providing reasonable accommodations to consumers who are deaf, deaf/blind, or hard of hearing. Various lawsuits have spurred program development of specialized services for the deaf in states such as Minnesota, Alabama, and South Carolina (Gournais, Hammerdinger, & Williams, 2010).

**Sociopolitical model.** The sociopolitical model of disability is a radical change from the previous models; it is also referred to as the minority model of disability (Hahn, 1985, 1988, 1991, 1996, 1997; Kleinfield, 1979). The model suggests that prejudice and discrimination found in the broader society are greater obstacles than the medical impairments or functional limitations (Smart & Smart, 2002). Proponents of the
sociopolitical model assert that this prejudice and discrimination against individuals with disabilities is long-standing, systematic, and institutionalized in American life. The ADA states,

> Individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based characteristics that re beyond the control of such individuals and resulting from stereotypical assumptions not truly indicative of the individual ability of such individuals to participate in and contribute society. (Seventh Finding)

The ADA (1990) further asserts, “unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination” (Fourth Finding). Deaf people are aware of this discrimination as they regard hearing loss as not problematic, but rather their status as a minority group (Jacobs, 1986; Lane et al., 1996; Padden & Humphries, 1988).

The Deaf community minority status has been compared to other minority groups. Like other minorities, the deaf suffer from unemployment and underemployment, poor social adjustment and poor public image (Jacobs, 1986). Deaf individuals are often persuaded to forgo college in favor of trade school (Higgins, 1980). Welsh (1991) conducted a study of deaf earnings and indicated that deaf individuals with high school diplomas earned nearly $610,000 less than their hearing counterparts, over the course of a lifetime. College-educated deaf persons with a BA degree earned $469,104 less than their
hearing counterparts, and those with an MA degree earned $365,440 less. Clearly, there are disparities among the Deaf community, and the knowledge of the sociopolitical model of disability might arm the substance counselor with information regarding the marginalization that Deaf individuals encounter.

The models of disability provide the bridge to comprehensively examine the totality of disability. The key concepts of the models address the entire manifestation of disability and how this impacts the existence of a disabled person; moreover, this information would assist the substance abuse counselor in understanding deafness and Deaf culture. The literature firmly supports the existence of a Deaf community and the existence of Deaf culture. The models of disability help to provide the theoretical lens through which the substance abuse counselor can examine Deaf culture; they also provide a mirror in which the counselors can assess their individual strengths and weaknesses pertaining to Deaf culture.

**Conclusion**

While the literature regarding the Deaf community is vast, the literature narrows when searching for substance abuse and the Deaf community. It can be inferred that the substance abuse field does not adequately address the deaf and hard-of-hearing population, and the deaf and hard-of-hearing population is in need of more education regarding substance abuse. The literature illustrates multiple meanings of deafness. The literature continues to struggle with accurately identifying the prevalence of substance abuse. With regard to counselors who provide substance abuse services to the Deaf and hard of hearing, the literature supports that more studies need to be done in this area.
Irene Leigh, in her book, *A Lens on Deaf Identities*, examined the Deaf experience and introduces one to the concept of a “Deaf center.” She suggested that this is what non-deaf persons need to consider when discussing the deaf. She remarked that the “Deaf center” reflects a “different normality” and considers a wide range of how deaf persons accept and define their deafness. The literature illustrates that there are multiple meanings of deaf. Deafness is often defined by the environment and context in which it is being used. For example, the biomedical definition of deafness is simply being without audio ability, whereas in the sociopolitical definition, deafness is defined as being part of a cultural, linguistic minority. The disability from this context is not the loss of audio ability but being in a non-signing world.

The literature supports that there is a scarcity of substance abuse programs for the deaf. There are no reliable estimates of the numbers of deaf people who may have a substance abuse disorder (Guthman & Sandberg, 1995; Steinberg, 1991; Sylvester, 1986). Some studies report that substance abuse use disorders occur at the same rate as hearing populations and others report the rate is higher (Guthman & Blozis, 2001; Sylvester, 1986; Whitehouse et al., 1991). The literature also infers that few programs earmark monies for staff trainings or staff that are knowledgeable in sign language and substance abuse treatment (Guthman & Sanberg, 1995).

The person who is diagnosed with a substance abuse disorder in general is often stigmatized and stereotyped. Stereotypes and misconceptions of the Deaf still abound with health care professionals, thus it is understandable that deaf people avoid hearing professionals who see them as having a pathology rather than a disability (Boros, 1981; Lane et al., 1996; Steinberg et al., 1998). Professionals often form their opinion about
their deaf clients based upon their own theoretical or philosophical orientation, which often times is not informed by the models of disability.

In conclusion, the literature supports further examination in the area of substance abuse and the deaf and hard-of-hearing population. There are no studies of the deaf substance abuse experience using the models of disability. The literature does support that, at best, substance abuse is becoming revealed in the deaf and hard-of-hearing community as well as emerging “deaf identities.” Professionals working with the deaf must become aware of this and how this may impact the Deaf therapeutic experience. It is imperative that substance abuse counselors understand how their cultural competence has an impact on their work with the deaf and hard-of-hearing population.

**Chapter Summary**

This chapter has reviewed the current scholarly literature and studies on the deaf and hard of hearing and substance abuse, defining deafness, and counseling the deaf with attention on the models of disability. Chapter 3 discusses the research design and methodology to be used in the study. Chapter 4 discusses the findings of the study, and Chapter 5 addresses the implications for practice and limitations of the study.
Chapter 3: Research Design Methodology

Introduction

This chapter describes the research design and methodology for a qualitative study examining the relationship between the substance abuse counselor’s knowledge of four models of disability and the substance abuse counselor’s self-assessment of cultural competence working with deaf sign-language users. The research question that will be informing the study is: “What is the relationship between the substance abuse counselors’ knowledge of the four models of disability and their self-assessment of cultural competence working with the deaf sign-language user?” An overview of the research context, participants (including selection), instrumentation, and data analysis are discussed.

Statement of the Problem

The World Health Organization has estimated the attributable burden of disease from substance abuse in established market economies like the U.S. conservatively at greater than 23% – from tobacco, from alcohol, and from illicit drugs (no mention of prescription drug abuse) (World Health Report, 2002). Substance abuse and dependency remains one of the greatest challenges facing any established nation. The evolving field of substance abuse research is very broad. The consideration of special populations, in particular persons with disabilities, and their treatment experiences is an area needing further exploration (Glazier & Kling, 2006; Krahan et al., 2004). The literature is rich in studies that discuss, describe, and illustrate the impact of substance abuse on the hearing
population; there is very little research that examines the relationship between models of
disability and the influence, if any, on the substance abuse counselor’s self-assessment of
cultural competence working with the deaf sign-language user. This study seeks to
understand counselor’s intended practices on the therapeutic relationship. While there is
considerable research on the role of the counselor and the various factors that may
influence the therapeutic nature, such as a counselor’s belief system or philosophical
orientation, there are no current studies that examine counselors’ understanding
(knowledge of) of a particular model of disability and their own self-assessment of
cultural competence.

General Perspective

One of the main purposes of qualitative research is to describe, explain, and
understand the complex nature of a phenomenon (Cottrell & McKenzie, 2005). The data
gathered from a qualitative study often contain some inherent “richness and holism, with
a strong potential for revealing complexity” (Miles & Huberman, 1994, p. 10) that yield
thick, rich descriptions that are contextualized (Onwuegbuzie & Leech, 2004).
Furthermore, qualitative data often center on people’s experiences, striving to make sense
of them or interpret the meanings of these experiences (Denzin & Lincoln, 2005). A
qualitative study that examines the relationship between the substance abuse counselors’
knowledge of the models of disability and their self-assessment working with the deaf
sign-language user can add to future opportunities for professional development in the
field of counseling. These future opportunities for professional development will be
critical in assisting the SACs in identifying their strengths and weaknesses in working
with the Deaf. As a result of identifying these strengths and weaknesses, more directive and deliberate training and preparation materials can be developed.

This study is exploratory in nature and seeks to: (a) generate plausible hypotheses between the SACs’ knowledge of the models of disability and their self-assessment of cultural competence working with the deaf sign-language user; and (b) be able to offer data-driven recommendations for professional development for substance abuse counselors.

**Research Context**

The study involved substance abuse counselors from the greater Rochester, Monroe County area treatment facilities that provide substance use disorder treatment to the deaf population. All facilities are regulated by New York State Office of Alcohol and Substance Abuse Services and authorized to provide alcohol and substance abuse preventive and treatment services. All treatment facilities have been providing treatment services for the substance abuse population for over 10 years and are actively certified by the New York State Office of Alcohol and Substance Services at the time this research was conducted.

**Research Participants**

In qualitative research, purposeful sampling is the most often selected sampling approach. In purposeful sampling, the participants are selected intentionally for their potential to inform the research topic (Creswell, 2010). Participants in this study are practicing substance abuse counselors who have varying experience working with deaf sign-language users. All participating counselors are master-level social workers and qualified health professionals credentialed to provide alcohol and substance abuse
counseling in New York State. Participants in the sample are representative of the greater Rochester, New York area.

For the purpose of this study, 10 certified substance abuse counselors/therapists and qualified health professional were recruited from the greater Rochester area. The researcher recruited from a pool of adjunct instructors (those adjuncts who are certified and still hold full-time positions in substance abuse counseling positions) from a local community college and outpatient community programs. The substance counselors’ titles included Addiction Therapist I, Program Coordinator, Program Therapist, and Qualified Health Professional, all of which are credentialed to provide substance abuse counseling services.

**Procedures Used**

The researcher used the following procedures in the data collection for this research study. All interviews were conducted in a private area at the interviewee’s location of choice; this was done to ensure confidentiality of all participants. All interviews were audio-taped and transcribed for coding purposes by a certified transcriptionist. The researcher conducted, on average, a 45-minute face-to-face interview with each interviewee, along with a 15-minute follow-up for clarification of inaudible sections of the transcripts. All participants received no monetary token in exchange for their participation in the study. Participants were thanked by the researcher for their valuable and voluntary participation in the study.

At the start of the interview, the researcher was deliberate in establishing an understanding of what is meant by “cultural competence” in the following way(s): (1) the researcher asked the interviewee to describe his/her personal definition of cultural
competence, (2) the researcher used a standardized definition as defined by the National Association of Social Workers to assist the interviewee in shaping an agreed upon “working definition” of cultural competence to guide the interviewee throughout the interview. Procedure number two was used only if the interviewee could not establish a personal definition of cultural competence. All interviewees were provided an overview of the study purpose and presented with informed consents for participation in the study prior to the start of the interview.

**Instruments Used in Data Collection**

The assumption being made is that the substance abuse counselor’s understanding as well as application of any model of disability will influence the therapy provided to the deaf client. Because the nature of the study seeks meaning in the “individual and personal experiences” of the participants, this study used a qualitative research approach with an interview strategy. In a qualitative research, the inquirer uses the literature in a manner consistent with the assumptions of learning from the participant, not necessarily ascribing to the detailed research question (Creswell, 2010). The qualitative research interview attempts to understand the world from the subjects’ points of view, to unfold the meaning of their experiences, to uncover their lived world prior to scientific explanations (Kvale & Brinkman, 2010). It is important in qualitative research that the participants’ “experiences” and meanings are unearthed. The primary purpose of this research study was to examine the substance abuse counselors’ knowledge of the models of disability and their self-assessment of cultural competence.

The primary instrument used was a semi-structured interview. The interview was structured in the sense that every respondent was asked a pre-determined series of
questions; however, different probes and follow-up questions were used. This allowed the researcher at her discretion to personalize the interview and acquire meaningful data pertinent to the models of disability and self-assessment of cultural competence. The interview format consisted of eight questions, generated by the researcher, to determine the substance abuse counselors’ understanding of the models and their self-assessment of cultural competence in counseling deaf sign-language users (Appendix A). In addition, the participants were provided with a brief description of the four models of disability, which was adapted from the evidence-base description of the models provided by the literature. The participants were instructed to read over the brief descriptions and select the model that best matched the description. This was done to provide a basis of common understanding of the four models of disability and to further facilitate the last three interview questions, which asked implicitly about the models of disability. The interviews concluded with the participant being provided an opportunity to further discuss with the researcher any other issues/concerns/thoughts that they might have regarding their professional practice and training experience. This was done to ensure that the participant had an opportunity to provide any further personal insight on the subject matter. Many of the participants used this opportunity to summarize their practice and or training experience.

As a point of reference, the researcher has a Master’s degree in Social Work and holds the credential as a Certified Drug and Alcohol Counselor as well as International Drug and Alcohol Counselor granted by the State of New York. The researcher brings a collection of experience of over 16 years of counseling experience and five years of substance abuse counseling instruction at the community college level. The researcher is
highly trained and skilled in variety of Socratic approaches that affords her the ability to deliver the questions, probes, and follow-ups in a deliberate manner to extrapolate meaningful information.

**Data Analysis**

One of the most important steps in any research process is the analysis of the data derived from the study. There are multiple types of data analysis techniques available (e.g., method of constant comparison, keywords in context, word count, classical content analysis, domain analysis, taxonomic analysis, and componential analysis), with the most widely used qualitative analysis approach being the general inductive approach. Although this study seeks to understand the “lived experienced’ of its participants which would warrant a more phenomenological analysis, the researcher will employ a directed content analysis approach. Many researchers are likely to find using a general inductive approach more straightforward than some of the other traditional approaches to qualitative data analysis (Thomas, 2003). A general inductive/deductive approach, such as directed content analysis, offers a systematic procedure for analyzing the data and is guided by specific objectives (Thomas, 2005). The researcher used a content analysis approach to develop categorical dimensions to code the data. Because the researcher is a certified substance abuse counselor, it was important that “bracketing” be done. Creswell (2007), states that it is important that the researcher suspend previous experiences and meanings to adequately hear the story from each participant’s place and experience prior to commencing with any research. The researcher employed this strategy prior to each interview. This process allowed for the researcher to read the transcribed text several times with fresh eyes and hear with fresh ears.
It should be noted that the coding schema was extrapolated from the researcher’s professional knowledge and experience. The terms used for the codes are factors and variables that are indicative of the nature of the counseling experience. In replicating the study coding structure, the researcher believes that an investigator who has experience in the field of substance abuse counseling will undoubtedly be familiar with the codes because the terminology used is germane to the field of substance abuse counseling.

The research employed the following process of content analysis:

1. Researcher developed an initial set of *a priori* codes that served as categories to group the data
   a. relationship between SAC preparation and cultural competence, SacCC
   b. knowledge of the models, KM
   c. multiple meanings of cultural competence, Mcc
   d. desire for SAC continuing education, DCE
   e. perception of SAC self-efficacy working with deaf population, SacE
   f. organizational/agency support for increased professional development, OSPD
   g. perception of the utility of professional development, PPD
   h. therapeutic techniques for working with the deaf, TT, and
   i. SAC attitudes, beliefs regarding the deaf, SacB

2. Close reading of text. The researcher read through the text to ensure that all questions had been answered so that if follow up was needed, the participant could be contacted.
3. Color coding of *a priori* codes. The researcher created a color coding system to delineate between the categories (codes).

4. Close reading of the text. The researcher read through each interview and color coded using the initial developed codes.

5. Development of other categories that emerged. The researcher developed codes for text that appeared to not fit in any of the prescribed categories.

6. Creation of categories. Subsets of categories were created (Cultural Competence Int. Intrinsic/ Ex. Extrinsic)

7. Axial coding to determine relationships. Developed spreadsheet to show prevalence of codes and to generalize across interviews. Eliminated redundancy and group similarities.


9. Member checks to determine credibility.

10. Finalize major themes.

It is the goal of the researcher to ensure trustworthiness of the study findings and to add to the literature in a meaningful way. Lincoln and Guba (1985) described four general types of trustworthiness in qualitative research: credibility, transferability, depended ability, and confirmability. Among the procedures they described, those most applicable to performing data analysis include conducting peer debriefings and stakeholders’ checks as part of establishing credibility and conducting a research audit for dependability. The researcher used member checking by allowing each participant the opportunity to approve their content as well as provide any information that they felt was needed to add to round out their input.
Summary

The literature clearly lacks a study that looks at the “lived” experience of the substance abuse counselor working with the deaf substance abuser. Several researchers have reported that the prevalence of substance abuse in the Deaf community is similar to that of the hearing population. It is important that substance abuse counselors who work with the deaf population are aware of the population. This study examined the SACs’ knowledge of the models of disability and their self-assessment of cultural competence to provide some insight for professional development. Chapter 4 presents the findings of the study participants. Chapter 5 provides implications and recommendations for the field of addiction.
Chapter 4: Results

Research Question

Substance abuse and dependency remains one of the greatest challenges facing any established nation. Substance abuse addiction professionals who work with people with disabilities, where the deaf and hard of hearing population are often grouped, continue to face a number of unique issues. To engage effectively in a counseling relationship with a client who is deaf, it is necessary to examine the counselors’ views and biases related to groups that are different from their own (Sue & Sue, 2003). This study examined the relationship among four specific models of disability and the substance abuse counselor’s (SAC) self-assessment of his or her cultural competency working with deaf sign-language users.

The National Association of Social Workers (NASW) (2008) Code of Ethics regards cultural competence as a fundamental ethical standard for social work in all settings. The current health literature indicates that there is ambiguity regarding what exactly is meant by cultural competence as a construct, how it is operationalized in health interventions, and whether it improves health outcomes (Horevitz, Lawson, & Chow, 2013). Cultural competence has emerged, though, as a strategy to deal with individual differences and reduce misunderstandings for the impactful effect of treatment and outcomes of diverse patients (Horevitz et al., 2013). Therefore, this study is significant as it attempts to discern the relationship between the self-assessment of the substance abuse counselors’ cultural competence and their knowledge of the models of disability. It is not
the intent of the researcher to prove whether therapy is effective but to offer future opportunities for professional development for substance abuse counselors. Future professional development opportunities could be designed exclusively to address substance abuse counselors’ cultural competence as well as knowledge of the models of disability.

The research question that informed the study, “What is the relationship between the substance abuse counselors’ knowledge of the four models of disability and their self-assessment of cultural competence working with the deaf sign-language user?” generated four conclusions based upon the patterns and the inferences made from the data:

1. **Substance abuse counselors recognize limitations in their certification/preparation process.** These limitations include, but are not limited to: (a) incomplete knowledge and marginal competence identifying models of disability, (b) absence of consideration about how models of disability affect the development of cultural competence, and (c) unfamiliarity with the concept of cultural competence as it pertains to working with deaf substance abusers.

2. When informed about the models of disability and reflecting upon their professional experience, SACs are able to link models of disability with elements of their own practice; moreover, the linkage is supported by their individual idiosyncratic understandings of cultural competence. These understandings tend to incorporate varying degrees of cultural awareness, cultural sensitivity, and cultural humility; however, there is no widely accepted, unified, comprehensive conceptual understanding of cultural competence among substance abuse counselors.
3. Due to the perceived limitations in professional preparation and certification, substance abuse counselors are motivated to proceed without external guidance (in most cases) to ameliorate gaps in their own perceived levels of cultural competence. 

**Substance abuse counselors have a desire to be competent in working with the deaf population.**

4. **Substance abuse counselors working with deaf substance abusers tend to view their clients as having a “double disability” and develop strategies for addressing both factors;** moreover, these strategies derive from the substance abuse counselor’s self-created ecological model of disability.

   The researcher believes that there is a relationship between the substance abuse counselors’ knowledge of the models of disability and their self-assessment of cultural competence and the data suggests that such a relationship does exist. Although the conclusions are a collective voice of the participants, each participant provided richness and value to the study. Their differences, as well as similarities in thought, philosophy, and general world views, were shared across all interviews and brought a sense of pride to the professions despite the perceived deficient in training and preparation experienced by the group.

**Demographic profile.** Table 4.1 illustrates the demographic profile of the study participants. The demographic profile form (Appendix E) provided the researcher with the participants’ years of experience in the substance abuse field, their academic degree or certification credential, years of experience working with the deaf and their gender. The study participants represented a cross section of substance abuse counselors (representing community outpatient, residential, and outpatient preventive) with a range
of experience working with the deaf, as well as diverse educational background (with one participant having a Bachelor’s degree). All participants are licensed to provide alcohol and substance abuse treatment services in the State of New York. It should be noted that all but one counselor holds, along with New York State certification credential, the title of International Drug and Alcohol Counselor (IDRC), because the New York State certification credential offers reciprocity to all those who receive certification credential in New York State. The researcher assigned pseudonyms to each participant to ensure confidentiality. These pseudonyms are used throughout the study.
Data Analysis and Findings

Table 4.1

Summary Demographics and Pseudonyms for Substance Abuse Counselors

<table>
<thead>
<tr>
<th>Participant</th>
<th>Degree</th>
<th>Years of Exp.</th>
<th>Clinical Setting</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
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<td>Female</td>
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<td>LCSW</td>
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<td>Community Outpatient</td>
<td>Male</td>
</tr>
<tr>
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<td>LMSW</td>
<td>16</td>
<td>Community Outpatient</td>
<td>Male</td>
</tr>
<tr>
<td>Julie</td>
<td>AAS, CASAC</td>
<td>21</td>
<td>Community Outpatient</td>
<td>Female</td>
</tr>
<tr>
<td>John</td>
<td>LMSW, BS</td>
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<td>Community Outpatient</td>
<td>Male</td>
</tr>
<tr>
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<td>LMSW</td>
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<td>Male</td>
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<td>LMSW</td>
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<td>Community Outpatient</td>
<td>Male</td>
</tr>
<tr>
<td>Thomas</td>
<td>LCSW</td>
<td>9</td>
<td>Preventive Program</td>
<td>Male</td>
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Summary of Results

In seeking to discern a relationship between the SACs’ knowledge of the four models of disability and their self-assessment of cultural competence, analysis of the interviews generated four data base conclusions, which provided rich, descriptive data.
These conclusions serve as pillars in the foundation that edifies a “collective voice” of the participants—not the researcher. The first conclusion derived from the data is that: SACs recognize limitations in their certification/preparation process. These limitations include, but are not limited to: (a) incomplete knowledge and marginal competence identifying models of disability, (b) lack of familiarity with the concept of cultural competence as it pertains to working with deaf substance abusers, and (c) absence of consideration about how models of disability affect the development of cultural competence.

**Limitations in certification/preparation.** Upon an initial discussion of their training and preparation of their substance abuse counseling, it was clear that the counselors recognized their limitations. Each participant was given the Knowledge of Disability Models Measure. The measure served as a baseline for determining what the participants knew as well their understanding/application of the models of disability. The model measure, along with the participants' interview responses, demonstrated that the participants had incomplete knowledge and marginal competence identifying models of disability. When the participants were provided with the Knowledge of Disability Models Measure and asked to choose the best answer for the descriptive narrative of each model, 40% correctly matched the models, with 60% matching at least two of the models correctly. Many of the counselors (50%) believed that the knowledge of these models informed their practice or could inform their practice and felt that the models should be included in the substance abuse certification training. Unfortunately, more than half of the substance abuse counselors could not accurately identify the models of disability. Because their certification and education process occurred so long ago, most of the participants felt this may have contributed to their lack of knowledge of the models.
Initially, the researcher agreed with the participants and compared this lack of knowledge with the notion of “if you do not use it, then you lose it.” However, with more than half of the counselors admitting that they had prior exposure to the model, the earlier notion was less significantly valued. It should be noted that 50% of the participants said that they had no prior exposure to the models of disability in their substance abuse certification; 30% said they remembered seeing the models, but they were unsure where, and it was not in their substance abuse certification training; and 20% were exposed to the models of disability in their Masters of Social Work education.

Considering that half of the counselors were exposed to the model, they still presented an incomplete understanding of it. Jack, a licensed clinical social worker (LCSW) with 21 years of experience, said:

I think I got some of it, [the models of disability] I don’t know. I’m very concrete of most things, so I guess the biomedical one probably informs me because I do believe that if someone has a disability that, it in many cases, [it is] no fault of their own.

In further discussion with Jack, there was a noticeable difference in his description of his practice and the biomedical model. Jack acknowledged the disability as not being the fault of the individual, thereby illustrating that the disability was not the problem. The biomedical model acknowledges the disability as the problem, but in positioning Jack’s belief that his practice is informed by the biomedical model, he did present (this is social-work jargon) with a paternalistic perspective, which aligns with the biomedical model. Jack’s paternalistic perspective was evident in his discussion, as he often referred to the
deaf client as needing special attention, and his effort to be overly sensitive in his therapeutic approach when working with the deaf.

Across the interviews, the participants continued to demonstrate similar marginal understanding of the models of disability. Arnold, who holds a Bachelor’s degree in Social Work and has 19 years of experience, said, “Yes, I can recall hearing about the models, like the medical model and the blended model.” Arnold described his understanding of the “models” in a manner that was consistent with one model in particular, the biomedical model, although he believed that his model was blended, because he applied elements to the biomedical model that were inherent to his practice, and thereby created a blended model perspective to guide his practice. He was unaware that he was doing this, primarily due to his marginal understanding of the biomedical model. Interestingly, the biomedical model, the most widely used model, is ingrained in the health-care field and the researcher is not surprised that there are elements of the biomedical model incorporated unknowingly throughout several, if not all, of the participants’ practices.

Richard, a licensed social worker (LMSW) who has six years of experience, struggled with the knowledge of the models, as did Betty, an LMSW who shared the biggest gap in the knowledge. Said Richard, “My professors talked about the models in their discussions but never really went further. I guess my understanding of the models is understanding that they are out there.” He further explained that “we never talked about [the] models of disability in my CASAC training.” Richard’s lack of understanding of the models was further illustrated when the researcher discussed the issue of disability, in general, with him. He said he believes disability is like a disease: “I am experiencing this
at home now with my wife who has diabetes, we [our family] is experiencing how this impacts us all.” Betty was adamant, that although knowing the models of disability appeared to be valuable to the counseling practice, she was unsure as to how this applied to her. She stated she “just does not do textbook.” This acknowledgement of marginal knowledge was met with less resistance from other participants, but nevertheless, it was becoming apparent.

In his initial response, John, an LMSW who has nine years of experience, believed he was exposed to the model, but then said that “The only mantra that we were ever told was that there’s no population that we won’t do our best to work with, and if we can’t, we will find them a place that can.” John’s response supports the notion that substance abuse counselors understand the need to be competent to work with diverse individuals but, in lieu of competence, simply referring the deaf client to other providers appeared sufficient.

Although the counselors were able to acknowledge their incomplete knowledge of the models of disability, they attempted to make concessions and to minimize this lack of knowledge. To further minimize their lack of knowledge of the models, the counselors’ attempted to identify elements of the models that aligned with their practices. Paula, an LMSW with 16 years of experience in the field, explained, “I don’t remember everything, but I do remember talking about the bio-psychosocial and genetics,” when asked to clarify which particular model (in general) she stated the biomedical model. Paula added that she believed the environment had an influence on people as well. Because of the limited discussion of the environment in the biomedical model, the researcher was able to
discern that Paula could not differentiate between the biomedical model and the biopsychosocial.

Two of the counselors responded in a manner that was consistent with the literature by attempting to make the deaf substance abusers “invisible,” implying that the deaf substance abuser was better off not coming to the hearing counselor and that “they,” the deaf substance abusers, should go to deaf substance abuse counselors to receive services. Both Marcus (LCSW) and John (LMSW) clearly articulated this in their comments. “I just refer them out,” said Marcus, and John supported this by saying, “I would not come here [hearing counselor practice] if I was deaf, I would go where I would be better served.” What appeared to the researcher was that both of these counselors did not want to take ownership and felt very comfortable referring the deaf clients to other providers.

An unfamiliarity with the concept of cultural competence pertaining to the deaf. Many of the counselors were unfamiliar with the concept of cultural competence pertaining to the deaf. Betty said she believed the deaf have their own culture, but it was more of a question than a declaration of fact. Paula and Natalie were, by far, more knowledgeable than their peers, because Paula’s son is deaf and one of Natalie’s first jobs was at the National Technical Institute for the Deaf. Both Paula and Natalie possess basic engagement-level skills when working with the Deaf as evidenced by Paula having to teach her son American Sign Language at the age of two, and Natalie having to possess basic-level sign-language knowledge as a requirement for her employment.

Paula discussed her familiarity through her access to the Deaf community by way of her son, and admitted that she may have been exposed to about 10 deaf clients
throughout her extensive career. She further admitted that she may have purposely declined accepting a deaf client when she had the opportunity to do so largely because she was not proficient in sign. As her son grew and utilized hearing aids, she did not sign as much. Natalie shared similar experiences which she believes makes her somewhat unfamiliar with the deaf. “What little sign I try to use, but I just use a lots and lots of notes now [when working with a deaf client],” she said. Both counselors admit that having a means of communicating with the deaf client is critical in understanding the client’s perspective. Without that, the counselors said they feel lost when working with the deaf, but still feel like they could work with the deaf if they had to, even considering their unfamiliarity with engagement techniques in working with the population.

All the counselors were asked to rate their self-assessment of cultural competence working with deaf sign-language users. More than 60% rated themselves at least a six on a 10-point scale. Half of the counselors still appeared to see themselves as “above average” (with five out of 10 being the average) in their perception of cultural competence. When asked to substantiate this above-average cultural competence rating, most counselors described the typical engagement strategies that a hearing counselor might use with a deaf client. Julie discussed her trial-and-error approach, “Just learning that I needed to turn on the lights to try to get their [deaf clients] attention, [and] tapping on their bed to try to wake them up.” Betty said she would simply email her client directly, as sometimes she felt the interpreter changed the dynamics of the group. It did not appear to Betty that the deaf client must have been experiencing a group where he/she might have felt that he/she was “the distraction.” Arnold openly discussed that, because of the limited access to interpreters, it is a good thing when clients can read lips. He
further stated that the deaf clients who can read lips as well as sign tend to do better. This approach tends to put most of the ownership on the deaf client, which is a common belief among the hearing; it is the deaf individual who must be able to communicate with me, not vice versa.

Marcus discussed previous encounters he had with a deaf client to demonstrate his perceived familiarity with the population, he explained, “I treat the deaf client the same as the hearing client.” When asked by the researcher to explain his approach, he noted that “some counselors make it [counseling environment] too serious and cold for the deaf.” In questioning Marcus further, he shared that he entered the two sessions (hearing and deaf client counseling session) because he wanted to create the same counseling environment; however, acknowledging the deaf client as being a deaf client and not a hearing client allows for the clients’ identity to matter. In recognizing his client is deaf, is not only to acknowledge his non-hearing abilities but to understand that he is a member of the Deaf community, which has its own culture.

This unfamiliarity was further exposed through the overwhelming belief of the counselors that if they used an interpreter, this would eliminate the differences between the hearing counselor and the deaf client. When the researcher asked why they believed the presence of an interpreter assisted the counselor in appearing to be more culturally competent in working with the deaf, almost all of the counselors said that this would enhance their communication with the client. The counselors believed that if they could at least communicate with the clients, then they were demonstrating cultural competence. The counselors’ unfamiliarity with the concept of linguistic competence as an element in becoming culturally competent added to their marginal competence working with this
population. Cultural linguistic competence affords the client an opportunity to express themselves directly in their primary language and, in some cases, without the use of an interpreter. About half of the counselors openly admitted that, even when using the interpreters, they did not feel that confident in their ability to provide quality counseling to the deaf. Jack noted that although he had worked with the deaf with an interpreter, he still felt, “much was lost in translation,” which added to his frustration as well as the client’s. It was mentioned previously how Betty felt interpreters changed the dynamics of her group counseling sessions because she felt they were a distraction to the other clients. Even with accommodations, such as the use of an interpreter, the counselors acknowledged, with ambivalence, their marginal cultural competence.

In further analysis of this unfamiliarity of the cultural competence pertaining to the deaf, it was unclear as to whether the models of disability would influence cultural competency working with the Deaf. This was largely due to the fact that the counselors—even the counselors who had prior exposure to the models—could not discern how the models actually affect cultural competence.

**Absence of consideration about how models affect cultural competence.**

Although the counselors in the study demonstrated a lack of understanding of how the models of disability affect cultural competence, they all agreed that cultural competence was, indeed, a critical skill for any health professional to possess. The researcher feels this belief is germane to the counseling field: that overall cultural competence is the responsibility of the counselor. Many of the participants acknowledged that the models helped them better understand individuals, but they failed to align any aspect of their practices with specific, strong, strategies from the models of disability that affect the
development of cultural competence. Without a doubt, the strongest evidence that the
models of disability affect cultural competence was when one participant addressed a
person’s belief system. When asked how the models inform cultural competence, Paula
stated, “Yes, the models could help, depending on an individual’s (counselor’s) belief
system.” Paula believed that the knowledge of the models could assist counselors in
challenging their belief systems, which in turn, could assist counselors in becoming
aware of their own assumptions in working with individuals with disabilities. This was a
surprising, but a limited finding, for the researcher, but it did shed some light as to how
the models might affect cultural competence.

Several of the counselors mentioned elements of what appeared to be culturally
safe terms that are germane to an effective counseling practice, such as humility. Jack
shared, “counselors just do not know enough and need more training.” In discussing how
the models of disability informed her cultural competence, Julie (CASAC) who has over
20 years’ experience said, “They help humanize people,” but offered no evidence of
“how” the models affected the development of cultural competence. It should be noted
that although there was an absence of consideration of how the models affect cultural
competence, the counselors “felt” the models would help. This was evidenced by a
repeated recommendation that future counselors should be exposed to the models in their
certification training. There was no doubt that the counselors recognized this limitation to
their practices and were surprised to learn that the current certification curriculum makes
no mention of the models of disability. Natalie and John discussed, with shock and awe,
as observed in their non-verbal as well as verbal responses, that this information is
critical, keeping in mind that Rochester, New York has a sizable deaf population. In
regard to cultural competence, all counselors believed it to be a critical skill, but without a comprehensive, foundational, centralized meaning of cultural competence driven by a model of disability, the substance abuse counselors could not articulate how the models would affect cultural competence development. What happened was a perceived and actual connection to the models of disability with elements of the counselors’ practices linked to their counselor idiosyncratic meaning, definition, conceptualizations, and understanding of cultural competence. The second conclusion was inferred from the interview data: *When informed about the models of disability and reflecting upon their professional experience, substance abuse counselors were able to link the models of disability with elements of their own practice; moreover, they were able to link these models with their individual idiosyncratic understandings of cultural competence. These understandings tended to incorporate varying degrees of cultural awareness, cultural sensitivity, and cultural humility; however, there was no widely accepted, unified, comprehensive conceptual understanding of cultural competence among the substance abuse counselors.*

**The connection between the models of disability and cultural competence.**

One question that remained the same for all study participants concerned the counselor’s individual practice. The researcher’s intent was to generate a discussion that would provide connections and evidence to substantiate claims made in the interviews. One of the researcher’s goals was to see if elements of the models of disability, as well as cultural competence, were incorporated in a counselor’s practice. The findings support that SACs are able to link elements of the practice with the models of disability. This linkage is both perceived, as well as actually demonstrated, in the counselors therapeutic
practices. Natalie, an LCSW with 29 years of experience, believed that she aligned with the sociopolitical model of disability; this was observed by her formal responses as well as informal responses. Natalie was observed as being a true advocate; she repeatedly discussed care and concern about the marginalization that she believes deaf clients (as well as women and children) face. She openly rejected the notions of labels (such as disabled) and the stigma that labels bring to the individual in need of services. “I think that we are very unfair sometimes with labels,” she said. “I don’t see disabilities as being inferior, and I think the environment plays a role.” In her responses, as well as her view of the client as not being inferior, Natalie clearly articulated a component of the sociopolitical model—that individuals who are different are not “inferior” and should not be marginalized. Interestingly, Natalie’s “advocacy nature”—which was conveyed in her conceptualization of cultural competence—is characteristic of a proponent of the sociopolitical model of disability. “I think that cultural competency involves being an advocate in the field.” She further provided an example of her intent of advocacy by stating, “The counselor will do something for the client, getting the appropriate provisions and advocating in the community for those services.” Natalie’s points articulate how her understanding of cultural competence framed her understanding of the models that cemented her connection and alignment to her practice. Although a notable finding, the researcher questioned whether this was a deliberate connection or a “luck-of-the-draw” situation. In either case, the clients served by the profession deserve a competent approach to deliver services that are helpful.

However articulated, the connections (linkages to the counselors’ practices) to the models, once they became apparent, appeared to enhance the counselors’ self-efficacy.
This knowledge and awareness of the models appeared to turn on a proverbial light for the counselor, which illuminated unspoken and unwritten nuances of their practices. However, the light also illuminated the connections that were being made between the models and practice, and they were not grounded in the core concepts of the models.

One participant responded that she believed that the biomedical model informed her practice; however, her description of her practice appeared to be more aligned with the sociopolitical model of disability. “I believe the biomedical model informs my practice,” Julie said, but in contrast with the biomedical model, she described her practice as one that “sees humans first” and always “humanizes people,” whereas the biomedical model is the one model, more than the others, that clearly “categorizes people,” and tends to see the disability as the problem with less emphasis on the human side. It was clear that Julie was not connecting her practice to the models of disability properly, but she was utilizing her understanding of cultural competence—a respect for individuals in general—otherwise she would not have expressed that her practice was aligned with the biomedical model of disability.

Across the study, it became clear many of the counselors were not practicing with a comprehensive, unified definition or understanding of cultural competence. In lieu of a unified understanding of cultural competence among the substance abuse counselors, what appeared were varying degrees of cultural awareness, cultural sensitivity, and cultural humility, which the counselors depicted as cultural competence.

_The counselor’s varying degrees of cultural competence._ When the substance abuse counselors were asked to describe or define their understanding of cultural competence, there were multiple interpretations presented. This appears to be consistent
with the state of the current literature with regard to cultural competence and multicultural counseling. The current literature has multiple meanings, definitions, as well as conceptualizations, of cultural competence and just as many strategies to infuse cultural competence into counseling. So, the researcher was not surprised to find that the counselors in the study developed similar therapeutic strategies.

In addition to linking their practices to the models, the counselors believed these models informed their cultural competence. The counselors were simply unaware that these connections to the models were aligned with their understanding of cultural competence because, again, they were unable to discuss how the models affect their cultural competence development. Nevertheless, the meanings of cultural competence were presented in varying degrees of what appeared to be cultural competence, cultural sensitivity, and cultural humility.

Jack illustrated the notion well when he was asked how the models informed his practice and informed his cultural competence. “I know, for myself, that if I understand [am aware] of these models, then I’m understanding their culture, as well [it makes me] culturally sensitive,” he said. It should be noted that when asked which model informed his practice, he mentioned the biomedical model, which only speaks to the nature of culture in medical terms. Although Jack felt that the biomedical model was informing his practice and cultural competence, it was really his own cultural sensitivity and awareness, regardless of the model. The general thread that was woven across the participants’ definitions, conceptualizations, and understanding of cultural competence was a sense that counselors have to be aware and astute to multicultural counseling. The counselors repeatedly acknowledged their responsibility to be aware of, as well as to be able to work
with, a diverse population, although the accountability for this was not as pronounced. Marcus profoundly stated, “Culturally competent counselors have [to have] the ability to work with diverse populations to understand their needs, their backgrounds, their customs, and traditions,” but he readily admitted he knew no sign language and knew very little in regard to the Deaf culture.

Arnold noted that it was the awareness of the cultural differences that counselors have to be on the alert for and he discussed the subtle differences between the hearing and the deaf. “The issue [difference] I am thinking of is boundaries; in the Deaf community you share personal information to develop a relationship, in the hearing community [addiction professionals] self-disclosure is restricted,” he said. Arnold’s astute consideration demonstrated his sensitivity in recognizing the small but important differences when working with the deaf. These differences, which appear immaterial in nature to the unprepared counselor, add to the lack of cultural competence knowledge that substance abuse counselors’ exhibit when working with the deaf.

The participants discussed multiple meanings of cultural competence, varying degrees of cultural awareness, cultural sensitivity, and cultural humility. In positioning their views with the current state of the literature in regard to cultural competence, the counselors aligned with the view of other health care professionals. The current literature recognizes a number of stages, processes, and levels of cultural competence that health professionals go through, and cultural awareness and cultural sensitivity are always included. Although there was an absence of a unified, widely accepted conceptualization similar to what is present across several fields (nursing, mental health counseling), the counselors exhibited humility in acknowledging their lack of cultural competence. This
sense of cultural humility was demonstrated by a majority of the participants who acknowledged they needed to learn more about disabilities and, in particular, the Deaf culture. Even though cultural humility is respectable, it does not account for a counselor’s incomplete or marginal cultural competence. What emerged from the interviews was a sense of responsibility but lack of accountability. Noticeably, the counselors understood what needed to be done, but it was the “how” and ultimately the “who” should take ownership of the deficiency with which they struggled.

The researcher questioned how the counselors were becoming competent. Betty, who seemed the least enthusiastic but was probably the most honest in her responses, articulated that the models did nothing for her or her practice. She said she did not need a “textbook” to inform her practice. She further discussed that her therapeutic approach was more naturalistic in style and that she valued everyone in her conceptualization of culture competence. Betty’s opposition to the models of disability was apparent, but in lieu of her lack of knowledge of the models, her practice was grounded in a sense of fairness for all. One can only speculate how enhanced or enriched Betty’s naturalistic therapeutic practice could be if she was better informed by the models of disability, particularly the sociopolitical model, which calls for individuals to create a sense of their “own,” in a more natural manner. Aligned with Betty’s ability to facilitate a natural environment, coupled with elements of the sociopolitical model of disability, it is possible that her clients could reap enhanced experiences. Fortunately for the field of addictions, Betty’s views regarding her dislike of the models of disability were not shared widely by the participants. It was clear that the majority of substance abuse counselors expressed a sincere desire in becoming competent, as evidenced in their cultural humility.
perspective. This desire that emerged from the participants’ evidenced cultural humility and significant regard of their lack of cultural competence generated the third finding of the study: Due to perceived limitations in professional preparation and certification, substance abuse counselors are motivated to proceed without external guidance (in most cases) to ameliorate gaps in their own perceived levels of cultural competence; moreover, substance abuse counselors have a desire to be competent in working with the deaf population.

**Motivation to become culturally competent in lieu of external guidance.**

Substance abuse counselors understand the multifaceted complexities of substance abuse; they want to alleviate the impact of substance abuse on an individual’s life. They understand the difficulties and challenges of substance abuse recovery. This was evident in the narratives shared by all participants, by the repeated occurrences of the statement, “it is very important to meet the client where they at.” Almost every participant stated this verbatim. These counselors recognized that in order to do this effectively, i.e., meet the clients where they are, they must have an understanding of their clients. It was clear that the counselors recognized their limits in meeting their deaf clients where they are and wanted to do it better. This motivation to do better, as it pertains to the deaf population, was self-directed the majority of the time. The counselor’s desire and motivation was not supported, in most cases, by external guidance, such as agency initiatives or re-certification credentialing requirements. What emerged was a desire that was self-directed and often driven by three leading indicators: (a) feeling a direct connection to the Deaf community (having deaf relatives, neighbors, etc.), (b) professional development, and (c) the counselor’s sense of cultural humility.
**Feeling connected to the deaf.** Having a sense of belonging to a group provides a connection in and between all group members. The counselors who expressed a shared experience with the Deaf community were the strongest, across all participants, in the desire and motivation to become competent working with the deaf population. This direct connection to the Deaf community was either through having a deaf relative, neighbor, or simply knowing someone who had a deaf family member. The connection to the Deaf community facilitated a genuine desire to want to understand more, as well as to appreciate more, about the Deaf community. Paula discussed her deaf son and the challenges she faced as a hearing parent; her tone and mannerisms expressed a deep concern, almost overprotective in regard to the Deaf community. “I know the deaf population is very close knit,” said Paula, “I respect where they are coming from, and I try to utilize some of their supports to help them.” The researcher observed that it was almost as if Paula was discussing her son and felt a sense of guilt that she could have done more for him.

Although Paula was a member of the Deaf community by virtue of her deaf son, this closeness to the Deaf community was also apparent among other counselors. Natalie expressed how one of her earlier experiences with the deaf population exposed her to this culture and left a lasting mark on her as well as her career. Natalie described an environment where she clearly was not prepared but had to do the best she could, because there was no one else to do the job. “The client was deaf and in trouble with substance use, and [we] could not find a place for him. I said with my limited sign-language skills, ‘something is better than nothing.’” She expressed with great remorse (similar to Paula) that the client was not successful in his recovery attempts, and she shouldered an amount
of the blame. It was apparent that this experience did not sit well with Natalie; she knew she needed to do and be more. Interestingly, Natalie was the only counselor to introduce the sense of advocacy in her definition of cultural competence. Clearly, her experience with the deaf client left her wanting to advocate and provide more for those in need.

The need for professional development. The motivation to do and be more for substance abuse clients was a driver behind some of the counselors expressing the need for more professional development. Almost all counselors mentioned never attending any training that focused exclusively on the deaf population. Furthermore, no counselor could recall ever attending any training that centered exclusively on people with disabilities. A significant portion of the substance abuse counselor’s training focused primarily on African Americans, Hispanics, Asian Americans, and youths. Much of the on-the-job training that slightly prepared the counselors was either through self-directed research or by the interpreters they encountered. Arnold praised the interpreters that provided him with the limited training to be able to work with the deaf. He mentioned it would have been a greater benefit if he could have secured agency funding so that all of his staff could be properly trained.

In addition to limited on-the-job training pertaining to the deaf, this was lacking in their certification training as well. Paula noted, with embarrassment, “We never discussed deaf people.” Betty stated, “I guess the deaf people have their own culture,” but failed to acknowledge why the inclusion of this information in her certification training would have helped her. Richard added, “Well, the training helped me to understand that substance abuse doesn’t discriminate.” In lieu of the lack of professional development
opportunities afforded to the counselors, there still was a resilience in spirit that counselors wanted more professional opportunities.

In discussing the lack of training as it pertains to the deaf and the models of disability, Marcus said “more training is needed, and counselors should get more direct practice [application].” He noted further that this is something that he practices, in general, whenever he is responsible for overseeing interns. He wished that he could have had the opportunity in his graduate work to interface with a more diverse client group, in particular the deaf. He disliked how counselors, who have to work with deaf clients with interpreters, create a sterile, very serious environment. He highly advocated for more training and professional development by saying, “It would only help.” Marcus saw the lack of training and professional development for substance abuse counselors as an issue that needed to be addressed. His sentiments were expressed by the other counselors who were driven by a sense of cultural humility to do more for the deaf.

**Because we have to do.** Substance abuse counselors often work with individuals who are experiencing debilitating events in their lives. The researcher is aware that substance abuse counselors do more than counsel individuals about substance use and abuse. Substance abuse counselors facilitate life-changing behavior, and most are sincere in their attempt to do this. Many of the counselors shared a sense of cultural humility as the motivation in becoming competent to work with the deaf.

These counselors were aware that they did not know what they needed to know and acknowledged the incompetence this created. Thomas, an LCSW with nine years’ experience, was adamant that the substance abuse certification preparation did not do enough to prepare counselors to address the whole person. He credits his graduate work
in helping him to develop this significant clinical viewpoint of the client. His approach is rooted in his therapeutic philosophy with the mantra, “How I can help get this person [to be] whole?”

The appeal of wanting to address the client beyond the substance abuse or disability and to develop an understanding of the client, which is rooted in a sense of deep respect for the client, was voiced by other counselors as well. In addition to becoming competent to deal with the whole person, Jack discussed how vital it is that counselors understand how to infuse the disability into the therapeutic experience. “By recognizing the disability, the whole person, you understand how they survive,” he said.

It was notably apparent that Jack did not take his counseling experiences as a few brief moments in time simply discussing substance abuse and use. He wanted to become competent because he wanted to afford his client with an enhanced quality of life. Similar to many substance abuse counselors, Jack understands the debilitating effects that substance abuse can have on an individual’s life. He articulated the point that substance abuse counseling is not simply a job. In further recognition of this point, other counselors discussed macro factors that extend the role of a substance abuse counselor. Julie and Natalie, in particular, noted the stigma that frames substance abuse and how this must manifest itself in the client’s sense of self-worth. Natalie discussed how the manifestation of the marginalization of substance abuse helps in “making an individual feel less than a person.” Julie discussed how she would encounter counselors who often treated their substance abuse clients worse than their other clients. She expressed the discrimination she observed of clients, which forced her to not “put herself in a box.” It was this notion that allowed her to “want to see beyond [the] disability,” to “pull people from their
condition and stretch themselves to see other opportunities.” She added that it is this notion that allows for clients to see more than their addiction, even more than recovery. Julie used this motivation as a spring board to enhance her counseling competences to enhance her clients’ lives, not only merely to stop using substances. Interestingly, she acknowledged she wanted to know more about the deaf and models of disability so that she could showcase clients’ abilities rather than have the disability lead the therapeutic experience.

For many of the counselors, the disability of deafness and the disability of substance abuse was a double jeopardy for their clients. What emerged from the data, was the fourth conclusion: Substance abuse counselors working with deaf substance abusers tend to view their clients as having a “double disability,” and they develop strategies for addressing both factors; moreover, these strategies derive from the substance abuse counselor’s self-created ecological model of disability.

Strategies derived to address the perceived double disability of substance abuse and deafness. The current Diagnostic and Statistical Manual, fifth edition (DSM V TR, 2013) defines substance use as a substance use disorder. The amended American with Disabilities Act (2008) has removed substance abuse and substance dependency as a disability, but interestingly enough, the Social Security Disability (SSD) entitlement program still regard substance abuse as a disability. It should be noted that individuals who receive SSD income are generally those individuals with a severe and persistent mental health illness coupled with a substance abuse diagnosis. Those individuals have to have the mental illness as being the more pronounced of the two, which was not in the case in the early 1960s when alcoholism was recognized as a disability. The study found
that substance abuse counselors still treated their substance abuse clients as having a
disability; moreover, deaf substance abuse clients were acknowledged as having a double
disability.

To ameliorate this situation of double disability in the therapeutic experience, the
substance abuse counselors in the study generated self-created strategies that align with
an ecological model of disability. The researcher contends that this was done to make up
for the incomplete and marginal knowledge of the models of disability, and this warrants
serious concern for the profession. It was clear that the substance abuse counselors in the
study wanted to address the condition of substance abuse as well as the disability, but in
lieu of evidence-base practices derived from the core concepts of the models of disability,
the counselors developed strategies that were: (a) guided by their definition of disability,
(b) guided by their idiosyncratic conceptualizations of cultural competence, and (c) the
culture of the agency environment; meaning, how does the agency address persons with
disabilities?

The counselor’s definition of disability. The common theme through all of the
participants’ definitions of disability was that the mere word “disability” was indicative
of a struggle. This struggle can manifest itself as a physical struggle, a cognitive struggle,
or both. Many of the counselors illustrated the dual struggle as something that can be
identified as “will power.” Richard said he saw deaf clients as presenting with a double
disability, because deaf clients cannot navigate the recovery environment the same as
hearing clients. “They [clients] have to change people, places, and things to identify
triggers.” he said. “Where do they [deaf clients] go? They [deaf clients] have both,
substance abuse and deafness as a disorder.”
Jack depicted the struggle in terms of deaf clients facing a challenge that is not within their control. “It’s a disability because it impacts their daily life, their ability to function; it’s something they have no control over,” he said. This made the researcher question if the substance abuse counselors understood that what they were demonstrating to the deaf substance abuser was that their recovery was doomed from the start. These counselors’ view of the deaf client’s recovery from substance abuse was only possible if the deafness was overcome or handled in such a manner that provided normal recovery environments. Furthermore Jack’s and Richard’s responses indicate these “normal recovery environments” do not exist for the deaf substance abusers because the deaf cannot simply change people, places, and things. The counselors believed it would be difficult for them to help the deaf substance abuser because they were not aware of the Deaf community.

The researcher felt that this was not a deliberate attempt on the behalf of the counselors; suggesting that the Deaf recovery is doomed from the start, but a dangerous perspective that emerged when substance abuse counselors are left to develop their own strategies in working with the deaf substance abuse client. It was clear that the counselors’ framing of the disability was informed by a lack of knowledge of the culture of disability.

The counselor’s idiosyncratic understanding of cultural competence. The element connecting the substance abuse counselors to the models of disability was, in fact, their understanding of cultural competence. The counselors addressed the issue of disability with strategies that derived from core concepts of their own understanding of cultural competence. So, the counselors infused a cultural view of disability and this
guided their practice; unfortunately, their cultural view of disability was ill-informed. This misguided cultural view of disability was not challenged by the agency either, and it appeared that the counselors were following the lead of their agencies.

**Agency cultural treatment of the deaf and disabled.** Several of the counselors mentioned a lack of funding for that kind of specialized training (Deaf culture training) was an indication of an agency’s lack of focus on the deaf. John and Marcus both said that they felt guilty for even asking their agencies to send them to Deaf culture training; said John, “to attend training all day, when honestly, I might only see a few deaf clients a year, may not be a good use of time.” Marcus stated, “I have to do that [learn more about the deaf].” Marcus’ comments left the impression that it was not the agency’s responsibility to make him competent to work with the deaf, but that it was his responsibility as a practitioner. The environment that was being created by the lack of funding for Deaf culture training resulted in the counselors learning what they could from whomever they could, whenever they could, as a means to become culturally aware of the deaf. So, in lieu of the agency-directed and guided support, the counselors haphazardly learned more, without external guidance, which placed the agency in a compromising, bordering on negligent, role.

**Summary**

In aggregate, the study participants presented a collection of factors that shaped and supported an interrelated relationship between the substance abuse counselor’s knowledge of the models of disability and their self-assessment of cultural competence. The diverse group of counselors portrayed experiences that supported the four data-base driven conclusions:
1. Substance abuse counselors recognize limitations in their certification/preparation process. These limitations include, but are not limited to: (a) incomplete knowledge and marginal competence identifying models of disability, (b) absence of consideration about how models of disability affect the development of cultural competence, and (c) unfamiliarity with the concept of cultural competence as it pertains to working with the deaf substance abuser.

2. When informed about the models of disability and reflecting upon their professional experience, SACs are able to link models of disability with elements of their own practice; moreover, the linkage is supported by their individual idiosyncratic understandings of cultural competence. These understandings tend to incorporate varying degrees of cultural awareness, cultural sensitivity, and cultural humility; however, there is no widely accepted, unified, comprehensive conceptual understanding of cultural competence among substance abuse counselors.

3. Due to perceived limitations in professional preparation and certification, substance abuse counselors are motivated to proceed without external guidance (in most cases) to alleviate gaps in their own perceived levels of cultural competence. Substance abuse counselors have a desire to be competent in working with the deaf population.

4. Substance abuse counselors working with deaf substance abusers tend to view their clients as having a “double disability” and they develop strategies for addressing both factors; moreover, these strategies derive from the substance abuse counselors’ self-created ecological model of disability.
Conclusion

The data-driven findings assisted the researcher in the formation of the following hypothesis, as well as an observation that warrants further examination, related to the relationship between the substance abuse counselor’s knowledge of the models of disability and their self-assessment of cultural competence:

1. Substance abuse counselors are able to recognize limits in their certification preparation and training. Those who have greater exposure to the models of disability in their training and education present with a higher self-assessment perception of cultural competence.

In addition, an observation that warrants further examination is:

2. Substance abuse counselors, in lieu of a centralized, widely used definition or conceptualization of cultural competence, will use an idiosyncratic conceptualization of cultural competence which closely aligns with cultural humility more than with cultural competence.

The purpose of the study was to generate plausible hypotheses relating to the relationship between substance abuse counselors’ knowledge of the models of disability and their self-assessment of cultural competence. A secondary purpose of the study was to provide the researcher with evidence-based recommendations for the substance abuse counseling profession. Chapter 5 discusses the formation of the hypotheses that were generated, resulting from the findings, and will provide contextualized, realistic, and impactful recommendations. In addition, Chapter 5 addresses potential future areas of research as well as the study limitations.
Chapter 5: Discussion

Introduction

Chapter 5 will provide closure to the research study and introduce discussions on the study implications, guided by the research question, “What is the relationship between substance abuse counselors’ knowledge of the models of disability and their self-assessment of cultural competence working with deaf sign-language users? This chapter discusses the empirical findings pursuant to the primary research question, the generation of plausible hypotheses for subsequent research, methodological limitations of the study, and closes with recommendations for the preparation and practice of substance abuse counselors working with the deaf.

In 2012, an estimated 2.5 million people, aged 12 or older, received some kind of treatment for a problem related to the use of alcohol or illicit drugs in the 12 months prior to being interviewed in 2011 for the National Survey on Drug Use and Health (NSDUH) (SAMHSA, 2013). In 2012, an estimated 20.6 million people, aged 12 or older (7.9 % of the total population), needed treatment for illicit drug abuse problems (SAMHSA, 2013). In relation to the deaf population, Steitler (1984) estimated that more than 1 million deaf Americans need substance abuse counseling, while other investigators report incidence levels ranging from 7 to 20%. Many think that the true extent of alcohol and drug abuse in this population is underestimated; however, most writers believe that the prevalence of abuse in the deaf population is at least high as the prevalence in the hearing population (Boros, 1981; Dixon, 1987; Ferrell and George, 1984; Guthmann, 1996; McCrone, 1982).
Hearing researchers, often unaware of the Deaf community, overlook it in their research efforts (Guthmann, Sanberg, & Dickinson, 2010).

This study was deliberate in its intent and relevance in addressing this issue. Substance abuse exists in the Deaf community, which means there are deaf people in need of substance abuse counseling. It is clear that substance abuse counselors need to be able to effectively provide services to the deaf. This study examined factors related to substance abuse counselors’ knowledge and competency in working with deaf substance abusers. The study participants’ voices assisted the researcher in generating data-base conclusions, which were used in the formation of plausible hypotheses. The data-base conclusions that were inferred from the data were:

1. Substance abuse counselors recognize limitations in their certification/preparation process. These limitations include, but are not limited to: (a) incomplete knowledge and marginal competence identifying models of disability, (b) unfamiliarity with the concept of cultural competence as it pertains to working with deaf substance abusers, and (c) an absence of the consideration about how models of disability affect the development of cultural competence.

2. When informed about the models of disability, and reflecting upon their professional experience, SACs are able to link models of disability with elements of their own practice; moreover, the linkage is supported by their individual idiosyncratic understandings of cultural competence. These understandings tend to incorporate varying degrees of cultural awareness, cultural sensitivity, and cultural humility; however, there is no widely accepted, unified, comprehensive, conceptual understanding of cultural competence among substance abuse counselors.
3. Due to perceived limitations in professional preparation and certification, substance abuse counselors are motivated to proceed without external guidance (in most cases) to alleviate gaps in their own perceived levels of cultural competence. Substance abuse counselors have a desire to be competent in working with the deaf population.

4. Substance abuse counselors working with deaf substance abusers tend to view their clients as having a “double disability” and develop strategies for addressing both factors; moreover, these strategies derive from the substance abuse counselor self-created ecological model of disability.

It should be noted that the fourth and final conclusion drawn, referring to the SAC’s perception of their clients as having a “double disability,” may be an outcome of the first three conclusions. The researcher is suggesting that the fourth conclusion is a consequence of the limitations in the counselors’ training and their unfamiliarity with cultural competency, coupled with the motivation to alleviate these gaps.

The study’s purpose was to offer hypotheses and evidence-based recommendations in an attempt to introduce new learnings to the field of substance abuse. The researcher offers the following hypothesis as well as an observation that warrants further research: \textit{Substance abuse counselor’s knowledge of models of disability will be positively related with their self-assessment of cultural competence.}

In addition to the hypothesis, the researcher’s observation warrants further examination: \textit{Substance abuse counselors, in lieu of a centralized, widely used definition or conceptualization of cultural competence, will use an idiosyncratic conceptualization of cultural competence, which more closely aligns with the concept of cultural humility than it does with cultural competence.}
The researcher recommends that future investigators pay close attention to what was observed in the current study to see whether their impressions are similar.

**Discussion**

The researcher believes the hypothesis is plausible because the following conditions have been satisfactorily met or considered in the formation of the hypothesis:

1. All of the substance abuse counselors are licensed and/or certified in the State of New York, which means all have met the training requirements of education and field training hours.

2. When administered the Knowledge of Model Measure, 40% of the counselors were able to correctly match the models, with 60% only able to match at least two out of four. Of the 40% who were able to correctly identify the models of disability, all but one counselor had prior exposure in their education and training. Of the remaining 60% of the counselors who struggled to correctly identify the models, 50% of those admitted no prior experience in their education and training.

3. The substance abuse counselors who were able to correctly identify the models of disability scored an average of 8 on a scale of 1 to 10 in their self-assessment of cultural competence. The substance abuse counselors who were not able to correctly identify the models of disability scored an average of 3.5 on a scale of 1 to 10 in their self-assessment of cultural competence.
In defending the plausibility of the observation, the researcher offers the following rationale:

- The researcher asked all participants to provide their understanding, definition, or conceptualization of cultural competence. The researcher did not use the National Association of Social Workers’ (NASW) standardized definition of cultural competence, as anticipated, because all counselors were able to provide their understanding of cultural competence. Over half of the participants expressed a desire to become culturally competent in working with the deaf; even though the counselors, on average, rated themselves above average in cultural competence, the desire still emerged to want to know more. This desire demonstrated by the counselors illustrates the concept of cultural humility, whereby the counselors recognized the need to learn more, which is different from presenting with competence, which is indicative of a “mastery” level.

With regard to future testing of the hypothesis generated by the study for future investigators, the researcher would offer the following instruments to be used; the knowledge of the models measure, as well as questioning the counselor’s in regards to their definition of cultural competence. The researcher further believes that using the mentioned instrument and questions presented, would produce similar findings.

Lastly, the researcher suggests that the models of disability do have an influence on the counselors’ cultural competence. Although the counselors were not able to discuss how the models of the disability affect their cultural competence, the perception that it did (as evidenced by the similarities that were drawn between the models and the
counselors’ practices) provided a sense of enhanced confidence for the counselors. The counselors’ believed that knowing the models of disability, directly or indirectly, enhanced their cultural competence because it increased their cultural awareness, heightened their cultural sensitivity, and formed the basis of their cultural humility.

The counselors supported an integration of the models-of-disability studies in substance abuse counselors’ certification and training and overwhelmingly recommended that future counselors receive this information in their training. All but one of the counselors reported that the additional information would enhance their practice. The articulation of this enhanced practice was evidenced when the counselors immediately drew similarities with elements of the models and their practice. Although the connections to the models were linked by the counselors’ understanding of cultural competence, the connections, nevertheless, were apparent. The models of disability allowed the counselors to understand and appreciate the culture of disability. This culture of disability perspective helped many counselors to acknowledge how an individual is impacted by the nature of disability and the manifestation of the marginalization of disability. Several of the counselors reported that the models framed their understanding of disability by challenging their assumptions about disability. This, they believed, was highly influential in grounding their cultural competence.

**Unintended Benefit of the Study**

Based upon the researcher’s conclusions from the study, it appears that the substance abuse counselors may have incomplete knowledge of the models of disability, may be unfamiliar with the concept of cultural competence, and are not cognizant of how the models affect the development of cultural competence. Further, it seems to follow
that SACs are likely to be unaware of their unawareness. The interview conducted by the researcher served not only to stimulate the SACs’ awareness but also their realization that they were previously unaware of these concepts. This finding was a vicarious benefit of conducting the study.

**Implications of Findings**

The study’s findings highly suggest that substance abuse counselors who are exposed to the models of disability in their preparation and training tend to perceive higher cultural competence working with the deaf. In addition, the models helped the counselors recognize elements of cultural competence that were incorporated in their practice as well as identify the cultural competence knowledge gaps. These gaps in cultural competence exposed the counselors’ limitations, as well as their desire, to become culturally competent. This desire formed the basis of their cultural humility. It was clear to the counselors that they needed to seek out the information to close the gap.

What the knowledge of the models of disability did, combined with the counselors’ desire to become culturally competent, was to create a cultural view of disability. The counselors used this cultural view of disability to guide their practice. The researcher believes that this creation of the counselors’ cultural view of disability was not deliberate, but is highly significant as it could provide clarity and direction to the counseling approach. By infusing the knowledge of the models of disability with a centralized concept of cultural competence in the preparation of their practices, counselors could reduce the ambiguity on how to infuse cultural competence into the substance abuse field. This infusion is needed to ensure culturally competent services to the deaf substance abuser. The implications for practice and policy will focus on
substance abuse counseling incorporating a cultural view of disability as a way of re-conceptualizing both disability and cultural competence and to bring new learning to the field.

**Practice and policy implications.** Understanding the intersectionality of culture and disability brings a sense of understanding to the delicate overlapping of the two. The phrase “a cultural view of disability” is intended to illustrate the nature of that intersectionality. The intersectionality recognizes the culture within disability and how the dominant culture uses mainstream cultural ideologies to frame and examine the disability. In further illustrating the example, members of the disability community believe that some deaf people continue to perpetuate disabilities in a negative light; society often groups deaf persons by their disability, but some members of the Deaf community do not consider themselves as having a disability. Health care professionals, in general, need to be aware of the complexity of the mentioned intersectionality to ensure services are comprehensive.

The following discussion frames the implications and recommendations to practice and policy as a way to illustrate the intersectionality of culture and disability. The researcher offers the following four recommendations to the field of substance abuse counseling: (a) establishment of a universal cultural view of the disability perspective, (b) political and social agenda changes, (c) structural, systemic, agency changes, and (d) education and staff training. The first recommendation can be linked directly to the researcher’s investigation; the remaining three are extensions of the first. The researcher believes that in order to implement the first recommendation, the remaining three are warranted and needed.
Establishing a universal cultural view of disability. Establishing a universal cultural view of disability in health care requires awareness of the culture within the disability and Deaf community, respectively. Participants in the study demonstrated incomplete knowledge of the models of disability as well as a lack of understanding of the culture of disability. To compensate for this incomplete knowledge, many of the participants derived strategies that were aligned with an ecological model of disability. Interestingly, what emerged as a result of the participants infusing elements of their idiosyncratic understanding of cultural competence with similarities drawn between the models of disability and their practice, was a cultural perspective of disability. The research suggests that the field of health care, particularly the substance abuse field, needs to foster a deliberate attempt to induce a global cultural view of disability. The researcher also suggests that an introductory action in fostering a global cultural view of disability should start with the awareness of the models of disability followed with the integration of a unified conceptualization of cultural competence.

The researcher contends the model of cultural competence recommended in this chapter, the Collins and Arthur (2007), Cultural Infused Counseling Model, as one that has been used to inform this recommendation. The Collins and Arthur’s model suggests that counselors become aware of an individual’s ability when considering their cultural identity. The model infuses the culture of disability and the individual’s cultural identity in the counseling experience. The researcher further offers that counselors must have an understanding of the models of disability, as well an awareness of cultural competence, to establish a cultural view of disability.
**Awareness of the models of disability.** With the emergence of disability studies emerged the models of disability that provide conceptual frameworks for examining disability and which define disability in a holistic manner. The nature of psychotherapy with deaf persons is dependent upon the model of deafness that one adopts (Glickman, 1996). The models of disability assist the counselor in guiding his or her practice, which helps to inform the counselor’s perspective “on” and “about” deafness. Glickman (1996) argued that shifting from the medical-pathological model of deafness (the most prevalent model of disability used) to the cultural model resulted in a radically different set of concerns. The participants in the study that were more aligned with the sociopolitical model of disability tended to view their clients more holistically than those who were more aligned with the biomedical model of disability. Many of the study participants readily admitted that, although they were not in agreement with the pathology element encompassed within the medical (biomedical) model, they did see similarities with elements of the biomedical model in their practice. Whether this alignment was deliberate or not, it clearly informed their practices such that they categorized deaf individuals. This categorization was evidenced by the undertone of “this is not my population” and “I refer them out” and “Why would a deaf substance abuser come see me?” “They would probably go places where they would be served better.” In addition, this categorization of the deaf was one of the factors in the paradoxical relationship in which the participants appeared to be engaged. The participants’ cultural humility was the result of trying to mitigate that paradoxical relationship. They knew it was not right to group the deaf patients, but they were limited in their experiences and skill sets to offer more.
In addition to using their idiosyncratic understanding of cultural competence along with incomplete knowledge of the models, the participants developed a home-grown perspective of disability as well. Many of the study participants offered varying perspectives of their home-grown ecological working definitions of disability. These ranged from recognizing “ableism” as a strength perspective to a rejection of the label and word “disabled.” These multiple definitions supported the notion of a positive reconceptualization of disability, but they should only be viewed as a starting point. Ware (2003) stated what the range of disability studies and knowledge can offer “a way to imagine disability otherwise.” Ware’s use of the phrase intended to make the point that the range of analyses and representations in disability studies scholarship offers “ways of knowing” and theoretical insights with which service providers can examine individual and societal attitudes, beliefs, and assumptions, including their own. In examining their incomplete knowledge of the models of disability, the participants were forced to develop insight that allowed them to derive strategies to mitigate their knowledge model deficiencies.

The researcher would further agree with Ware that this critical reflection is needed to move health professionals and society, in general, away from “fix the person practices” to one that allows for a broader understanding of disability as part of the shared human experience. This reflection allows for the individuals to consider and appreciate the human culture, one that allows for purpose and worth to be afforded to all. This shift in focus to the limitations of attitudes, environments, contexts, and practices allows disability-related professionals to actually redefine the “problem” traditionally associated with disability (Biklen, 2007; Biklen & Burke, 2006; Nusbaum & Rodriguez,
2010) and continue to support disability as a natural part of the human experience (Fergueson & Nusbaum). One could easily see throughout the course of the interviews that the counselors respected the nature and experience of disability. The participants strongly articulated that the “disability” even including the “double disability of deafness and substance abuse” was not the problem, but they failed to reduce the influence of these assumptions in their practice. It was almost as if they could not see their blind spots with regard to how they seamlessly guided their practice with their home-grown model of disability. The counselors failed to see that although they have expertise in counseling, their beliefs created by their expertise (in particular their cultural beliefs and limited expertise) stereotyped their clients. All of the participants argued that, although their practice was not intently informed by the models, their practice still benefitted indirectly due to their own home-grown approach encompassing respect for all, regardless of ability.

The researcher could almost feel how careful and sensitive each participant was when discussing his/her knowledge of the models. It was clear the counselors were aware of the limitations their practice experienced as a result of the deficient in knowledge. The researcher could sense the remorse resulting from that lack of prior exposure to the models of disability, which forced them to use their understanding of cultural competence to enhance their disability counseling approach when working with the deaf. It was also apparent that the counselors shared an absence of cultural competence awareness as well.

**Cultural competence awareness.** Exposure to the knowledge of the models of disability is one piece in the formulation of a cultural view of disability. The infusion calls for knowledge of disability as well as a centralized conceptualization of cultural
competence. The study participants, similar to the general population of health care providers, did not present with a unified definition of cultural competence. The participants supported a range of cultural adaptations that are encompassed a larger cultural competence model that included cultural awareness, cultural sensitivity, and cultural humility. The researcher highly suggests by, including a unified model of cultural competence in the field of substance abuse counseling, counselors’ cultural view of disability would be better informed. The researcher offers the culture-infused counseling model, developed by Sandra Collins and Nancy Arthur, 2007, as a starting point.

The model was organized according to three core competency domains (which appear in the center inner circle):

- Cultural Awareness – Self: Active awareness of personal assumptions, values, and biases
- Cultural Awareness – Other: Understanding the worldview of the client
- Cultural Sensitive Working Alliance

The core competencies in this model suggest and illustrate there is an interaction with the personal culture identities of both the counselor and the client. The researcher believes this point to be critical, considering the majority of counselor learning tends to advise counselors to set aside their values, biases, and beliefs when working with diverse client populations. This model illustrates that this should be the starting point for counselors. The model contends that the counselor’s cultural awareness of self should be seen as core to professional practice.
Figure 5.1. Cultural Infused Model.

Correct usage of the model starts with acknowledging the three inner core competencies and then integrating the levels in the next ring out to further depict the interaction that occurs in a cultural infused counseling environment. Moving away from the inner center ring begins to describe the intersection between the core elements of a culturally infused practice with the cultural identity of the client (which considers the clients’ ability), the counselor area of practice (as this will have an impact reflective of the area), personal/contextual identity factors of the counselor, and the integration of attitude/beliefs, knowledge, and skills. Personal identity factors may include idiosyncratic experiences and socialization, while the contextual factors refer to the historical, social, and political contexts in which individuals live. These core competencies provide the
foundation for building an effective working alliance and engaging the process of cultural inquiry to assess the role of personal cultural identity in the client’s presenting concern.

The model provides a template to assist counselors in assessing their current level of multicultural counseling competence and to identify areas where further professional development may be required. The following is a collapsed snapshot of the template listing the domain and the core competencies within that domain.

Domain I: Cultural Awareness – Self: Active awareness of personal assumptions, values, and biases. Core competencies:

1. Demonstrate awareness of your own cultural identities.
2. Demonstrate awareness of differences between your own cultural identities and those of individuals from other dominant or non-dominant groups.
3. Demonstrate awareness of the impact of culture on the theory and practice of counseling/psychology.
4. Demonstrate an awareness of the personal and professional impact of the discrepancy between dominant and non-dominant groups in North America.
5. Demonstrate awareness of your level of multicultural competence.

Domain II: Cultural Awareness – Other: Understanding the worldview of the client. Core competencies:

1. Demonstrate awareness of the cultural identities of your clients.
2. Demonstrate awareness of the relationship of personal culture to health and well-being.
3. Demonstrate awareness of the sociopolitical influences that impinge on the lives of non-dominant populations.
Domain III: Culturally Sensitive Working Alliance. Core Competencies:

1. Establish trusting and respectful relationships with clients that take into account cultural identities.

2. Collaborate with clients to establish counseling goals that are responsive to salient dimensions of cultural identity.

The researcher believes that a culture-infused counseling model can be used as a starting point in assisting agencies and counselors in utilizing a unified cultural competency tool to increase cultural competence. The researcher further believes that the model allows for the desire to want to learn more, as well as the cultural humility expressed by the participants in the study, as a means to better inform a cultural view of disability. The model forces counselors to acknowledge that attitudes and beliefs, knowledge from diverse sources, and skills are needed in order to be competent. The researcher would add that the cultural humility expressed by the participants in the study illustrates there is an environment among substance abuse counselors that would support the acceptance and appreciation of the recommended cultural infusing model.

In positioning some of the Collins and Arthur (2007) model with the conclusions inferred from the data, explicit links exist. Collins and Arthur suggested that there is an interaction between the counselors’ cultural identity and the clients’ cultural identity. It was evident that the counselors in the study failed to encompass all of the deaf clients’ identities when they failed to recognize Deaf culture. This was further illustrated when the counselors used idiosyncratic conceptualizations to guide their practice when working with the deaf client, resulting in several of the counselors viewing deaf clients as having a double disability. Furthermore, the use of the model demonstrates that counselors should
be aware of their culture and the culture of others to be able to provide a working collaborative relationship. In an effort to create a working alliance relationship, the counselors unknowingly created a cultural view of disability, which they used in working with the deaf client.

To move the perspective of a cultural view of disability to a global health care perspective requires legislative changes. The following discussion offers political implications and recommendations in further establishing a cultural view of disability in working with the deaf. The researcher would suggest this sequencing of the recommendations as a starting point and highly suggests that the “stage” needs to be set in order for the proceeding changes to occur. Furthermore, the researcher does not believe that it is solely the responsibility of the state to make the necessary changes, but that a collaborative effort and partnership between all political levels needs to emerge. The researcher starts with the State’s efforts because the researcher believes that public funding is critical.

**Political and social agenda changing.** The political implications of the findings suggest that a new agenda needs to be set—one that addresses the cultural view of disability. This new agenda has to call for the development of advocacy and awareness that directly address the issue of substance abuse counseling for individuals with disabilities, in particular the deaf substance abuser. The researcher offers the New Jersey Alcohol and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled: From Advocacy to Implementation, as an illustration of committed political agenda changing. This innovative legislation was an accumulation of 14 years of advocacy efforts, resulting in Governor Whitman signing Public Law 1995, Chapter 318, establishing the Alcohol
and Drug Abuse Program for the Deaf, Hard of Hearing and Disabled. Public Law 1995, Chapter 318 was, indeed, a true victory for the state of New Jersey, but it was a national victory for those who advocated continuously for alcohol and drug prevention and treatment services for persons with disabilities. On a national scale, advocacy groups such as the National Association on Alcohol, Drugs and Disability (NAADD) utilize P.L. 1995, Chapter 318 as national tool for other states in their efforts to bring about policy changes in their respective states as it pertains to substance counseling with persons with disabilities. The researcher will offer points from the New Jersey case study as to illustrate the difference legislation can make to a statewide committed constituency.

The researcher believes that to ensure a new political agenda is set, one that encompasses a cultural view of disability among the substance abuse field, the following initial steps should be taken:

1. Statewide community education efforts need to focus on defining and establishing a cultural view of disability in working with the deaf.

2. Organized statewide efforts have to effectively gather information on the state of the deaf substance abusers.

3. Recommendations should be made as a result of this collective effort, which would include the voice of the deaf, (deaf clients, deaf advocates, treatment providers who serve the deaf).

4. Statewide funds need to be set aside to ensure effective implementation of the developed recommendations.

**Community education.** The participants in the study had a combined experience more than 100 years in the substance abuse field. Given that combined experience, the
fact that more than 60% of the counselors had a marginal knowledge in the area of disability warrants serious concern for the field of substance abuse counseling. Interestingly, what was extrapolated from that lack of knowledge was a cultural view of disability that was used to guide their practice. This information is valuable and should not fall to the side but be used as a starting point in a discussion among the community of substance abuse providers and advocates.

The researcher suggests that the cultural view of disability counseling supported by the substance abuse participants in the study be used to educate and inform the substance abuse community. This education can be presented in a number of forums: (a) workshops, (b) recertification credential qualifications, and (c) printed and electronic materials easily accessible to the counselors. One of the necessary requirements for every substance abuse counselor is recertification. Substance abuse counselors have to recertify for their credential every three years by law; 60 training hours are required in order to be recertified. The New York State Office of Alcohol and Substance Services (OASAS) provides guidelines for the new training, such as new learning on teens and tobacco, or new information on methadone treatment. This researcher is recommending OASAS specifically address disability and substance abuse, giving counselors the opportunity to engage in discussions pertaining to developing a cultural view of disability.

An educated substance abuse community will undoubtedly strengthen the cause and build legislative support statewide. In addition, there needs to be an accurate depiction that can illustrate the scope of substance abuse in the disability and in the Deaf community. To accomplish this task, a concerted effort needs to be made to gather
meaningful data pertaining to the disabled community with particular emphasis on the deaf substance abuser.

**Organized state-wide data collection.** One of the steps utilized in the New Jersey case study was the creation of task forces to address the problem of substance abuse among the state’s disability community including the deaf. The researcher recommends that the substance abuse community be diligent in its efforts to gather information on the deaf substance abuser and start with a task force whose sole purpose is to gather such information. Many of the counselor participants in the study said they simply referred deaf clients away. When questioned to as to where within the Rochester community, less than one-third responded with Substance and Alcohol Intervention Services for the Deaf (SAISD). The SAISD program is a grant-based program that provides information, education, prevention, and intervention services to the deaf and hard of hearing population of the greater Rochester, NY area (SAISD, 2014). This program is the combined effort of the Rochester Institute of Technology, New York State Office of Alcohol and Substance Abuse Services, and the Monroe County Department of Mental Health. Since its inception, SAISD has worked to provide education on substance abuse and the Deaf culture in the Monroe County area. Sadly, less than half of the study participants were even aware of the SAISD and its community education efforts.

The starting point for gathering information about deaf substance abusers should include collaborative efforts to join with SAISD on a local level to strengthen the efforts in providing a broader scope of substance abuse treatment for the deaf. SASID has a National Directory (where they attempted to collect real-time statistics on the number of deaf substance abusers across all 50 states, including two providences in Ontario,
Canada). This information can be used to create an international task force designed to capture a true depiction of the plight and experiences of the deaf to truly bring the voice of the deaf to the agenda.

**Collective voice recommendations.** Policy changes call for more than data gathering; there has to be meaning behind the data. Creditability and validity of any data can only be measured by the processes designed to do exactly that, measure credibly and validly. One such measure to check for credibility is to utilize a member check to test the authenticity of the participants’ responses. The researcher proposes this same methodology to ensure that a collective voice of the deaf substance abuser is heard. In gathering the necessary experience of the deaf substance abusers, efforts need to be made to ensure that what is being offered, such as recommendations for the improvement or enhancement of services, is directly coming from the most important stakeholder—the deaf client.

Along with the deaf substance abuse clients, substance abuse providers, as well as organized deaf advocacy groups, need to be the group that develops impactful policy and legislative requests. One such policy and legislative request that the researcher suggests is a legislative funding set-aside, which can be used to allocate a desirable financial, statewide commitment, to push those recommendations into the implementation stage.

**Statewide funding set aside.** One of the most strategic outcomes of New Jersey Public Law 1995, Chapter 318, was state-committed legislative funding that was set aside to ensure continued comprehensive services to persons with disabilities, with particular focus on the deaf. This setting aside was deliberate in the effort to guarantee these
essential services would be delivered and showed a state-wide commitment to the targeted population.

The researcher further recommends more lobbying advocacy to ensure a directed push for more purposeful state financial set asides as it pertains to providing comprehensive services to the deaf. These funds would enable agencies to make the necessary changes that need to occur on an agency and systems level that would provide more culturally competent services to the deaf.

**Structural, systemic, and agency changes.** Few agencies report services specifically targeted to people with disabilities, despite the belief that these specialized programs would be most effective because more general substance abuse programs have neither the knowledge nor the resources to adequately serve these individuals (Bachman, Drainoni, & Tobias, 2003). This was clearly evidenced by the study participants. They acknowledged their incomplete knowledge as it pertains to the deaf population, but, much like their agencies, they did not know where to start. It should be noted that although the counselors did not know where to start, their cultural humility helped them understand that a starting point was needed. The researcher recommends that agencies develop a sense of organizational humility that facilitates an organizational action call. The researcher further recommends that this action plan include; (a) an agency needs assessment, (b) agency-wide coordination, and (c) innovative funding strategies.

**Agency needs assessment.** The primary purpose of any agency needs assessment is to identify strengths, expose weaknesses, and generate goals to move the agency forward. The substance abuse provider needs to be able to identify what his/her agency culture is saying in regard to the disability and Deaf community. One of the participants
in the study stated that the only mantra he has ever heard from the agency in regard to providing services to the disabled community is that every effort will be made to ensure some level of service is provided. It is imperative that agencies address the deaf population with the same zeal and energy as the hearing population, and they must be diligent in their efforts to deliver services to diverse populations.

There are a proliferation of agency assessment tools that agencies can use. The researcher recommends Table 5.1, the SAMHSA, Agency Self-Assessment, Offered in Treatment Improvement Protocol (TIP) 38 series, entitled, *Integrating Substance Abuse Treatment and Vocational Services*. The agency-assessment tool provides a template for agencies to use to assess agency client knowledge, mission, and agency-fit as it pertains to positioning in the field and in the market, and endpoints—the desirables the agency is seeking. This assessment provides the agency with a realistic appraisal of the program’s strengths and limitations. In addition to assessing the agency environment, the assessment has a secondary purpose to strategic assist the agency in identifying funding streams.
Table 5.1

SAMHSA TIP 38 – Agency Self-Assessment Categories

<table>
<thead>
<tr>
<th>Client</th>
<th>Agency Mission</th>
<th>Agency Fit</th>
<th>Endpoints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Capacity</td>
<td>Analyze agency's service delivery profile versus what clients need</td>
<td>Sustainable employment</td>
</tr>
<tr>
<td>Culture</td>
<td>Staffing</td>
<td>Choose to provide services in-house or by referral</td>
<td>Better client outcomes</td>
</tr>
<tr>
<td>Family</td>
<td>Cultural competence</td>
<td>Identify community resources and partners</td>
<td>Improved community conditions</td>
</tr>
<tr>
<td>Trends</td>
<td>Readiness for collaboration</td>
<td>Build relationships</td>
<td>Multiple access points</td>
</tr>
<tr>
<td>Focus groups</td>
<td>Accountability</td>
<td>Changes in organizational structure</td>
<td></td>
</tr>
<tr>
<td>Client feedback</td>
<td>Resources</td>
<td>Specialization and market segmentation</td>
<td></td>
</tr>
<tr>
<td>Inclusion of clients in planning</td>
<td>Technological capability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability issues</td>
<td>Desired outcome</td>
<td>Client centeredness</td>
<td></td>
</tr>
</tbody>
</table>

To ensure correct use of the tool, agencies would factor in the bulleted items as considerations in assessing the agencies, strengths and limitations as it pertains to the category that is being assessed. For example, in the client category, agencies would have
to consider disability issues as they pertain to their clients. One of the areas that could be evaluated for substance abuse agencies, would be their service delivery to their clients with disabilities; considering access, cultural aspects, including communication barriers, etc. Agencies could then further evaluate how the agency mission aligns with the client disability issues, and where the agency fits with regard to comparable agencies as well the broader substance abuse field, and then decide where the agency wants to end up as it pertains to the particular community.

**Agency-wide coordination.** In an effort to provide a thorough review and assessment of the agency, the researcher would offer that the agency have agency-wide coordination. This agency-wide coordination would ensure a well-integrated cultural view of disability across the agency. In an attempt to further strengthen the coordination, the researcher suggests that the agency must engage in intergroup dialogue to ensure agency buy-in. Several of the participants in the study noted the guilt they felt when asking their supervisors’ permission to attend training that would assist them in working with the deaf. An agency-wide cultivation of an appreciation for and acceptance of Deaf culture would provide an environment where the former would not be tolerated.

**Innovative funding strategies.** To ensure agency buy-in, and in an effort to facilitate agency culture change, funding has to be in place to implement the necessary change. The researcher suggests that agencies become creative and innovative in their funding strategies. Agencies have to become knowledgeable about government entities that support communities, agencies, and states in providing services to the disability community. One such entity, Disability and Rehabilitation Research Project and Centers Program, can be a valuable financial resource. This program is funded under the auspices
of the National Institute on Disability and Rehabilitation Research. The purpose of the Disability and Rehabilitation Research Project and Centers Program is to plan and conduct research, demonstration projects, training, and related activities, including international activities, to: (a) develop methods, procedures, and rehabilitation technology, that maximize the full inclusion and integration into society, employment, independent living, family support, and economic and social self-sufficiency of individuals with disabilities, especially individuals with the most severe disabilities and (b) improve the effectiveness of services authorized under the Rehabilitation Act. This program provides grants to assist (a) states; (b) public or private agencies, including for-profit agencies; (c) public or private organizations, including for-profit organizations; (d) institutions of higher education, and (e) Indian tribes and tribal organizations. Substance abuse providers need to become creative in developing new funding streams that are outside of their normal funding streams.

The researcher believes that by doing an agency self-assessment, ensuring agency-wide coordination, and making a commitment to innovative funding development, agencies can change their organizational cultures. These efforts could assist the agency in further identifying areas of professional development for the staff. The researcher would suggest that the agencies could factor in, as an endpoint, the creation of a cultural view of disability training initiative for staff to ensure culturally competent services.

**Education and staff training.** There needs to be an investment in the people who provide the most intimate, life-changing services to the client—the counselors. Agencies need to invest in trainings that provide and produce learning environments that keep their
counselors abreast of the new, innovative, and evidence-based knowledge and skills that progressively move the field along. The study findings clearly showed the apparent limitations in the participants’ training and preparation in working with the deaf.

Using the agency assessment tool, these limitations could be mitigated by utilizing evidence-based training practices. The SAMHSA is a branch of the United States Department of Health and Human Services, which is charged with improving the quality and availability of prevention, treatment, and rehabilitative services, in order to reduce death, disability, and cost to society resulting from substance abuse and mental health, and it is leading the charged in developing competent service-provider personnel. In its Evidence-Based Practices Knowledge Informing Transformation (KIT), the agency proposes a few suggestions as a means of putting cultural competence in practice with regard to staff development, which should start with the suggestions being implemented in agency policy and procedures:

- Incorporate cultural awareness into consumer’s needs.
- Offer training to staff in culturally responsive communication or interviewing skills.

The researcher would strongly recommend the Collins and Arthur Cultural Infused Counseling Model (2007), as a guide in directing those evidence-based practices. Again, the model addresses the cultural awareness of self as well as others to create a culturally working alliance.

Betancourt et al. (2003) offered recommendations for staff in becoming “clinically cultural competent” by being exposed to educational initiatives that aim to teach providers the key tools and skills to deliver quality care to diverse population. The
The overarching goal of these educational and training interventions is to equip health care providers with the knowledge, tools, and skills to better understand and manage sociocultural issues in the clinical encounter. The methods for delivering this education have varied and range from the “categorical” or “multicultural” in which specific information about certain cultures is taught to providers to a more “cross-cultural approach” and that focuses on key process issues of caring for patients from diverse backgrounds (Betancourt et al., 2003).

Cooper et al. (2004), in their survey of mental health professionals’ attitudes toward deaf clients, found that the professionals who were comfortable working with these clients had received some training in issues related to the individuals who were deaf. Peters (2007) suggested that counselors who may consider working with the deaf client enroll in a sign-language class or attend a class on Deaf culture, he further stated that counselor education programs consider these classes as electives in their training program. In an effort to better inform the counselor’s cultural view of disability, the researcher highly suggests the integration of experiential learning to provide for a more comprehensive approach.

All of the counselors interviewed for the study mentioned that they were not exposed to the models of disability in their substance abuse certification preparation; this is a cause of concern for the researcher. The researcher believes that the counselors interviewed for the study were good counselors who undoubtedly cared about, and for, the population they serve; the researcher further believes that these good counselors could become great counselors if they were better informed.
It should be noted that the New York State Office of Alcohol and Substance Abuse Certification curriculum has a 300-hour field work component. The researcher strongly suggests that this fieldwork experience be deliberate in its intent at placing individuals in agencies that are committed to diversity with the caveat that these interns have full exposure to all clients, including deaf clients. One of the common practices in the field of addiction counseling is that interns do not get full exposure to the clients. While the researcher understands the liability that agencies assume, it is the ultimately the agency who can “break away” from the norm and help in the restructuring that is needed to develop a workforce that is prepared to deliver culturally informed counseling.

Limitations

The researcher is firm in her belief that the findings generated by the study are significant in introducing new learning to the field; however, the researcher also acknowledges that there were limitations within the study. The first limitation was the coding design. The researcher acknowledges there is no specific measurement instrument to test the validity of the codes. The coding structure was extrapolated from the researcher’s professional knowledge and experience, which includes a combined experience of 16 years of direct counseling practice as well as five years of substance abuse certification instruction at the community college level. In replicating the study coding structure, the researcher believes that an investigator who has experience in the field of substance abuse counseling will undoubtedly be familiar with the codes, as the terminology is germane to the body of knowledge in the field of substance abuse counseling.
The second limitation is not a methodological limitation but a critical element of consideration for future studies. The researcher wishes to acknowledge the lack of the deaf substance abuser’s voice in this study as a means to substantiate the intended counseling practices of the participants. The researcher recognizes that only half of the counseling experience was exposed and would suggest that future research attempt to engage the deaf substance abuse client.

**Recommendations for Future Research**

In light of the limitations suggested and highlighted in this study, the researcher offers the following recommendations for future research:

- Studies examining the clients’ perspective of their counselors’ perceived and actual level of cultural competency.
- Studies that address testing of the hypotheses generated here.

As stated in the limitations section, this study presented half of the picture of cultural competence in substance abuse counseling pertaining to the deaf. The study participants discussed their intended practices; but without validation from the client experience, it is unknown if the counselors’ intended practices are being experienced. Future studies that engage the deaf substance abuser could bring validity to the counselors’ intended practices as well as bring new learning to the field on how to effectively work with the deaf.

In addition to learning from the deaf substance abuser, counselors need to receive evidence-based knowledge on how best to engage the deaf substance abusers, in addition to working with interpreters. The researcher strongly suggests that the substance abuse certification and training programs adapt the models of disability in the preparation of
counselors. The researcher also suggests that a centralized model of cultural competence be infused as a means to further educate the counselors on creating a cultural view of disability. Future research studies examining the inclusion of the models of disability in the certification preparation would provide a means to test both hypotheses that were generated from this study.

**Conclusion**

This research, which was exploratory in nature, generated findings that supported two hypotheses, which later evolved into a single implication. The researcher believes that the single implication of creating a cultural view of disability in the field of substance abuse would be highly significant.

The researcher has suggested that the field of substance abuse counseling can facilitate a cultural view of disability by: (a) creating a social-justice counseling perspective in the field by addressing the intersectionality of cultural competence and disability, (b) creating a political-social environment that embraces that intersectionality by advocating for a cultural view of disability through setting aside budget funds, (c) endorsing the agency and systemic changes that are needed, and (d) to support the education and training efforts that need to be made to ensure that counselors can provide services that support a cultural view of disability.
References


TAP 21: *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice.* (Substance Abuse and Mental Health Services, DHHS Publication No. SMA 98-3117). Rockville MD: SAMHSA, CSAT.


Appendix A

Interview Protocol

Time of Interview:
Date:
Interviewer:
Participant (Interviewee):

Interview Questions
*Please note prior to interview all participants have filled out a demographic form to gather all demographic information

Introductory script-

Hello, today I would like to talk with you about your education, training and your perception of your own cultural competence. Can you please discuss with me your understanding of cultural competence-?

1. How has your substance abuse counseling training (certification; education hours, etc.) prepared you professionally to work with Deaf sign language users clients?

2. How has your substance counseling training prepared you to become or in becoming culturally competent to work with Deaf sign language users?

3. Describe your experiences in working with Deaf sign language users? If limited describe your perception with working with Deaf sign language users?

4. How would you describe your therapeutic practice? (further probes listed below)

   • What are some elements
   • View of client
   • Theoretical orientation
   • View of disability

Next you will be provided a sheet describing four specific models of disability (Appendix D). Please select an answer from the answer list that best describes the described model.
For example if you believed the description provided is the “biomedical model,” please select that model.

5. Do you believe any of these models inform your practice? If so, how and how not?

6. Do you believe any of these models inform the cultural competence of a counselor?

7. Were you exposed to any of these models in your substance abuse counselor training?

8. Any other things you would like me to know that pertains to your practice in regards to your training?

9. As a result of having a discussion regarding the models of disability, has your perception about your preparedness for working with the Deaf population changed? How? If not, why?

Thank you.
Appendix B

Letter of Introduction to Participants and Invitation to Participate in Study

Angelia Smith Wilson, MSW, CASAC
Community Outpatient Program
Rochester, NY
RE: Study Participation Invitation
Hello,

My name is Angelia Smith Wilson and I am a doctoral candidate at St. John Fisher College. I am interested in learning about the relationship between the substance abuse counselor knowledge of the models of disability and their self-assessment of cultural competence working with the Deaf. I would like to interview, face-to-face substance abuse counselors to collect qualitative data. The interview will take approximately one hour to an hour and a half and can occur at a separate location, in a private area, near the counselor place of employment. The interviews will be audio-taped and later transcribed by a transcriptionist. All information provided in the interview, will be strictly confidential and only the researcher and transcriptionist will see the original transcripts. To ensure confidentiality, no names will be used to identify participants.

The purpose of this study is to gain a better understanding of the relationship between substance abuse counselor knowledge of the models of disability and their self-assessment of cultural competence. It is the hope of the researcher to be able to provide future opportunities of professional development for substance abuse counselors. The information you share may help with this.
Participation is entirely voluntary, or you may choose not to answer certain questions or discontinue your participation at any time without any penalty. Any counselor who is certified to provide alcohol and substance abuse treatment can participate. If you would like to participate in the research study, please call (585)259-7728 or email asmwilson13@gmail.com and leave a message regarding the best way to contact you.

Please be advised that this study has been approved by the Institutional Review Board at St. John Fisher and the researcher has completed the National Institute of Health training on conducting research. Informed consent will be obtained prior to the start of the interview.

I sincerely thank you for your consideration and ultimately, your participation.

Thank you,

Angelia Smith Wilson, MSW, CASAC
Doctoral Candidate
Ralph C. Wilson, School of Education
St. John Fisher College
Rochester, NY
Appendix C

St. John Fisher College
Institutional Review Board
Informed Consent Form

Title of study: Are we prepared to hear? Examining the relationship between the substance abuse counselor knowledge of the models of disability and their perceived preparedness of cultural competence when working with Deaf sign-language users.

Name(s) of researcher(s): Angelia Smith Wilson

Faculty Supervisor: Dr. Jason Berman Phone for further information (585)385-8086

Purpose of study: A qualitative study that seeks to examine the relationship between the substance abuse counselor knowledge of the models of disability and their self-assessment of cultural competence working with the Deaf sign language user.

Study Procedures: Qualitative, face-to-face, one-on-one, interviews with ten substance abuse counselors. Interviews to be audio tapped, off-location of participant work place, and conducted in private area.

Approval of study: This study has been reviewed and approved by the St. John Fisher College Institutional Review Board (IRB).

Place of study: Rochester Area, Community Outpatient Programs
Length of participation: 3 months

Risks and benefits: The expected risks and benefits of participation in this study are explained below:

A minimal risk related to possible emotional distress that can be associated with a counselor low perception of preparedness when working with the Deaf.
The benefits to include an awareness of a counselor potential lack of knowledge base regarding the models of disability, increased awareness of a potential lack of preparedness and increased opportunity for professional development.

Method for protecting confidentiality/privacy:

1. There will be no participant names used in the study.
2. All participants will be identified by a color such as, red, blue, green, purple, pink, etc.
3. All audio will be coded accordingly and transcribed by a transcriptionist.
4. All interviews will be conducted outside of the participant place of employment and in a private area.
5. No report of the findings of this information will be used or provided as an agency report

Your rights:

As a research participant, you have the right to:

1. Have the purpose of the study, and the expected risks and benefits fully explained to you before you choose to participate.
2. Withdraw from participation at any time without penalty.
3. Refuse to answer a particular question without penalty.
4. Be informed of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to you.
5. Be informed of the results of the study.

I have read the above, received a copy of this form, and I agree to participate in the above-named study.

_________________________________________  ____________________________  ____________
Print name (Participant)  Signature  Date

Angelia Smith-Wilson

_________________________________________  ____________________________  ____________
Print name (Investigator)  Signature  Date

If you have any further questions regarding this study, please contact the researcher listed above for appropriate referrals.
Appendix D

Model Knowledge Measure

Please read the following four descriptions of the models of disability, which are presented in random order. Please indicate which model is being described; biomedical, environmental, functional and sociopolitical.

1. The underlying assumption in this model of disability is that pathology is present, and, in addition, disabilities are objective conditions that exist in and of themselves (Smart, Smart, 2006). This conceptualization of pathology being connected to the disability opens the door to the possibility of dehumanizing the disabled person because attention is focused on the supposed pathology (Albrecht, 1992; Longmore, 1995) The model considers disability to be biological inferiority, malfunction, pathology, and deviance when compared with (or normed) individuals without disabilities (McCarthy, 1993).

2. This model defines disability, the causal attribution, and the solution attribution is not found wholly within the individual (or his or her disability). Therefore, the “problem” is not the disability but suggests that many of the difficulties of are located outside the individual, specially within the environment and its functional requirements (Wolfensberger, 1972) It is this interactional premise that is the foundation of this model as well closely related to the theoretical assumption and practice orientations of most counselors (Smart & Smart, 2006).

3. By viewing the disability as not the “problem,” but one that environment that can exacerbate disability supports this model. The model of disability posits that society can cause disabilities, exaggerate disabilities, and in the words of some disability scholars, “make disabilities” (Higgins, 1982). If the location of the problem shifts, the onus for the solution for the solution of the problem also shifts. By viewing the definition, the cause,
and the difficulties of disability as interactional, helping professionals can aim interventions at adapting the environment and functional demands to the needs of the individual with a disability in addition to “rehabilitating” the individual.

4. This model does not accept the inferiority, categorizing or stigmatization of disability. Disability in this model is defined as a social construction of society’s view on disability and has nothing to do with the disability itself. Stigmatization, prejudice, discrimination, inferiority and not handicapism are not inevitable, natural, or unavoidable consequences of disabilities. The model has three aspects that are included in conceptualizing disability: (a) people with disability must define disability; (b) people with disabilities must refuse to allow “experts” or “professionals” to define the disability, determine the outcomes of their lives, or judge the quality of their lives; and (c) people with disabilities refuse the “disabled role” of deviance and pathology (Smart & Smart, 2006).
Appendix E

Demographic Profile Form

Participant Identification Color ________________________________

Instructions: Fill and the mark the choices that apply to you, the participant.

1. Age: ________________

2. Gender: Male ______ or Female _________

3. Job Title: __________________________

4. List degrees or certifications you possess:

5. How many years have you worked in the substance abuse field? __________

6. How many years working with Deaf sign-language user? ______________

7. Please list any experience you have working with Deaf sign-language user if under a year of direct experience with working with this population. ______________
Appendix F

April 25, 2014

Institutional Review Board
St. John Fisher College
Office of Academic Affairs, K0202
3690 East Avenue
Rochester, NY 14618

Dear Institutional Review Board:

The purpose of this letter is to grant Angelia Smith Wilson, MSW, CASAC, a graduate researcher at St. John Fisher College, permission to conduct research at Substance and Alcohol Intervention Services for the Deaf (SAISD). The project, entitled, “Are We Prepared to Hear Them All”, entails exploring the self-assessment of cultural competency of substance abuse counselors who work with the Deaf population.

Ms. Smith-Wilson will be recruiting voluntary participants at our agency for the project. She will interview the participants (substance abuse counselors) asking them about their counseling practice in the context of their education and training, knowledge base, as well as their attitudes and beliefs when working with the Deaf population. Ms. Smith-Wilson has agreed to keep us informed about the results of her study once it is completed, if requested.

I, Jeff Rubin, do hereby grant permission for Angelia Smith-Wilson to recruit voluntary participants for her study at Substance and Alcohol Intervention Services for the Deaf.

Sincerely,

Jeffrey Rubin
Principal Investigator/Director SAISD
Jeffrey. Rubin @ RIT. Edu
585-475-5002

[Signature]
Appendix G

May 2, 2014

File No: 3339-041714-07

Anglia Smith Wilson
829 Pond View Heights
Rochester, NY 14612

Dear Ms. Smith Wilson:

Thank you for submitting your research proposal to the Institutional Review Board.

I am pleased to inform you that the Board has approved your Expedited Review project, "Are We Prepared to Hear Them All?"

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at 385-5262 or by e-mail to mergen@stfc.edu, or if unable to reach me, please contact the IRB Administrator, Jamie Musca, at 385-8318, e-mail jjm2@stfc.edu.

Sincerely,

Eileen M. Mergen, Ph.D.
Chair, Institutional Review Board

EM:JMN

Copy OAA IRB
IRB: Approve expedited.doc

3690 East Avenue • Rochester, NY 14618 • 585-385-8000 • www.sjfc.edu
Decision of Institutional Review Board

Reviewed by: [Signature]
Subcommittee Member #1
[Signature]
Subcommittee Member #2

Date: 5/1/14
Date: 4/23/14

☑ Approved
☐ Not Approved

Comments:

☐ No Research
☐ Minimal Risk
☐ Research & Risk

The proposed project has not research component and does not need be in further compliance with Article 24-A.

The proposed project has a research component but does not place subjects “At Risk” and need not be in further compliance with Article 24-A.

The proposed project has a research component and places subjects at risk. The proposal must be in compliance with Article 24-A.

[Signature]
Chairperson, Institutional Review Board

Date: 5/2/14

Rev 12/10 jra