9-21-2005

Alcohol awareness education in the deaf and hard of hearing classroom

Julie Wainman

Alcohol Awareness Education in the Deaf and Hard of Hearing Classroom

Master's Thesis

Submitted to the Faculty
Of the Master of Science Program in Secondary Education
Of Students who are Deaf or Hard of Hearing

National Technical Institute for the Deaf
ROCHESTER INSTITUTE OF TECHNOLOGY

By

Julie D. Wainman

In Partial Fulfillment of the Requirements
For the Degree of Master of Science

Rochester, New York **May 25, 2002**

Approved: _____
(Project Advisor)

_____
(Second Project Advisor)

_____
(Program Director)

Many thanks to:

Gerry Buckley

Gerry Bateman

And

Jean Bondi-Wolcott

For their tremendous support and feedback.

As well as:

Sam Russotto and my wonderful family, because without them, I would not have made it this far.

Alcohol Awareness Education in the Deaf and Hard of Hearing Classroom: Modifying an Alcohol Awareness/Prevention Curriculum for use with Deaf Secondary Students

By Julie D. Wainman

Section One: Abstract

It has often been pointed out that education/prevention curricula in the schools has not accommodated the communication skills of deaf or hard of hearing students and have often been insensitive to their culture. For example, the lessons are frequently presented in a language that the deaf student cannot understand. Furthermore, it has been indicated that there is a need for further study focusing on alcohol abuse by deaf adolescents and its contributing factors. There is also a need to recognize that the deaf population has been mostly overlooked in terms of understanding that they are at-risk and changes need to be made to accommodate and increase this new awareness.

Little research has been done to accurately identify the level of substance abuse among deaf people. 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 & Sandberg, 2).

This paper will be looking at many issues regarding alcohol abuse by deaf and hard of hearing adolescents and how we can positively change how deaf and hard of hearing adolescents learn about alcohol and drug use and how we can incorporate alcohol

awareness into the curriculum in a form that they can understand. In addition, this paper will be proposing guidelines on how to teach alcohol awareness effectively to deaf and hard of hearing students and will also take a look at an alcohol awareness curriculum that has been revised solely for the purpose of this paper.

Section Two: Introduction and Statement of Problem

For many years, there have been countless debates on deafness and what it means. For the purpose of this project, the following description was incorporated to show the two different perspectives seen in society.

> "Deafness is commonly considered from two different perspectives. One perspective identifies Deafness as a disability; this is commonly referred to as the medical model. The second perspective recognizes Deaf people as a cultural group with common language, experiences, and values. Both perspectives offer a unique look at the Deaf population. Each viewpoint is important when considering the provision of substance abuse services for people who are Deaf." (Guthmann & Sandberg, 1).

This brings about the question of why many are concerned about the alcohol abuse problems of deaf and hard of hearing adolescents when the hearing population has the same issues to deal with as well. Alcoholism is a pervasive problem for our society but our hearing peers are able to get access to information and services for alcoholism

whereas within the deaf population, this kind of information as well as services are not accessible to the deaf. Again, it should be noted that alcohol usage is pervasive in our culture because it is estimated that there are roughly 100 million users of alcohol in the United States of which approximately 10% are heavy users or problem drinkers (Isaacs, Buckley & Martin, 1979). Also, much of the programming in schools for the deaf has been found to have a moralistic slant. In many, children are "overprotected" from exposure to films, magazines, and other media which discuss alcoholism and drug use realistically (Isaacs, Buckley & Martin, 1979).

This issue of alcoholism among our adolescents is a very serious problem that needs to be addressed for many reasons. The issue of substance abuse is one that affects virtually everyone in this country. Individuals who are deaf or hard of hearing are affected by substance abuse just like hearing people. Although research has been scarce, the assumption has been made that this population maintains at least the level of addiction found in the general population (Sandberg, Korwin & Mathews, 2002). What's more, it has been stated that deaf adolescents may experience a higher level of stress in their lives than adolescents who can hear. As a result, these individuals may turn to drinking and drug use to reduce stress and/or to fit in with hearing students and peers. Dick (1996) found that deaf and hard of hearing adolescents who attended mainstreamed schools and had high numbers of hearing friends at school reported higher rates of alcohol use than those with smaller numbers of hearing friends at school (Guthmann, 5).

While prevalence figures for deaf and hard of hearing individuals in the United States vary widely due to inconsistencies in measuring and defining deafness, a study conducted in 1980 indicated that there may be over 73,000 deaf alcoholics residing in the

States (Lipton & Goldstein, 1997). Seeing as how there is a large population struggling with alcohol abuse, not much has been done to counteract this problem or even to address this problem. As an indication of how far back this "problem" goes, in a 1984 publication of U.S. Journal of Drug and Alcohol Dependence, the author stated that "the deaf and hearing impaired with problems are one of the most neglected and underserved areas in the alcoholism field" (Sabin, 1986).

In addition, several studies reported a higher incidence of substance abuse in the deaf community, largely due to lack of access to information or understanding about substance abuse. Another barrier is the lack of quality services in programs with knowledge and expertise in deafness (Searls, 2001).

Not only is there an indication that deaf adolescents are not aware of the dangers of alcohol and if this problem is not caught on time, but it can lead to many problems for the deaf adolescents, which can also impact their behavior in school and family life. Alcohol abuse among deaf adolescents is a problem that needs to be recognized and addressed now for several reasons: to educate on the dangers of alcohol abuse, to understand what the signs/symptoms of alcohol abuse are, and also what the contributing factors for alcohol abuse are.

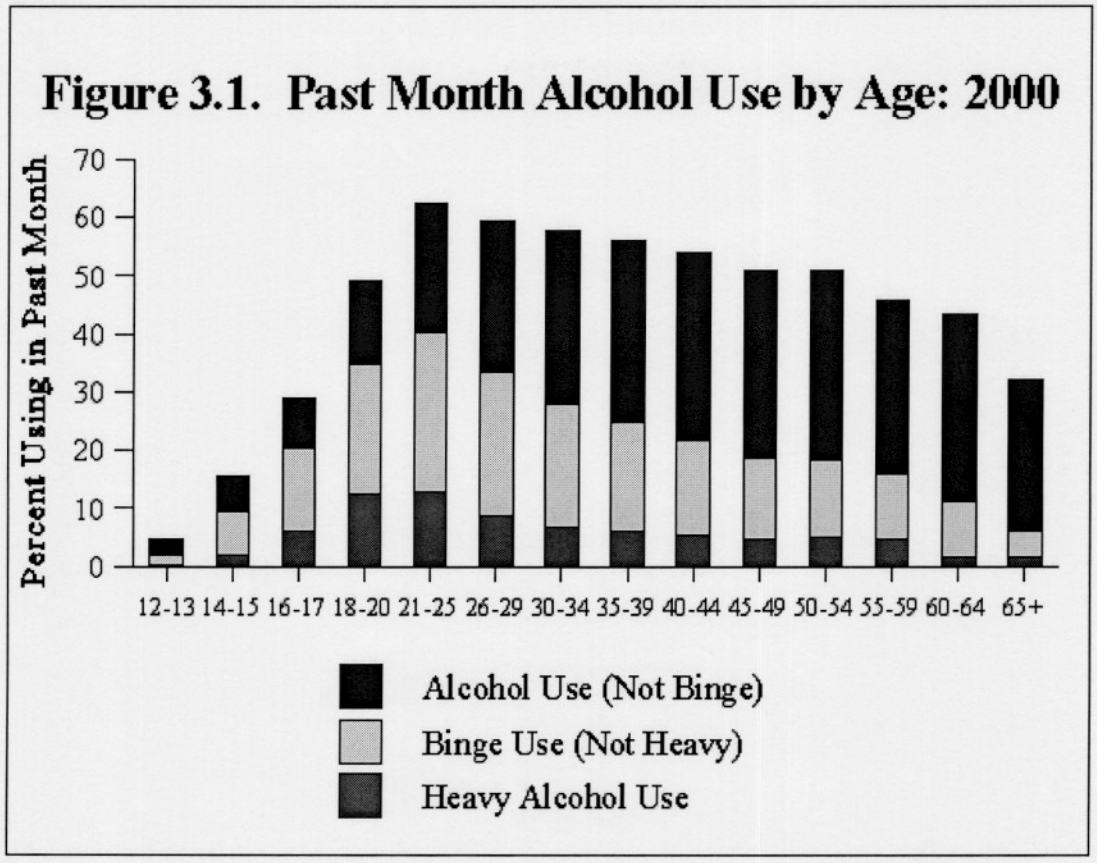
Section Three: Literature Review on the General Population

According to U.S. News, "Alcohol is far and away the top drug of abuse for American kids. The college binging drinking problem starts with children and teens and that's where our prevention and education efforts must be focused." (Llanos, 2002, p. 3). In addition, it has also been reported that:

- Approximately one-fifth (20.6 percent) of persons aged 12 years and older (46 million people) participated in binge drinking at least once in the 30 days prior to survey. This represents approximately 44 percent of all current drinkers. (SAMHSA, 2002)
- 81% of high school students have consumed alcohol compared with 70% who have smoked cigarettes and 74% who have used marijuana (Llanos, 2002).
- Most teens who experiment with alcohol continue using it. Among high school freshmen who had tried alcohol, 91.3% were still drinking in the 12th grade (Llanos, 2002).
- Almost half of Americans aged 12 and older reported being current drinkers of alcohol in the 2000 survey (46.6 percent). This translates to an estimated 104 million people (SAMHSA, 2002).
- Heavy drinking was reported by 5.6 percent of the population aged 12 and older, or 12.6 million people (SAMHSA, 2002)
- For current alcohol use, binge drinking, and heavy alcohol use, 21 is the age of peak prevalence (SAMHSA, 2002)
- The prevalence of current alcohol use in 2000 increased with increasing age for youth, from 2.4 percent at age 12 to a peak of 65.2 percent for persons 21 years old. Unlike prevalence patterns observed for cigarettes and illicit drugs, current alcohol use remained steady among older age groups. For people aged 21 to 25 and those aged 26 to 34, the rates of current alcohol use were 62.4 and 58.3 percent, respectively, in 2000. The prevalence of alcohol use was slightly lower for persons in their 40s. In the case of those aged 60 to 64, past month drinking

was reported by 43.2 percent of respondents and 32.0 percent of persons 65 and older reported current drinking (Figure 3.1) (SAMHSA, 2002)

- The highest prevalence of both binge and heavy drinking in 2000 was for young adults aged 18 to 25, with the peak rate occurring at age 21. The rate of binge drinking was 37.8 percent for young adults and 45.2 percent at age 21. Heavy alcohol use was reported by 12.8 percent of persons aged 18 to 25, and 16.7 percent among persons age 21. Binge and heavy alcohol use rates decrease faster with increasing age than do rates of past month alcohol use. While half of the population aged 45 to 49 in 2000 were current drinkers, fewer than one in five persons within this age range binge drank and fewer than one in twenty drank heavily (Figure 3.1) (SAMHSA, 2002).



(SAMHSA, 2002)

A look at the above statistics only reiterates the severity of the problem of adolescents, hearing or deaf, alcohol and emphasizes the need for intervention and prevention by our teachers, parents, and friends. There is a strong need for alcohol awareness to be taught in the classroom and this is the reason for why it is important for teachers to get an idea of the statistics that exists out there and just how severe the problem of alcoholism is for our students, especially our deaf students.

So how does it all begin? It has been stated that oftentimes, it is easy for teens to obtain access to alcohol. According to the National Household Survey on Drug Abuse Report, one-third of sixth- and ninth graders get alcohol from their own homes, and these students also cited other people's homes s the most common setting for drinking (Llanos,

2002). Furthermore, to indicate the wide knowledge of alcohol beverages by our students, it has been reported that:

> "Almost half the teenagers have tried the new Alco pops, fruit flavored malt-based alcoholic beverages with names like Hard Lemonade, Smirnoff Ice, Skyy Blue, Tequiza and Hooper's Hooch. These drinks are particularly appealing to the young because of their sweet taste. Teenagers were three times likely to know about these drinks than adults, and 14- to 16- year olds preferred them to beer."
>
> (Lewin, 2002).

Section Four: Literature Review on Deaf and Hard of Hearing Youths

The initial literature review for this topic had been completed many years ago with adequate information to be found, however there were many gaps and areas that were not covered. Today, the results of that same literature review presented much of the same information with only a few new pieces of information to be added to the literature review. In the course of conducting the literature review, there were a variety of places to find information from: journals on line, websites, books, and random articles found on the WWW as well. However, it should be noted that many of the articles on this subject are outdated and limited, empirical data involving this population is almost non-existent. More research on this population and alcohol abuse needs to be conducted with concrete statistics as well.

A review of the literature review shows the following: deaf people experience similar drinking and drug use patterns as most Americans (Lipton & Goldstein, 1997). The concern for this population stems mostly from the fact that there is not sufficient help for deaf people with an alcohol problem (Lipton & Goldstein, 1997).

There are many factors that contribute to deaf adolescents with alcohol problems, some of these factors include social isolation, frustration, loneliness, poor academic achievement, poor decision-making skills, lack of education, inadequate coping skills, identity problems, low self-esteem, communication barriers, and family problems (Sabin, 1986). A study conducted by Locke and Johnson (1981) reported the results of drinking patterns of 46 deaf adolescents attending a high school for the deaf, found patterns of use similar to the non disabled population. In addition, this study reported that 63% of the subjects used alcohol at or before 14 years of age and 10% had encountered legal problems because of their drinking behavior. While these studies focused on persons who had attended or were attending special schools for youths who are deaf or hearing impaired. Vernon and Andrews (1990) reinforced this finding from their own study and reported that drug and alcohol problems are especially prevalent among deaf adolescents in mainstreamed programs who may find social acceptance among marginal hearing peer groups who have been rejected themselves and consequently become involved with drugs and alcohol (Sabin, 1986). The deaf and hard of hearing population has to cope with more frustrations in daily life as a result of communication barriers. Sometimes people who lack the coping mechanisms to deal with frustration turn to alcohol.

While conducting this literature review, much of the review concentrated on Deaf adults with the focus only starting to shift to deaf adolescents in the late 1990s. As such,

recent research studies like one conducted by Guthmann and Blozis (2001) pointed out that within the deaf and hard of hearing community, there is a lack of awareness about the problem of alcohol abuse, and many of these people have not had access to the recent widespread attempts to educate people about the dangers of alcohol abuse. The authors have also indicated that preventive curricula in schools have not accommodated the communications skills of deaf and hard of hearing students and have often been insensitive to their culture and this also presents a problem when trying to admit that there is a problem.

When looking at the general population versus the deaf, there were strong comparisons made. There are approximately 10 million alcoholics residing in the States (Steitler, 1984). Comparisons of the abuse of alcohol within the deaf and hard of hearing populations range from a lower incidence among deaf alcohol users to a greater risk among disabled individuals (Lane, 1989). The majority of research, however, indicates that deaf people face at least the same risk of alcoholism abuse as their hearing counterparts do (Lane, 1989).

Why do the deaf choose to abuse alcohol? Suggested reasons for abusing alcohol among the deaf population included: (1) easy access to drugs/alcohol and widespread resistance among educators, parents, and others recognizing the warning signs; (2) abuse of alcohol occurs in an attempt to manage frustration and anxiety; (3) disabled people are an oppressed minority, and alcohol promises numbness and relief; and (4) alcohol abuse may result from medical intervention and the rehabilitation process (Lane, 1989).

Three factors may influence a deaf or hard of hearing person to abuse or become dependent on alcohol or drugs: isolation from the mainstreamed population, cultural

issues, and communication barriers. To support this reasoning, SAISD, a local organization for the prevention of alcohol abuse found that people who are deaf or hard of hearing feel "different" from the mainstream population that hears (2001). They feel a lack of social acceptance and isolation. That isolation may be felt even within the family unit. If there is only one deaf or hard of hearing person in a family, that person may feel isolated because of the language and environmental differences arising from being deaf in a hearing world. Research shows that a person who feels isolated through non-communication with family and friends may be at greater risk for addiction (SAISD, 2001).

Furthermore, some deaf and hard of hearing people feel there is a social stigma attached to being deaf and they do not want to admit they may have a chemical dependency problem too (SAISD, 2001). If such a person were to admit to being both deaf and an alcoholic, she or he would have a doubly negative social stigma or label in mainstream society. The deaf community perceives addiction as a personal weakness and a moral sin. Many deaf and hard of hearing individuals who are addicted feel a deep sense of shame. This shame discourages deaf alcoholics from admitting their problem and seeking treatment (SAISD, 2001).

With regard to prevention efforts, comprehensive substance abuse prevention programs were implemented in many public schools for hearing students beginning in the 1980s. According to epidemiological studies (Johnson & O'Malley, in press), the rates of alcohol and drug use for hearing adolescents have declined since that time. In contrast, prevention programs for deaf and hard of hearing students in either mainstream or residential schools are limited, if they exist at all. Many schools do not have a chemical

healthy specialist who can offer assessment, intervention, or counseling services. Also, mainstream schools often have not modified extant prevention approaches and materials to meet the communication and cultural needs of Deaf and hard of hearing students. To offer evidence for this statement, Guthmann and Sandberg4 stated that many of the prevention efforts through the media have been inaccessible to deaf people. Radio announcements miss this population entirely and many TV announcements are not captioned. With the lack of education and information, Deaf people are not likely well informed about the risks of using alcohol and other drugs and are not prepared with the necessary skills to deal with the dangers they represent.

Many deaf and hard of hearing young people grow up in families and attend schools where their language isolates them from the normal information flow. The availability of information on substance abuse and treatment is fragmentary, haphazard and slow (Guthmann, 5). Essential to prevention, assessment is having materials and approaches to these chemical dependency topics. For those persons who use ASL or another manual language, it is necessary that these materials and approaches are presented in ways that are readily processed. Currently, the written and visual materials that address this knowledge gap are inadequate and often written at a level the deaf child cannot understand. Those that are available are not systematically distributed or used (Guthmann, 5).

While a great deal of clinical concern has been expressed regarding the substance abuse problems among this population, limited research has been conducted on which to base generalizations. Whitehouse et al (1991) purport that persons who are deaf or hearing impaired continue to experience a disproportionate lack of attention in regard to

substance abuse research and prevention. After searching several literature databases, including United States government documents, these authors could only find 4 dozen articles regarding persons who are deaf or hearing impaired. Of these articles, 50% were classified incorrectly, focusing on hearing loss resulting from substance abuse (Sabin, 1986).

Educational levels of deaf and hard of hearing individuals can pose a problem when giving them information. Sometimes an audience has a wide variety of education levels, and one form of communication will not satisfy all the needs of the audience. Knowledge of the general level of education and communication proficiency of the audience is needed. The activity and discussion format should allow for many different education and communication needs. It is extremely important that the facilitator/counselor be fluent in ASL and knowledgeable about Deaf culture. (SAISD, 2001).

Section Five: A Model Prevention/Education Program for Deaf and Hard of Hearing Youths

It has been stated time and again that there is a strong need for a program that educates deaf students on alcohol and its dangers in the schools. Research shows that Deaf people receive little or no information about drugs and alcohol. Few residential schools and almost no mainstream public school programs involve deaf students in substance abuse prevention curricula. It is not uncommon for young deaf substance abusers to overdose on drugs because they are unaware of drug tolerance, drug purity or

impurity, drug interactions, and other consumer issues which by and large are better understood by the hearing community (McCrone, 1982).

A study in 1974 (Smart and Fejer) listed the following characters as descriptive of an ideal drug and alcohol education program:

1. All programs should be established as evaluation studies with pre- and post-test measures and follow-up studies several months after they end.
2. Evaluation instruments must be both reliable and valid.
3. Progress evaluations should be based primarily on changes in drug attitudes and drug use behavior rather than merely on increases in knowledge levels.
4. Expectations for major change should be based on coursework extending a minimum of 1 to 12 class hours.
5. Permanence of change should be judged after 6 to 12 months through follow-up evaluations.
6. The modality for delivery of information should include alternatives to drug use, i.e., social organizations, sports, community service work, meditation, and natural highs.
7. Programming should be delivered continuously over a period of several years beginning with non-users 8 or 9 years of age.

Parents with deaf adolescents in a school program that offers a drug and alcohol education curriculum in the format described above are encouraged to become familiar with the program content (Steitler, 1990). The concepts listed here should serve as a guide for any programs that are geared towards educating the deaf and hard of hearing.

As such, it was with a great deal of searching that finally uncovered a drug and alcohol awareness program guide that was geared towards educating deaf youth on the dangers of alcohol and drug use and how to say no. By modifying the contents of "ME TOO!: A Substance Abuse Prevention Project for Deaf Youth," (1992) which was developed by The Community Network of Ohio and written by Darlene Goncz-Zangara, this writer was able to develop a more cohesive alcohol awareness tool that can be used in the classroom to teach our deaf students about the dangers of alcohol and this can be done at a very young age. The contents of this newly modified project, which has not yet been approved or field tested in the classroom, can be easily adapted for any grades using more or less materials as well as a more developed language.

Again, after researching over a course of a few months and finding only limited empirical resources such as the curriculum being adapted here, I still was not able to find adequate sources of information. I chose to use "ME TOO!: A Substance Abuse Prevention Project for Deaf Youth," due to the fact that the findings were very limited. Frankly, this was the only piece of curriculum that I was able to find on the internet. It should be noted that there are many curriculum materials for education on alcohol awareness; it is just not being made accessible to the public. I really liked this curriculum for the main reason that it showed strong potential of adaptability with different grades and education levels, which I feel is very important to have in the classroom.

Before discussing the modifications of "ME TOO!: A Substance Abuse Prevention Project for Deaf Youth," it is important to note that this program was conducted in the form of workshops and addressed issues from "Harmful and Unknown Substances", "alcohol abuse", "self-esteem and self-acceptance" to "saying no!"

However for the purpose of this research, this writer has adapted the contents of this project to just focus on alcohol abuse and the issues around it. Although these are in workshop formats, they can easily be broken down into classroom formats with whatever changes and additions necessary.

Part One: Alcohol Awareness

Objective: To teach young children how to identify aspects and effects of alcohol abuse.

Plan Outline:

1. Alcohol is a DRUG
    a. Ask: "What is alcohol?" (We need to figure out what our students know about alcohol before continuing on.) Pass out a Quiz to test our students' knowledge or experience with alcohol.
    b. Define alcohol – a drug that changes how we think, how we behave, and how we feel.
    c. What are some kinds of alcohol? – Beer, whiskey, wine, wine coolers. Use visual props for this discussion.
    d. Where can we get alcohol from?
    e. How old do we have to be to drink alcohol?

A. Alcohol use in moderation … (when do people drink alcohol?)
    a. Celebrations like parties, religion, weddings.
    b. With dinner to add enjoyment of the meal.
    c. Adding alcohol to food to add flavor.
    d. Others?

B. What are some unhealthy ways of using alcohol?
    a. Drinking too much (ask what drinking too much means and if they have seen a drunk person before.
    b. How can you tell if he or she is drunk?
    c. Could it be dangerous? Why?
    d. How do you feel when you see a drunken person? (Are you scared, confused?)
    e. What do you think when you see a drunk person? (Do you think this is a normal thing to be drunk or what?)

C. Drinking at the wrong time? (What does this mean? Why can it be dangerous?)
    a. While driving or operating dangerous equipment. (car, bus, plane, machines, etc.)
    b. Discuss the dangers that might be there when you cannot keep your balance, focus your eyes, or coordinate your body).

Activity #1 – Ask for volunteers

a. Cover the volunteer's eyes with a blindfold and have them try to reach for an object.
b. Spin a volunteer around (in a safe place) with eyes closed or have them blindfolded for fifteen seconds. Next, give a task involving:
    i. Tying a bow
    ii. Writing their name on the board
    iii. Put a puzzle piece together
    iv. Walking a straight line
c. Discussed what just happened and why it happened. Link this activity with how it must feel being drunk. Discuss how it felt when trying to do one of the tasks.

D. Drinking changes how people feel.
    a. Discuss how people drink to feel good or to forget about things but it can easily turn into a bad habit.
    b. What are some of the feelings people try to get when they drink? Why do they drink to get that "good" feeling?
    c. Discuss how people drink to change feelings. (sad/mad/lonely/shy to courageous/witty/outgoing…). Do you know anyone who does this?
    d. What are some of the better ways we can do to have fun and feel better? List them down on board, i.e. play ball, workout, talk to someone.
E. Habit – When it turns into alcoholism
    a. Define habit and alcoholism
        i. **Alcoholism** – when people drink too much and can't stop. They need special help to stop.
        ii. **Habit** – when drinking became a habit? How does it become a habit? Is it dangerous? Why? What happens to the person who has a habit?
        iii. **Show slides on how excessive consumption of alcohol can affect your internal organs**. i.e. liver.
    b. Discuss how the alcoholic person would feel?
        i. How would the person feel if they could not stop drinking? (scared, mad, doesn't know he/she has a problem or won't admit it)
        ii. Why would the person have these kinds of feelings? Give examples or ask for examples.
    c. Discuss how alcoholism makes the people who love them unhappy.
    d. What can we do about someone who we know or love that drinks too much?
    e. Discuss these viewpoints:
        i. It is not our fault
        ii. People who drink too much are sick
        iii. Never ride in a car of the person who is drunk
        iv. Leave the drunk person alone

v. Find someone or someplace to stay safe
vi. Talk to someone (teacher, friend, parent, relative, counselor…)
vii. Stay safe!

Part Two: Self-Esteem and Self-Acceptance

Objective: To develop and strengthen self-esteem and facilitate towards self-acceptance through exploration of positive and negative thinking and feeling influences.

Plan Outline:

1. What is SELF-ESTEEM?
   a. What is self-esteem? What does it mean? Give examples or ask for examples.
   b. Self-Esteem – Means what I think of myself and how I feel about myself.

What kinds of feelings are good feelings? What happened to create these feelings? How did it happen?	What kinds of feelings are bad feelings? What happened to create these feelings? How did it happen?

Positive	**Negative**
Positive good attitude	***Bad attitude***
Happy	Fights
"I can do it!"	"I can't do it!"
Feel satisfied	sad
Loved	unloved
Like myself	hate myself
Do well in school	dumb
Happy family	messed up family
Friends	wrong friends
Healthy	unhealthy, sick
Strong	problems
- - - - -	Unwanted

Activity #1 - - Roleplays and Discussion
(Students and facilitators will roleplay different situations to initiate discussion.)

1. **BAD** - - "You are stupid and funny. You got funny things in your ears and you can't even hear! You move your hands weird.
2. **GOOD** - - "Wow, that's great! You are so smart. I like you. Can you teach me sign language?"
3. **BAD** - - "C'mon, don't be a baby. Are you chicken or something? Hey, I don't like you. I will tell everyone not to play with you!"
4. **GOOD** - - "Wow, super job! I like the way you did your project!"

2. How can we feel better? (Discussion)
    a. Make new friends
    b. Hobbies
    c. Counseling
    d. Ignore
    e. Help somebody
    f. Find fun things to do
    g. Meet other deaf people

Activity #2 – Apples are Apples

Give each student an apple. Tell them to study it carefully. Put it back into a pile. Mix it up. Tell the students to find their apple.

a. Ask: How did you know that apple was yours? How are the apples different?
b. Argue the sameness: red, round, tastes the same…
c. Insides are the same but the outsides may look a bit different.

Activity #3 – Deaf and Hearing

How are they the same or different?

a. list the differences and sameness on board.
b. Discuss the relationship to the apples. (Hearing and deaf are the same except the ear doesn't work. Inside we are the same, just like the apples.)

Activity #4 – Who Knows Some Famous Deaf People?

a. Discuss famous deaf individuals and their accomplishments.
    - I. King Jordan - - President of Gallaudet
    - Kitty O'Neil - - Fastest woman on Earth
    - Lou Ferrigno - - The "Hulk"
    - Dr. Edward Corbett - - Superintendent
    - Marlee Maitlin – Academy Award Actress
    - Beethoven - - Famous composer
    - Helen Keller – Deaf and Blind
    - Dummy Hoy - - Baseball Player invented hand signals
    - Laurent Clerc - - Teacher who brought sign language
    - The Huddle - - Gallaudet Football Team's invention
    - Linda Bove - - Sesame Street's actress

Discussion: Did their deafness and who they were prevent them from being famous?

Part Three - - "Say No!"

Objective: To help the students identify and explore ways on how to say NO to

inappropriate situations and peer pressure.

Plan Outline:

1. Drugs are BAD?
    a. Review information about WHY drugs and alcohol are bad for you.
    b. Why is alcohol bad for you?
    c. What happens to your body when you "abuse" alcohol?
2. Peer Pressure?!?
    a. Discussion: You are at a party and everyone is drinking. What do you do?
    b. Peer Pressure: what does the word **PEER** mean? (someone your age; someone you go to school with; do the same kinds of things that you like to do; want to be liked by everybody; and you want your friends to like you too.)
    c. Peer Pressure - - is a feeling you have when you have to do what your peers want you to do.
        i. In other words, you play the game they want to play so you don't feel left out.
        ii. You may want to do something different and they don't – they might ask you again and again. They may even start to tease you.
        iii. They may want you to do something wrong or to be mean or take something that is not yours.
    d. Is drinking a way of making friends?

    e. How do we deal with peer pressure? (discussion)
        Saying **NO** can be hard!
3. Why is it hard? (we do not like to be teased or left out; it can be hard to decide, just saying **NO** can be hard)
    a. Ways to say NO:
        i. "NO"
        ii. "NO way"
        iii. "Forget it"
        iv. "No, I don't want to hurt myself"
        v. "No, it is against the law"
        vi. "I just don't want to"

There are many more ways to say "NO" Any other ways?

        vii. You can simply walk away.
        viii. You can say no, walk away, and talk to someone about it
        ix. Make friends with others who feel the same way as you
        x. Learn more about the effects of alcohol. Talk to you parents or friends about alcohol. Don't be afraid to ask questions about drugs.

    b. More Roleplays on how to say "No"
        i. Break into groups of 3 or 4. give each group a situation card. Allow 5 to 10 minutes to practice the roleplay. The co-facilitators

can help with the roleplays. Next, each group will present their role-plays.

This was just a basic outline that can be elaborated on and added to as well. Suggested activities to accommodate this outline is: 1) Students investigates effects on body by alcohol; 2) Science projects like dissecting a damaged liver as a result of excessive drinking; 3) Math projects that deals with figuring out how much alcohol is too much? Or how much alcohol is there in various beverages? 3) Other class ideas include finding out what the legal alcohol limits are, what the ingredients are in alcohol, and how alcohol is made.

By involving the students in activities like these and allowing them to find out on their own just what alcohol is and its affects on the body, this may have a more profound impact on these students rather then being preached at or "taught" at. Oftentimes, students learn best when they find out on their own and they are able to discuss the ramifications of drinking alcohol with their peers and other important people in their lives. In essence, we are forcing our students to learn the truth for themselves and taking responsibility for what they are learning and what they choose to do with the information they found. In terms of applying this concept to our deaf students, it is important to use as much visual aid as possible and that these assignments are presented in a way that is understood by our students.

In addition, to better serve our teachers' knowledge about our students in various grades, a website posted two different background information about our students from grades 7 to 8 and 9 to 12. It is extremely important that our teachers, either deaf or hearing class teachers, have a general idea of where their students stand and how they

think in terms of alcohol and drug use. As a result, the information has been transported to this research paper in order to provide a nice background dossier on our students to accompany the outline modified for this research.

Background for Teachers Grades 7-8 (ages 12-14)

Youths in grades 7-8 are in a period characterized by much "storm and stress." Many child development experts believe adolescence is stormy because adults are ambivalent about how grown-up they want youths this age to be. Although many 12- to 14-year-olds are maturing physiologically--they look older and are more mature sexually--most remain emotionally, cognitively, and morally immature. Seeing large and physically mature bodies, adults often expect more than adolescents are capable of giving.

In the midst of the storm and stress of adolescence, youths undergo a rebirth. Adolescents perceive that everything out of the past, especially their identity as a child, is up for reconsideration. With their new bodies comes the potential of a new identity--everything is possible, nothing is certain. This state of rebirth produces confusion, frustration, excitement, fear--and ultimately high levels of stress.

It is important that youths of this age do the following:

- Develop a positive sense of self and of their own capabilities;
- Understand the importance of continuing their education;
- Understand the pressures of peers and be able to resist them;
- Know sources of help other than their peers.

Influence of Peers

Youths in grades 7-8 have had little experience in coping with stress, and they believe that the only persons who can really understand and help them are their age-mates, or peers. As a result, they increasingly want to spend time with friends their own age. They talk endlessly on the telephone, pass notes in school, make excuses to get out of class or out of the house, ostensibly to accomplish some task, but really just to see each other. They seem to need constant reassurance that what is happening to them is normal and

okay. Only an age-mate can provide this reassurance. They believe that adults in their lives are unable to identify with their concerns. In addition, school programs often are not organized to provide the high level of personal interaction that adolescents want and need.

Youths in grades 7-8 want to be noticed. Mostly they want to be seen and noticed by each other. In their attempts to be visible and to break with the past, they dress alike, talk alike, and share many of the same thoughts, values, and likes and dislikes.

This is a time of upheaval in relationships. The family no longer is as much a part of their identity, the peer group assumes more significance, and communication between the youths and their families begins to break down. Adolescents tend to prefer traveling, shopping, or engaging in recreational activities with their peers rather than their families. Families may react to this situation with anger or hurt, which makes an already stormy period more stressful. Parents and other adults may become confused and upset because the child they knew seemingly no longer exists.

In addition to rejecting their families to one degree or another, many adolescents call into question everything out of the past--old friendships, old values, old beliefs, and old ways of doing things such as solving problems. Adults once held in high esteem may be criticized and argued with. The simple ideas and truths that adults may have presented earlier no longer work for adolescents. Directives or responses such as "because I told you so" or "just say no" are no longer adequate. Adolescents want explanations and real answers. They often assume they should disagree with anything an adult says or find it distasteful and search out an alternative answer from a peer. Persons most trusted by this age level are family members who work hard to retain levels of trust or slightly older adolescents who have recently experienced this period of storm and stress. Parents and teachers can continue to be influential, but such adult influence requires a lot of effort and outstanding communication skills.

Importance of Belonging

The motivation for much of adolescents' behavior is the desire to belong, especially to a peer group. The feeling of belonging may in fact be vicarious; they may only be reading, listening to music, or viewing movies or television programs in which youths their age are involved. The desire to belong produces a need to behave as their peers do. Peer pressure is not so much an actual pressure by one person or a group to behave in a certain way, but rather the self-imposed pressure an individual feels to behave like others in the group to feel a part of the group. Because of their desire to belong by looking like everyone else their age, adolescents select clothing that appears to be virtually a uniform.

Youths in grades 7-8 are often controlled by the moment. They may do things that violate a value or belief on the spur of the moment, depending to a great extent on the situation and who they are with. They may find themselves doing something they formerly considered wrong because, at that moment, it seems okay, fun, or necessary to prove they

are like everyone else. Alcohol and other drug use often arise out of such situational ethics.

Because their bodies change rapidly at this time, many adolescents become almost obsessed about their appearance and the size and shape of various body parts or the speed at which they are developing. They do not feel comfortable talking with their families about these physical changes and thus spend much time with peers talking and joking about the changes. The information they receive from peers often is inappropriate and inaccurate.

Educators can use the interest adolescents have in their bodies as a springboard for teaching about the hazards that tobacco, alcohol, and other drugs pose to developing bodies. Educators should emphasize that remaining drug free is the best way to ensure a physically healthy and attractive body now and in the future.

Influences on Learning

Youths in grades 7-8 are risk takers. What scared them before intrigues them now. They believe they are invincible. They are quick to accept dares, to test rules and laws to the limit, and to flirt with death, believing it will never touch them. The risks of using drugs are intriguing on several levels: Violating the law, breaking parental and school rules, and defying physical danger and even death. Drug prevention programs, and especially information related to the short- and long-term consequences of drug use, should address this attraction to risks.

Adolescents enjoy danger and do not believe that the consequences of drug use are a threat to them. The best way to present information is not through threats, statistics, or lectures about morality but by focusing on how drugs affect the human body and mind, human relationships, and their environment. Adolescents are sufficiently future-oriented that they can see the payoff of education and their own behavior choices, as long as the adults in their lives do not make some future payoff the reason to do or not do something.

Youths in grades 7-8 are beginning to think abstractly and to deal with the future. They can process more complex ideas and understand incongruities among words, behavior, and consequences of behavior. As a result, drug prevention education can be broadened and presented in a variety of contexts and subjects. Infusing drug prevention messages into various subjects within the school curriculum is one way to do this.

Adolescents are beginning to recognize that everything is not strictly good or bad, right or wrong, but that there are shades of gray to moral problem solving and decision making. As a result, they are influenced less by the power of individuals who are bigger, older, or in authority, and more by their own ability to make moral decisions. Helping adolescents learn how to make good decisions is an essential component of drug prevention education.

Although the peer group is an important and sometimes controlling influence, friendships are perhaps more important. Friends are generally close, trusted peers, often of the same sex or if of the opposite sex, not necessarily controlled by sexuality. Friendships are developed through shared experiences, interests, values, beliefs, and proximity. Friendships are so important to helping youths choose a path in life that it is important for adults, especially parents, to know who their children's friends are; to encourage positive, healthy, helpful friendships; and to guide their children away from friendships that are potentially harmful. Parents and teachers should work together to help adolescents develop friendships that encourage growth toward healthy, responsible adulthood.

The search for identity in early adolescence takes time and considerable energy. Without adult supervision and guidance, it may falter or veer off in a potentially dangerous direction. Adults should seek to be models of healthy, responsible behavior. And they should know the adults, as well as peers, with whom their children or students spend time.

Background for Teachers - Grades 9-12 (ages 14-18)

Youths in grades 9-12 (14 to 18-year-olds, approximately) are a diverse population. The year between 14 and 18 represent vast changes from the immaturity of early adolescence to the nearly full maturity of adulthood.

Perhaps the most problematic aspect of grouping students at these ages together in high school is that the young ninth graders are exposed to much older youths, many of whom have greater mobility and exposure to the world (they are driving automobiles and are legally able to work). Youths at risk of drugs use find themselves exposed to a much less sheltered world than in their elementary or middle school; as a consequence they are suddenly exposed to more opportunities, both good and bad.

For younger people in this age grouping, older schoolmates can be the link to drug use. Wanting to belong, the younger ones may engage in dangerous and self-destructive activities. The "trickle-down" effect described by proponents of raising the legal drinking age argue this point persuasively by citing evidence that older youths may entice the younger ones to drink alcohol. Adults become especially important as resources for helping youths resist drugs. Adults can influence atheist by being models of positive, healthy, responsible attitude and behavior.

Influence of Peers and Adults

From ages 14 to 18, friendships become increasingly important to youths, and friends become a source of information for making sometimes significant decisions. At these ages, friendships can be volatile, girls especially may be friendly and supportive of one another one day and noncommunicative and hurtful the nest. Adults may wish to intervene, but they need to exercise restraint so that youths can work out their own relationship problems and improve their communication skill.

Friendships with persons of the opposite sex become increasingly important. Physiologically, youths feel an increasing attraction to the opposite sex, and to some extent, social norms push the adolescents to pair off. Many events, school-sponsored or not, encourage youths to relate to the opposite sex. During the course of this "pairing-off", some youths may be pressured to engage in behavior that is contrary to their own of their families' values. Such pressure may cause conflict and stress.

In addition, interest in the opposite sex may push adolescents to accept dares, take risks, or take advantage of others by boasting about nonexistent accomplishments so they can appear more worldly. Such behavior is troubling to adolescents, and they need help dealing with feelings of guilt. This is a risky time, because the future is at stake. Parents who can keep lines of communication open during this period are giving one of the greatest gifts they can provide. Being authoritative without being overly judgmental and listening without giving advice unless it is asked for, are two important communication skills that parents and other adults should try to cultivate to help adolescents.

Tailoring the Prevention Message

Older adolescents increasingly are able to deal with abstract concepts such as truth and justice. Together with a more mature moral view of the world, which allows them to consider how individuals and their actions affect others' lives, this ability to think and reason in the abstract allows them to consider the economic costs of drug use; the results of teenage pregnancy; the reasons for laws; and the impact of drugs on our health care, rehabilitation, and judicial systems. Drug prevention education consequently should focus less on drugs and their use as on the ways in which drugs affect society. Infusing drug prevention education throughout the curriculum is essential, and the entire school staff should be involved in presenting the drug prevention message.

As adolescents move toward the legal drinking age of 21, alcohol use tends to be heavy. Drug prevention for older adolescents, consequently, should stress the necessity of responsible behavior by those who choose to drink when they become of legal age to do so. They should understand the dangers and consequences associated with alcohol use (during pregnancy and while driving a car or operating machinery, for example). This, of course, should be discussed in the context of the prevention message that alcohol is not legal for youths under age 21, that is harmful to developing bodies, and that many people choose not to drink.

At ages 14 through 18, youths are interested in the future, they understand how choices they make now can have both immediate and long-term implications and consequences. They are increasingly able to understand that seeking instant gratification can result in events that may change the entire direction of a person's life: a pregnancy, an arrest for drug possession, or exclusion from a sports team for drug use. Adolescents need to know that certain choices now can limit them later on. This message must be presented straightforward and early.

Adolescents continue to be body- oriented; they want to be physically healthy and attractive. Drug prevention education consequently needs to point out the inconsistencies between using drugs and maintaining a healthy, attractive body. Youths may deny that drugs will harm them, but they need to be aware regardless. In particular, they should know that drug use lowers the immune system, and that sharing needles during intravenous drug use is one way to get AIDS. They must have straightforward, accurate information to help them prevent the spread of AIDS.

Influences on Learning

Adolescents face a great deal of stress from competing in school, learning how to handle relationships with other people, dealing with societal pressures, and planning for the future. Often, they are not prepared to cope with this stress. When they were younger and felt ill, a pill might have helped. Now the pill becomes alcohol, an illegal drug, or a relationship that does more harm than good. These inappropriate coping mechanisms cause more stress. Adults can help adolescents cope with stress by listening to them and by supervising outlets for stress through art, drama, music, and sports.

Youths ages 14 through 18 are creating their own ethical systems. They no longer believe that adults are always right by virtue of their age. These older adolescents believe that they are right, and they tend to try to justify their actions as correct moral choices. They perceive decisions and issues as falling less into exclusive categories of right or wrong, and more into a vast gray area between right and wrong. They like to explore various angles and interpretations of decisions and issues. As a result, they are willing to consider the implications of decisions, and they respond to attempts to develop decision-making skills in various subjects.

Drug prevention messages must have as a foundation accurate, factual information from which youths can draw conclusions about the dangers of drug use. Youths need to continue to learn and practice peer refusal skills, but they also need to understand the reasons for saying no.

As the next generation of American leaders, high school students need to feel competent in themselves and hopeful about their prospects for the future. They need to be able to make independent decisions and to assume responsibility for choices that affect themselves and others. They need to see that, as citizens, they are responsible for making their communities better, safer places to live. They should be encouraged to develop civic responsibility by volunteering for projects such as cleaning up neighborhoods, assisting elderly or handicapped citizens, tutoring younger children, and beautifying public places.

At these ages, youths use critical thinking skills to assess the credibility of persons who influence them, to assess low they may be models for others, and to determine how their behavior corresponds with their goals for the future.

Section Six: Conclusion

While research in the area of substance abuse problems among the deaf and hearing impaired population has not established accurate prevalence rates, a significant body of literature does exist which supports the notion that this population may be considered at comparable risk as the general population (Sabin, 1986).

It has long been recognized that there is a need to reach our deaf and hard of hearing students in a format they can understand. Our deaf and hard of hearing students are at-risk because they are not getting the vital services that their hearing peers are and as a result, the problems of this group is largely ignored.

It was the goal of this writer to come up with guidelines that can be applied to future education programs for alcohol awareness as well as adapt whatever curriculum was already out there to give a general idea of what can be taught and how. It is important to note that we need to reach these students using any and all materials at hand. Hopefully, by reading the information presented in this research paper, education teachers may be persuaded to take a more active role in educating our deaf and hard of hearing students about the dangers of alcohol.

Section Seven: References

Background For Teachers - - Grades 7 to 8 (ages 12 to 14). http://www.uen.org/utahlink/lp_res/preve106.html

Background for Teachers - - Grades 9 to 12 (ages 14 – 18). http://www.uen.org/utahlink/lp_res/preve110.html

Dick, J. (1996). Signing for a High: A study of Alcohol and Drug Use by Deaf and Hard of Hearing Adolescents. Microfiche: Ann Arbor, MI.

Goncz-Zangara, D. (1992). "ME TOO: A Substance Abuse Prevention Project for Deaf Youth. The Community Network; Yellow Springs, OH.

Guthmann, D.S. & Sandberg, K.A. (1). Access to Treatment Services for Deaf and Hard of Hearing Individuals. http://home.earthlink.net/~drblood/minn/articles/access_ad.htm

Guthmann, D.S. & Sandberg, K.A. (2). Providing Substance Abuse Treatment to Deaf and Hard of Hearing Clients. http://home.earthlink.net/~drblood/minn/articles/treatment_ad.htm

Guthmann, D.S. & Sandberg, K.A. (3). Assessing Substance Abuse Problems with Deaf and Hard of Hearing Students. http://home.earthlink.net/~drblood/minn/articles/students_ad.htm

Guthmann, D.S. & Sandberg, K.A. (4). Positive Youth Development: Helping Postsecondary Students Deal with Pressures to Use Alcohol and Other Drugs. www.home.earthlink.net/~drblood/minn/articles/positive_ad.htm

Guthmann, D.S. (5). Is There a Substance Abuse Problem Among Deaf and Hard of Hearing Individuals? www.home.earthlink.net/~drblood/minn/articles/problem_ad.htm

Guthmann, D. & Blozis, S.A. (2001). Unique Issues faced by deaf individuals entering substance abuse treatment and following discharge. American Annals of the Deaf, 146,(3), 294-304.

Isaacs, M., Buckley, G., & Martin, D. (1979). Patterns of Drinking among the Deaf. American Journal of Drug and Alcohol Abuse, 6(4), 463-476.

Lane, K. (1989, April). "Substance Abuse Among the Deaf Population: An Overview of Current Strategies, Programs, & Barriers to Recovery." Journal of American Deafness and Rehabilitation Association, 22,(4).

Lewin, T. (2002, Feb 27). Disturbing Findings on Young Drinkers turn out to be Wrong. New York Times: http://www.nytimes.com/2002/02/27/national/27ALCO.html

Lipton, D. & Goldstein, M. (1997, Fall). Measuring Substance Abuse Among the Deaf." Journal of Drug Issues, 4, 773.

Llanos, M. (2002, Feb 26). Report Fuels teen Drinking Debate. U.S. News: http://www.msnbc.com/news/716146.asp?pne=msn

McCrone, W.P. (1982, July-Sept). Serving the Deaf Abuser. Journal of Psychoactive Drugs,14,(3), 199-203.

Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. (?). Barriers to Treatment and Recovery. http://home.earthlink.net/~drblood/minn/articles/barriers_ad.htm

Sabin, M. (1986). Responses of deaf high school students to an "Attitudes towards Alcohol Scale. Microfiche. Ann Arbor, MI.

SAISD. (2001). Deafness and Chemical Dependency: A Paper. http://www.rit.edu/~257www/tips/paper.htm

Sandberg, K.A., Korwin, K, & Mathews, A. (2002). Rehabilitation and Substance Abuse Treatment: Working Together to Serve Deaf Clients. http://home.earthlink.net/~drblood/minn/articles/rehab_ad.htm

Searls, J.M. (2001). Tipsheet: Counseling Services for Students who are Deaf and Hard of Hearing. NETAC: http://www.netac.rit.edu/publication/tipsheet/cnslsvcs.html

Steitler, K. (1984). Substance Abuse and the Deaf Adolescent. Substance Abuse and Intervention for the Deaf. Rochester, NY.