The Role of the Occupational Therapist Treatment of Alcoholism

(alcoholism rehabilitation, treatment model, behavior change, use of activities)

Wanda P. Lindsay

This paper presents brief information on the incidence of alcoholism, its effects on physiological and psychosocial dysfunction, and the disease concept. More detailed information is provided on a treatment program designed to meet the special needs of the alcoholic patient, and the integral role of the occupational therapist in this program is explained.

Patients are given support to accept the chronic disease of alcoholism, are taught skills needed to maintain sobriety, have opportunities to begin utilizing resources for sobriety, and are assisted in regaining a sense of self-worth.

Before examining the role of the occupational therapist in the treatment of alcoholism, it is important to understand the incidence of alcoholism, its impact on health care, and some basic concepts about the disease. Alcoholism is a disease of considerable magnitude. In 1973, there were 9,500,000 people with alcoholism on the North American continent, of which 90 percent or more represent a cross section of the population (1). Recent studies estimate that 4 percent of the United States population over age 20 suffer from alcoholism, or 9 million of 2 billion people (2-4). These figures do not reflect nonalcoholics who abuse alcohol or the growing numbers of teenagers with the disease. In addition, at least 36 million Americans are affected by their relationships with active alcoholics (2-4). Children of female alcoholics who may be suffering from fetal alcohol syndrome or fetal alcohol effects as a result of maternal alcohol consumption during gestation must also be considered (5, 6). (Fetal alcohol syndrome is a pattern of altered growth, morphogenesis, and behavioral impairment manifested in a wide range of abnormal characteristics (7).)

Alcohol also has a significant
impact on health care. In the United States 20 percent of all hospitalized persons have an alcohol problem in addition to the presenting problem (2). In several countries alcoholism is the third leading cause of death (after heart disease and cancer), and in France, 48 percent of the industrial accidents are attributed to alcohol abuse (8).

Effects of Alcohol. Alcohol use affects many organs and systems of the body. In the digestive system it acts as an irritant, increasing acid flow, and at times impeding digestion. In the circulatory system alcohol acts as a vasodilator, aggravating high blood pressure and contributing to heart problems. A kidney-controlling hormone is inhibited by alcohol, causing the kidneys to produce too much urine. Alcohol also has marked effects on the liver, preventing maintenance of proper sugar levels in the body, depriving the brain and other organs of adequate nourishment. Long-term use damages the liver permanently (1, 2, 9).

The central nervous system, particularly the brain, is most sensitive to alcohol. Alcohol interferes with brain activity by acting as a depressant. Behavioral changes that make alcohol appear to be a stimulant are due to the suspension of inhibitions in several areas of the brain. Judgment, muscle coordination, control of emotions, and sensory perception are all affected. Large amounts of alcohol anesthetize the brain centers that control heart rate and breathing to the degree that convulsions or even death can occur (1, 2, 9).

Alcoholism is classified as a disease because it is predictable, exhibits symptoms, and is progressive if not arrested. In addition to the physical effects described, the disease affects the emotional and spiritual aspects of a person (2). It creates a defense system that makes alcoholic persons unwilling or unable to look at their lives and the problems drinking has caused. Antisocial or isolative behavior results and the person may begin to view alcohol as a best friend. Alcoholism destroys self-respect because its victims have tried to stop drinking and failed, not knowing the inability to stop is part of the disease process and requires professional help. Specific maladaptive behaviors may be seen in the alcoholic person: inability to tolerate pressure and stress, dependency, failure to express one's self, feelings of being "put down" by others, and lashing out at people and circumstances through drinking. It is important for professionals who work with alcoholic patients to accept the effects of alcoholism on the person or their work will be hindered by a lack of understanding and poor communication (10, 11).

Examining various stages and specific symptoms of the disease will enhance the professional's understanding of the patient. In the early stages of the disease there is an increased tolerance to alcohol, blackouts (memory impairment), gulping and sneaking drinks, and some guilt feelings about drinking. The onset of the early-stage symptoms can occur at any age and there is no specific time one crosses from "social drinking" into the early stages of the disease. In the middle stages of the disease, other symptoms become apparent including loss of control, use of alibis for abnormal behavior, geographic escape, change in drinking patterns, and periods of abstinence. Other symptoms that may be apparent at this time are the appearance of a "Dr. Jekyll/Mr. Hyde" personality, Monday morning absenteeism, taking long lunch hours, inconsistent work performance, addiction to other drugs, increased physical problems, and morning drinking. The progression through these stages may last a few months to several years, and is different for each person. By the late stages of the disease the family unit has often deteriorated, the job may have been lost, and the person's life revolves around drinking. Symptoms manifest at this time are an inability to abstain, decreased tolerance to alcohol, tremors, hallucinations, and delirium (REM) (a life-threatening part of withdrawal) (1, 2, 12).

Treatment and the beginning of the recovery process can be initiated at any stage but often realization of the need for help is not recognized until the late stages. All symptoms may not appear in every patient and are not necessary for the diagnosis of alcoholism. Impaired life adjustment in terms of health, personal and social relationships, and occupational functioning identify alcoholism (12, 13). Figure 1 further illustrates the symptoms of the disease and their progression.

Literature Review

No current literature is available on the specific role of the occupational therapist in alcoholism treatment. Although a 1952 occupational therapy article referred to alcoholism as a disease rather than a social disgrace, it did not discuss approaches to the alcoholic patient that would differ from those used with patients having a variety of psychiatric disorders (14). Alcoholic patients have traditionally been treated in inpatient health settings with no attention given to their special needs, or the different approaches necessary to meet those needs (14-19). Detoxification centers have specialized in "drying out" alcoholic persons, but patients usually returned to their
former lifestyle without the skills and resources needed to maintain sobriety. This treatment approach was consistent with views of alcoholism at that time, as seen in classifications of alcoholism by the American Psychiatric Association. In 1952 alcoholism was classified as a sociopathic personality disorder (20). In 1968 alcoholism was classified as a personality disorder and a psychological disorder was implied (21). The most recent (1980) classification of alcoholism as a substance use disorder does not assume the involvement of emotional disorder, but does outline the basis on which a diagnosis can be formed (22). Reclassification of alcoholism from psychiatric or psychological disorder into addiction and disease process categories has a significant impact on the treatment approach used with the patient, and has been helpful in improving patient's attitudes and outlook for recovery (23).

No occupational therapy literature exists which reflects a change in classification or approach. Some publications on alcoholism have referred to the benefit of activities therapy programs (1, 23). Blum and Blum (12) discuss the therapeutic value of an occupational therapy program for alcoholic patients, including positive reinforcement for socially acceptable behavior; increased self-esteem; learning safe, structured expression of emotions; and corrected patient attitudes and perceptions. The treatment program and occupational therapy services that reflect the reclassification of alcoholism as a disease and which emphasizes an approach of learning new skills is described next.

The Alcoholism Treatment Unit

The 12-bed alcoholism treatment unit at Mercy Hospital admits both male and female patients from a variety of ethnic and socioeconomic groups. Most patients are young through middle-aged adults and the length of stay is 28 days. (When third-party payers reimburse for only 20 days of hospitalization, the full program is adapted to fit the shorter period.) The treatment team consists of trained alcoholism counselors and technicians, nurses, the occupational therapist, a physician, and at times, occupational therapy and counseling students. Each patient is assigned a counselor, a primary nurse, and is referred to occupational therapy. In addition, a psycho-drama consultant and yoga instructor provide services once weekly.

The unit's philosophy recognizes
alcoholism as a chronic illness with its own symptomatology that affects all aspects of a person's life and also as a treatable illness of a complexity that requires a multidisciplinary team for effective treatment. The philosophy maintains that internal patient's motivation is essential to recovery and that a therapeutic milieu of staff and patients provides the best climate for learning the new behaviors that are necessary for sobriety. Within this milieu, group-oriented experiences are utilized as major facilitators of change. Support and involvement of significant others is also considered necessary. The ongoing process of recovery from alcoholism is best maintained, after treatment, through active participation in the Alcoholic Anonymous program (24).

The first objective of treatment is to interrupt the drinking pattern and facilitate commitment to permanent sobriety. The second is to surround the person with the reality of the effects of his or her drinking. Family members, employers, and significant others are used to assist with this. The third objective is to provide a therapeutic milieu to develop greater ego strength through the practice of new behaviors and to improve confidence through positive peer relationships. Additional objectives include involving patients in group experiences where they can learn about themselves and how they relate to others, assisting patients and their families to improve their communication, and assisting them in obtaining a deeper understanding of the disease. Other objectives are to help the person learn to identify daily problems and develop alternative coping behaviors, to evaluate children of female patients for fetal alcohol syndrome or fetal alcohol effects, and to facilitate return to an improved physiological and emotional state (24).

To achieve these objectives, a wide variety of treatment modalities are provided. Movies, seminars, and discussion groups educate patients and family members about the disease. Group and individual counseling sessions provide opportunities for the discussion of problems that occurred as a result of drinking and for dealing with issues that arise during treatment. The opportunity to meet with former patients and Alcoholic Anonymous volunteers and to attend Alcoholic Anonymous meetings helps to link what is learned in treatment with life outside the hospital setting.

The occupational therapist contributes to the overall treatment program by working with patients to achieve specific objectives such as increasing socialization, improving interpersonal relations, and decreasing isolation. The therapist also assists the patient to improve planning and problem solving, fine eye-hand coordination, and memory. (Tremulousness and memory loss are exhibited primarily during detoxification but persist in some patients.) Occupational therapy groups provide support and opportunities for growth through facilitating realistic perceptions of one's assets and limitations. Group objectives include increasing self-esteem and learning frustration tolerance and appropriate tension release. Developing an understanding of how to plan and use leisure time is also addressed. For most patients this time was previously spent drinking or in drinking-related activities. Planning and use of spare time is important for establishing permanent sobriety. Creating an awareness in patients that new behaviors can be learned and providing opportunities for experimenting with socially acceptable ways of expressing feelings are also emphasized.

Evaluation. A self-image collage, combined with an interview and goal-setting session, is the foundation of the occupational therapy program. Although similar to other collage techniques (25-27), it is used and interpreted differently. Patients are instructed to use magazine pictures to describe themselves, focusing on three areas: personal strengths, personal weaknesses, and the effect of drinking on their lives. Upon completion, the collage is discussed individually, giving the therapist an opportunity to get to know the patient, and to assist him or her in gaining self-awareness. Patients who say "I have no strengths" may be revealing low self-esteem. Some patients do not represent any of the three areas specified and fill the collage with pictures of things they like or pictures of how they would like their lives to be. Others select pictures that do not accurately reflect current life experiences. These patients may be having difficulty looking at their lives, and at their alcoholism, so that breaking through denial will be one of the first treatment goals. The collage elicits much useful information and stimulates meaningful discussion about the patient's problems. It also provides useful information in planning treatment for that patient.

After discussing the collage, the patient and therapist set behavioral goals for the hospitalization period. The patient's participation in goal setting helps to ensure an investment in working on goals and provides insight as to what the patient expects to accomplish during treatment. If the only goal identified is "to stay sober forever," the patient...
needs to learn that staying sober is an immense task that has to be broken down into smaller steps. This could be achieved by working with the patient on other tasks that have to be done step by step. The goal-setting exercise also indicates the patient’s motivation for working in the treatment program. A patient may set many goals for treatment but if most of them are to be accomplished by staff, the patient may have an unrealistic view of the personal effort required. Goal setting helps patients to see that the treatment process is something the team assists them with, but that they have the responsibility for the final outcome.

Vocational and avocational assessments are also part of the evaluation process. Observing the patient during recreational periods, and discussing avocational interests with the aid of an Interest Checklist (28) give information about use of leisure time and the need for intervention in this area. A leisure planning assignment may be given to patients who demonstrate particular difficulties in this area. For unemployed patients, informal observation and interview are used to gain information about previous work experience, task skills, social skills, dress and grooming, and motivation for seeking employment (28). (Job problems related to drinking are dealt with by the counselor of employed patients, often with the employer’s assistance.) Unemployed patients who appear to need assistance in finding work or who need further training are referred to a vocational rehabilitation agency.

Therapeutic Use of Craft Activities. Patients have many opportunities to demonstrate their willingness to participate in the treatment program. Resistance to one treatment modality, which may indicate underlying resistance to the entire program, can surface when patients are asked to perform specific tasks. While the patient works on craft activities, the therapeutic focus is on dealing with behaviors and attitudes that relate to the person’s alcoholism and sobriety program.
Patients are encouraged to choose an interest area that they do not associate with drinking. One patient had done much of his drinking in his woodworking shop. It was recommended that he pursue an alternate interest for 6 months to a year during the first year of sobriety in order to firmly establish new behaviors that are necessary for sobriety. Choosing new activities not associated with drinking is consistent with a philosophy of doing things differently.

High expectations are held for the quality of work, which provides patients with a sense of achievement they have seldom experienced. It also provides opportunities to work on frustration level, tolerance, and patience. Those patients who expect an overnight cure are given a complex task, are taught to break the task into several steps, and to measure progress within each step. This is then related directly to the recovery process from alcoholism, and seems to reduce anxiety a patient may have about coping with a chronic illness.

Time spent in the occupational therapy clinic can reveal other things about patients. For example, patients who display an "I don't care" attitude about their work may have the same attitude toward treatment, sobriety, or dealing with their alcoholism. Isolative behavior may predict future difficulty in participating in Alcoholics Anonymous or an outpatient group. The earlier patients become aware of these behaviors, the easier they are to modify. The occupational therapy clinic also provides patients with opportunities to explore leisure time interests and to develop planning skills. Patients are encouraged to make specific leisure time plans during hospitalization to increase successful follow through after discharge. Patients are also encouraged to select projects for themselves to aid in rebuilding self-esteem, and to reinforce the fact that they are in treatment to improve the quality of their own life.

**Recreation.** A recreational program, including a weekly outing, provides further opportunity for socialization, development of interpersonal relationships, group interaction, and a decrease in isolation. The alcoholic person has frequently had little experience relating to a group of people. The positive group recreational experiences are particularly beneficial to those who have difficulty interacting in structured, formal group settings. Also, participation and enjoyment of recreational activities without drinking is a new behavior for most patients. They realize that they can experience fun without drinking. Patients comment with much surprise on this new experience during a game or outing. In providing opportunities for practicing new behaviors, the recreational program offers constructive outlets for anxiety, anger, and other unexpressed feelings. Planning the weekly outing aids in making decisions with others and further development of skills for enjoyment of leisure time without drinking.

**Group Process.** In the task-oriented group, patients meet with the occupational therapist to discuss issues or problems related to alcoholism. The group deals with a single issue or problem through a variety of experiential activities. The therapist may choose the activity based on group needs or the needs of certain patients. The treatment team has the opportunity to have input if desired, and the patients may be asked whether they have a specific problem they would like to work on. The group is similar in theory to one described by Fidler (30), but the emphasis is on learning alternative ways of dealing with problems and issues related to the recovery process. For example, impaired communication skills of the alcoholic person can be improved through communication exercises, role-playing, and discussion. The experiential activities are used as discussion starters (31, 32). In addition, patients learn how to express their feelings, begin to share about their alcoholism, and to clarify values (31, 33-36). Value clarification activities usually promote a great deal of discussion because, with a change in life style, a change in values is predictable and probably necessary. Patients are helped to recognize that some of the things they value have to change in order for them to maintain sobriety. Also used are activities to build group cohesiveness, to experience risk taking, to improve self-esteem, and to learn to give and receive positive and negative feedback (31, 33, 35). The task-oriented group is used at times specifically as a way to raise issues and to get people to talk before a group counseling session that focuses on the issue more deeply.

*Team Approach.* The occupational therapist implements these specific aspects of the treatment program and also works with other team members to achieve previously stated objectives for each patient. Acting as a co-therapist in group counseling sessions, interacting with patients in informal discussions, processing films and lectures, and speaking in the Family Lecture series are examples of roles the occupational therapist share with other team members. The treatment team meets formally a minimum of three times a week for patient evaluation sessions. All staff members
provide input on behavior observed and information gained from the patient, and together the team decides upon treatment plans and approaches for each patient. In addition to formal sessions, the team meets informally once or twice daily to review patients’ progress. This supplements routine communication through the medical chart. No decision regarding a patient is made without input from all available team members and the consistent approach by all team members is significant in assisting patients to make behavioral changes. Figure 2 illustrates the team approach and responsibilities of team members. The input of the occupational therapist is integral due to the variety of situations available to the therapist during which to observe patient behavior. Occupational therapy programs also afford the treatment team a wider selection of treatment modalities for dealing with specific problems a patient may be having. In some cases, presence of the occupational therapist on the unit permitted treatment for patients who would have otherwise been more difficult to treat. Examples of these include a patient with recently acquired blindness, a mentally impaired young adult, and a patient with an above-the-knee amputation.

Re-evaluation and Closure. A final part of the occupational therapy program is to re-evaluate treatment: to assess patients’ perceptions of what they have accomplished, to let them know the therapist’s perceptions of progress in treatment, and to give patients feedback on areas in need of continued work during the ongoing recovery process. As a sharing of successes and continued concerns, this wrap-up session with each patient is important and occurs just before discharge. The therapist’s impressions are also shared with the outpatient counselor who will continue to see that patient after termination of the inpatient program.

Outcome
Alcoholics Anonymous estimates that alcoholic persons have a recovery rate of between 50 and 85 percent (due to the confidential nature of this self-help group, permanent records are not kept) (23). The variety of definitions used for the term recovery may account for the wide variance in this estimate. Mercy Hospital defines recovery from alcoholism as 1½ years of uninterrupted sobriety. Based on this definition, a study done by the director of Mercy Hospital’s Alcoholism Treatment Unit indicated that the program recovery rate is 43 percent (D. Stamas, Evaluation Questionnaire, 1976, 24). The rate of recovery increased dramatically for patients from Mercy Hospital who lived in an after-care residence following inpatient treatment. An after-care residence is a home staffed by trained alcoholism counselors, where recovering alcoholic persons live together for an average of 3 months. Alcoholics Anonymous and other group-oriented experiences are used to assist patients to firmly establish their sobriety. Stay in an after-care residence, potentially helpful to any recovering alcoholic person, is recommended to patients who would otherwise be returning to an unstable or particularly difficult living situation (i.e., a drinking spouse), or to patients who have been in treatment programs previously.

Discussion
Because of the complex nature of the disease of alcoholism, it seems that a multidisciplinary approach is the most effective way to treat the disease. The treatment experiences that the occupational therapist offers enrich the inpatient treatment program at Mercy Hospital and promote the recovery process from alcoholism. Providing patients opportunities while in treatment to practice the new behaviors that will help them stay sober generates confidence in their ability to cope with problems after treatment. A review of patient charts for a 6-month period revealed that 37 percent of patients who completed treatment stated upon discharge that they felt better about themselves and that they learned some things in occupational therapy sessions they feel will help them to stay sober. Patients have increased the amount of sharing personal incidents and feelings, both in groups and on a one-to-one basis. Learning to ask for help, learning how to handle frustration and tension, and increased awareness of personal strengths and weaknesses are other areas in which many patients have shown dramatic improvement. Even subtle changes are seen as a victory for the alcoholic person. A review of a program evaluation patients complete before discharge, using a five-point scale (five meaning “most helpful,” four meaning “very helpful,” and so on) indicated that 96 out of 154 patients rated occupational therapy as a five or four. Examples of comments that accompanied ratings of five or four included: “This helped me sort out priorities,” “You learn with your mind and your hands,” and “It showed me I can do things.” It seems that learning may be enhanced if patients have such a positive attitude about a particular treatment modality.

The responsibility for working on goals throughout treatment contributes to a smoother transition for return to the community, rather
than assuming this responsibility for the first time on the day of discharge. Throughout the patient’s hospitalization, the occupational therapist contributes to this process by observing and pointing out behavior incompatible with sobriety, and helping the patient to take responsibility for needed change. Approaches varying from very supportive to confrontive are used, as determined by the treatment team. Participation by the therapist in milieu activities allows many opportunities for observation and intervention.

Significant in this observation and intervention are the therapist’s own attitudes and beliefs about alcoholism. The disease concept, the fact that alcoholism causes problems in every area of a person’s life, and a belief that alcoholic persons can and do recover are all central to effective interactions with patients. Approached in this manner, the skills the occupational therapist can teach the alcoholic patient may assist in establishing a firm base for permanent sobriety. This can permit the person to live a happy and productive life in spite of the presence of a chronic disease.

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