The purpose of the following case report is to demonstrate how the Americans With Disabilities Act of 1990 (ADA) (Public Law 101-336) can be integrated into occupational therapy treatment for a client with alcohol dependence. This report provides an example of how an occupational therapist used the Model of Human Occupation (Kielhofner & Burke, 1980) to work with a client with alcohol dependence. Treatment focused on the performance subsystem. The client’s self-efficacy, roles, habits, and skills were assessed. The client was helped to develop skills to attain and maintain abstinence from alcohol and all other mood-altering substances, to cope with the stressors of daily life that could place him at high risk for relapse (i.e., a return to drinking), and to understand how his unemployment related to his alcohol dependence.

Client History

The client, a 27-year-old married, unemployed mechanic and factory worker, was admitted to an outpatient alcoholism treatment program in a metropolitan midwestern city. He was referred by his county’s Council on Alcohol and Drug Abuse after being charged with domestic abuse that allegedly occurred while the client was intoxicated. He was ordered by the court to follow through with alcoholism assessment and treatment, as supervised by the county’s Council on Alcohol and Drug Abuse.

The client reported regular excessive use of alcohol from age 14 years to the present. Other drugs abused in the past were marijuana, cocaine, hallucinogens, and barbiturates; the client denied current use of any chemicals other than alcohol. The client had previously been involved in a 3-month residential treatment program for alcohol and drug dependence 1 year prior to this admission. He reported that he was able to remain chemically free for a total of 8 months during and after the aforementioned treatment.

At the time of the present admission, the client had been married for 7 months. His wife indicated that she would allow him to live with her and her two sons, aged 3 and 5 years, only if he followed through on this treatment. She also expressed concern about his unemployment, because they were barely making it on the child support she was receiving from her children’s father.

Despite his history of early alcohol and drug use, the client did complete high school. The client had several periods of unemployment, all of which he attributed to his drinking. Formerly, he had worked as a mechanic in the army for 6 years. Most recently, he had worked as an assembler in a factory. He reported that he began this job within the first month after completion of his residential treatment, while he was still chemically free. After 1 month of employment, he injured his arm on the job, and while temporarily disabled due to his arm injury, he relapsed by returning to excessive drinking. The client ad-
mitted that his drinking was so out of control that he failed to report to work after his arm healed, so his employment was terminated.

In addition to legal problems around the domestic abuse, the client reported he had lost his driver's license after being arrested for driving while intoxicated. If he successfully completed this treatment program, he would be eligible to regain his driving privileges for occupational purposes.

In addition to beginning this treatment, the client reported that he occasionally attended Alcoholics Anonymous, attended a weekly self-help group with his wife for couples in dysfunctional relationships, was involved in a weekly bible study with his church group, and had weekly telephone contact or face-to-face visits from social welfare personnel in his county. Most of these activities had been initiated within the month preceding his referral to this treatment program and were evidence of the client's efforts to turn his life around. His wife also indicated a willingness to be involved in his treatment program.

Evaluation

Using the Role Checklist (Oakley, Kielhofner, Barris, & Reichler, 1986), the client reviewed those roles he would like to be involved with. He indicated that all his roles were negatively affected by his drinking. He selected the following roles: (a) as a participant in Alcoholics Anonymous and self-help groups; (b) as a friend, especially with other recovering alcoholics; (c) as a family member, improving his communication with his wife; (d) as a caregiver in parenting his stepsons; (e) as a religious participant, especially in his bible study group; and (f) as a worker, finding a full-time job as a mechanic or an assembler in a factory. He also indicated he wanted to develop leisure interests that would be compatible with abstinence and that he might share with his wife and stepsons.

He identified the following as problems needing attention in the treatment program: (a) inability to remain chemically free; (b) poor communication skills, especially with his wife; (c) lack of role definition with his stepsons, resulting in parenting concerns; (d) difficulty managing anger without drinking or behaving aggressively; (e) few leisure interests; (f) few friends, especially those who would be supportive of his abstinence; (g) difficulty problem-solving in a constructive manner; and (h) unemployment.

Treatment Plan

The client's primary treatment objective was to attain and maintain abstinence, to enhance his self-efficacy in his ability to be abstinent and manage his stress, to improve his relationship and communication with his wife, and to obtain a full-time job by the completion of treatment.

The client was seen one time per week for 1 to 1½ hr per session over a 12-week period. Each session was structured consistent with cognitive behavioral strategies, based on a specific topic for each session. The Coping Skills Model described by Monti, Abrams, Kadden, and Cooney (1989) was used to direct the topic and format of each session. Monti et al. (1989) suggested that the following be included in each session: (a) a rationale as to how each skill is related to the overall goals of abstinence, relapse prevention, and coping-skills enhancement; (b) a set of skill guidelines; (c) practice of the skills using modeling, role playing, and cognitive strategies; (d) a handout for the client with a summary of the content covered in the session and written guidelines for practicing the skill between sessions; and (e) a homework assignment to allow for generalization training, to be followed up at the subsequent session.

Monti et al. (1989) suggested a variety of topics that could be addressed for treating alcohol dependence. I selected those topics that seemed most applicable to this client and had 2 of the 12 sessions focus on skill development with both the client and his wife. As these treatment processes are described, I have added specific comments regarding how information on the ADA could be integrated into the session. Because alcohol dependence substantially limits one or more of this client's life activities, he is classified as having a disability under the ADA.

The topics for each of the 12 sessions, which were selected from 29 possible topics as described by Monti et al. (1989), were as follows:

1. Introduction to coping skills; managing cravings and thoughts about drinking.
2. Drink-refusal skills and self-advocacy.
3. Problem-solving skills.
4. Problem-solving skills (with spouse).
5. Planning for emergencies.
7. Communication skills (with spouse).
8. Enhancing social-support networks.
9. Increasing pleasant activities.
10. Anger awareness.
11. Anger management.
12. Closure, review skills, goals, and plans.

In Session 1, the client identified situations he considered to be high risk for drinking, such as going to a bar, being offered a drink in social situations, and having access to alcohol in his home. He also indicated that having any extra money in his pocket was a trigger to drink. He reported that when he thought about drinking, he usually expected that drinking would improve whatever was going on, but found that in actuality, it usually worsened whatever was happening and increased his feeling negatively about himself (e.g., "I saw myself as a loser."). He reported that feeling like a loser and being unemployed often triggered feelings of helplessness, which, in the past, ultimately led him to drink. Specific strategies to manage his thoughts were emphasized, such as challeng-
ing his thoughts by countering them with nondrinking solutions (e.g., "I have a number of strengths I could offer an employer. If I work on my abstinence, I would be more likely to get and keep a job"). He was encouraged to write on one side of a 3-in. by 5-in. card the benefits of not drinking and, on the other side, notes about the unpleasant consequences of drinking (e.g., "My marriage is on the rocks because of my drinking. When I drink I hurt the people I care most about"). He found that getting involved in a pleasurable, distracting activity, such as taking a walk or watching a movie from his video library, provided a helpful means to make it through cravings. Here, more information about the ADA could have been reviewed to reinforce the client's perceptions about employment issues and their relatedness to his drinking. For example, the client might not even be aware that alcohol dependence, under the ADA, qualifies for protection from discrimination as long as the employee no longer actively drinks or uses illegal drugs.

During Session 2, the client reported that he was able to remain chemically free that week. He indicated that he coped with high-risk situations noted in the previous session by avoiding them. He practiced saying no to the offer of a drink. He was able to state his refusal in an assertive manner, using eye contact and a firm, unhesitating voice, after getting coached on these nonverbal skills. He was able to use these skills in the community the following week when he attended a family party. He also decided to bring his beverage of choice with him to gatherings. He and his wife chose to spend time with their own family rather than attend several holiday gatherings. Here, saying no was linked to self-advocacy, a skill needed both for maintaining abstinence and in requesting reasonable accommodations under the ADA. Even the act of identifying oneself as having a disability due to alcohol dependence, when one is in remission, is for some a difficult task. Because the ADA does not mandate disclosure of a disability, the client could be reassured that, ultimately, the decision to disclose or not would be totally up to him. Emphasis on understanding Title I of the ADA, which prohibits discrimination on the basis of disability in application procedures, hiring and firing, pay, advancement, job training, and "other terms, conditions and privileges of employment" (p. 42), could be stressed.

Sessions 3 and 4 were spent on problem-solving skills, both individually and as a couple. The five-step problem-solving process spelled out by Monti et al. (1989) and reviewed in these sessions was as follows:

1. Problem recognition: "Is there a problem?"
2. Problem identification: "What exactly is the problem?"
3. Consider various approaches: "What could I (we) do?"
4. Select the most promising approach and implement it: "What will I do and how will I do it?"
5. Evaluate the effectiveness: "How did it work? Will I do it again?" (pp. 84-86)

The client and his wife were encouraged to work as a team in using the steps, especially around problems that involved both of them. They reported they were able to use the steps in considering several issues related to setting limits with their children and were grateful to have a structured process to work from, rather than doing whatever occurred to them at the time. The client applied the problem-solving steps to consider how and if, while in remission, he would disclose his alcohol dependence with a potential employer. Here, some discussion about what is meant by reasonable accommodation in the ADA could assist the client in determining what could be gained by self-disclosure of the disability.

During Session 5, the client was coached to make a plan for how he could cope with an emergency, defined by the client as "anything that would put me at high risk for a return to drinking." He listed several situations that he would identify as emergencies, including not being able to get hired, losing yet another job, or having his wife leave him. He developed a list of telephone contacts he would initiate for support, identified several Alcoholics Anonymous meetings he could attend, and recognized that he could leave or change his response to the emergency situation. Because this was not the first treatment for this client, he knew many of the strategies but had not yet organized them into habits for recovery.

Session 6 helped the client look at the interrelationship of his decisions in affecting subsequent decisions. He was encouraged to think through the potential consequences of his seemingly irrelevant decisions in terms of getting into high-risk situations that could lead to relapse of his alcohol dependence. One example of the sequence of seemingly irrelevant decisions could have been emphasized relating to employment and the ADA. For example, if the client interviewed for a job where many of his drinking friends work, it could lead to a decision to join them after work, which could lead to the client drinking with them, which could lead to a relapse in his alcohol dependence, which would leave him unprotected by the ADA. The client reported that he found it helpful to think through several potential decision steps in this manner. He indicated that consideration of potential consequences among chains of decisions was a new process for him.

Session 7, the second session scheduled for both the client and his wife, focused on enhancing communication skills. They worked on sharing positive feedback with one another based on "catching their partner doing something right" and renewed a model for sharing constructive criticism. Active listening was another skill component that they had an opportunity to practice in the session. The client was confronted by his wife with his apparent unwillingness to share his feelings with her. He was able
to clarify to her that he felt so much anxiety and conflict about her response to his sharing that he avoided this. She agreed that she needed to work on being open and accepting of his feelings, especially when they disagreed or had conflicting perspectives.

Sessions 8 and 9 helped the client look at the resources available to him regarding social supports and leisure. The client and his wife joined the YMCA, enrolled in a low-impact aerobics class, and started swimming several times a week. They were able to use the child-care services at the YMCA to avail themselves of time away from the children. They also found several other families with young children in their church and joined them for a monthly family dinner and activity.

Sessions 10 and 11 were focused on helping the client become more aware of situations that seemed linked with his anger responses and reviewing several techniques to manage his anger constructively. One concept emphasized his becoming aware of how his cognitions affected his display of anger in various situations. For example, the client indicated that in the past, when his wife was unusually quiet at the end of the day, he might think, "Uh oh, she must be upset with me. She has nothing to be mad about. I'll show her!" This awareness seemed helpful to the client because it gave him another tool to use to confirm his cognitions and challenge them by asking the other person for more information (e.g., "I notice you’re quiet tonight. Is there anything going on with you?"). He also talked about how, in the past, he would display anger toward his supervisors and coworkers if they gave him feedback that he did not like. After discussing these situations, the client came to the awareness that anger was what he displayed if he felt he was shamed in front of others. Here, as it relates to a potential reasonable accommodation under the ADA, the client could ask a future supervisor to give him feedback about his performance privately. The client noted that when he is new to a work environment, he feels uncertain about his performance, so requesting weekly feedback about his assets as well as areas to work on could be an additional reasonable accommodation to overcome his low self-efficacy.

The final session occurred on the same day that he interviewed for and was offered a job in an area manufacturing plant. He appeared optimistic about his ability to return to full-time employment and stay chemically free, because he now had almost 13 weeks of abstinence. The client reviewed the skills he found helpful in maintaining abstinence: (a) finding a distracting activity when cravings occurred, (b) challenging his old thoughts about drinking and replacing them with nondrinking thoughts, (c) avoiding high-risk drinking environments, and (d) having social contact with other recovering people. He reported that his relationship with his wife and her children had greatly improved and said that he was grateful he had the opportunity to have his wife join several of the sessions.

He reviewed his plans for coping with stressful high-risk situations without drinking and was reminded of signs of potential relapse that he needed to carefully monitor to prevent relapse. He reported that he planned to continue with weekly Alcoholics Anonymous involvement, the self-help group for couples, bible study, activities at the YMCA, and contact with the county social worker.

Follow-Up

The client and his wife were contacted approximately 1 year after his completion of treatment. They reported that he was continuing to maintain his abstinence. He reported being laid off from his job after 10 months due to changes in the economy. Despite this stress, he reported he was able to stay chemically free, which he saw as a positive indicator of his efficacy around his recovery. His wife reported that they continue to work on their communication, and they feel committed to supporting one another through this difficult time. Given that the equal employment protections of the ADA will not be phased in until July 26, 1992, for companies with 25 or more workers and July 26, 1994, for companies with 15 to 24 employees, the client may wish to pay attention to this information, since he is currently seeking employment. He would continue to qualify for protection from discrimination as noted earlier, as long as he continues to be chemically free.

Conclusion

Occupational therapists who work with clients with alcohol dependence must keep the implications of the ADA in mind as they plan for and implement their treatment approaches. Clients may not be fully informed as to their rights and responsibilities under the ADA. This information can be integrated into occupational therapy treatment, because it can affect resumption of one of the client's major occupational roles, that of worker. Crist and Stoffel (1992) have developed a list of potential reasonable accommodations for recurrent functional problems among persons with psychiatric disorders. Their suggestions regarding reasonable accommodations can assist the occupational therapist working in alcohol and drug treatment centers and in psychiatric programs. Use of a coping skills model to affect performance of the person with alcohol dependence can bring about a return to the client's desired role functions and enhanced self-efficacy. The Model of Human Occupation can assist the therapist in developing programs that enhance the occupational role performance of persons whose lives have been disrupted by alcohol dependence.

References


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