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Prescott V.A. Medical Center

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Prescott V.A.
Medical Center

MOHO
COTE
PTSD
Alcoholism
Randy Myers is a fifty two year old Caucasian male. He is a realtor who resides in a lower-middle class neighborhood in Rochester Hills, MI. A Vietnam veteran, he was referred to Western’s VA Hospital for an occupational therapy evaluation by Dr. Swanbeck, a psychologist, after a court ordered psychiatric evaluation. Randy was ordered to seek counseling after being charged with assault and battery for a bar fight. A review of Randy’s medical records revealed that he has been diagnosed with Post Traumatic Stress Disorder, he abuses alcohol, and his wife of twenty years recently moved out of their house, took their five and ten year old sons (Scott and Andy), and requested a divorce. Randy’s records also indicate that he was diagnosed with Conduct Disorder when he was thirteen years old and that his father was physically abusive and an alcoholic. During the occupational therapy evaluation, Randy was quiet and timid. Randy appeared to be sleep-deprived and unkempt as evidenced by stained clothes, greasy hair, and a foul body odor. He had difficulty maintaining eye contact and appeared to be in denial about his current situation. When asked what a typical day is like for him, Randy reported that he stays in bed until 10:30 a.m., has his wife help him get dressed, walks to the bar and arrives at 11:00 a.m. when it opens, and drinks four glasses of beer before noon (he stated that he is very shaky and unfocused until he has his first few drinks of the day; since his wife has left him, he takes clean clothes to the bar and changes there after he has his drinks). After this, Randy stated he goes to his office for two hours and then heads to the bar with friends from work for lunch. At this time he drinks five beers in one hour. After his friends leave to go back to the office, Randy reported that he will go home, sleep until 6:00 p.m., have dinner, and then go back to the bar and drink continuously until midnight. He stated that he is usually unable to walk home at this point so his wife must pick him up. Since she left, Randy reported that the bartenders have called him cabs.

When administering the COTE, Randy put together a puzzle with ten other clients (each client had their own puzzle and sat next to each other). Randy became confused and agitated when he could not find all of his puzzle pieces and when others approached him to see if he had missing pieces from their puzzles. He refused to allow anyone to look at his puzzle pieces and did not make an effort to approach others to see if they had his missing pieces. Randy’s total score was 84. He received a 25 in the general behaviors area (Part One), a 24 in the interpersonal area (Part Two), and a 35 in the task behaviors area (Part Three). These scores indicate impaired function in all three areas. In Part One, Randy displayed an unkempt and disorganized appearance, decreased activity level, and
he took little responsibility for his actions. In Part Two, Randy displayed poor cooperation and sociability skills, attention seeking behaviors, and negative responses from others. In Part Three, Randy displayed little engagement in the puzzle activity, poor concentration and attention span, poor coordination, decreased ability to follow directions, little attention to detail and neatness, poor problem solving skills, little interest in the activity and activity accomplishment, and low frustration tolerance.

When discussing areas related to the volition subsystem of the MOHO, Randy admitted that he feels like he has no control over his drinking or the course of his life. He stated that, “It’s pointless to try to do any better. It won’t make a difference.” Randy remarked that he values honesty, integrity, and his friends and family. He stated that he used to be interested in sports, building remote control cars, woodworking, and sailing. Randy explained that he no longer engages in these leisure interests and is only motivated and interested in drinking: “It makes me feel good and forget all the sh_t that happened in Vietnam.”

When discussing areas related to the habituation subsystem of the MOHO, Randy stated that he lives in a lower-middle class Caucasian neighborhood in Rochester Hills, Michigan. He is a realtor for Century 21, where his main responsibilities include showing and selling homes, completing the business aspects of showing/selling homes, and making arrangements for court-ordered home sales to be cleaned and maintained. When questioned about his ability to maintain a steady job working approximately two hours a day, Randy reported that he no longer cares about selling real estate or maintaining his home. He stated that, “As long as I can afford my drinks, I’m doing fine.” Randy admitted that he has not been doing well at work and his boss told him that he had one month to improve his performance before he would be let go. Randy stated that he is not worried, “I can always find something else.” Randy’s boss, Mr. Smith, was contacted with Randy’s permission. Mr. Smith reported that Randy use to be an “exceptional employee” up until the past two or three years, when Randy started continuously drinking more heavily. Mr. Smith said that when Randy started out at Century 21 ten years ago, he was intelligent, cooperative, a team player, motivated, determined, prompt, and dependable. He described Randy as currently being forgetful, unreliable, argumentative, unkempt, and crude. Mr. Smith stated that, “Randy has not sold a house in over three months. Five years ago he was selling at least five a week! He just doesn’t care about his work anymore.” Randy stated that the majority of his friends are from work, although he remarked that he has not been out with any of them for at least three months. Randy stated that when he was initially married, he and his wife (an occupational therapist who works full time at an outpatient rehabilitation clinic) shared the burden of home maintenance, housekeeping and laundry tasks, and the like. Randy also stated that he was active in taking care of their two children. Randy remarked that he currently has no trouble fulfilling his role as husband, father, and realtor. He stated that, “Things are just fine. I’m just in a slight rut at work and home. Maybe I have backed off a little bit in maintaining the house and helping out with the kids. But I just need a break. If my wife gave me another chance things would be back to normal in no time! It has nothing to do with my drinking. And I can always find another job” Sara Myers, Randy’s estranged wife, confirms that Randy was formally an active and involved husband and father.
However, she stated that he stopped doing things like housework, helping the kids with homework, and other daily tasks when he started drinking heavily three years ago. When interviewed, Mrs. Myers reported that Randy used to be a supportive and loving spouse and father, motivated, caring, intelligent, helpful, and understanding. Mrs. Myers said he no longer engages in the leisure activities he used to enjoy, such as golf, basketball, and woodworking. She also reported that he has lost interest in the house, their marriage, the children, his friends, and his work. Mrs. Myers stated that about three years ago Randy started having nightmares about his Vietnam experience. She reported that Randy saw numerous friends and comrades get brutally wounded or killed and that he shot an innocent Vietnamese civilian as she pleaded to live. This woman’s daughter watched from the front window as he shot her. Mrs. Myers stated that Randy seems to feel remorse and guilt yet he will not discuss the situation with her or his friends. She explained that Randy has become extremely “jumpy” and oversensitive to loud and unexpected sounds. Furthermore, Mrs. Myers stated that Randy experiences alcohol withdrawal symptoms such as increased agitation, anxiety, and sleep disturbances and that he is in denial about his excessive alcohol use, his increased alcohol tolerance, and the effects alcohol has on him physically, emotionally, socially, and financially. She believes Randy’s nightmares, guilt, and alcohol use are affecting his ability to function and fulfill his daily roles.

When discussing areas related to the mind-brain-body performance subsystem of the MOHO, Randy stated that he has no physical problems and that he is as, “smart and sharp as a whip!” Medical records indicate that he has been to the emergency room five times in the past three months for bar-fight related injuries to his head, legs, and arms and that he has high blood pressure and cirrhosis of the liver. During the evaluation, Randy appeared to have delayed cognitive functioning as evidenced by decreased understanding of simple questions and inappropriate responses to questions (i.e., when asked about his leisure interests, Randy stated “It’s hot outside today”). In addition, he expressed feelings of hopelessness at one point when he said trying to improve himself would not help and then stated later on that he was just in a rut right now and things would get better with time and a second chance.

Recommendations-
It is recommended that Randy be seen in occupational therapy two times a week for six months. At that time Randy’s progress and need for further treatment will be re-assessed. The following areas would be addressed:
- Provide education on alcohol use and its side effects
- Teach relaxation techniques
- Teach stress management techniques
- Work on anger management
- Explore leisure interests
- Improve social interaction skills
- Teach time management skills
- Teach sleep hygiene habits
- Provide motivational enhancement
- Improve problem solving skills
- Provide vocational assistance; assist with current job/explore other vocational pursuits
- Assist in re-learning basic life skills (i.e., home maintenance, cooking, laundry, money management)

A thorough exam by a physician and follow through with Dr. Swanbeck, Psychologist, is also recommended. Marriage and family counseling may be beneficial for Randy's wife and children once he has become more stable. Community support and individual counseling should be looked into for Randy's wife and children.
I will be completing my second level two fieldwork at a VA Medical Hospital in Prescott, Arizona. I initially contacted by fieldwork supervisor, Sharla Peterson, and Scott, the last occupational therapy student from Western Michigan University to complete a fieldwork at the site. I learned that the Model of Human Occupation (MOHO) Frame of Reference and the Comprehensive Occupational Therapy Evaluation (COTE) are extensively used at the hospital. To be more prepared, I decided to research these two areas to gain a general understanding of them. I did a comprehensive review of the literature available on the MOHO and COTE, including both articles and books. To find appropriate resources, I searched WestCat (Western Michigan University’s libraries search site), OT Search on the American Occupational Therapy Association’s website, and First Search. I discovered that the MOHO takes a comprehensive look at the factors affecting a client’s general behavior and the COTE is an assessment and progress report tool used in psychiatric settings.

I first researched the MOHO. In the book Conceptual Foundations of Occupational Therapy, Kielhofner, one of the author’s of the MOHO, states that, “This model began with the development of its theoretical arguments, followed by clinical and research application. It emerged from the occupational behavior tradition developed by Reilly and her colleagues and students. Kielhofner, Burke, and Igi first published the model in 1980.” (page 154). Kielhofner and Barrett state in Willard and Spackman that, “The MOHO provides a way of thinking about persons’ occupational behavior and occupational dysfunction. . . .” (page 527). Overall, the MOHO provides clinicians with a structure for gathering data on a variety of populations who may be experiencing deficits in occupational functioning. It displays a client’s strengths and weaknesses, which helps determine which direction therapy should take. The model has an interdisciplinary base, including philosophy, psychology, anthropology, social psychology, and sociology. In Infusing Occupation Into Practice, Kielhofner states that, “. . . the model of human occupation views the human being as a dynamic self-organizing system that exists and acts in relationship to a physical, temporal, and social environment. The model attempts to address (a) how people are motivated to choose, experience, and interpret their occupations; (b) how occupational behavior is organized into the patterns that make up everyday life; and (c) how performance is constructed. . . . It emphasizes process over structure, calling attention to occupation as the process (a) by which we take hold of, and are influenced by, the world around us; (b) by which we fill our days with action; and (c) by which we fashion ourselves into the beings we are becoming” (page 13). The Theoretical Arguments of the Model of Human Occupation are as follows (page nine, table one, Infusing Occupation Into Practice):

1. The human being is a complex organization of three subsystems (volition, habituation, and mind-brain body performance) that motivate, organize, and make possible the performance of occupation.
2. Occupational behavior emerges from interaction of the human system with the environment. Further, occupational behavior shapes the subsequent organization of the human system.
3. The volition subsystem arises from a need for action and is composed of personal causation (beliefs and feelings about one’s capacity and control), values, and interests. This subsystem anticipates, chooses, experiences, and interprets occupational behavior.
4. Occupational behavior demonstrates a pattern that is influenced by one’s habituation subsystem; this subsystem is composed of habits and internalized roles.
5. Occupational performance is composed of motor, process, and communication/interaction skills, which emerge from the interaction of one’s mind-brain-body performance subsystem with the environment.
6. The social environment (including occupational forms and social groups) and the physical environment (including objects and spaces) provide both opportunities and constraints, which shape occupational behavior.

The volition subsystem motivates an individual and helps choose occupational behavior. It comes from a need for action, and anticipates, chooses, experiences, and interprets occupational behavior. Kielhofner states in Infusing Occupation Into Practice that, “As people act in the world, they accumulate a sense of (a) their own effectiveness and awareness of potentials for enjoyment, (b) potentials for satisfaction, and (c) a view of life that commits them to behave in a certain way. These areas of self-awareness are referred to, respectively, as personal causation, values, and interests” (page 10). The habituation subsystem organizes occupational behavior into patterns. Kielhofner states in Infusing Occupation Into Practice that, “Habituation is a dynamic process in which internalized roles and habits allow us to appreciate and cooperate with our familiar and recurrent temporal, physical, and social environments. Our awareness of our roles affects how we interact with others, the tasks we engage in, and how we spend our time. Social groups include both stable and temporary groups of people, and the physical environment includes both natural and fabricated spaces and objects. The final component, the mind-brain-body performance subsystem, enables skilled performance of occupations. Kielhofner and Barrett state in Williard and Spackman that, “The mind-brain-body performance subsystem includes the musculoskeletal, neurological, perceptual, and cognitive capacities needed for occupational performance. Effective occupational performance is the result of the unified action of all components of the mind-brain-body performance subsystem as they work in collaboration with unfolding circumstances and environmental conditions” (page 529).

Therapists can use the MOHO as a framework for approaching the initial data of the case. It helps clinicians generate a set of conceptual questions to guide the data-gathering process and creates an overview of the client’s situation. In Conceptual Foundations of Occupational Therapy, Kielhofner states that, “. . . the model of human occupation sees maintenance and change as a holistic process that involves reorganization throughout the system’s many components. Moreover, the model holds that preservation and change takes place in all three subsystem components . . . The kinds of change that take place in the system depend on the state of each individual component and the dynamic relationships within the whole . . . different parts of the system can adapt to alterations or limitations in other parts” (page 160). The MOHO does not define specific intervention protocols. Instead it relies on the therapist’s reasoning skills as he/she assesses the client and determines the best course of treatment that takes the client’s unique environment and circumstances into account. Miller and Walker state in Perspectives On Theory for the Practice of Occupational Therapy that, “The model of human occupation helps the occupational therapist find an explanation for the pattern of occupational function and dysfunction presented by the patient by (1) indicating the variables on which one should gather information, (2) pointing out the relationships among those variables through the schema of the subsystems and their . . . relationships, (3) indicating the relationship between subsystem components and the environment and the effect of this relationship on the whole system, (4) providing an outline of changes that can be expected at different levels of occupational development, and (5) presenting an occupational function-dysfunction continuum from which one can determine a patient’s level of performance” (page 199). Finally, Mackenzie explains in “An Application of the Model of Human Occupation to Fieldwork Supervision and Fieldwork Issues in NSW” that the MOHO explains the importance of taking all three subsystems into account when making a decision and determining a course of action for intervention. She states that changes, which lead to a reorganization of the entire system, need to focus on the underlying actions and processes of the whole system. Mackenzie believes that changes can be
disorderly but experimentation is required when making decisions and treatment plans so the
most effective course of treatment can be determined.

In terms of research on the MOHO, Miller and Walker state in Perspectives on Theory for the
Practice of Occupational Therapy that, “The model of human occupation has stimulated research
in the last decade, most of it since 1980. Kielhofner’s students and colleagues have researched the
model of human occupation with several patient groups, including children with learning
disabilities, alcoholics, adults with retardation, persons with spinal cord injury, and the elderly.
Other research efforts have addressed assessment and instrument development” (page 280).
McGruder writes in Willard and Spackman that, “...elements of the model, especially in its
earlier articulations, showed a distinct North American dominant culture bias” (page 63). In “Use
of the Model of Human Occupation: A Survey of Therapists in Psychiatric Practice,” Munoz,
Lawlor, and Kielhofner explain that seventy eight percent of the therapists interviewed believed
that the model provides a comprehensive and organized framework. The authors state that, “...findings clearly suggest that these therapists believe the major components proposed in this
model provided them with an organizing framework with which they could frame and understand
their client’s occupational behavior” (page 133). Finally, in “A Critical Analysis of the Model of
Human Occupation,” Haglund and Kjellberg state that, “It is suggested that Kielhofner’s
description of the dialectical relationship between the individual and the environment is unclear,
and its possible role in intervention would benefit from further description. We consider that the
belief that individual has an innate and spontaneous urge to explore and master the world is
inaccurately downplayed in the revised Model, and that the volition subsystem is hierarchically
more important for the intervention process than the other subsystems” (page 107).

After researching the MOHO, I explored that COTE. Sara J. Brayman, PhD, OTR/L,
FAOTA, Thomas Kirby, PhD, Aletha M. Misenheimer, COTA, and M.J. Short, MD are the
authors of the COTE. Kunz and Brayman state in Assessments in Occupational Therapy Mental
Health: An Integrative Approach that, “The comprehensive occupational therapy evaluation is a
behavioral rating scales for use in psychiatric programs. The impetus guiding the development of
the original COTE was the need to delineate occupational therapy’s unique role in comprehensive
adult mental health programs, and to provide a standard and objective means of reporting patient
behaviors observed by occupational therapists. ... the scales enable the therapists to report a
large volume of diverse and pertinent information quickly in a consistent format, using defined
terminology” (page 259). They explain that the COTE can be used in the majority of psychiatric
settings and with numerous activities and assists occupational therapists with clinical
observations and recognizing diverse behaviors. The COTE is a way to evaluate and document
observed behaviors that directly relate to functional performance. Finally, Asher states that, “The
COTE ... can serve as an initial evaluation and progress record to assist with treatment and
discharge planning” (page 7). According to Asher, required materials include the COTE Scale
and Definitions and a writing utensil.

Kunz and Brayman state that, “The COTE was developed in 1975 by the occupational
therapists, a psychiatrist, and a psychologist practicing at the Greenville Hospital System in
Greenville, South Carolina. The instrument was designed to address four objectives” (page 259).
The objectives, quoting from Kunz and Brayman, are as follows:
1. “... to identify the behaviors that occurred in and were particularly pertinent to the practice
   of occupational therapy. The behaviors included in the COTE Scale reflect the profession’s
   traditional emphasis on occupational performance.
2. “... to define the behaviors in a manner that would allow the observations of different
   occupational therapists to correspond. Each of the behaviors included on the COTE was
   defined and subdivided into five levels of performance. These definitions, complete with the
description of each level of performance, are printed on the instrument. This immediate reference decreases misinterpretation... and eliminates the use of vague descriptions" (page 260).

3. “... finding an efficient and effective tool to communicate a great deal of information to the physician and other members of the treatment team...” (page 260).

4. “... to provide an efficient means of retrieving data needed for treatment planning and evaluating treatment results. Since the COTE uses numbers to rate behaviors, progress or change in behaviors can be easily noted and measured” (page 260).

The twenty-six behaviors included on the COTE are divided in three areas titled General Behaviors (the eight behaviors in this area offer general information about the client’s overall performance and functioning), Interpersonal Behaviors (the six behaviors in this area deal with interpersonal skill during structured and non-structured activities), and Task Behaviors (the twelve behaviors in this area deal with task performance). The therapist rates each behavior on a scale of 0 to 4, with 0 displaying normal behavior and 4 displaying greatly impaired behavior. There are specific criteria for the scoring of each item, with the final result displaying a general picture of their behavior on the day of testing. Kunz and Brayman explain that, “The occupational therapist can select numerous types of activities that involve task performance. Various activities are included as examples to clarify these 12 task behaviors and to illustrate how these behaviors are rated on the COTE. It is possible to evaluate most behaviors by using most treatment activities” (page 262). Recommended activities include making magazine collages or a tile trivet, doing copper tooling or leather lacing, glazing a ceramic stein, playing charades, completing jigsaw puzzles, and assembling a leather belt link or wooden kits. Revisions have been made in the COTE since its conception. Revised to keep up to date with times

The benefits of the COTE are expansive. The COTE helps occupational therapists develop treatment plans and determine treatment priorities by graphically displaying a client’s strengths and weakness. The grid format also makes it easy for therapists to compare and contrast a client’s admission and discharge scores to determine functional outcomes. It takes only three minutes to complete, Kunz and Brayman explain that, “The COTE and KidCOTE each include opportunities for the clinician to record short-term treatment goals, test results, pertinent demographic information, and a statement of the patient’s expectations. This information is on a supplemental sheet that is tailored to meet the specific demands of each clinical team. This information is supplemental to the patient’s scores and assures compliance with the documentation requirements of the facility and the payors” (page 273). Kunz and Brayman state that, “The COTE and the KidCOTE create structures for organizing and recording diverse patient behaviors that may be addressed in therapy. Because the listing of behaviors is expansive...the rater is compelled to consider many components of patient performance and can contribute more comprehensive information to the treatment planning process. The grid simplifies comparison of variances in patient behaviors, and is especially helpful when reviewing the effects of a new medication or a change in treatment intervention or milieu. The numerical scores can be easily monitored and provide hard data that is useful in documenting patient outcomes for quality improvement...the comparison between admission and discharge behaviors offers measurable performance outcome data... The COTE and KidCOTE also provide a mechanism for teaching students and new therapists how to observe and document patient behaviors in occupational therapy... A comparison of the COTE...with treatment plans can also be useful in assessing whether patient goals and treatment plans appropriately reflect patient performance. The COTE... can assist the therapist in defining occupational therapy services in psychiatry. The listing of behaviors is straightforward and relates directly to functional performance. Discussing the COTE score with the patient allows the therapist to explain how the patient’s behaviors affect his or her
performance. . .  (and) The COTE and KidCOTE are effective and efficient instruments for use in the evaluative process in psychiatric occupational therapy” (page 273).

The reliability and validity of the COTE has been determined. Kunz and Brayman state that, “Interrater reliability of the initial COTE was determined by computing percentage agreement between the ratings of two therapists, with five different therapists involved. Ratings within one degree of each other were considered acceptable and the percent agreements for 55 patients ranged from 76% to 100% and averaged 95%. Percentage agreements for exact agreements ranged from 36% to 84% and averaged 63% . . . In personal correspondence from the director of occupational therapy of a large general hospital with a 13-bed psychiatric unit, reliability data were reported on seven patients. Percentage agreements for ratings within one degree of each other ranged from 96% to 100% and averaged 98%” (page 272). Kunz and Brayman explain that, “Validity was determined by randomly selecting the charts of five discharged patients from a group of 400. Total scores for the first and last days in occupational therapy were compared. The scores averaged 31 to 17, respectively, and the drop in the score agreed with the observation of other professionals in the acute hospital setting. A similar review comparing initial and discharge scores showed average admission scores of 33.5, with a discharge score of 22.25 and an average variance of 10.8. In a study conducted by an occupational therapy student in the psychiatric unit of a medical university hospital, it was observed that a patient’s total scores decreased from the first to the last days in occupational therapy. To insure validity of each day’s ratings, the student scored the patients on a new scale each day to avoid the influence of the score from the previous day. The average score for the first day of occupational therapy was 20 with a range of 0 to 28. The average decrease in score was 11 points, with a range of 0 to 57” (page 272). Finally, Asher states that, “Scores obtained on first day of hospitalizations were compared with predischarge scores, and significant improvements in ratings were noted on the latter” (page 7).

I am looking forward to going to Arizona and using the MOHO and COTE. They appear to be well-established, beneficial tools that will enhance my observational and clinical reasoning skills. I am now more confident in my ability to effectively use these occupational therapy tools with my future clients at the VA Hospital.
MODEL OF HUMAN OCCUPATION (MOHO)

Overview
In the book Conceptual Foundations of Occupational Therapy, Kielhofner states that, “This model began with the development of its theoretical arguments, followed by clinical and research application. It emerged from the occupational behavior tradition developed by Reilly and her colleagues and students. Kielhofner, Burke, and Igi first published the model in 1980. . . . Five years later a book introduced an expanded theory and a wide range of clinical applications. Since its inception, a number of persons have contributed to the development, testing, and application of this model. . . . this model is designed for application to any person experiencing difficulty in occupational functioning. However, it’s actual application and the resources for application vary across population” (page 154). Kielhofner and Barrett state in Willard and Spackman that, “The MOHO provides a way of thinking about persons’ occupational behavior and occupational dysfunction. Its concepts address motivation for occupation, the routine patterning of occupational behavior, the nature of skilled performance, and the influence of environment on occupation. The model provides a broad framework for gathering data about a client’s circumstance, for generating an understanding of the client’s strengths and weaknesses, and for selecting and implementing a course of therapy” (page 527). The model has an interdisciplinary base, including philosophy, psychology, anthropology, social psychology, and sociology.

Theory
In Infusing Occupation Into Practice, Kielhofner states that, “. . . the model of human occupation views the human being as a dynamic self-organizing system that exists and acts in relationship to a physical, temporal, and social environment. The model attempts to address (a) how people are motivated to choose, experience, and interpret their occupations; (b) how occupational behavior is organized into the patterns that make up everyday life; and (c) how performance is constructed. The model emphasizes the centrality of occupational behavior in shaping the organization of the human being. It emphasizes process over structure, calling attention to occupation as the process (a) by which we take hold of, and are influenced by, the world around us; (b) by which we fill our days with action; and (c) by which we fashion ourselves into the beings we are becoming” (page 13).

Theoretical Arguments of the Model of Human Occupation
(page nine, table one. Infusing Occupation Into Practice)

1. The human being is a complex organization of three subsystems (volition, habituation, and mind-brain body performance) that motivate, organize, and make possible the performance of occupation.
2. Occupational behavior emerges from interaction of the human system with the environment. Further, occupational behavior shapes the subsequent organization of the human system.
3. The volition system arises from a need for action and is composed of personal causation (beliefs and feelings about one’s capacity and control), values, and interests. This subsystem anticipates, chooses, experiences, and interprets occupational behavior.

4. Occupational behavior demonstrates a pattern that is influenced by one’s habituation subsystem; this subsystem is composed of habits and internalized roles.

5. Occupational performance is composed of motor, process, and communication/interaction skills, which emerge from the interaction of one’s mind-brain-body performance subsystem with the environment.

6. The social environment (including occupational forms and social groups) and the physical environment (including objects and spaces) provide both opportunities and constraints, which shape occupational behavior.

**Volition Subsystem**

The volition subsystem motivates an individual and helps choose occupational behavior. It is composed of personal causation, values, and interests, comes from a need for action, and anticipates, chooses, experiences, and interprets occupational behavior. Kielhofner states in Infusing Occupation Into Practice that, “Volition emerges and changes through occupational behavior. As people act in the world, they accumulate a sense of (a) their own effectiveness and awareness of potentials for enjoyment, (b) potentials for satisfaction, and (c) a view of life that commits them to behave in a certain way. These areas of self-awareness are referred to, respectively, as personal causation, values, and interests” (page 10).

**Habituation Subsystem**

The habituation subsystem organizes occupational behavior into patterns. Kielhofner states in Infusing Occupation Into Practice that it “...is composed of habits and internalized roles. To be competent, people must be integrated into the rhythm and customs that make up their physical, social, and temporal worlds... Habituation is a dynamic process in which internalized roles and habits allow us to appreciate and cooperate with our familiar and recurrent temporal, physical, and social environments. Habits and roles are... tacit frameworks from which we encounter and traverse our world. ... Habituation is a self-organizing process by which the very behaviors that habituation evokes will serve to sustain habituation” (page 11). Social groups include both stable and temporary groups of people, and the physical environment includes both natural and fabricated spaces and objects.

**Mind-Brain-Body Performance Subsystem**

The mind-brain-body performance subsystem enables skilled performance of occupations. Kielhofner and Barrett state in Williard and Spackman that, “The mind-brain-body performance subsystem includes the musculoskeletal, neurological, perceptual, and cognitive capacities needed for occupational performance. Effective occupational performance is the result of the unified action of all constituents of the mind-brain-body performance subsystem as they work in collaboration with unfolding circumstances and environmental conditions” (page 529).
Using the MOHO in Practice
The MOHO can be used as a framework for approaching the initial data of the case. It helps clinicians generate a set of conceptual questions to guide the data-gathering process and leads to a specific theory of the client’s situation. In Conceptual Foundations of Occupational Therapy, Kielhofner states that, “...the model of human occupation sees maintenance and change as a holistic process that involves reorganization throughout the system’s many components. Moreover, the model holds that preservation and change takes place in all three subsystem components—values, interests, personal causation, roles, habits, and skills. Additionally, changes in the environment may also be a necessary part of maintaining and changing function. The kinds of change that take place in the system depend on the state of each individual component and the dynamic relationships within the whole. ... This model argues that different parts of the system can adapt to alterations or limitations in other parts” (page 160). He goes on to state that, “Because this model attempts to address a wide range of factors across the age continuum and within a variety of disability areas, it does not provide strictly defined intervention protocols. Rather, the model calls for a reasoning process, whereby the therapist assesses the individual and decides on a holistic approach to treatment based on the unique circumstances of the individual and his or her environment. ... a wide variety of programs for application with specific populations has been developed. These programs illustrate how the model is used to conceptualize the problems of the population. Moreover, the programs propose general strategies and resources for application” (page 160). Miller and Walker state in Perspectives On Theory for the Practice of Occupational Therapy that, “The model of human occupation helps the occupational therapist find an explanation for the pattern of occupational function and dysfunction presented by the patient by (1) indicating the variables on which one should gather information, (2) pointing out the relationships among those variables through the schema of the subsystems and their ... relationships, (3) indicating the relationship between subsystem subsystem components and the environment and the effect of this relationship on the whole system, (4) providing an outline of changes that can be expected at different levels of occupational development, and (5) presenting an occupational function-dysfunction continuum from which one can determine a patient’s level of performance” (page 199). Finally, in “An Application of the Model of Human Occupation to Fieldwork Supervision and Fieldwork Issues in NSW,” Mackenzie states that, “In managing change positively. Kielhofner suggested several principles that operate within the model of human occupation ... These are summarized as follows: (I) any interventions/decisions/actions must be understood and undertaken in the context of the ongoing progress of the system; (ii) change should be focused on the actions or processes underlying the system as a whole; (iii) change means a reorganization of the system; (iv) changes will occur in many parts of the system simultaneously; (v) change is often disorderly; (vi) interventions/decisions/actions should involve experimentation to find the best solutions; (vii) it is essential to effect change in the relevant environment if change within the system can be supported or initiated” (page 78).
Research
In Perspectives on Theory for the Practice of Occupational Therapy, Miller and Walker state that, “The model of human occupation has stimulated research in the last decade, most of it since 1980. Kielhofner’s students and colleagues have researched the model of human occupation with several patient groups, including children with learning disabilities, alcoholics, adults with retardation, persons with spinal cord injury, and the elderly. Other research efforts have addressed assessment and instrument development” (page 280). McGruder writes in Willard and Spackman that, “Although the model is valued for its attempts to attend to issues of culture and social environment, descriptions of the . . . elements of the model, especially in its earlier articulations, showed a distinct North American dominant culture bias” (page 63). In “Use of the Model of Human Occupation: A Survey of Therapists in Psychiatric Practice,” Munoz, Lawlor, and Kielhofner state that seventy eight percent of the therapists interviewed believed that the model provides a comprehensive and organized framework. The authors state that, “. . . findings clearly suggest that these therapists believe the major components proposed in this model provided them with an organizing framework with which they could frame and understand their client’s occupational behavior” (page 133). Finally, in “A Critical Analysis of the Model of Human Occupation,” Haglund and Kjellberg state that, “It is suggested that Kielhofner’s description of the dialectical relationship between the individual and the environment is unclear, and its possible role in intervention would benefit from further description. We consider that the belief that individual has an innate and spontaneous urge to explore and master the world is inaccurately downplayed in the revised Model, and that the volition subsystem is hierarchically more important for the intervention process than the other subsystems” (page 107).
**Vocabulary**

* Unless otherwise stated, these definitions are given by Kielhofner in *Infusing Occupation Into Practice*

Activity choices: “. . . decisions about the use of discretionary time in everyday life. . . .” (page 10).

Affording: (referring to the environment’s influence on occupational behavior) “. . . affording or giving opportunities for performance” (page 12).

Capacity: “. . . refers to the underlying potential for behavior . . .” (page 12).

Habits: “. . . preserve our way of doing things that we’ve learned from earlier performance. . . . Habits organize occupational behavior by (a) influencing how one performs routine activities, (b) regulating how time is typically used, and (c) generating styles of behavior” (page 11).

Habituation: “. . . people move through life occupying a sequence of social positions. The process of acquiring and repeating these patterns of occupational behavior is referred to as habituation” (page 11).

Habituation Subsystem: “. . . a collection of images which trigger and guide the performance of routine patterns of behavior” (A Model of Human Occupation: Theory and Application, Page 24).

Interests: “. . . dispositions to find pleasure and satisfaction in occupations, coupled with the self-knowledge of this enjoyment of occupations” (page 10).

Internalized role: “. . . a broad awareness of a particular social identity and related obligations, which together provide a framework for appreciating situations and constructing behavior. Roles influence (a) our interactions with others, (b) the kinds of tasks we perform, and (c) the way we partition time” (page 12).

Occupational behavior settings: “Groups, occupational forms, spaces, and objects coalesce into coherent environments that we refer to as occupational behavior” (page 13).

Occupational choices: When “. . . persons select the roles and habits that constitute their lifestyle” (page 10).

Occupational forms: “. . . refers to coherent sets of actions that are oriented to a purpose or goal and that are generated and sustained in the social collective” (page 12).
Personal causation: “. . . includes one’s knowledge of capacity (i.e., an awareness and an attitude toward one’s present and potential abilities) and one’s sense of efficacy (i.e., the perceptions of one’s command of personal behavior and of one’s effectiveness in achieving desired outcomes” (page 10).

“Personal causation is defined as a collection of beliefs and expectations which a person holds about his or her effectiveness in the environment” (A Model of Human Occupation: Theory and Application, Page 15). * Need to see skills as relevant and useful in one’s life

Pressing: (referring to the environment’s influence on occupational behavior) “. . . to recruit or demand particular behavior” (page 12).

Skill: “. . . refers to the characteristics of actual performance” (page 12)

Values: “. . . an individual’s internal images concerning what is good and right. They are expressed as commitments to participate in certain occupations and to perform in a certain manner. Values include one’s degree of orientation to past, present, and future and one’s convictions about how time should be used. They also include one’s occupational goals and standards of performance and the meaning attributed to certain occupations. “ (Conceptual Foundations of Occupational Therapy, page 157)

“. . . a coherent set of convictions that assign significance or standards to occupations, creating in each person a strong disposition to perform accordingly. Personal convictions refer to one’s way of viewing life and the goals to be pursued in life. These convictions are, simply, commonsense beliefs about what matters in life” (page 10).

Volition Subsystem: “The volition subsystem is defined as an interrelated set of energizing and symbolic components which together determine conscious choices for occupational behavior. The energizing component is a generalized urge for exploration and mastery. The symbolic components are images (i.e. beliefs, recollections, convictions, expectations) which include, personal causation, values, and interests” (Model of Human Occupation: Theory and Application, Page 14).

Volitional narratives: “People integrate their past, present, and future into a coherent whole that we call volitional narratives. These are very highly personal life stories. Within the volitional narrative, an individual makes sense of his or her own competence and considers how to find satisfaction and value in life. Through their occupational behavior, people strive to continue the volitional narrative in ways that they believe are important, that bring satisfaction, and that are seen as achievable. . . (volitional narratives) influence how we select and organize our behavior” (page 11).
References


COMPREHENSIVE OCCUPATIONAL THERAPY EVALUATION (COTE)

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Overview
Kunz and Brayman state in Assessments in Occupational Therapy Mental Health: An Integrative Approach that, "The comprehensive occupational therapy evaluations (COTE and KidCOTE) are behavioral rating scales for use in psychiatric programs. The impetus guiding the development of the original COTE was the need to delineate occupational therapy’s unique role in comprehensive adult mental health programs, and to provide a standard and objective means of reporting patient behaviors observed by occupational therapists. The KidCOTE was developed nearly twenty years later to address the similar needs of therapists working with children and young adolescents. Each of the scales enable the therapists to report a large volume of diverse and pertinent information quickly in a consistent format, using defined terminology" (page 259). They explain that, "The COTE and the KidCOTE provide a structure to clinical observation by occupational therapists. Their formats guide the therapist’s attention to diverse behaviors. These instruments can be successfully utilized with most activities and in most psychiatric settings. The instruments serve only to evaluate observed behaviors and to communicate those observations. The behaviors included on both scales are directly related to functional performance. The evaluation is recorded numerically so changes in behavior can be easily measured, compared, and retrieved for study" (page 274). Asher states that, "The COTE was developed to provide a standard and objective method of observing and rating behaviors of psychiatric patients on a regular basis. It can serve as an initial evaluation and progress record to assist with treatment and discharge planning” (page 7). Finally, the COTE recommends activities that may be used for observation purposes. Required materials include the COTE Scale and Definitions and a writing utensil.

Background
Kunz and Brayman state that, “The COTE was developed in 1975 by the occupational therapists, a psychiatrist, and a psychologist practicing at the Greenville Hospital System in Greenville, South Carolina. The instrument was designed to address four objectives” (page 259). The objectives, quoting from Kunz and Brayman, are as follows:
1. “The first objective concerned the focus of the instrument- to identify the behaviors that occurred in and were particularly pertinent to the practice of occupational therapy. The behaviors included in the COTE Scale reflect the profession’s traditional emphasis on occupational performance. . . . Many of the behaviors included in the COTE were identified in 1954 by Ayres as being important factors in successful participation and production in a work setting. These behaviors . . . serve as the basis of the instrument” (page 259).
2. “The second objective guiding the development of the COTE was to define the behaviors in a manner that would allow the observations of different occupational
therapists to correspond. Each of the behaviors included on the COTE was defined and subdivided into five levels of performance. These definitions, complete with the description of each level of performance, are printed on the instrument. This immediate reference decreases misinterpretation by both the reader and the therapist, and eliminates the use of vague descriptions” (page 260).

3. “The third objective related to finding an efficient and effective tool to communicate a great deal of information to the physician and other members of the treatment team. . . . The COTE imposes a structure for reporting observations made during the occupational therapy treatment process” (page 260).

4. “The fourth objective . . . was to provide an efficient means of retrieving data needed for treatment planning and evaluating treatment results. Since the COTE uses numbers to rate behaviors, progress or change in behaviors can be easily noted and measured” (page 260).

Kunz and Brayman state that, “Twenty-six behaviors are included in the COTE. These are divided into three areas: 1) General Behaviors, 2) Interpersonal Behaviors, and 3) Task Behaviors” (page 260). Asher states that, “The behaviors are rated by the therapist on a scale of 0 (normal) to 4 (greatest impairment), based on criteria listed for each item. The therapist rates the client on all behaviors at each session, providing a simple record in which the individual’s behaviors can be compared over time. Each recording requires two minutes . . . COTE yields a daily summary of the client’s behavior over the entire acute care hospitalization” (page 7).

Revisions have been made in the COTE. For example, documentation formats have been revised to accommodate for the shorter length of hospital stays, definitions and descriptions are now printed on the back of the form for reference, current terminology has resulted in the refinement of behavior definitions, and interrater reliability has been increased by tightening some behavioral parameters. In addition, Kunz and Brayman state that, “One item, conceptualization, which addresses the ability to abstract, has been added to the list of behaviors. Punctuality was replaced by attendance” (page 260). They explain that this last change was made because clients today are often escorted to and from therapy sessions. In the past they were able to go to and from therapy sessions independently.

General Behaviors
Kunz and Brayman state that, “The eight behaviors included in part one of the scale provide information about the patient’s general functioning. These behaviors . . . are included to provide some general information about the patient’s overall performance” (page 260).

Interpersonal Behaviors
Kunz and Brayman state that, “The six behaviors listed in part two involve interpersonal skills . . . These behaviors are included because the occupational therapy environment provides opportunities for the patient to interact with others during structured and non-structured activities. Patients may behave differently during occupational therapy than they do during group therapy or while on the ward” (page 260).
Task Behaviors
Kunz and Brayman state that, “Part three of the COTE Scale consists of 12 behaviors that relate to task performance, an area central to occupational therapy. The COTE’s emphasis on task behaviors emphasizes the importance of occupation” (page 260). They explain that, “The occupational therapist can select numerous types of activities that involve task performance. Various activities are included as examples to clarify these 12 task behaviors and to illustrate how these behaviors are rated on the COTE. It is possible to evaluate most behaviors by using most treatment activities” (page 262).

Format
Kunz and Brayman state that, “The format of the COTE is helpful in developing a treatment plan. The COTE graphically displays areas of strength and weaknesses, and can help the therapist to determine treatment priorities” (page 266). The also explain that, “... the grid format does afford the opportunity to easily compare and contrast patient admission and discharge behaviors, thus providing information about functional outcomes. The actual COTE document has been designed so that the parameters of each behavior are printed on the back of the document. ... The COTE and KidCOTE each includes opportunities for the clinician to record short-term treatment goals, test results, pertinent demographic information, and a statement of the patient’s expectations. This information is on a supplemental sheet that is tailored to meet the specific demands of each clinical team. This information is supplemental to the patient’s scores and assures compliance with the documentation requirements of the facility and the payors” (page 273).

Attributes
Kunz and Brayman state that, “The COTE and the KidCOTE create structures for organizing and recording diverse patient behaviors that may be addressed in therapy. Because the listing of behaviors is expansive and includes more than one performance area, the rater is compelled to consider many components of patient performance and can contribute more comprehensive information to the treatment planning process. The grid simplifies comparison of variances in patient behaviors, and is especially helpful when reviewing the effects of a new medication or a change in treatment intervention or milieu. The numerical scores can be easily monitored and provide hard data that is useful in documenting patient outcomes for quality improvement. Quality management/improvement initiatives are data-driven, and the comparison between admission and discharge behaviors offers measurable performance outcome data. The emphasis of COTE and KidCOTE on function is compatible with accreditation standards and patient-focused care. ... Another focus of quality management is to improve the efficiency of service delivery. ... It takes less than 3 minutes to complete a COTE or KidCOTE. ... The structure of these instruments guides the therapists’ reports so that the patient’s functional performance is documented. The COTE and KidCOTE provide a strong foundation for discussion of patient goals and treatment priorities. ... The COTE and KidCOTE also provide a mechanism for teaching students and new therapists how to observe and document patient behaviors in occupational therapy. ... A comparison of the COTE ... with treatment plans can also be useful in assessing whether patient goals
and treatment plans appropriately reflect patient performance. The COTE... can assist
the therapist in defining occupational therapy services in psychiatry. The listing of
behaviors is straightforward and relates directly to functional performance. Discussing
the COTE score with the patient allows the therapist to explain how the patient’s
behaviors affect his or her performance. Using the profile outlined on the COTE, the
patient and the therapist can collaborate on the appropriate treatment plan. . . . The COTE
and KidCOTE are effective and efficient instruments for use in the evaluative process in
psychiatric occupational therapy” (page 273).

Reliability
Kunz and Brayman state that, “Interrater reliability of the initial COTE was determined
by computing percentage agreement between the ratings of two therapists, with five
different therapists involved. Ratings within one degree of each other were considered
acceptable and the percent agreements for 55 patients ranged from 76% to 100% and
averaged 95%. Percentage agreements for exact agreements ranged from 36% to 84%
and averaged 63% . . . In personal correspondence from the director of occupational
therapy of a large general hospital with a 13-bed psychiatric unit, reliability data were
reported on seven patients. Percentage agreements for ratings within one degree of each
other ranged from 96% to 100% and averaged 98%” (page 272). Asher states that,
“Interrater reliability is good (0.95 average) for ratings within one degree of each other”
(page 7).

Validity
Kunz and Brayman explain that, “Validity was determined by randomly selecting the
charts of five discharged patients from a group of 400. Total scores for the first and last
days in occupational therapy were compared. The scores averaged 31 to 17, respectively,
and the drop in the score agreed with the observation of other professionals in the acute
hospital setting. In a similar review, comparing initial and discharge scores, showed
average admission scores of 33.5, with a discharge score of 22.25 and an average
variance of 10.8 In a study conducted by an occupational therapy student in the
psychiatric unit of a medical university hospital, it was observed that a patient’s total
scores decreased from the first to the last days in occupational therapy. To insure validity
of each day’s ratings, the student scored the patients on a new scale each day to avoid the
influence of the score from the previous day. The average score for the first day of
occupational therapy was 20 with a range of 0 to 28. The average decrease in score was
11 points, with a range of 0 to 57” (page 272). Asher states that, “Scores obtained on first
day of hospitalizations were compared with predischarge scores, and significant
improvements in ratings were noted on the latter” (page 7).

References

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POST TRAUMATIC STRESS DISORDER (PTSD)

Definition-
The DSM-IV states that, “The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor . . . PTSD has been associated with a wide range of events which would not be considered extraordinary or particularly severe stressors. These include idiopathic illness, apparently uncomplicated medical procedures, and ‘normal’ loss events. Scott . . . has said that there are patients who have all of the symptoms of PTSD but in whom no single ‘extreme’ stressor can be identified although their symptoms seem to be related to a series of less severe stressors or one chronic stressful situation.” (Page 83; Traumatic Events and Mental Health). The DSM-IV criterion for “stressor” is as follows: “Experienced, witnessed, or been confronted with an event or events which involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others . . . and response involved intense fear, helplessness, or horror (Page 125; Traumatic Events and Mental Health). The risk of developing PTSD increases as the intensity of the stressor increases and the proximity decreases. McCarroll, Uranso, and Fullerton write that, “The extent and intensity of sensory properties of remains- such as visual grotesqueness, smell, and tactile qualities- are important aspects of the stressor.” (Page 50; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster).

Bonder states that, “The trauma is usually accompanied by extreme feelings of terror and helplessness, and a primary characteristic of PTSD is a re-experiencing of both the event and these feelings, which are recurrent and intrusive. The individual may have bad dreams, or find these feelings welling up at unpredictable times and in unpredictable places. As this occurs, the individual begins to avoid the situations which seem to stimulate it, or to develop a diminished ability to respond to the world as a mechanism for avoiding the unpleasant emotions” (Page 136). Blitz and Greenber state that, “The traumatic experiences seems to assault one’s basic assumptions about oneself in relation to the world, and one’s capacity to bear the feelings in response to it. The traumatized person has lost a basic trust in himself and in the world about him and has lost the capacity to self soothe. . . . The veteran frequently reports feeling that he has lost something of himself, that he is not the same person, that things have lost their meaning. Current relationships and accomplishments do not appear to be able to mitigate the sense that something has shattered inside, as if connections with other meaningful memories and present experiences cannot be made” (Page 105; Psychotherapy of the Combat Veteran). Other symptoms of PTSD include:

• Despair
• Sense of hopelessness
• Decreased motivation for self-directed and productive involvement in work, education, recreation, and relationships
• Faster resting heart rate
• Higher blood pressure
• Readjustment difficulties (social, family, sex, employment)
• Intrafamilial conflict
• Dissociation
• Increased arousal (i.e. chronic tension and irritability)
• Impaired concentration and memory
• Depression
• Anxiety
• Difficulty with interpersonal functioning
• Feeling detached or constricted
• Decreased self-esteem
• Sense of isolation and aloneness
• Desire for revenge against the lost
• Agitation and impulsive outbursts
• Insomnia

Van der Kolk et al. defined five principal features of PTSD. They are:
1. Persistence of startle responses and irritability
2. Proclivity to explosive reactions
3. Atypical dream life
4. Fixation on the trauma
5. Constriction of the general level of personality functioning

Epidemiology-
“The Epidemiological Catchment Area (ECA) study found prevalence rates of PTSD in the general population of 1.0% to 2.6%” (Page 9; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster).

“The National Vietnam Veterans Readjustment Study (NVVRS) is the most extensive epidemiological study to date of the long-term psychiatric effects of combat. The prevalence of PTSD in Vietnam veterans up to 19 years after war was 15%. Preliminary studies of Persian Gulf war veterans during their first year after return indicated that approximately 9% of veterans exhibited PTSD” (Page 9; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster).

“Several epidemiological investigations in the 1970s and 1980s demonstrated that as many as one in two military veterans who served in the Vietnam war zone experiences PTSD at some point since the war, documenting war-related PTSD’s prevalence, severity and chronicity.” (Page 75; Group Treatments for Post-Traumatic Stress Disorder).

Theories of PTSD
“The behavioral view of PTSD identifies classical conditioning as the mechanism that links symptoms of PTSD to the precipitating trauma. According to this model, patients who originally react to a traumatic event (unconditioned stimulus) with fear and arousal (unconditioned response) continue to show the same response to cues (conditioned stimuli) that have been paired with the stressful response. Learned responses in PTSD do not diminish with time” (Page 216; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster). Avoiding these cues reduces distress and prevents the extinction of the conditioned response over time.

“The cognitive model of PTSD postulates that a traumatic experience may reveal basic assumptions that normally underlie a patient’s expectations, behavior, and appraisal (e.g., identity, world view, safety, trust, esteem, intimacy, power, or independence) as
inaccurate, insufficient, or inadequate. Pathogenic assumptions (e.g., vulnerability, mistrust, or disempowerment) may subsequently replace previous assumptions and generalize to many areas of life" (Page 224; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster).

Predictors of PTSD-
“A complex interaction of environment, biology, and mind determines which individuals develop posttraumatic psychiatric disease” (Page 3; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster).

Pre-trauma risk factors include:
- Familial psychiatric illness
- Low self-confidence at age 15
- Prior psychiatric disorder
- Adverse life events before/after trauma
- Parental poverty
- Academic difficulties
- Family instability
- Father who was exposed to combat
- Ethnic minority status
- Joining the military at a younger age
- Willingness to serve in military (increase risk if willing to serve)
- Possible genetic or inherited susceptibility
- Negative homecoming
- Poor social support
- Prior physical health problems
- Being female and between ages 36 and 50
- Personality factors (personal view of life and perception of events, neuroticism and introversion)
- Childhood trauma (e.g., sexual assault, separated or divorced parents before age 10)

“Posttraumatic stress responses are determined by type of stressor, stressor severity, and individual biological, psychosocial, and cognitive factors” Page 49; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster). “The severity, nature, and duration of the stressor are primary risk factors for the development of PTSD” (Page 39; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster). In Vietnam, “The best predictors of distress related to the first viewing of a dead American soldier were having little or no prior contact with death, having children, low educational achievement, and thinking a lot about death when young” (Page 47; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster). Other risk factors include being exposed to combat and abusive violence/gruesome death, witnessing/participating in atrocities, being wounded, having an emotional attachment to the deceased, decreased combat experience, and experiencing a threat to one’s life.

Treatment
“Interventions based on behavior theory are designed to undo conditioned responses to conditioning stimuli that have been paired with trauma. Behavior therapy proceeds either by gradual reexposure (desensitization) or massive reexposure (flooding) to the conditioning stimuli” (Page 217; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster). Exposure-based therapies, such as systematic desensitization or flooding, and anger management have proven to be beneficial in the treatment of PTSD. “The role of cognitions (beliefs and attitudes) is an important factor
in adaptation after a traumatic event. Individuals and groups attach meaning to traumatic experiences to integrate those experiences into what is familiar and accommodate the changes required. People need to reestablish feelings of trust, safety, and predictability in the world and establish continuity among the past, present, and future. The experience of traumatic death shatters the assumption of invulnerability...creates feelings of identification with the victim...and brings about a search for meaning” (Page 49; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster).

Occupational Therapy Goals for clients with PTSD include encouraging relaxation (this involves teaching relaxation and diversion techniques), providing opportunities to express emotions, and assisting in re-establishing social ties, work activities, and leisure pursuits.

The following areas may also be addressed:

- **Provide education on alcohol use and it’s effects** (alcohol’s short/long-term effects—narrows attention, interferes with sleep cycles, and attempts to abstain may exacerbate nightmares) and how it relates to PTSD symptoms (increases depression associated with PTSD and reduces ability to learn and use tools necessary to cope with PTSD)
- **Teach sleep hygiene habits** (i.e. establish bedtime routine, avoid caffeinated beverages after 4 p.m., use warm baths, warm milk, and herbal teas, use night lights)
- **Provide motivational enhancement**—this includes capitalizing on a client’s motivation for change and enhancing motivation (view resistance/ambivalence as normal and an appropriate target for therapy intervention; express empathy, understanding—validate experiences, show discrepancy between where client says they want to be and where they are, develop collaborative spirit in treatment, support self-efficacy and provide them with confidence in their ability to change)
- **Teach self-management skills**—this includes teaching the skills and tools needed to manage emotional and behavioral responses to internal and external stimuli
  - **Problem-solving:** teach systematic method for identifying and addressing problems in their lives by dividing the process into five distinct components—problem recognition and acknowledgment, problem identification, generate solutions, evaluate solutions and each solutions pro’s and con’s, implement a plan of action
  - **Relaxation skills:** provide information about flight/flight reaction and effects of hyperarousal on body, mind, and emotions, teach diaphragmatic breathing skills, progressive muscle relaxation, positive relaxing imagery
  - **Anger management:** keeping low arousal level, recognizing things that trigger anger, and learning short-term cooling off strategies
  - **Self-reinforcement:** explore activities and objects that one can use to reward self for increased independence and decreased alcohol reliance
  - **Cognitive refocusing:** providing strategies to refocus, including thought-stopping techniques and meditation
- **Provide social skills training**—facilitate interaction with the world in a positive and productive way
  - **Assertiveness:** discuss assertiveness/aggression and passive/passive-aggressive styles as well as using assertiveness to gain control of one’s life
• Drink refusal skills: saying no, avoiding making excuses, having alternatives
• Receiving criticism: accepting constructive criticism
• Seeking and accepting social support: may have decreased social support as a result of social avoidance, isolation, and drinking- examine existing social supports and perceived barriers to support such as environment and personal/interpersonal factors- various types of support are discussed (i.e., moral/financial) and importance of support and ways to form and maintain support

Harney and Harvey identified eight domains of functioning that need to be taken into account at all stages of treatment. They are as follows:
1. Authority over memory. The process by which an individual experiences a sense of control over the remembering process. In this domain, survivors range from those who feel besieged by intrusive memories or have no access to memories, to those who feel that they can choose to remember events in their lives.
2. Integration of memory with affect. The extent to which a survivor experiences her memories as interwoven with feeling. Survivors may recall traumatic images without feeling or suffering from painful feelings uncontained by images. Others have memories that are braided with tolerable doses of negative affect and new affects that arise from contemporary understanding of the traumatic past.
3. Affect tolerance. The extent to which survivors can bear painful feelings. Survivors may present as unable to experience a range of feelings, as flooded by a few particular feelings, or as comfortable with positive as well as negative affect.
4. Symptom mastery. The degree to which survivors can anticipate, manage, contain, or prevent the cognitive and emotional disruption that arises from post-traumatic arousal.
5. Self-esteem and self-care. The degree to which survivors experience themselves as worthy of care and behave in ways that promote their best interest.
6. Self-cohesion. The extent to which survivors experience themselves as integrated or fragmented, in terms of thought, feeling, and action.
7. Safe attachment. The ability of the survivor to develop feelings of trust, safety, and enduring connection in relationships with others.
8. Meaning-making. The process of understanding what the survivor develops about himself or herself, in relation to the traumatic experience and to the world in which the trauma occurred.

Stephen O’Brien identifies the following intervention phases after one has experienced a trauma:
1. Primary Prevention
   • Education about the expected
   • Training to develop mastery and control
   • Limit exposure
   • Sleep hygiene
   • Rest and maintains physiologic needs
   • Education of spouse/significant others to encourage “natural debriefing”
2. Secondary Prevention
   - Restore safety and community services
   - Educate primary care providers
   - Triage
   - Outreach to injured for early diagnosis
   - Recognition of somatization as possible psychiatric distress
   - Educate teachers in early detection of distress
   - Debriefing
   - Psychotherapy and appropriate medication

3. Tertiary Prevention
   - Treatment of comorbid disorders
   - Alertness to family distress of chronic loss and demoralization, spouse and child abuse
   - Compensation
   - Counteracting withdrawal and social detachment
   - Psychotherapy and appropriate medication

Stages by Dimensions Model:
   Developed by clinical theorists at the Victims of Violence Program; Views recovery as a process that moves through three stages and entails change along eight dimensions of psychological functioning
   1. Establishment of safety (physical well-being) and self-care
   2. Remembrance and mourning- weave traumatic memory into the survivor’s general life narrative to develop a coherent sense of self
   3. Repair relationships with others in their immediate and wider community

Prout and Schwarz suggest five stages of treatment:
   1. Supporting adaptive coping skills and strategies
   2. Normalizing experiences and sensations
   3. Decreasing avoidance
   4. Producing an alternative attribution of meaning
   5. Facilitating the integration or re-integration of self

Brende’s suggest the following stages for treatment:
   1. Stabilization of target symptoms
   2. Confronting emotional detachment, smoldering rage, and self-destructive symptoms
   3. Simultaneously controlling intrusive memories and uncovering traumatic experiences
   4. Resolving guilt and facing grief
   5. Re-integration of self
   6. Finding atonement with God, self, and others

It is imperative to involve the patient’s family in the therapeutic process for numerous reasons:
- All family members are affected by the trauma (old wounds may be rehashed, they may feel responsible or helpless, lose their sense of physical/emotional safety, have ineffective problem solving or communication skills, problems in the family structure
may emerge, relationship changes may be hindered by prior experiences and expectations.

- Families have inherent roles and belief/attitude systems that can be observed; these may be affected by therapy intervention
- Enables the clinician to observe a survivor's group interaction skills
- Families provide a source of support

Group Treatment

Groups help restore the commonality and connection in relationships, help survivors learn to speak publicly about what happened and make sense of their experiences and reactions, share coping tools, provide a structured network of relationships that assist in integration of traumatic memories and help develop a wide range of feelings that can be examined and understood, place less emphasis on the therapist, and offers a safe place to vent emotions. Communicating with those who have had similar experiences can help sufferers establish their sense of safety and social support. In a group members are able to discuss how feelings of competence and self worth changed during wartime without fear of judgment. Groups also allow members to work in a cooperative rather than combative environment where they can gradually take initiative.

The various types of groups for veterans include:

- Psychoeducational groups: Teach structured behavioral exercises that teach a defined set of topics or skills such as anger/stress management; leader directs
- Supportive/expressive groups: Facilitate interaction and discussion of current relational and psychological issues related to PTSD, such as identification of critical themes linking formative past experiences with current concerns and impairments tend to meet regularly with a closed membership and have relatively open-ended structure
- Trauma exploration: Detailed review by each member of key military and war trauma experiences- usually followed by an examination of earlier development benchmarks and a discussion of postwar psychological adjustment issues- more formally structure the main body of each session to ensure that all developmental phases are reviewed in detail orally by each member

Comorbidity Disorders-

"PTSD shares symptomatology with panic disorder, phobic anxiety, generalized anxiety disorder, and obsessive compulsive disorder, although none of these diagnoses covers the whole of the PTSD syndrome. . . . physiological assessment indicates that PTSD, like anxiety disorders, involves an increase, or at least an abnormality, in sympathetic nervous system activity" (Page 19; Traumatic Events and Mental Health).

"Kulka and colleagues also found in the PTSD cases a current total comorbidity rate of approximately 50% for several other psychiatric disorders (50% total for panic disorder, general anxiety disorder, obsessive-compulsive disorder, major depression, manic episode, substance use disorder, and antisocial personality). . . . The lifetime rate of comorbidity with PTSD for the same group of disorders was 99%" (Page 14; Post Traumatic Stress Disorder: DSM-IV and Beyond)
“Alcohol use disorders are a common and clinically challenging problem among individuals with post-traumatic-stress disorder (PTSD). Prevalence estimates of alcohol abuse among trauma victims seeking treatment for PTSD have ranged as high as 75% . . . Often, these individuals suffer from comorbid anxiety or depressive disorders as well as other substance use disorders, further complicating evaluation and treatment” (Page 117; Group Treatments for Post-Traumatic Stress Disorder).

“. . . Keane. Et al. (1988) summarized results of previous studies as well as their own data by suggesting that 60%-80% of treatment-seeking Vietnam veterans with PTSD also met criteria for current alcohol or drug abuse, or both” (Page 118; Group Treatments for Post-Traumatic Stress Disorder). Substance abusers frequently experience stressors when intoxicated, vivid dreams during drug craving and recovery, avoidance of the environment and thoughts related to the traumatic event in the form of denial of a substance abuse problem, and autonomic arousal symptoms of substance abuse withdrawal. These resemble the criteria for PTSD. “Furthermore, individuals experiencing PTSD may use drugs as a “numbing” tactic. Also, PTSD and alcohol withdrawal may well have common underlying psychobiological mechanisms. Current research implicates limbic structures in the symptoms of alcohol withdrawal and increased arousal symptoms of PTSD” (Page 160; Posttraumatic Stress Disorder: Acute and long-term responses to trauma and disaster).

References


References


ALCOHOLISM

Definition:
The American Psychiatric Association identifies an alcoholic as one who remains intoxicated for at least two days and one who becomes tolerant of alcohol, needing markedly increased amounts to achieve the same effects (Page 157, Alcoholism).

“Keller describes alcoholism as the condition where an individual is unable to give up drinking in spite of the hurt it is causing himself healthwise, socially, and economically” (Page 46, Alcoholism).

Jellinek’s Typology of Alcoholism
Page 47- The Treatment of Drinking Problems: A guide for the helping professions

• Alpha Alcoholism: Excessive drinking for purely psychological reasons without evidence of ‘tissue adaptation’ - no loss of control
• Beta Alcoholism: Excessive drinking which has led to tissue damage, but where there is no dependence on alcohol
• Gamma Alcoholism: Excessive drinking where there is evidence of tolerance and withdrawal, a peaky and fluctuant alcohol intake, and marked ‘loss of control.’ Jellinek saw this as the pattern typical of Anglo-Saxon countries.
• Delta Alcoholism: Excessive drinking where there is evidence of tolerance and withdrawal, but with a much steadier level of alcohol intake. Rather than the patient manifesting ‘loss of control,’ they would exhibit what was called ‘inability to abstain.’ The pattern was seen as typical of France and of other wine-drinking countries.
• Epsilon Alcoholism: Bout drinking, or what use to be termed dispomania

Classification of Drinkers-
From Alcoholism: Page 7; adapted from Caetano’s study
- Frequent Heavy Drinkers: Drinks five or more drinks at a sitting, once a week or more often
- Frequent High Maximum: Drinks once a week or more often and drinks five or more drinks at a sitting occasionally (at least once a year)
- Frequent Low Maximum: Drinks once a week or more often but never drinks as many as five drinks at a sitting
- Infrequent: Drinks less than once a week but at least once a month; may or may not drink five drinks at a sitting
- Occasional: Drinks less often than once a month
- Abstainer: Has not drunk alcoholic beverages in the last six months
- Social Drinker: Drinks when the occasion warrants it
- Problem Drinker: Drinks until he becomes intoxicated
- Alcoholic: Drinks till it interferes with the everyday functioning of his roles
“Tolerance is a condition in which ‘repeated doses of the same amount of drug become diminishly effective and progressively larger doses are required to secure a desired effect’” (Page 2; Substance Use Disorders: Assessment and treatment).

“Withdrawal is a ‘maladaptive behavioural change’, with physiological and cognitive concomitants, that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged heavy use of a substance” (Page 2; Substance Use Disorders: Assessment and treatment).

Types of Dependence:
1. Psychological Dependence (user feels that he/she needs drug to reach maximum level of functioning)
2. Physical Dependence (body has adapted physiologically to chronic use of substance with evident tolerance or withdrawal symptoms)

The Alcohol Dependence Syndrome- Key Elements
Page 35- The Treatment of Drinking Problems: A guide for the helping professions
- Narrowing of repertoire (drink the same regardless of day or occasion)
- Salience of drinking
- Increased tolerance to alcohol
- Withdrawal symptoms
  - Autonomic hyperactivity
  - Elevated pulse rate
  - Psychomotor agitation
  - Anxiety
  - Tremors
  - Nausea
  - Sweating
  - Hyperacusis (sensitivity to sound)
  - Tinnitus (ringing in ears)
- Relief or avoidance of withdrawal symptoms by further drinking
- Subjective awareness of compulsion to drink
- Reinstatement after abstinence

Substance Use Disorders: Assessment and treatment; Page 14
1) Blood alcohol content of 0.0 to 19 (mg/100 ml blood). Mild sedation and relaxation may be observed.
2) Blood alcohol content of 20/99 (mg/100ml blood). Impairment of motor coordination and diminished reaction time may be observed.
3) Blood alcohol content of 100/199 (mg/100ml blood). More severely impaired coordination, impairment of judgment, and decreased mental activity may be observed.
4) Blood alcohol content of 200/299 (mg/100ml blood). Slurred speech, marked incoordination, impaired judgment, and labile mood may be observed.
5) Blood alcohol content of 300/399 (mg/100ml blood). Anesthesia, memory impairment, labile mood, and loss of consciousness may be observed.
6) Blood alcohol content of 400 (mg/100 ml blood) and higher. Respiratory failure, coma, or death may occur.

EPIDEMIOLOGY

"Alcohol is the most widely abused substance in the United States" (Page 12; Substance Use Disorders: Assessment and treatment).

"Alcohol addiction is second only to nicotine in incidence and prevalence in the United States. There are approximately seven to nine million alcoholics or problem drinkers in America . . ." (Page 193; Alcoholism).

"Over 75% of men and 50% of women in Western countries drink more than an occasional alcoholic beverage. . . . Over a lifetime, 5% to 10% of adult males in the United States will meet the criteria for alcohol dependence; 17% if the less severe criteria for abuse are included. Highest rates of alcohol dependence are seen in men aged 30 to 50; rates increase as income, education, and SES decrease. High consumption is noted among Catholics (especially French and Irish). When corrected for SES, most racial or ethnic groups show similar rates of alcohol dependence. Exceptions include low rates of alcohol dependence among Asian Americans and Jewish Americans, and high rates among Native American Indians and Eskimos" (Page 24, Substance Use Disorders: Assessment and treatment).

"According to research undertaken among persons fifty-five years and over, approximately 10-15 percent of them use alcohol" (Page 105, Alcoholism).

"Epidemiological studies have found about 14 million U.S. adults (i.e. 7.5% of the adult population) meet criteria for substance abuse or dependence at any time, and approximately 1/3 are women" (Page 151, Handbook of Alcoholism).

More women are becoming alcoholics than ever before and at a rate faster than males. While middle-and-upper class people tend to report drinking more frequently, heavy drinking occurs at greater levels in lower socio-economic groups.

Progression of Alcoholism

• Need to consider quantity and frequency of alcohol intake

Classic Model of Progression of Alcoholism

Substance Use Disorders: Assessment and treatment; Page 45

"Longitudinal studies have demonstrated that there is no single course of alcohol abuse."  

1) Prealcoholic: use of alcohol as social lubricant; future alcoholic may experience relief from tension and dysphoria; phase last through variable periods of time through which the drinker moves from drinking to relieve states of dysphoria to preoccupation with drinking and daily consumption- drinking becomes a central part of life; loss of control has not occurred yet and excess drinking may not be obvious to self or others
2) Prodromal: alcoholic blackouts (memory blackouts associated with an episode of intoxication despite being conscious during this period)- become a source of intense fear and shame since the individual does not know what he/she did during the blackout; drinking is daily; tolerance and physical dependence are evident; negative psychosocial consequences become apparent

3) Crucial: signaled by loss of control- cannot predict what will happen after a single drink; negative psychosocial consequences increases in number and severity; alcohol problem becomes apparent to others

4) Chronic: characterized by prolonged periods of intoxication, often lasting for days; severe medical consequences are apparent (i.e. alcoholic hallucinosis that are usually auditory, tremors, and grand mal seizures during withdrawal, delirium tremens marked by confusion/profuse sweating/seizures/elevated temperature); reverse tolerance; psychosocial deterioration; Wernicke-Korsakoff syndrome (confusion, disorientation; anterograde and retrograde amnesia, confabulations); death

Models of Progression of Substance Use

Substance Use Disorders: Assessment and treatment; Page 46

1. Initiation (experimentation)
2. Positive consequences (pleasurable psychological and social benefits from substance)
3. Negative consequences (deter regular use for most users; those that continue regular use do not link drug use with the negative consequences)
4. Turning point (initiation of quitting- realize link between substance abuse and negative consequences; time of marked ambivalence)
5. Active quitting (concrete behavior changes in terms of abstinence from abused drug and lifestyle changes)
6. Relapse prevention (change maintenance; consolidation of behavior changes and further development of lifestyle changes)

Theories-

"Family and twin studies provide strong evidence to support genetic transmission of alcoholism, but also indicate an equally important role for shared environment" (Page 305; Handbook of Alcoholism).

"There is increasing evidence that the evolution of alcohol dependence can be explained in terms of both psychological and pharmacological processes, and it appears likely that neuroadaptation changes in the brain underly the compulsion to drink, increase tolerance, alcohol withdrawal, and the other features of the syndrome" (Page 24; The Treatment of Drinking Problems: A guide for the helping professions).

"Anyone can become an alcoholic; you do not have to be born an alcoholic. Sociological and environmental factors may do the job! Social irresponsibility will complete it" (Page 46, Alcoholism).

- Medical Model-Genetics (hereditary factors may increase one’s susceptibility to developing alcoholics, unclear how it is transmitted)
- Sociological Model- Group perspective, influence of environment and social groups
- Social Learning Theory- Reinforcement though modeling, frequency, devotion, and intensity because of benefits it provides (i.e. history of drinking, cultural and social acceptability of drinking), self-efficacy, association with peers and family members who model substance use; cognitive mediation of behavior (thoughts, feelings, expectations)
- Psychological Model- Self image and repressive forces
- Personality Theory-“Disturbed Personality” (i.e. low self-esteem, perfectionist, poor interpersonal relationships)
- Cultural Theory- Culpability resides in the culture itself (i.e. how the culture interprets drinking and when/where it is accepted)
  Modern-Day Society- Increase sense of alienation, decreased self-esteem and self-confidence, search for a quick fix
- Societal View- Society tends to believe that a drink increases camaraderie, decreases inhibitions, draws people together, may drink to decrease stress and anxiety (it is common for the elderly to drink in response to the stresses associated with aging), a stimulant/euphorant, sedative
- Psychodynamic Theory- Individual drinks to overcome inhibitions; emphasize pleasure-seeking or destructive motives, range of ego deficits and difficulty, trouble with self-esteem/self-care and establishing relationships with others, controlling/regulating affect (overwhelming, intolerable feelings)
Elements Common to Psychoanalytic Theories of Substance Abuse:
  Substance Use Disorders: Assessment and treatment; Page 117
  1. Substance abuse is seen as a symptom of more basic disturbance
  2. Problems in the regulation of affect and pathological object relations are core difficulties
Strengths and Weaknesses:
  Consideration of the entire personality seen as a strength
  Weaknesses:
  1. They focus on psychogenic factors and neglect other factors known to contribute to substance abuse (e.g., social, genetic, and pharmacological factors)
  2. They make no attempt to discern preexisting problems from those resulting from substance abuse
  3. They view substance abuse disorder as homogeneous
- Classical Conditioning- Environmental cues become associated with the use of a substance after repeated pairings, resulting in physiological responses that are experienced as urges for the drug
- Operant Conditioning- Focus on reinforcing qualities of substance abuse (produce positive effect or eliminate negative experience) that increase the likelihood of further substance use
- Biopsychosocial Model: Acknowledges and accepts that biological (genetic predisposition), psychological (psychodynamics, learning aspects), and social factors (availability, culture, peer, family modeling) must be considered in etiology and treatment
Environmental and Individual Factors:
- Socio-cultural background (age, gender, community, socio-economic status, ethnicity, religion, neighborhood values, availability of alcohol, values attached to drinking and when and how much one drinks - low SES, high population density, low population mobility, physical deterioration, high crime or unemployment, deviant norms condoning substance abuse, high alienation of citizens, and availability all increase risk of substance use or abuse)
- Religion
- Stressful job
- Family upbringing
- Peer group
- Job status
- Marital stability
- Early childhood characteristics such as conduct disorder/aggression
- Poor academic performance/school failure or low commitment to school
- Early onset of substance abuse
- Risk-taking/sensation-seeking behavior
- High tolerance of deviance/nonconformity relative to traditional values
- Positive expectancies regarding the effects of substances
- Premature sex and early pregnancy
- External locus of control
- Decreased self-esteem and impulse control
- Anxiety/depression/poor coping skills
- Interpersonal/social difficulties
- Traumatic experiences

Factors that increase a female’s risk of alcohol abuse include infertility, premenstrual and menstrual problems, miscarriages, lack of sexual interest, those seeking work, and those who are married. In his study, Fellios discovered that the largest population of female drinkers were in professional, technical, and business jobs as opposed to semi-skilled and laborer jobs.

"... use of substances appears more related to curiosity and peer/social influences; abuse of substances appears more a function of significant psychological distress, poor coping skills, an association of substance abuse with need satisfaction, and biological predisposition ... (Page 41; Substance Use Disorders: Assessment and treatment).

"Vaillant noted that general patterns of substance abuse are related to age: youth use drugs to produce novelty and excitement, those in midlife use drugs for social purposes, and older adults use drugs to produce quiet and sameness. Vaillant identified four general trends associated with the aging process that affect the use of substances:
1. The ability to tolerate dysphoria increases with age. This lessens the motivation to use drugs in order to change feeling status.
2. Antisocial behavior decreases with age. There is a strong association between antisocial behavior and substance abuse.
3. Emotional maturation occurs allowing for improved relationships. The social motives to use substances are diminished.
4. The effect of drugs is partially dependent on setting, and with advancing age there is less involvement in settings explicitly for partying and using drugs.” (Page 41; Substance Use Disorders: Assessment and treatment).
Effects of Alcohol & General Characteristics of Problem Drinkers

“The effects of alcohol on a given individual may be modified by age, weight, sex, and tolerance. Alcohol exhibits cross-tolerance with other CNS depressants and with opioids; alcohol and heroin are frequently used together” (Page 13; Substance Use Disorders: Assessment and treatment).

“Across the board, and generally speaking, male drinking and female drinking show more or less consistent patterns of behavior” (Page 88, Alcoholism).

Alcohol is a central nervous (CNS) depressant. CNS depressants produce antianxiety, sedation, hypnosis (altered state of consciousness resembling sleep), anesthesia (loss of sensation), coma, and death. “The principal ingredient of all alcoholic beverages is ethyl alcohol (also known as ethanol or alcohol). . . . Alcohol . . . is sometimes mistakenly thought of as a stimulant; the increased energy that is observed is due to increased blood sugar and decreased inhibition” (Page 12; Substance Use Disorders: Assessment and treatment). Those who have been drinking exhibit loss of control over behavior and are more susceptible to environmental cues (may engage in illegal/immoral behavior more readily).

- Alcohol use affects or increases the likelihood of problems in the following areas:
  - Nervous system
  - Liver and digestive system
  - Gastrointestinal system and pancreas
  - Cardiovascular system & stroke
  - Respiratory system
  - Musculoskeletal system
  - Kidneys and electrolytes
  - Endocrine system
  - Glucose and vitamin deficiencies
  - Zinc deficiencies
  - Skin
  - Pneumonia and TB
  - Myopathy
  - Body temperature
- “It is estimated that approximately 1 in 3 heavy drinkers develop scars on the liver, loss of cells in different regions of the brain, inflamed lining of the stomach and hypertension, or high blood pressure” (Page 120, Alcoholism).
- Hypertension: “Acute ethanol intake causes peripheral vasodilation, together with an acute reduction in myocardial contractility, resulting in a decrease of blood pressure and a compensatory increase in heart rate and cardiac output due to elevation of sympathetic tone. In addition chronic drinking of low daily doses of alcohol also may cause a mild drop in blood pressure. No clear mechanism has so far been reported for these effects for alcohol on blood pressure. In contrast, chronic intake of more than 30 to 60 g alcohol per day clearly increases blood pressure, but the amount of rise of blood pressure individually varies within wide ranges” (Page 206, Handbook of Alcoholism).
Comorbid disorders include:
- Anxiety disorders
- Mood disorders
- Posttraumatic stress disorder
- Affective disorders (i.e. depression)
- Bipolar disorders
- Eating disorders
- Personality disorders
- Schizophrenia
- Substance abuse

- Suicidal behavior
- Hallucinations
- Blackouts
- Hypomania
- Jealousy
- Drug addiction (drugs are often taken to enhance or counteract the effects of each other)

Percentage of Alcohol Abusers Presenting with Comorbid Psychiatric Disorders

1. Anxiety Disorders; 19.4%
2. Antisocial Personality Disorder; 14.3%
3. Mood Disorder; 13.4%
4. Schizophrenia; 3.8%

Social problems that may arise from drinking include:
- Family difficulties
- Problems at work
- Housing (poor maintenance of house and relations with neighbors)
- Financial difficulties
- Homelessness and vagrancy

Male alcoholics marry at the same rate as the general population, but they have a higher divorce rate than non-alcoholic males.

In the later stages, dependence becomes progressively worse, gross and incapacitating intoxication becomes more common (unable to drink as much without getting drunk), and drinking makes the patient feel very ill.

Effects of Alcohol Use:

1) Acute psychological effects
a) Relaxation
b) Mild sedation
c) Disinhibition
At higher levels:
d) Incoordination
e) Slurred speech
f) Nystagmus
g) Impairment in attention and memory
h) Confusion
i) Impaired judgment
j) Disorientation
At very high (toxic) levels:
k) Stupor
l) Coma
m) Respiratory depression
n) Death

2) Toxic reactions
   a) Alcohol by itself is not highly toxic, but when combined with other drugs its toxicity increases (e.g. barbiturates).

3) Symptoms of chronic alcohol use
   a) Damage to the liver
   b) Cardiac muscle damage
   c) Damage to circulatory, gastrointestinal, and genitourinary systems
   d) Brain damage. Wernicke-Korsakoff Syndrome describes the extreme end of the spectrum of cognitive impairment resulting from chronic alcohol abuse.
   e) Teratogenic effects. Fetal alcohol syndrome (FAS) is characterized by adverse CNS effects (microcephaly, developmental delay, mental retardation, and abnormal neuronal integration), growth retardation, and characteristic facial distortion
   f) Accidental injuries due to impairment in cognition, visual-motor functioning, and judgment

Katz and Ney’s Series of Common Factors Among Alcoholics
Behavioral:
   Decreasing recovery-oriented activities
   Isolating oneself from others
   Avoiding support system recovery
  Avoiding talking about alcoholism and recovery

Cognitive:
   Preoccupation with thoughts of drinking
   Believing that one can control drinking
   Focusing on everything but recovery
   Questioning one’s identity as an alcoholic

Social/Interpersonal:
   Withdrawing/distancing from social relationships
   Experiencing peer/cultural pressure to drink
   Making recovery contingent on other people
   Lacking family or peer support
   Blaming family/friends for problems
   Openly rejecting help

Affective:
   Experiencing heightened anxiety
   Judging oneself harshly
   Feeling ashamed
   Feeling overwhelmed/helpless
   Losing confidence in oneself
   Experiencing ambivalence and doubt

Psychological:
   Denying the need for a program
   Feeling inflated, i.e., that one is cured
Projecting onto/blaming others
  Distancing reality

Physiological:
  Having cravings
  Sleeping or eating irregularly
  Experiencing difficulties in physical coordination

Spiritual:
  Depending on willpower to stay sober
  Feeling unable to relinquish control
  Letting go of hope, faith

Treatment
Three important therapist characteristics are authenticity, unconditional respect, and empathy.

"The six elements commonly used in brief interventions have been summarized by the acronym FRAMES: feedback, responsibility, advice, menu, empathy, and self-efficacy” (Page 287 The Treatment of Drinking Problems: A guide for the helping professions).
  Menu: options on work/leisure activities, methods to refuse drinks, etc.

Professional roles:
  • Medical practitioners (provide education & medications, treat withdrawal symptoms)
  • Nursing (provide education, advice, counseling)
  • Social work (engage the problem drinker in appropriate counseling/therapeutic work, work with family, assist with housing/benefits/employment/legal matters)
  • Occupational therapy (assist individuals in learning/relearning behaviors necessary in daily life such as time management skills, leisure activities, stress management, vocational assistance, basic life skills, problem solving, goal setting, group interactions)
  • Psychology
  • Counseling
  • Psychotherapy
  • Teamwork/group work

Important Factors:
  • Emphasize the patient’s responsibility for his/her actions
  • Provide education on how drugs are negatively impacting their lives (i.e. physically, emotionally, socially)
  • “The most common defense mechanisms are denial, rationalization, and projection. These mechanisms must be understood as protective efforts to keep away feelings of guilt, shame, total submission to significant others (including you as the therapist), or defeat” (Page 8, Handbook of Alcoholism).
  • Increase motivation

The Three Goals of Motivational Intervention Strategies
  Table 1.2; Handbook of Alcoholism
1. Motivate the patient to accept treatment (short-term goal); treatment motivation is proportional to the
   • Extent of suffering
   • Likelihood of success
   • Practicability (amount of subjective costs)
2. Motivate the patient to become and remain abstinent (abstinence motivation- long-term goal)
3. Motivate the patient to change his/her lifestyle (long-term goal)
   • Teach relaxation techniques and self-management tactics
   • Role-playing and coping strategies in high-risk situations
   • Social skills training and assertiveness training (social adaptation skills, appropriate body language/behavior, giving/receiving compliments, work related concerns, engaging in conversation, refusal skills)
   • Problem-solving skills
   • Relaxation training/anxiety control
   • Anger management
   • Stress Management (biofeedback, relaxation training, desensitization and exercise)
   • Disulfiram (Antabuse): Drug that causes nausea when alcohol is ingested
   • Cognitive restructuring
     Helps interrupt the client’s series of thoughts that would usually lead to drinking and replaces them with positive thoughts
     • Behavioral self-control
     • Contingency management (based on operant learning principles, encourages desired behaviors my providing positive reinforcement and discouraging undesirable behavior by removing positive reinforcement)
     • Aversion Therapies (covert sensitization: cognitive-behavioral technique in which personally unpleasant images are incorporated into thoughts and fantasies of substance abuse; used to interfere with cravings or urges for substance use)
     • Community Reinforcement Approach (involves marital-family counseling, relapse prevention, employment counseling, and social-recreational counseling; goal is to make abusers life more rewarding and provide positive reinforcement of desirable behavior)
     • Relapse prevention (identify personal high-risk situations, develop strategies to effectively cope with these situations, and modify cognitive and emotional reactions- i.e. sense of low self-efficacy in high-risk situations, positive expectations about use of substances, and specific causal attributions- and develop healthy behaviors to replace behaviors associated with substance abuse to reinforce abstinence)
   Triggers of relapse include:
   • Experiencing negative emotions or mood disturbances (i.e. tension, annoyance)
   • Positive emotions
   • Cravings
   • Wish to see if one can change to ‘controlled drinking’
   • Conflicts with friends/family/colleagues
   • Social situations with high drinking pressure
   • Insufficient coping mechanisms
   • Failure to find sobriety rewarding
   • Stressful life events
“Overall, 80% of those initiating abstinence relapse within one year. However, if 1 year of abstinence is achieved, there is an 80% chance of achieving a second year of abstinence” (Page 140; Substance Use Disorders: Assessment and treatment).

- Cue Exposure (based on Pavlovian conditioning paradigm—believe environmental cues become associated/conditioned with use of substance that can evoke cravings and lead to a relapse: treatment consists of exposure to these cues and response-prevention to ensure extinction; client’s confidence in ability to resist cravings is important, need to look at increasing coping skills and self-confidence)
  “Cue exposure reduces the likelihood that the stimulus will trigger a response in the future and improves the individual’s self-efficacy. It can be combined with coping skills or incorporated into a relapse prevention programme” (Page 289; The Treatment of Drinking Problems: A guide for the helping professions).

- “The cognitive-behavioural approach to treatment is based on the assumption that it is the problem drinking that is to be treated . . . Implicit in this approach is the belief that problem drinking is mainly a learned behaviour and that treatment involves replacing the maladaptive pattern of drinking behaviour with more appropriate drinking or abstinence. Cognitive-behavioural psychology also highlights the role of expectations about alcohol in the development of drinking and its consequences” (Page 287- The Treatment of Drinking Problems: A guide for the helping professions).

- Classical Conditioning: exposure, stimulus control techniques, relaxation training, covert sensitization

- Social Learning Theory: social skills training, refusal skills, anger management, relaxation, coping self-statements, relapse prevention model

- Behavior Approach to the Treatment of Substance Abuse: Substance Use Disorders: Assessment and treatment; Page 119

Advantages:
1. Empowerment of clients
2. Improved compliance due to client collaboration in the treatment
3. Flexibility and individualization of treatment

Weaknesses:
1. Possible therapist rejection due to a preference for traditional psychotherapy
2. The lack of emphasis on spirituality
3. The lack of empirical support of effective, long-lasting change through behavioral therapies

Interesting Facts-
- Alcoholics are better able to understand their sober state when they are drunk than they are able to understand their drunken state when sober.
- “Hidden Alcoholics,” who drink in private and may be in denial of their drinking problem, may not seek help due to the potential financial and social losses.
- Elderly alcoholics may exhibit signs of personality deterioration and antisocial behavior; when dealing with the elderly, it is important to remember that decreased cognition and increased psychological distress (i.e. moving in with children,
loneliness, decreased physical health and social activities) may have taken place. They best therapy is most likely social.

- Clients need family support, cohesion, and organization.
- Clients are more likely to recover if they have a steady income, belong to a high social class, and receive social approval.

"According to Beshai, detoxification straddles a three-part process: (1) drying out, (2) fully assessing the patients' problems against the backdrop of his/her lifestyle and attitude, (3) the development of rehabilitation. Beshai identifies four types of detoxification services, namely (1) the medical model- involving hospitalization, (2) the non-medical model- involving non-hospitalization, but needing medical support, (3) outpatient model- receiving treatment from private practitioner, and (4) social model- involving the use of a supportive environment" (Page 128, Alcoholism).

Wallace’s Phases of Recovery
Substance Use Disorders: Assessment and treatment; Page 139
- Phase 1 (Withdrawal Phase): Days 1-14 of initial abstinence, clinical tasks include assessment, stabilization, treatment retention, motivation enhancement, relapse prevention
- Phase 2 (Prolonging Abstinence): First six months of abstinence, clinical tasks include continuing assessment, reducing risk of relapse, sustaining motivation, supporting ego functioning, improve self-regulation
- Phase 3 (Pursuing Lifetime Recovery): Six months and beyond, clinical tasks include continuing assessment, fostering a stable drug-free lifestyle, relapse prevention, addressing other psychopathy, improve self-regulation

Rounsaville Stages of Treatment
Substance Use Disorders: Assessment and treatment; Page 140
- Abstinence Initiation: Intensive treatment facilitates development of new ways to think and behave, multidimensional assessments are conducted and multidimensional treatment options are offered- options need to be adapted to patient’s stage of motivation- it’s recommended that less intensive treatment be attempted first and both pharmacotherapy and psychotherapy be employed
- Relapse Prevention: Formal relapse prevention training and consolidation of therapeutic gains
- Managing Relapse: Analyze precipitants and consequences of relapse and adjusting treatment accordingly- intensify treatment after serious relapse, considering changes in modality or change in setting

Prochaska and DiClemente’s Changing Habit Pattern Stages
Handbook of Alcoholism; Page 99
1. Precontemplation
2. Contemplation
3. Preparation (or determination)
4. Action
5. Maintenance
Stages of Change Model
Substance Use Disorders: Assessment and treatment; Page 48
1. Consciousness raising (increasing information about self and problem)
2. Self-liberation (belief in ability to change)
3. Dramatic relief (experiencing and expressing feelings about problems and solutions)
4. Environment reevaluation (assessing how one’s problems affect the environment)
5. Helping relationships (being in an open and trusting relationship with one who cares)
6. Stimulus control (avoid stimuli that are associated with problem behaviors)
7. Counter-conditioning (substituting alternatives for problem behaviors)
8. Social liberation (increase alternatives for nonproblem behaviors)
9. Self-reevaluation (assess how one things and feels about self in respect to a problem)
10. Reinforcement management (rewarding self or being rewarded by others for changes)

TREATMENT SETTINGS
“The goal of the clinician is to place the patient in the least intensive level of care that will facilitate the achievement of treatment goals” (Page 115; Substance Use Disorders: Assessment and treatment).

Placement decisions are based on a thorough assessment of six problem areas (ASAM)
1. Acute intoxication or withdrawal potential
2. Biomedical conditions or complications
3. Emotional/behavioral conditions or complications
4. Treatment acceptance/resistance
5. Relapse potential
6. Recovery environment and support

Placement Criteria, developed by American Society of Addiction Medicine (ASAM):
Levels differ with respect to provision of medical management; structure, safety, security; and intensity of services—placement based on clinical and financial considerations
(Page 114; Substance Use Disorders: Assessment and treatment).
- Level One: Outpatient treatment (nonresidential treatment provided in an office practice or professional setting offering services for fewer than 9 contact hours per week)
- Level Two: Intensive outpatient/partial hospital treatment (nonresidential treatment provided in a professional setting offering services for 9 to 20 contact hours per week)
- Level Three: Medically monitored intensive inpatient treatment (residential program provided in a free-standing licensed health care facility or specialized unit in a general or psychiatric hospital offering 24-hr professionally directed care)
- Level Four: Medically managed intensive inpatient treatment (residential program provided in an acute care general hospital, psychiatric unit in an acute care general hospital, acute care psychiatric hospital, or appropriately licensed chemical dependency specialty hospital with acute medical and nursing staff and life support
equipment- services include 24-hr medically directed care requiring primary medical and nursing care)

Inpatient treatment settings: More extensive, intensive, costlier- considered treatment of last resort

- Traditional rehabilitation program: acute care hospital setting or psychiatric facility, usually around 28 days
- Halfway and three-quarter houses (usually a transitional program; ½ houses have structured hours, meetings, programs- ¾ houses have less restrictions and usually consist of recovering alcoholics who seek their own treatment)
- Therapeutic communities: usually 9 to 12 months (long-term, self-help based residential programs- staff members usually recovering alcoholics; rigid programs are formed to promote independence, responsibility, and stable relationships; hierarchical organization: earn privileges based on quality of their program participation; tend to be highly confrontation oriented)
References


