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Models of Alcohol and Other Drug Treatment for Consideration when Working with Deaf and Hard of Hearing Individuals

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Abstract

There are numerous models and approaches used to treat chemical dependency. The majority of these programs are used with hearing people, and there is a lack of experience in the use of these models within the deaf and hard of hearing community. This article will focus on the Twelve Step model, Cognitive Behavioral Therapy Model and the Bio-Pscho-Social Model (Social Program Model). A discussion and comparison with the harm reduction model will also be discussed.

Introduction

When looking for the most appropriate alcohol or drug treatment program for a deaf or hard of hearing individual, its important for disability service providers, vocational rehabilitation counselors, clinicians, family, friends or others who are involved in the search to know the elements of the most common treatment models and of quality programs. There are several main models or approaches to alcohol and drug treatment..

One of the most traditional and prevalent ways to treat substance abuse problems is the abstinence-based approach. This model is based on the philosophy that once a person is addicted, he or she needs to stop using alcohol and drugs entirely; the person has gone beyond the point of being able to make choices about when or how much to use. Within the general category of abstinence-based programs there are several components of these models that can be used in a treatment program, making the approach quite eclectic. Another model gaining recognition for the treatment of substance abuse is called a harm reduction approach. People using this model do not disagree with the idea of abstinence, but believe that abstinence is an unrealistic goal, and instead focus on other goals such as less problematic use. For example, methadone maintenance are a way of ensuring the addict will not obtain narcotics illegally, and will not be exposed to the dangers of injection. Harm reduction approaches have also been found useful when a person is not at a point of addiction but may be abusing chemicals and could be taught to use in a more responsible manner.

12-Step Model/ Disease Model / Minnesota Model

The Twelve Step/Disease Model/Minnesota Model is a comprehensive, multi-disciplinary approach to the treatment of addictions which is abstinence oriented and based on the principles of Alcoholics Anonymous. There are a variety of elements that are commonly associated with primary treatment when using this model and they include: group therapy, lectures, recovering persons as counselors, multi-disciplinary staff, a therapeutic milieu, therapeutic work assignments, family counseling, the use of a Twelve Step program, daily reading (Twelve Step literature) groups, the presentation of a life history, attendance at AA/NA meetings and the opportunity for recreation/physical activity. These elements are generally integrated into a structured daily routine. Local AA/NA groups provide the mainstay of the aftercare phase.

This model focuses on chemical dependency as the primary problem. It is neither blaming nor punitive and it views seeking treatment as an appropriate response. E.M. Jellinek was one of the most influential contributors to the disease concept of alcoholism. Jellinek characterizes alcoholism as a progressive disease with several stages with the final stage as one in which there is liver, nervous system and other physical damage. This stage requires medical monitoring of withdrawal because of the serious symptoms that develop when alcohol intake is stopped. More recent studies suggest that not all alcoholics reach this stage. In fact, perhaps most do not.

This model is by far the most widely used treatment model. Using the Twelve Steps, individuals are guided through a process of understanding the nature and extent of their alcohol/drug problem, how their unique characteristics create barriers and/or strengths for recovery, and the importance of relying on a power or powers greater than themselves rather than willpower. According to this view, alcohol abuse is a disease. Treatment emphasizes admitting powerlessness over alcohol and advocates adopting the norms and values of a new social group, the AA self-help group, in order to achieve total abstinence. These programs typically provide the best match for persons who are physically dependent on alcohol, benefit from the support of a self-help group, and have a spiritual *orientation*. Hospital-based medical programs are described as including inpatient detoxification and rehabilitation services, and day/evening outpatient services. The program capacity typically will vary in size and inpatient stays historically are about 28 days but have been severely shortened largely because of funding considerations. Day outpatient

services and evening outpatient services are spread over a longer period and tailored to the needs of the individual.

In addition to the therapeutic portion of the program, as the name suggests, this model also attends to the physical/health/medical needs of the patient. Typically alcoholics or addicts have neglected their health and physical care. Symptomatic medical treatment may be required for malnutrition, liver problems or other health care concerns.

Twelve-Step programs emphasize treatment activities such as attending Twelve Step meetings in the community and/or facility, and participating in psychotherapy groups that cover topics such as working the steps, using the Big Book, and writing an autobiography. Outcomes desired in Twelve Step treatment include acceptance of an alcoholic/addict identity, acknowledgment of a loss of control/ powerlessness over the abused substance, and adherence to abstinence as a treatment goal.

There is also an emphasis on a solid aftercare plan to support ongoing recovery after treatment completion. Typically aftercare plans incorporate securing a safe, sober living environment; attending AA or other Twelve Step support meetings several times each week; securing a sponsor in AA; and ongoing support and counseling sessions to continue the work begun in treatment.

Cognitive Behavioral Treatment Model

The Cognitive Behavioral Treatment Model (CBT) involves individuals learning how their thoughts, feelings and behaviors (especially drinking/using behaviors) are connected, and how to break those connections. The counselor helps the person analyze his or her environment and ways of responding to cues to use alcohol or drugs, and establish new patterns of response to those cues. The Cognitive Behavioral Therapy Model (CBT) is based on cognitive therapy which is a system of psychotherapy that attempts to reduce excessive emotional reactions and self-defeating behavior by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions (Beck et al. 1993). Cognitive Behavioral Therapy (CBT) is similar to cognitive therapy in its emphasis on functional analysis of substance abuse and identifying cognitions associated with substance abuse. It differs from cognitive therapy primarily in terms of emphasis on identifying, understanding, and changing underlying beliefs about the self and the self in relationship to substance abuse as a primary focus of treatment. In the initial sessions of CBT, the focus is on learning and practicing a variety of coping skills, only some of which are cognitive. Initial strategies stress behavioral aspects of

coping (e.g., avoiding or leaving the situation, distraction, and so on) rather than thinking one's way out of a situation. This type of program requires participation in relapse prevention groups and therapy groups as well as training in cognitive skills, behavioral skills, and abstinence skills. The goals of treatment are for the patient to develop ways of coping, enhanced sense of self-efficacy, and modification of expectations of the substances effects.

CBT is a short term, focused approach to helping chemically dependent individuals become abstinent from alcohol and other substances. The underlying assumption is that the learning processes play an important role in the development and continuation of alcohol and drug abuse and dependency. CBT attempts to help patients recognize the situations in which they are most likely to use alcohol and/or other drugs, avoid these situations when appropriate, and cope more effectively with a range of problems and problematic behaviors associated with substance abuse.

For each patient who is in treatment, the therapist and patient do a functional analysis, that is, they identify the patients thoughts, feelings and circumstances before and after the drug and/or alcohol use. Early in treatment, the functional analysis plays a critical role in helping the patient and therapist assess the determinants or high-risk situations, that are likely to lead to chemical use. It also provides insights into some of the reasons the individual may be using alcohol and/or other drugs (e.g. to cope with interpersonal difficulties, to experience risk or euphoria not otherwise available in the patients life). Later in treatment functional analyses of episodes of chemical use may identify those situations or states in which the individual still has difficulty coping. Training focused on interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships is a crucial element of the treatment process.

An individual format is preferred for CBT because it allows for better tailoring of treatment to meet the needs of the specific patients. Patients are better able to build relationships with the therapist over time and have more flexibility in scheduling sessions. Also, the comparatively high rates of retention in programs and studies may reflect, in part, particular advantages of individual treatment. CBT is usually offered in 12-16 sessions, usually over 12 weeks. This comparatively brief, short-term treatment is intended to produce initial abstinence and stabilization. In many cases, this is sufficient to bring about sustained improvement for as long as a year after treatment ends. Treatment is usually delivered as an outpatient service focusing on understanding the determinants of substance

use. By understanding who the patients are, where they live, and how they spend their time, therapists can develop more elaborate functional analyses. It has also been found that skills training is most effective when patients have an opportunity to practice new skills and approaches within the context of their daily routine, learn what does and does not work for them, and discuss new strategies with the therapist. CBT is generally not appropriate for those who have psychotic or bipolar disorders and are not stabilized on medication; those who have no stable living arrangements; or those who are not medically stable.

CBT is highly compatible with a variety of other treatments including pharmacotherapy, self-help groups such as Alcoholics Anonymous, family and couples therapy, vocational counseling, and parenting skills training. While Twelve Step meeting attendance is not required or encouraged in CBT, some patients find attending meetings helpful in their efforts to become or remain abstinent. CBT therapists take a neutral stance and may explore how going to a meeting when faced with strong urges to use may be a very useful strategy. However, therapists will also encourage patients to develop a range of other strategies. The characteristics that distinguish CBT from other treatment approaches include functional analyses of substance abuse, individualized training in recognizing craving, managing thoughts about substance use, problem-solving, planning for emergencies, recognizing seemingly irrelevant decisions, refusal skills, examination of the patient's cognitive process related to substance use, the identification and debriefing of past and future high-risk situations, the encouragement and review of extra-session implementation of skills, and the practice of skills within sessions.

Bio-Psycho-Social Model/Social Model

The Bio-Psycho-Social Model is an experiential, peer oriented process that represents a much less expensive alternative to medically oriented substance abuse treatment delivered by clinicians. The Social Model has broadly been categorized as a sociocultural model stressing that alcohol problems stem from a lifetime socialization process in a particular social and cultural milieu that implicitly or explicitly encourages alcohol drinking. This model is participatory versus non-participatory and the community orientation is integration versus introduction. Like Alcoholics Anonymous (AA), social model practitioners believe that alcoholism is a multifaceted disease, one that is caused by a combination of factors: moral/spiritual, biological, psychological, and social/environmental. This definition represents an expansion of the medical model's

conceptualization of alcoholism as a unitary disease with physiological roots only, best treated by medical expertise (Miller & Kurtz, 1994).

In the social model, chemical dependency is believed to result from environmental, cultural, social, peer or family influences. Substance abuse is viewed as an outcome of external forces such as poverty, drug availability, peer pressure, and family dysfunction. Using this model, the goal of treatment is to improve the social functioning of substance abusers by either altering the social environment or altering the individual's coping responses to environmental stressors. The strategies for changing the environment include family or couples therapy, attendance at self-help groups where, one is surrounded by nonusers, residential treatment, and avoidance of stressful environments where substances are available. The strategies for changing a substance abusers coping responses include group therapy, individual therapy, social skills or assertiveness training, and stress management.

The Social Model Programs evolved in the late 1940's out of the AA 12th Step of reaching out to help other alcoholics as a way of sustaining sobriety. Known in academic circles as the helper-therapy principle (Reissman, 1965) and in AA as Twelve Stepping or Twelve Step work, a major principle guiding both AA and social model programs is that alcoholics are themselves helped when they provide service to others. Other similarities to AA include participant involvement in running the program (self-governance) and in maintaining it (self-supporting) and the eschewing of hierarchy. Unlike AA, Social Model Programs act as advocates for participants and put them in contact with community resources for legal, family, medical and employment problems. Some encourage the community to create sober activities and environments. Many Social Model Programs have paid staff, accommodate funders and regulatory agencies, and provide clients with educational sessions, relapse prevention groups and other structured activities that go beyond the AA paradigm.

In 1980, Social Model Programs added community advocacy to the program services. Its proponents recognized the need to promote not only individual recovery but also to change the norms, values, policies and practices regarding alcohol in the community and society (Hayes et al., 1993). This community aspect examines the context in which drinking occurs and seeks ways to modify the environment.

As mentioned above, the Social Model Program structure is based on the Twelve Traditions of AA and seeks to create democratic group processes in which leadership is shared and rotated with little hierarchy. Recovering participants are viewed as the top of an inverted pyramid,

followed by the program staff, and then the board of trustees at the bottom. Individuals and groups of recovering participants are given as much authority as they can handle responsibly. Social Model Programs configure human resources differently than professional treatment programs. Directors, staff and volunteers who contribute to staffing are usually recovering alcoholics and drug addicts with experiential knowledge of recovery. Recovering residents/participants are providers as much as consumers of service and persons in recovery are viewed as critical to the peer recovery process. Programs are client run in day to day problem solving, rule making and enforcement by a Residents Council of participants who have been sober in the program for a designated time period. There appear to be self-correcting mechanisms that discourage resident abuse of power, in part via AA Traditions 2(our leaders are but trusted servants, they do not govern) and 12(practice principles before personalities) (Alcoholics Anonymous World Services Inc., 1991)

Recovering alcoholics and substance abusers who staff Social Model Programs are often alumni of the programs in which they work, sometimes with degrees in related fields. This model of recovery emphasizes that the peer recovery process within programs does not need to be managed or controlled; the major objective of the director and his/her staff is to provide and sustain a physical, social and spiritual environment conducive to recovery. Clinical case-management programs schedule activities and use counselors and therapists to motivate clients and provide recovery information but the peer group serves as the primary motivator for the new resident to participate in recovery activities.

Harm Reduction

Harm reduction is a public-health approach to dealing with drug-related issues that places first priority on reducing the negative consequences of drug use rather than on eliminating drug use or ensuring abstinence. The harm reduction model upholds that abstinence is the ideal goal for those using illegal drugs. Abstinence from drugs reduces drug-related harm completely. It is hoped that all individuals who use illicit substances will eventually come to give them up entirely. Proponents of harm reduction recognize that there will always be illicit drug use and that many people are simply unwilling or unable to give up drugs entirely but nonetheless could benefit from intervention. Harm reduction accepts that some use of mind-altering substances is a common feature of human experience. It acknowledges that, while carrying risks, drug use also provides the user with benefits that must be taken into account if drug-using

behavior is to be understood. Ambivalence is such a strong factor in drug abuse that when the abstinence mandate is in effect, many people will just avoid addiction services.

Over the last decade, harm reduction has become a subject of growing discussion and debate within the addiction community and, increasingly, by the media and the general public. It has emerged as an alternative approach to abstinence-oriented drug policies and programs. A significant degree of confusion and controversy has also attended its rise to prominence. Some harm reduction advocates consider the reform of laws prohibiting drug possession to be an integral part of harm reduction, while others do not. Some persons consider the imprisonment of drug users for simple possession to be a form of harm reduction. Practitioners dedicated to abstinence may also think of themselves as reducing the harms of substance abuse. It may help to distinguish between harm reduction as a goal and harm reduction as a strategy. As a general goal, all drug policies and programs aim to reduce the harm associated with drug use. As a specific strategy, the term harm reduction generally refers to only those policies and programs which aim at reducing drug-related harm without requiring abstention from drug use. Thus defined, harm reduction strategies would not include strategies such as abstinence-oriented treatment programs or the criminalization of illicit drug use—even though these policies and programs share the same goals as harm reduction strategies.

Many harm reduction based programs such as needle exchanges are of more recent origin. Others however, have a long and proven history. Methadone programs for example date back to the 1960's and have demonstrated their effectiveness in assisting drug users to stabilize and normalize their lifestyles and to provide many with a bridge to abstinence from narcotic use. Helping people avoid harm has also been an established part of the alcohol field for many years. Examples include promotion of responsible drinking, controlled drinking interventions, avoidance of drinking and driving, and low alcohol content beverages. Other approaches may also include finding a safer route of drug administration, safer substances, reduction of harmful consequences of drug use, reduction of frequency of drug use, reduction of the intensity of drug use and the reduction of the duration of drug use. Several European cities have developed facilities known as tolerance zones, injection rooms, health rooms, or contact centers where drug users can get together and obtain clean injection equipment, condoms, advice and /or medical attention.

The drug users decision to use drugs is accepted as fact. No moral judgement is made either to condemn or to support use of drugs, regardless of level of use or mode of intake. The dignity and rights of the drug user are respected. The fact or extent of a person's drug use is secondary to the risk of harm consequent to use. The first priority is to decrease the negative consequences of drug use to the user and to others. Harm reduction neither excludes nor presumes the long-term treatment goal of abstinence.

Harm reduction approaches to addictive behavior are based on three central beliefs which include the following. (1) Excessive behaviors occur along a continuum of risk ranging from minimal to extreme. Addictive behaviors are not all or nothing phenomena. A drug or alcohol abstainer is at risk of less harm than a drug or alcohol user; a moderate drinker is causing less harm than a binge drinker; a crystal meth smoker or sniffer is causing less harm than a crystal injector. (2) Changing addictive behavior is a step-wise process, complete abstinence being the final step. Those who embrace the harm reduction model believe that any movement in the direction of reduced harm, no matter how small, is positive in and of itself. (3) Sobriety simply isn't for everybody. Bold and radical, this statement requires the acceptance that many people live in horrible circumstances. Some are able to cope without the use of drugs, and others use drugs as a primary means of coping. Until we are in a position to offer an alternative means of survival to these folks, we are in no position to cast moral judgement.

Case Study

Sue is a 29 year-old single white deaf female who lives alone in a one-bedroom apartment. Sue graduated from a residential school for the deaf and is the only deaf member of her family. Her family signs very little using writing and lipreading for most of their communication with Sue. The Deaf community near her home is very small with limited opportunities for socialization. She is not involved in a long-term relationship and works at a job located about 10 miles from her home. Her brother and mother live about 200 miles away and have been concerned for some time about her drinking. They report she drinks heavily and that her apartment is extremely untidy and poorly maintained. They are concerned that she regularly overeats to cope with her problems, and are afraid that she might attempt suicide.

Sue's supervisor at work became concerned due to frequent absences and some occasions where Sue fell asleep at work. He referred her to an EAP counselor affiliated with her place of employment. Sue went

to see the EAP counselor because it was strongly recommended, but she didn't feel any need to see the person.

Sue met the EAP counselor and communicated using an interpreter. She appeared to the EAP counselor to be overweight, tired and sad. When asked by the EAP counselor about her drinking habits, she denied drinking excessively but admitted she did overeat. Sue stated that she had been stopped for drinking while under the influence but had been let go when the police officer realized she was deaf. Sue also talked about drinking alone at home to help her fall asleep at night. She described having a friendship with a man on e-mail. She stated that she hoped their relationship would become closer in the future. She talked about another male friend with whom she had discussed her depression, and who had been encouraging her to get help. She explained her absences as due to being tired and not feeling well. She admitted to drinking once in a while and to eating excessively in an effort to feel better. Sue's family has a history of depression, although neither her mother nor her grandmother had ever been treated. The family norms seems to discourage "complaining" about problems or admitting to depressed feelings. The EAP counselor recommended that she attend outpatient chemical dependency treatment to further evaluate and address her drinking problems as well as the other issues.

Application of the Twelve Step Model to the Case Study

When Sue is admitted to the program, she meets with the nursing staff and is seen the same day by a physician. Her physical condition is assessed. Because she has been drinking so heavily, she is closely monitored for signs of withdrawal for the first 24 hours. Her doctor writes a standing order for Ativan to help her deal with withdrawal symptoms. As a part of her admission process, she is asked about her eating habits and her weight. A multi-vitamin is prescribed and an appointment is arranged for Sue to see the hospital dietician. Because of concerns about suicide, a suicide assessment is also completed with Sue.

Sue begins the process of treatment with an assignment designed to help her share her drug use history and the consequences of her use. Because she is deaf and English is not her first language, Sue will be asked to produce her work using drawing. The purpose of the evaluation assignment is to help Sue identify the extent of her alcohol/other drug problem and to enable staff to make a diagnosis. Once she has been detoxed, a determination will be made about any signs of depression. If

depressive symptoms persist, a trial on anti depressant medication will be implemented.

Once Sue has completed her assignment and presented her work in group, she is referred into primary treatment. She will begin working on assignments related to the Twelve Steps of AA. Step One work will emphasize the concepts of unmanageable and powerlessness over drugs/alcohol. Step One work also emphasizes that Sue is not alone, that she is similar to her peers in group. After completing Step One, Sue will move on to Steps Two and Three which will focus on developing a relationship with a higher power, developing a sense of hope and practicing new behaviors that support recovery. Steps Four and Five will be pursued with Sue if she is determined to be emotionally stable and willing to do a complete moral inventory. If Steps four and five are not appropriate at this time, Sue will be advised to pursue them at a later time with a minister or a sponsor. Family members will be encouraged to participate with Sue in a family week experience. Sue will complete her treatment stay by looking a relapse prevention information and skills and by working on an aftercare plan with the staff. Throughout her treatment stay, her eating problems and depression will be monitored. These factors will be taken into consideration when developing assignments but are not the primary focus of her treatment experience.

Aftercare recommendations for Sue will likely include abstinence from all mood altering chemicals (unless following the prescription of a doctor), ongoing counseling related to her eating problems and depression, attendance at Twelve Step meetings, securing a sponsor and participation in relapse prevention efforts and support groups. Ongoing family counseling should also be considered. Sue will need a safe, sober living environment and will be encouraged to develop new relationships with people who are sober.

Application of the Cognitive Behavioral Treatment Model to the Case Study

During a diagnostic interview, Sue reported to the counselor that she had been abstinent from the use of alcohol for approximately ten days. The clinician gathered a thorough history and scheduled Sue for bi-weekly individual sessions.

Based on the information gathered in the intake interview, it was determined that Sue was suffering from alcohol dependence, depression, and the counselor identified a possible eating disorder. A referral was made to a psychiatrist so that she could be evaluated for an antidepressant

medication. Sue and the clinician collaborated on a treatment plan that included a primary focus on her drinking behaviors. It was also decided to address negative thoughts and behaviors that contribute to her depression within the context of substance abuse counseling. It was agreed that if Sue could continue to remain abstinent from the use of alcohol and begin to identify the thoughts, feelings, and behaviors that led her to drink and experience depression, she would be more capable of addressing her other issues in time.

In the first scheduled individual appointment Sue and her therapist did a functional analysis of her alcohol abuse. The emphasis was placed on identifying the thoughts, feelings and behaviors that led to the use of alcohol. They reviewed this analysis and identified various high-risk situations that led to drinking behavior. Subsequent sessions focused on providing Sue with information regarding the process of addiction, recovery, and relapse with an emphasis on the individual, idiosyncratic nature of Sue's drinking behavior.

Sue was supported in the process of developing more effective coping skills by focusing on tasks including emotional identification and regulation, self-efficacy development, problem solving, communication, refusal skills, self-regulation, and planning. She was also encouraged to attend support group meetings.

As Sue effectively maintained sobriety, she was supported and encouraged to identify ways her thinking, feeling, and behavior had changed. Her personal responsibility in the change that had occurred was heavily emphasized. Special emphasis was placed on how her decision making had resulted in the outcomes she had experienced. Prior to the completion of Sue's treatment, her family members were involved in a session and provided with information related to addiction, recovery and relapse and offered recommendations regarding how they could support Sues ongoing recovery.

Sue and her counselor developed and implemented detailed relapse prevention during the later part of treatment. In the last session of the sixteen-week course of treatment, Sue and her therapist reviewed the treatment and assessed its current status. Sue had successfully maintained sobriety for nearly 12 weeks and her feelings of depression were subjectively improved. Sue reported that she continued to be concerned about her eating behavior. She was referred for an assessment at a local eating disorders program. In addition to completing this assessment, follow-up sessions were recommended along with regular attendance at

support group meetings and active practice of her relapse prevention plan. Medication compliance was also strongly recommended.

Application of the Social Treatment Model to the Case Study

Sue arrived at the program, located in a large refurbished boarding home, and immediately participated in a community meeting. During this community meeting she was introduced to the program staff, all of whom were recovering and deaf. Sue was informed that she would receive support and encouragement primarily from her peers. She was instructed to seek them out for information and support. In her orientation to the house, she was educated about the community emphasis of the program. She would be expected to participate in all program activities including daily house meetings, peer government, regular attendance at AA/NA meetings, lecture/discussion groups with the other residents. She would also be responsible to maintain her living area as well as completing a community task each day.

Sue experienced some mild withdrawal during her first few days in the program. She was paired with another resident who was near the completion of her treatment. Her peer monitored Sue's situation and provided emotional support. This peer communicated with the program staff and there was a contingency plan in the event Sue need medical attention. Sue did not require medical intervention and was soon participating, in all aspects of the program.

Sue's typical day included morning lectures, noon meetings of AA/NA, afternoon skills building classes, and evening 12 step meetings. Morning lectures focused on topics such as the 12 Steps, the 12 traditions, the disease concept of addiction, the process of addiction and recovery, the dynamics of relapse, nutrition, family dynamics, community resources, and recreation. Skills building classes included interactive discussions of coping and problem solving strategies, assertiveness training, goal setting, communication, social competence, and emotional identification and regulation. Sue secured an AA sponsor and had frequent contact with her and began to establish a new peer group through people she met at support group meetings.

As Sue progressed through the program, she was given more responsibility and eventually became a leader within the community. Sue invited her family to participate in the later stages of her treatment and they became a source of support. She was able to communicate with them more openly and effectively. The program provided an interpreter for family groups and interactions between Sue, her mother, and brother.

Sue returned to work after a month in the program and maintained residence at the house for an additional 30 days. She transitioned to Oxford House and moved there upon completion of treatment. Upon discharge, Sue reported that she felt she had made significant progress. She had maintained sobriety for 60 days and reported that many of her depressive symptoms had improved. She indicated that she would seek medical assistance if her depression returned. Sue also reported that her eating habits had changed and that she had lost weight, and would monitor her eating and seek help if needed. Sue's goal in the near future was to return to the treatment program attended and provide support to other residents in the program.

Application of the Harm Reduction Treatment Model to the Case Study

Sue chose the option of participating in a Harm Reduction program in response to the recommendation by her EAP counselor to attend outpatient chemical dependency treatment. Sue met with her counselor and completed an intake interview. Based on information obtained during this interview, Sue's counselor, a deaf social worker, informed her that her drinking behavior constituted a moderate risk. Sue was referred to a psychologist for evaluation of her depression and eating behaviors. The psychologist recommended a trial on antidepressant medication and individual sessions with a therapist who specialized in working with individuals who suffer from eating disorders. Sue accepted and followed both recommendations.

Sue's chemical dependency counselor explained that the philosophy of the program was to encourage her to minimize the harm she caused herself and others through her use of alcohol. Sue was told that abstinence was the ideal goal but that she might reach this goal gradually over time, and that she could possibly eliminate the risks involved with drinking or eventually be able to drink in moderation.

Sue was encouraged to abstain from the use of alcohol for at least 30 days and it was recommended that she meet with her chemical dependency counselor twice weekly. A counselor assisted her in the process of examining how drinking had impacted her life including ways it had prevented her from pursuing her priorities in life. Sue and the counselor generated a list of life priorities and goals. They worked together to assess how much, how often, and under what circumstances Sue drank and what the outcomes of her drinking behavior involved. In counseling sessions, Sue was given the opportunity to discuss her family history and other significant events of her development and reflect on how this history

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impacted her current drinking behavior. She was also provided with information on coping and problem solving strategies, assertiveness, communication, emotional identification and regulation, relationships, and sources of social support in the community.

Upon completion of the 30-day outpatient treatment program Sue reported that she had successfully remained abstinent for 30 days. She indicated that she had gained significant insight into how her drinking negatively impacted her life and expressed a desire to pursue ongoing sobriety. She was encouraged to continue practicing the new skills she had developed and to establish new social relationships. Her counselor recommended that she attend AA meetings and continue her sessions with her psychologist.

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