AN ALCOHOL TREATMENT GROUP FOR ADULTS WITH INTELLECTUAL DISABILITES: AN EMPOWERMENT APPROACH

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Masters of Social Work

By

Heather Funk

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AN ALCOHOL TREATMENT GROUP FOR ADULTS WITH INTELLECTUAL DISABILITIES: AN EMPOWERMENT APPROACH

BY

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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ABSTRACT

There is a dearth of programming options available for the intellectually disabled in relation to alcohol treatment. This practicum was designed to provide an alcohol treatment program for adults with intellectual disabilities and to increase independent decision making abilities. A group intervention program was designed specifically to meet the needs of the intellectually disabled, using cognitive-behavioral and cue exposure techniques. The intervention also attempted to incorporate empowerment skills, as historically adults with intellectual disabilities have lacked these opportunities.

The results indicate a decrease in alcohol consumption for all group members. Independent decision making showed little change. Given the history of dependency among the intellectually disabled, longer term efforts may be required to establish significant change in this regard. Replication of this intervention over a longer period of time may yield more significant results in relation to independent decision making. Overall, the results of this intervention are promising in terms of a reduction of alcohol use among the intellectually disabled.

INTRODUCTION

In my work with persons with intellectual disabilities I have been asked to assist a portion of clients with alcohol abuse issues. The actual number of individuals affected is small relative to my entire caseload. Taking a closer look at individual histories of clients affected by alcoholism, I discovered that the struggle with alcohol affected many aspects of their lives and was life long. In many cases this was familial and cyclical. For most of these individuals the struggle with alcohol had been long term and without any professional intervention.

Six years ago I was looking for a treatment facility for a particular intellectually disabled client and was concerned by the lack of resources. Some of the difficulties encountered included a service delivery system that did not meet the learning needs of my clients, or programs that did not address issues salient to this population in relation to their disability. A number of alcohol treatment centers in Canada had included persons with intellectual disabilities as participants, but there were difficulties with each of the programs. These included an expectation of the ability to read at a certain level, reason abstractly, and possess the social skills needed to function in a group as any other member (Christian and Poling, 1997). There appeared to be a gap in alcohol treatment services for this population, thus providing the impetus for service provision specifically tailored to meet the needs of persons with intellectual disabilities.

There were three main objectives in this project. The first objective was to develop an alcohol treatment program using cognitive behavioral therapy,

specifically using the self-instructional problem-solving approach and cue exposure, in a group setting with adults with intellectual disabilities. The self instructional approach has a cognitive focus in contrast to the more traditional behavioral approaches used with persons with intellectual disabilities. Cue exposure is a behavioral technique traditionally used in the treatment of psychopathologies and has more recently been incorporated into the treatment of other psychological problems. The American Psychiatric Association (1995) notes that cognitive behavioral therapies used with substance abusers focus on four main areas;

a) altering the cognitive processes that lead to maladaptive behaviors in substance users,

b) intervening in the behavioral chain of events that lead to substance use,

c) helping patients deal successfully with acute or chronic drug cravings, and

d) promoting and reinforcing the development of social skills and behaviors compatible with remaining drug free. (p. 18)

The basic premise of cognitive therapy is that individuals can reduce negative feelings and behavior by identifying and then modifying maladaptive thinking patterns (American Psychiatric Association, 1995). Traditionally, cognitive approaches have not been used with persons with intellectual disabilities so the combination of a cognitive approach framing an alcohol treatment was a unique venture.

The second objective was to facilitate the development of autonomous problem-solving among group members, particularly regarding the issue of alcohol use/misuse. It was conjectured that these problem-solving skills may then be extrapolated to other life situations. In addition to attempting to provide a more effective form of service delivery for clients, this project provided an opportunity for advanced clinical skill development. My third objective was to increase my competency at group facilitation.

The intent of the project was to assess whether the self-instructional problem-solving approach combined with cue exposure decreased drinking behavior in persons with intellectual disabilities and increased autonomous decision-making generally across the lives of the individuals involved.

CHAPTER ONE

LITERATURE REVIEW

ALCOHOL AND INTELLECTUAL DISABILITY

Prevalence Rates

Mental retardation is a condition that affects approximately 2% of the population (Resource Center on Substance Abuse Prevention and Disability, 1991b) and generally as a group, the drinking patterns of persons with intellectual disabilities are similar to the general population. Christian and Poling (1997) report that adults with intellectual disabilities have gained access to and are using most, if not all, of the drugs available to society at large. Because drinking often occurs in social situations problems arise as these individuals frequently have less exposure to mainstream society and their social skills may be limited (Resource Center on Substance Abuse Prevention and Disability, 1991b).

A number of studies have attempted to determine the prevalence of alcohol consumption in this population. Consumption began increasing when adults with intellectual disabilities began to live in mainstream society. Since the mid 1980's the trend in housing for disabled adults has been away from institutions and back into the community. Many studies have been completed on the prevalence of drinking with varying results. DiNitto and Krishef (1983/84) reported that 52% of adults with intellectual disabilities surveyed consumed alcohol. Only 7% consumed alcohol on a daily basis, while 33% drank at least once a week. Edgerton (1986) reported that adults with intellectual disabilities rarely, if ever, use drugs or

alcohol. This data came from independent samples involving 181 individuals with intellectual disabilities. Halpern, Close, and Nelson, (1986) interviewed 596 individuals with an intellectual disability in which 56% drank alcohol. Prevalence rates in the general population in the United States report 88% of individuals using alcohol once a month (U.S. Bureau of the Census, 1995). Alcohol usage by adults with intellectual disabilities is lower than that of the general population, but accurate measures of prevalence rates are limited by the lack of research in this area. Hence, greater research efforts are required to determine prevalence rates of alcohol consumption among the intellectually disabled.

Explanatory approaches

To date there is not one accepted etiology of alcoholism. A multitude of studies have begun to put together the complex puzzle of why an individual becomes dependent on alcohol. What is clear is that alcoholism is a multifactoral dependency whose etiology can only be explained through an examination of many factors.

Social learning theory (Bandura, 1977) contends that behavior such as alcohol abuse is a learned response and a function of how a person thinks and feels about the particular situation, the social setting of the behavior, and the specific reinforcements that are available in the environment. Bandura espouses that alcohol abuse may also be partly explained by dysfunction in a person's self-regulatory system. It is thought that people can damage their self-esteem, become depressed and demoralized if they make their self-reward contingent on unrealistic

performance standards, thereby producing socially inappropriate behavior like alcohol abuse. Bandura also suggests that alcohol abuse may be a coping skill we learn from our role models, our parents and other family members.

Another etiological theme includes research that focuses on heredity or a physiological pre-disposition to the development of alcoholism. One series of studies identify the "alcoholic personality," or the personality traits that are similar in alcoholics (Barry, 1974; Barnes, 1979; Weissman & Meyers, 1980). Barnes (1979) suggests that a lifetime of drinking leads to identifiable traits such as low self-esteem, anxiety, and depression. These are the same personality traits that are associated with the pre-alcoholic personality. The research does not consider whether alcoholism causes these traits or whether the traits predispose individuals to alcoholism. A large number of studies have generated vast amounts of information making it possible to identify most personality traits found in the general population (Keller, 1972). Researchers have also looked at the possibility of a neuropsychiatric predisposition to alcoholism as an explanation. Tarter, McBride, Buonpane, and Schneider (1977) and Tarter, Hegedus, Goldstein, Shelly, and Alterman (1984) concluded that hyperactivity in childhood is an indicator of future alcoholism. Their list of pre-existing circumstances includes a lack of self-regulation, planning memory, language processing and perceptual motor skills.

Included in the research is an explanation of the role of genetics in the development of alcoholism. For example, Frances, Timm, and Bucky (1980) found

an increased amount of mental illness and alcoholism in relatives of alcoholics than in individuals who had no family history of drinking. Adoption studies have uncovered information regarding reared-away biological male twins born from an alcoholic father. These individuals have a four to five times greater rate of alcoholism than the general population (Goodwin, Schulsinger & Hermansen, 1973 and Goodwin, 1979).

Other research focuses on sociocultural factors. Results of these studies conclude that in Western society, men are four times more likely to have drinking problems than women (Goodwin, 1979). Other studies indicate that certain customs and ethnic traditions promote the development of alcoholism (Bacon, 1974; Snyder, 1962; Valliant, 1983). The variations of customs within a culture make it difficult to establish norms across cultures. Also, ethnic groups often share similar family structure, genes, and recreational customs making it difficult to establish whether the critical factors are sociocultural, genetics or a combination thereof. These studies that focus on the sociocultural factors do not control for other potentially critical issues that may also be at play.

Donavan (1986) has combined research results from numerous sources and developed a multifactoral model identifying the primary risk factors, mediating conditions and the expression of the alcoholism. He categorizes his primary risk factors into three areas. These include hereditary or constitutional factors such as male individuals who have a positive family history with neuropsychological deficits. The second set of risk factors include psychostructural deficits such as an

antisocial personality and generalized ego weakness. The final risk category considers sociocultural factors and includes identifying factors of the ethnic or subcultural group. Mediating conditions include two sub-categories. In the first subcategory are psychostructural deficits such as antisocial personality and generalized ego weakness. Secondly, environmental variables such as social class of an adoptive father; age at placement, if adopted; and family interactional patterns that maintain the disease are recognized risk factors. As alcohol abuse always precedes alcohol addiction, recognized risk factors include blackouts and increased tolerance to alcohol.

Studies have indicated that the cause of alcoholism is complex and multifactoral involving heredity, culture, environmental and constitutional factors. Adults with intellectual disabilities share these circumstances but their unique history and general disempowerment in society has impacted on their use/abuse of alcohol. These circumstances and the desire for increased autonomy for persons with an intellectual disability directed the design of this treatment group.

Risk factors

Risk factors for alcohol abuse among adults with intellectual disabilities are often the same factors that affect the general population. However, their unique history and vulnerability must also be taken into consideration as these elements play a part in understanding alcohol abuse behavior with this population.

Moore and Polsgrove (1989) point out that low self-esteem is common with alcohol abusers and that it is often a characteristic of both substance abusers and

persons with disabilities. They concluded that these individuals are at a higher risk of substance misuse because of the stress of their disability. Also, persons who are intellectually disabled may have problems of self-control that, combined with the need for social acceptance, may increase their use of substances. This includes the influence of peer pressure on this population and the desire of intellectually disabled individuals to fit in which may lead to increased alcohol consumption. These factors all point to the reliance on alcohol as a coping device for the various stresses in life an intellectually disabled person may encounter.

Wurmser (1974), Weider and Kaplan (1969) discuss that intellectually disabled individuals may begin drinking due to their feelings of isolation and being different which may lead to low self-esteem, depression, or rebellion. These authors propose that the concrete thinking of the intellectually disabled makes them a target of exploitation and scapegoating which may lead to increased use of alcohol.

Moore and Polsgrove (1989) also found that disabled individuals are under more stress more often, and over a longer period of time than non-disabled persons. This stress leads to poor mental health and increases the chances of self-medicating with substances. Other factors which may increase the risk of substance misuse are difficulties with relationships, peer acceptance, difficulties at work, too much free time, and loneliness.

The literature proposes other reasons why persons with intellectual disabilities become problem drinkers. Vash (1981) believed that a problem with alcohol was

the result of the disabled person's need to change an unpleasant reality. Hepner, Kirshbaum and Landes (1980-1981) conclude that drinking provides an escape from frustration. Wenc (1980-1981) thought that the movement towards deinstitutionalization influenced persons with intellectual disabilities to drink. He believed that integration back into the community often created feelings of isolation and loneliness especially if the person was moving into an independent living situation instead of a family environment. Wenc's study also asked intellectually disabled individuals why they drink in bars. Their answers often indicated that it was there that they felt accepted by society. Edgerton (1986) found that the degree of substance misuse was primarily influenced by the individual's immediate environment. Those individuals who were candidates for independent living were most at risk for substance misuse. In contrast, a study done by DiNitto and Krishef (1983-1984) found that the majority of intellectually disabled individuals drank alcohol at home (52%), while 30% of those surveyed said they drank in bars. Genne-Phillips (1993) concluded that "the drinking patterns and behavior of mentally retarded people are similar to those in the general population."

Rivinus (1988) distinguishes five risk factors for alcoholism for those who are intellectually disabled. These include: having a family history of alcohol use, being a child of alcoholic parent(s), starting to use alcohol at a young age, living alone in an unsupervised setting, and denial or ignorance of alcohol use by the individual, family, and caretakers. The earliest signs of alcohol misuse by persons with

intellectual disabilities may include irritability, loss of cognitive abilities and self-care skills, behavior disturbances such as increased aggression, fire-setting, window breaking, and self-destructive acts. Other more obvious signs are work disturbances, decreased quality of work, arguments or fighting with other workers or staff, irritability, and lateness.

The data thus far points to a number of risk factors that are often repeated in the literature when discussing alcoholism in this population. Characteristics such as low self-esteem, poorer coping skills, depression, and the desire to fit into mainstream society are also characteristics that are common in persons with an intellectual disability (Edgerton,1986; Glow,1989; Greer,1986; Moore & Polsgrove, 1989). Even so, we do not see an unusually high percentage of intellectually disabled persons becoming alcoholic. This may be due to a number of factors. Services to individuals with intellectual disabilities in the area of alcohol rehabilitation are fewer. If these individuals are not accessing treatment facilities as often as nondisabled persons, their numbers go uncounted. The lifestyle of many of these individuals may not provide sufficient opportunities to become involved in drinking behavior. Often these individuals have many support people involved in their lives. They may live in group home settings or be a part of a supportive living situation. They usually have a case manager who is aware of their day to day schedule, and day program staff who are also involved in their lives. With all of these players involved in their decisions independence is difficult. Another explanation may involve the level of disability of adults who abuse alcohol.

Perhaps the rate of alcohol abuse is dependent on the level of disability. Individuals with moderate and severe disabilities rarely drink alcohol, while adults with mild or borderline disabilities are overrepresented in the literature. Compiling data without attention to the differences associated with the severity of the disability may have caused the overall rates of alcoholism to be lower than that of the general population, while within a particular level of disability drinking behavior is elevated.

Alcohol related problems

There are a number of studies that have documented the harm that is caused when adults with intellectual disabilities abuse alcohol. Krishef and DiNitto (1981) recorded that alcohol abuse contributed to job related problems such as lateness, absenteeism, and poor relationships with co-workers and supervisors. In an additional study, DiNitto and Krishef also found that 33% of the people in their study missed work due to alcohol related illness. Krishef (1986) also discovered that 7% reported drinking on the job while 2% had been suspended or reprimanded for drinking behavior.

Krishef (1986) also reported that alcohol abuse also affected family relationships. Krishef found that 13% of adults with intellectual disabilities who drank reported that family problems occurred including arguments and fighting. This sometimes resulted in the individual having to leave the family home. Westermeyer, Phaotong, and Neider (1988) found that problems also occur in

relationships outside of the family. These included losing a partner or other friends, or arguing with friends.

In addition, problems with the law also occurred as a result of alcohol abuse. Krishef (1986) found that 7% of alcohol users who reported being involved with the law were jailed or received warnings. Most often the charges involved being arrested for disorderly conduct, driving while intoxicated, or being intoxicated in public

Health problems also result from alcohol abuse among this population. The nature of the disability makes them susceptible to particular health conditions when combined with alcohol abuse. Krishef (1986) found that 40% of the individuals surveyed who drank alcohol reported having medical problems; 36% had seizures and 50% were taking prescription medication. Because the drugs prescribed to persons with intellectual disabilities are primarily psychotropic or anti-convulsant (Gadow & Poling, 1988), the smallest amount of alcohol combined with these drugs can produce harmful results (Resource Center on Substance Abuse Prevention and Disability, 1991a).

Although many of the issues related to alcohol abuse are the same faced by the general population, persons with intellectual disabilities need to be informed of the potential danger for them specifically. It is also important that other people who may be involved in the life of a person with an intellectual disability know the possible risks.

Treatment considerations

a) Current realities

An Ontario study (Tyas & Rush, 1989) examined the problem of alcohol and drug abuse in the disabled population. The aim of the study was to determine what percentage of people seeking treatment were people with disabilities and what services were offered to this population in the province of Ontario. Persons with intellectual disabilities made up 2.3% of persons in treatment. It was discovered that there were few specialized services offered to this population. Most of the services consisted of individualized treatment or mobile assessment/referral. These potential service options are extremely limited when compared to the variety of services available to the general population which include in-patient programs and out-patient programs of varying lengths, self-help groups for the individual or those affected by drinking, and detoxification services. Interestingly, two-thirds of the treatment providers felt that this population was best serviced with programs designed specifically to meet their individualized learning needs to ensure information was understood, although those programs providing detoxification services indicated all clients could receive detoxification and benefit from the service without any specialized program. Treatment providers also reported that they were not trained in delivering services to adults with intellectual disabilities and that additional training was needed by staff in order to provide a beneficial treatment program to all members of this group.

Campell, Essex, and Held (1994) cite the lack of training among chemical dependency treatment staff as one of the most critical barriers for the intellectually disabled in accessing treatment. Characteristics of the intellectually disabled also contribute to the lack of accessibility of treatment programs. Social skills deficits and cognitive deficits pose as formidable barriers among the intellectually disabled. Complex written and audio-visual materials as well as group counseling are standard components of substance abuse treatment programs (Campbell et al. 1994). The intellectually disabled rarely use generic treatment programs. Possible factors contributing to lower utilization rates include referral and intake processes which may exclude the intellectually disabled and complex medical regimes that prohibit individuals from being accepted (Lottman, 1993).

b) Modifications required to accommodate persons with an intellectual disability

Genne-Phillips (1993) contends that there are four specific factors that need to be considered when developing a treatment program for people with intellectual disabilities. Firstly, many adults with intellectual disabilities have spent part of their lives living in institutional settings. This sheltered environment makes them potential prey for exploitation. Secondly, their formal education has been limited, making it difficult to comprehend mainstream treatment information. Thirdly, cognitive impairments demand that material be presented in a format that is understandable, and with specific learning needs in mind. Finally, individuals with intellectual disabilities may have motivational factors that differ from the general population. General services for this population provide a continuous safety net

which does not allow the drinker to experience the realistic of consequences of this lifestyle. Therefore, a program that espouses personal responsibility needs to be aware that a care providers' role is to ensure that no harm come to that individual.

Additionally, authors such as Lottman (1993) and Campbell et al. (1994) report that staff training is an essential part of modifying and developing specific programs for this population. Training should include orientation on intellectual disabilities and how alcohol affects them specifically. Krishef and DiNitto (1983/84) add that programs should be extended beyond there regular lengths, information should be made more simple, that more repetition should be used, intensive work with family or significant others should be considered, and individual counseling should be an integral part of any program. Moore, and Ford (1991) add that an aftercare program and relapse prevention should be arranged as part of any generic program. These authors also suggest that by involving family or significant others, the individual has a resource that can reinforce information that may not have been understood by the person initially; This group may also support an aftercare program once treatment is completed.

A treatment program that allows a continuation of a medication regime is another important consideration. A program should provide education on the difference between prescription medication and the misuse and danger of alcohol and other drugs (Moore et al. 1991).

CHAPTER TWO

RATIONALE FOR PRACTICUM INTERVENTION METHODS

Empowerment/disempowerment

The issue of empowerment must be a primary consideration in the development of alcohol treatment for adults with intellectual disabilities. Intellectually disabled clients are frequently treated like they are invisible or unable to talk and think for themselves. I wanted my treatment group to be a supportive, non-judgmental source of support assisting individuals to exercise control and choice in their lives, as well as teaching them ways of dealing with the problem of alcohol dependency.

This particular client group has a long term history of powerlessness and lack of self-determination in relation to care providers, government representatives, and counsellors. The difficulty of ensuring personal choice for adults with intellectual disabilities was one that I had come up against many times in my work. Until relatively recently, this client group was not considered capable of making their own decisions.

A philosophical shift in the way society percieved and addressed the needs of the intellectually disabled was initiated by the social unrest and climate of self-determination of the 1960's (Rhodes, Browning & Thorin,1986) and the concept of normalization. Normalization, as it relates to adults with intellectual disabilities, was first introduced in print in Scandinavia in 1969 by Nirje (1969). Normalization involves the provision of options and opportunities to the intellectually disabled

which are generally available to others in society. Wolfensberger (1972) played a lead role in introducing normalization to North America with his publication of "The Principle of Normalization in Human Services." Paternalistic attitudes were challenged as deliberate initiatives were undertaken by government agencies and citizens groups to increase control and choice in the lives of the disabled. Whether the demand for more autonomy came from the client group directly or from those representing them is unclear. Either way, the Manitoba government soon adopted a change in attitude and policy, which at first moved slowly but which resulted in dramatic change for clients.

Many of these individuals had grown up in institutions. In the 1960's most families were not encouraged to keep a child with intellectual disabilities in their home. It was believed that the care needs were too great for a family to manage. Routinely these children were institutionalized. The settings were often large and hospital-like with locked wards and staff who provided or assisted with almost every task associated with daily living. In the late 1970's and early 1980's the Manitoba government embarked on an initiative called "Welcome Home." This consisted of mass deinstitutionalization and repatriation of individuals back into their home communities, or the nearest community with the appropriate resources. Group homes were opened and materials were provided to help facilitate community integration and assimilation. Such programs moved individuals away from the institution and into the community, but policy still dictated that the government had control over individuals lives. Re-integration into the community

was the primary focus, rather than the provision of a range of options to maximize personal choice. The onus of community re-integration was placed on the intellectually disabled, however similar efforts were not directed at eliminating the barriers faced by the intellectually disabled within the community. Stigmatization of the intellectually disabled as people to be avoided or feared still existed. Self-determination has been a missing feature in the lives of many adults with intellectual disabilities. Until the 1970's, the prevailing belief was that persons with intellectual disabilities were unable to make decisions because of their disability. It was assumed that the intellectually disabled needed non-disabled persons to make decisions for them. This type of helping was characteristic of relationships with caregivers, agency personnel, social workers, and, often family members. Like many other groups in the 1960's and 1970's, the intellectually disabled and their advocates were also affected by the "climate of self- determination" (Rhodes, et al. 1986), and began challenging the way services were being delivered.

> Persons with disabilities were rarely given opportunities to develop the life skills they needed to control their own lives and thus became dependent on the individuals making decisions for them. This resulted in a group of individuals who had never been taught how to problem solve, how to deal with normal life stressors, manage money, or think about their goals for the future. The controlling environment for persons with intellectual disabilities left these individuals without the

training and skills necessary for life. (Rhodes, Browning & Thorin, 1986, p. 2)

From the mid 1980's to 1995 the focus for adults with intellectual disabilities was to develop programs that attempted to teach integration skills, such as behaving like other members of society. Recreation, vocational and social needs were most often met through solitary group activity. Individuals were expected to fit into the programs that were offered in communities, not vice versa. In the mid 1990's the government officially embraced the philosophy of self-determination when the Vulnerable Persons with a Disability Act was passed in October, 1996.

The government continues to provide programs for adults with disabilities but now policy guidelines demand that individuals be given a choice in how they spend their days, where they live and with whom they live. They make or are assisted to make choices about how their money is spent and saved, what programs if any, they take part in, and how they spend their leisure time. The Act directs that these individuals are the consumers of a service provided by the government and challenges individuals to make their own decisions or at least be a large part of the decision making process.

The Vulnerable Person's Act has its roots in the liberation movement of the 1960's and was fueled by the energy of parents, parent groups, associations representing disabled persons, and government agencies. The foundation required for independent decision making, the requisite knowledge and skills, have not been efficiently provided to the intellectually disabled. The result is that many

intellectually disabled individuals operate under the assumption that government representatives still run their lives and have the right to tell them what to do, what to spend their money on, where to live, and what decisions to make.

The development of the critical life skills for surviving in the world are still missing for many individuals. A study on self-determination of people with intellectual disabilities by Wehmeyer and Metzler (1995) indicated the following:

> The data suggests very strongly that people with mental retardation are not likely to be self-determining. Respondents perceived themselves as having fewer choices and less control than did respondents without disabilities. . . the reasons for this are undoubtedly numerous. Educational and home environments that are overly structured or overprotective and do not place emphasis on opportunities to make meaningful choices and decisions and to develop the skills necessary to make decisions and solve problems are contributors. Individual limitations inherent in the severity of a person's disability also play a role as do the expectations of families, educators, and service providers. People with mental retardation are not perceived as capable of assuming adult roles, such as spouse or home owner. (Wehmeyer and Metzler, 1995, p. 117)

Solomon (as cited in Lee 1996) describes two very distinctive blocks, indirect and direct, to gaining power and control over our existence. Indirect power blocks represent internalized negative valuations, which are "incorporated into the

developmental experiences of the individual as mediated by significant others." Direct power blocks "are applied directly by some agent of society's major social institutions" (Lee, 1996, p. 224). Intellectually disabled individuals have been affected by both types of power blocks. Institutions, government agencies, advocacy groups all represented these individuals, never questioning why they were not a part of their own decision making. Because of these blocks to personal power, the individuals themselves lacked the confidence to make their own decisions. The result of a lifetime of lack of control was apathy, helplessness and powerlessness.

Power, as defined by Pinderhughes (1983) "is the capacity to influence the forces which affect one's life space for one's own benefit. Powerlessness is the incapacity to exert such influence" (Pinderhughes 1983 p.331,332). The empowerment approach views social and economic injustice as directly connected to individual pain and suffering. Empowerment as a method of practice promotes an approach that can meet the needs of those who are oppressed (Lee, 1996). The strategy is to review and challenge the injustices that are suffered by the oppressed group.

> People must examine the forces of oppression, name them, face them, and join together to challenge them as they have been internalized and encountered in external power structures. The greatest potentiality to tap is the power of collectivity, people joining together

to act, reflect, and act again in the process of praxis. This process is fueled by mutual caring and support. (Lee, 1996, p. 220)

The job of the social worker is to support the self determination of people and their ability to make decisions. The goal of the social worker is to give tools to the disempowered. Lee (1996) identifies three interlocking dimensions of empowerment:

(1) the development of a more positive and potent sense of self;

(2) the construction of knowledge and capacity for more critical comprehension of social and political realities of one's environment; and

(3) the cultivation of resources and strategies, or more functional competence, for attainment of personal and collective social goals, or liberation. (Lee, 1996, p. 224)

For the intellectually disabled this means that there is a need to assume adult roles in society that involve making choices and decisions. As it relates to alcohol consumption, adults need to be empowered to decide whether or not they drink, how much they drink, and how to say no to those who may try to influence drinking. They also need to find a treatment program that takes their particular learning needs into consideration.

Teaching methods and the self- instructional problem solving approach

There are currently numerous teaching methods used to assist people with intellectual disabilities. Some of these are used with the specific purpose of

vocational training while others are used primarily in the area of teaching social skills and sexuality training. There are three main methods that have traditionally been used with their roots in behaviorism; task analysis, behavior modification and the developmental model. The premise of these three main methods is that most human behavior is learned behavior, including maladaptive behavior. It is believed that learning new behavior is guided by the law of consequences, that behaviors that are reinforced are most often repeated and those not reinforced are weakened and extinguished. The developmental model finds its roots in Piagetian theory which recognized that every individual passes through specific cognitive stages of growth and development. Piaget believed that there was a blueprint for cognitive growth that was marked by developmental stages (Elkind, & Flavell, 1969).

Task analysis, behavior modification, and the developmental model all stress learning from the most simple to the more complex taking into account the unique learning needs of adults with intellectual disabilities. These methods have been used with this population for the past fifty years, often with much success. The missing component of each of these teaching methods has been the lack of consideration for dignity and choice in the learning experience. However, adults with intellectual disabilities now have the right to be in charge of their learning experience. The results of the experience are secondary to the individual's feelings of self-esteem and empowerment.

The method used in this group intervention was based on the work of Lyn Gow (1987) who developed a teaching method that she calls 'The self-

instructional problem-solving approach.' This approach was derived from the original work of Meichenbaum (1977) and is rooted in cognitive psychology (Beck, Emery, & Greenberg,1985). Gow's method has also been influenced by the numerous studies in the 1960's and 1970's involving self-verbalization and self-instruction (Bender,1976; Borkowski, & Varnhagan, 1984; Bornstein & Quevillon, 1976; Kellas, Ashcraft, & Johnson 1973).

A cognitive approach defines learning by the perceptual ways we acquire, store and utilize information in our attempts to change our behavior.

> A cognitive strategy (such as talking to oneself or "self-verbalization") that can be viewed as an internally organized skill that enables the selection and guidance of the internal processes involved in defining and solving problems... it is a skill by means of which the learner manages his/her own thinking behavior which in turn effects overt or observable behavior. Thus, through using cognitive strategies, an individual can learn to control his/her behavior, with clear implications for instructional efficiency. (Gow, 1987 p.19)

Gow (1987) and her colleagues found certain learning characteristics of persons with intellectual disabilities that needed to be targeted. The instructional model assisted in coping with some of these difficulties. Some of the difficulties included an absence of any kind of learning strategy, the lack of independence or self-management skills, the tendency to be passive learners, the lack of response to obvious stimuli, and the belief that individuals with intellectual

disabilities have less verbal control of non-verbal behavior than their non-disabled peers. To counter some of these difficulties Gow ensured that the model provided a concrete learning strategy, that the learner is in control of the process and decides the appropriate pace of the learning. Instructions are in the learner's language and at the specific cognitive level of the learner. This model also checks for comprehension at each specific learning step. The theory has three fundamental assumptions according to Gow:

1) that every one of an individual's behaviors reflect the interaction of a number of cognitive processes,

2) a variation of behaviors across situations is a result of the particular cognitive process or strategy employed by the individual,

3) teaching the basic principles of thinking and problem-solving through the use of cognitive learning strategies increases the effectiveness of academic and social learning. (Gow, 1987, p,19)

There are a number of assumptions made when using verbal self-instructional therapy. These include the belief that a person's thoughts are automatic and may be part of a thinking pattern that is maladaptive. When the trainer begins working with an individual, the first stage involves making the person aware of these maladaptive thoughts and the role that they play in their decision making. The student is taught a model that is designed to control their behavior by learning a new way of problem solving. This includes four main areas of learning:

1) Problem identification,

2) Attention Control,

3) Self-reinforcement and self-evaluation, and,

4) Coping skills involving self-correction of errors. (Gow, 1987, p.19)

The trainer ensures that the student can identify the problem and is able to give himself or herself instruction about the solution. The program follows a step by step sequence of verbalizations, both before and during the task. It also involves the student evaluating their own performance. The verbalizations will move from the overt to the covert level but are first modeled by the trainer and then rehearsed with the student. All the while the trainer's involvement decreases as they fade out their guidance. Specifically the model follows five steps:

1) Cognitive modeling, where the trainer models or performs the task while talking out loud,

2) Overt external guidance, requiring the learner to perform the same task under the verbal direction of the instructor,

3) Overt self-guidance, requiring the student to whisper the instructions while instructing him/herself,

4) Faded overt guidance, requiring the student to whisper the instructions while working through the task,

5) Covert self-instruction, involving the learner performing the task while guiding his/her performance via private speech. (Gow, 1987, p.20)

The trainer will begin by teaching the student to imitate questions involving identification of the problem, such as " I should stop and think before I act. What is it I should do in this situation?" Then the student will be taught to rehearse out loud what to do next in the task "Right, I'm suppose to say no if asked do I want a drink." The student is then taught to act on specific tasks. "First I must ask if there is pop to drink, if not I must drink water." There is next a need for developing coping statements such as "I should try hard to refuse a drink, but even if there is a lot of pressure I can still refuse, no one can force me to drink." The student will then be taught to develop self-reinforcing statements like, "I really did well at telling them I don't drink and that I don't want a drink no matter what." Then the student will perform a self-evaluation such as "Can I control my drinking? Yes, I've done fine today."

The student learns to self-verbalize on two levels, the general and the specific. At the general level, the individual will learn to ask themselves, "What am I going to do, and how am I going to do it?" At the specific level the individual will then focus on the specific ways that they will achieve the tasks such as "I will say to him, I don't drink anymore but I will have a pop if you have one." These verbalizations provide the student with transferable coping strategies that are adaptable across many different situations. These verbalizations should be in the

student's own language to increase the chances of generalization across different situations.

The approach teaches problem solving in two ways. First, by teaching 'how' and not 'what', it teaches the individual how to work through a problem instead of presenting them with a solution that they should adopt and secondly, by learning to approach each new situation as a problem that they are responsible to solve. The solution will be developed by the student along with their personal verbalizations. The individual is expected to evaluate his/her own performance by analyzing each step of the solution.

The approach transfers learning control to the learner because the approach is client-focused, and lessens dependence on the instructor. It also encourages self-initiated learning because the instructor intervenes only when necessary and their involvement is faded out early in the process.

Unlike many other teaching models, this model avoids the use of external reinforcement because the goal of the program is the ability to act alone. Verbal reinforcement is provided in the latter stages of the process. Gow (1987) believes that it is important to give constant clear feedback to the student about the purpose and effectiveness of the program they are using. This will help the student to recognize the connection between how the program works and their particular goals. The student will become aware that an improvement resulted from the process that was used, which will increase the likelihood of the process being used again.

While individual training should occur across a variety of settings and by several different people, Gow (1987) encourages the use of peer tutoring which is believed to improve the behavior of both the student and the peer tutor. This method of reciprocal teaching involves both individuals in the teacher and learner roles and provides an opportunity for modeling desired behavior.

The model ensures ecological validity of training tasks and settings because training should take place where the problem occurs, using real life situations.

If this is difficult to achieve, natural setting distracters should be introduced to teach the student regarding how to deal with these situations.

The method is different from those traditionally used because it demands that the person take responsibility for their own learning. Every problem is presented as an opportunity for the student to take control of their own life. The problem is worked on with minimal intervention from the trainer.

This method was designed for persons with intellectual disabilities and takes into account the specific way that persons with intellectual disabilities learn. It identifies the cognitive characteristics that make universal teaching methods inappropriate for this client group. Instead we see an entirely new teaching strategy.

The method is progressive in that it teaches independence and ownership of problems. The teacher fades out involvement gradually but leaves the client with a concrete tool for problem solving. I believe that this approach fits well for intellectually disabled clients in terms of facilitating their long awaited autonomy.

Cue exposure

Cue exposure therapy is relatively new as a treatment for alcohol abuse. Its primary use has been with anxiety disorders such as panic disorder, compulsive disorder and simple phobias. Hodgson and Rankin (1976) proposed a parallel between anxiety disorders and alcohol dependency. They suggest that based on the similarities, exposure therapy might have some usefullness with alcohol treatment.

Cue exposure treatment assumes that cravings are a behavioral response that has been classically conditioned to internal and environmental stimuli related to the drinking situation. Treatment then involves an extinction process that recognizes the particular cues in the individual's environment that elicit cravings (Lee and Oei, 1993). Cue exposure assumes "that repeated exposure to drug-taking cues (alcoholic beverages) will eventually lead to the extinction of appetitive responses including "craving" and urges to engage in drug taking behavior" (Marlatt, 1990, p. 395). Cognitive therapists, on the other hand, think that cue exposure is effective because it increases an individual's feeling of being in control and extends positive outcome expectancies that are associated with alcohol use (Marlatt, 1990).

Hodgson (1989) and Blakey and Baker (1980) suggest that cue exposure can assist in alcohol treatment in three different ways. It stops the conditioned craving. It also assists the individual to feel in control of the drinking behavior through rehearsal of self-control and the development of subsequent coping strategies. In

addition, the individual's expectations about the inevitability of drinking are changed through the therapy.

Cue exposure was chosen for this group to strengthen the treatment program. Cooney, Baker and Pomerleau (1983) proposed combining cue exposure with social skills training, including aspects of both behavioral and cognitive therapy. This combination of treatment methods was appealing because they encourage autonomous decision making, unlike traditional behavioral methods such as behavior modification and task analysis.

Groupwork method

The treatment process was delivered in a group setting based upon my own positive experiences using a group format with adults with intellectual disabilities and from the support for this method that was found in the literature (Davis & Shapiro, 1979; Favell, Favell, & McGimsey,1978; Lee & Lee, 1989; Monfils, 1985; Richards & Lee, 1972; Small, 1980/81; & Steiner, 1984).

The benefits of groups are many. They can link people together who have similar issues and fears. They reassure members that they are not isolated in their difficulty. Groups may also provide an opportunity for members to behave socially in an environment that may not always seem welcoming and where members fear rejection or expulsion. With certain guidelines, it is a place where personal struggles can be worked out at a pace that is dictated by the individual and in a situation that is more similar to real life than individual counseling (Schulman,

1980). The group process is often an empowering one for many people. Davis and Schapiro (1979) have shown us that adults with intellectual disabilities can use a group as a means of ongoing strength and ownership of issues.

A group may provide unique ideas on problem-solving that a counsellor and the client may not have thought of. Many individuals with intellectual disabilities have been through similar life experiences such as institutionalization, group home living, supervised apartment living, and supported employment. Groups members may be a unique source of empathy for each other and may provide solutions that are not usually considered. It may also provide a forum for peer confrontation that may be more helpful to a client than confrontation from a counsellor. Schulman (1980) believes that individuals find it comforting to know that there are other people who struggle with the same problems and they then may be more likely to share their own experiences.

Group process is used with a wide variety of issues in almost any therapeutic situation. The self-help model is used by Alcoholics Anonymous and Al-Anon. A group to teach adults with intellectual disabilities social skills evolved into a self-help group after its original format became redundant (Davis & Shapiro, 1979). Bandura (as cited in Chaudron, 1988) discusses 'vicarious learning' as a way that people learn behavior through watching the behaviors of others. The group process provides an opportunity for peer modeling that can teach healthy coping strategies and an avenue to building self-esteem that Bandura believes is damaged by repeatedly falling short of an elevated self-image.

Most often group work done with this client population involves the development of social skills or communication skills often through direct feedback by way of video or audio tape and that this helps solidify concepts (Schulman, 1980). Schulman also comments that when leading a group made up of persons with intellectual disabilities it is necessary that the leader have a positive attitude towards their learning potential, and not a belief that these individuals are child-like. The leader must emanate feelings of respect and appreciation towards all group members.

Difficulties experienced by Davis and Shapiro (1979) in their work with this client group included members seeking approval from authority figures and at the same time avoiding relationships with peers. Most stifling to the group process was the nervousness of the group members. This was rectified through the use of humor and role-playing. Strategies to counter these obstacles included targeting one group member who was especially good at a certain behavior and elevating her status by identifying her as a known expert at this task. This encouraged the other group members to look to their peers for acceptance and guidance. When issues were brought to the leaders for solution or clarification the leaders would quickly deflect the issues back to the individual targeted. This role-modeling resulted in group members imitating the leaders behavior and initiating peer discussion. The leaders determined that this population was quite capable of developing the skills necessary to facilitate the group process, once training and orientation was provided.

An individual may have difficulty controlling the abuse of alcohol because they have been taught very few alternative ways of coping with difficulties. A group provides a opportunity to role-play situations in a more realistic arena (Schulman, 1980) and provides a safe setting for rehearsal. A group may provide a warehouse of new ideas for coping strategies that an individual may not have considered. The awareness that there are others in the group that are experiencing the same feelings around a certain situation universalizes and normalizes the situation hence decreasing the stigma (Schulman, 1989).One of the biggest strengths of using the group process to deal with issues is that it provides a safety net for the group members. Often people share their most intimate struggles with those in the group and through this process find people that they can trust to help them during difficult times.

The choice of using group treatment was based on the many advantages it offered for individuals with special learning needs. The information that was being delivered needed to be provided in a way that increased the opportunity for learning. For adults with intellectual disabilities group learning provided an environment where similar life issues were identified and discussed in a forum of support.

Summary of treatment method

The treatment program provided information on alcohol misuse in a group format, using cognitive/ behavioral therapy. These are non-traditional methods of treatment that are rarely used with adults with intellectual disabilities. The idea to use these non-traditional treatment methods originated from the work of Gow (1987) and "the self-instructional problem solving approach." This approach taught vocational skills to adults with intellectual disabilities using instruction and reinforcing self talk.

In addition to cognitive/behavioral therapy, cue exposure was also used in the treatment program because of its success in decreasing alcohol dependency, especially when combined with social skills training (Marlatt, 1990). Social skills training was the medium that was used to deliver information on alcohol misuse/abuse.

In developing an alcohol treatment program for adults with intellectual disabilities, the issues of self determination and empowerment were critical elements. In an attempt to increase self determination the members were repeatedly encouraged to question their own actions, and the motives of others, especially as it related to drinking.

CHAPTER THREE

Methodology

Research Statement/Practicum Proposal

The goals of the group were to assess whether the self-instructional problem-solving approach combined with cue exposure decreased drinking behavior in persons with intellectual disabilities and increased autonomous decision-making generally across the lives of the individuals involved. The treatment program consisted of forty eight sessions that were divided into two sections. The first twenty four sessions focused on education about alcohol, while the last twenty four sessions focused on relapse prevention. Both sections attempted to teach empowerment skills as it related to decision making.

Description of Sample

The group began with five members but only four members completed the group. The original group of five individuals consisted of four males and one female ranging in age from 33 to 63 years old. The intellectual capacity of the members varied. One member had a moderate intellectual disability, three members had mild intellectual disabilities and one member had borderline intelligence. If both the individual and the collateral determined there was a drinking problem and if there was a desire for treatment, individuals were invited to join the group.

Three of the five individuals were status Indian while the other two members each had one parent who was of aboriginal descent. All of the members were

voluntary clients of the Rehabilitation and Community Living Program, a branch of Family Services.

Member A was involved extensively in the child welfare system while living with his biological family. As a child this member was placed permanently in care because of parental neglect and chronic alcohol abuse.

Member B lived with family and extended family in the same small community until recently. Historical data is lacking as this member is very reluctant to share any information and there is no family history documented on the adult file. No familial alcohol history is available.

Member C spent a significant part of life living in an institution for adults with intellectual disabilities. This individual was institutionalized along with many other individuals in the province with intellectual disabilities. The family of origin had a chronic history of alcohol abuse and child neglect. This member was also involved extensively with the child welfare system for much of their childhood, until institutionalized in early adolescence.

Member D lived with his immediate family in a small remote northern reserve community during childhood and much of adulthood. Some of the family members abused alcohol but many in this large family did not. The community in which this individual was raised had a long-standing problem with alcohol abuse.

Member E, the one member who did not complete the group, grew up in a family and community where there was extreme substance abuse and violence.

The Measurement Tools

All data was collected at baseline, post intervention, and six months follow up (see Table 1). A frequency count of drinking behavior was also recorded six months prior to the intervention, immediately following the intervention, and six months post intervention, then compared to the alcohol use score (see Table 2).

To establish participation in the group without coercion, individuals completed the questionnaire with a neutral third party rather than the case manager (see Appendix II). This was a necessary step as the group leader had previous knowledge and influence of potential members. The questionnaire (see Appendix III) was read to each individual by the interviewer instead of self-reporting as many of the potential group members were unable to read.

Prior to the commencement of the group, historical data on the frequency and details of drinking episodes were collected from agency files and compared to the information obtained from collateral sources such as the case manager or other support personnel. This was done to establish accuracy. The information was collected from the files only after a consent for a release of information was signed and witnessed.

Two custom designed questionnaires were delivered to potential group members.

Client and Collateral Questionnaires-Independent Decision Making (Appendix III & IV)

This questionnaire determined how independent the individual was in making their own decisions before, during, and after the group process. The potential maximum score for both the client and collateral independent decision making (IDM) questionnaire was 20, indicating dependence in decision making. The minimum score was 4, indicating independence in decision making. A collateral source was also asked to complete a complimentary questionnaire, Collateral Questionnaire-Independent Decision-Making (Appendix IV). A collateral source was necessary as the ability to recall past details accurately by this particular client group is weak. The collateral source was a person who had a significant relationship with the individual and was in a position to know the details of the individual's life.

Client and Collateral Questionnaires-Alcohol Use (Appendix V & VI)

The second variable examined was alcohol use(AU). Each question was given a rating and then added to produce a summary score. The lower the score, the less the individual was drinking. The maximum score for alcohol use was 50, the minimum score was 10. Scores close to fifty would indicate a drinking problem, scores closer to ten indicate less of a problem. Each member's baseline scores are above 25, the midpoint of the questionnaire. This information came through the weekly meetings with each member and through monthly interviews with the other professionals involved in their lives. This questionaire measured drinking behavior

determining if an individual had a drinking problem, the extent of the problem, and whether an individual wanted treatment. If a client indicated they had a drinking problem, a collateral source was selected by the case managers to verify the information through completion of Collateral Questionnaire-Alcohol Use(Appendix VI). The alcohol use questionnaire was utilized to determine eligibility for the group and to measure drinking behavior both during and after the group experience.

Summary scores were generated and compared for member and collateral questionnaires throughout the three times the questionnaires were delivered. This information helped to determine the accuracy of the self reports of group members and hence, to validate the results of the intervention. Both questionnaires identified historic information which became useful throughout the group sessions. This information was often used in role play exercises throughout the group sessions as it provided specific details about drinking episodes.

A frequency count of drinking behavior six months prior to the intervention, immediately following the intervention, and six months post intervention was also recorded and compared to the alcohol use score.

Setting

The group was in place for 24 weeks and the members participated in 48 sessions in total. The sessions were held two evenings per week for three hours.

The meeting took place in the early evening to accommodate employment commitments of the members.

The length of the group, frequency and location were all originally set by the group leader. After the first session the members often changed the duration and location of the meetings depending on the length of time it took to complete the activity, what they wanted to work on that session, or what they felt like doing. The leader felt that this flexibility within the group sessions provided an opportunity for empowerment for the members.

Once a week the group worked out of a formal setting i.e., the community residence or the Family Services Building in Thompson, Manitoba. Alternate meetings were held at members homes, community spaces, and drinking facilities. Each session incorporated a theme and activity. This accommodated both cue exposure and the self instructional problem-solving approach by providing the intervention in the most familiar and relevant locations.

CHAPTER FOUR

GROUP PROCESS

Structure and Format

Classification of the group

This group can be categorized as a therapeutic group. The therapeutic group's purpose is to " increase people's knowledge of themselves and others, help them clarify the changes they most want to make in their life, and give them some of the tools necessary to make these desired changes" (Corey & Corey, 1992, p.9).

In keeping with the therapeutic group format, this group encouraged members to interact, to communicate openly, and to use their own personal experiences in group sessions. The group was a long term, time limited group with a psycho-educational format including structured didactic content, as well as experiential exercises. It was also a closed group as members were expected to remain in the group until it ended (Corey et al, 1992). The sessional information built upon knowledge of the previous sessions.

Objectives and Intervention Methods - Cue Exposure and Cognitive Therapy

Group Objectives

1) To provide opportunities for individuals to learn to refrain from drinking alcohol.
2) To discuss and work through alternative ways of coping with the pressure to drink.

3) To teach and encourage independent decision making and problem solving, specifically regarding alcohol consumption and, more generally, in relation to other aspects of their lives.

The first session was used as an opportunity to invite all those who fit the membership criteria to a general orientation meeting. The treatment methods were not discussed in detail at this session as it was felt that a separate session was needed to provide this information. Cue exposure and cognitive therapy were explained to the group members in the second session as the two methods that were being used in the group. Cue exposure was described as a learning tool that can train people how not to drink when they are in a situation where they typically drink. The cue exposure exercises were held at all sessions except those where members decided they did not want the cue exposure exercises, thereby emphasizing the element of choice amoung members. These exercises were done in conjunction with cognitive therapy during the sessions.

Cognitive behavioral approaches were used through role play exercises. These exercises used client information that was gathered from historic data or client disclosure in the group. Weekly, the group would act out scenarios centered on the use of alcohol and plan alternate strategies where they did not drink. These exercises were done repeatedly and with all group members playing each role. A discussion would then follow that reinforced the alternate behavior.

Structurally, the first session of the week was used to focus on different educational themes around alcohol. This session was characterized by experiential

learning and included smaller group brainstorming activities, collages, murals, and creative drawing. The second session of the week involved cue exposure in public spaces with the aim of learning how to not drink alcohol where alcohol use is common place.

The cue exposure and cognitive therapy exercises often had a theme. It was discovered that members responded better to the material when it included experiential learning, humor, variety and fun rather than a didactic or discussion format. The leader provided a theme and related role play experiences to this theme each meeting, such as experiencing the pressures of drinking, practicing refusal techniques, dealing with particular individuals that are difficult to say no to, identifying different drinking situations, and trying to convince other members in the group to drink. Alcohol would be used and each member would pour their own drink. Members then discussed how they felt about having it present. The alcohol was then used as a prop in the role-play. For example, one session included a cue exposure/cognitive therapy exercise where each person imagined themselves as the person in their life who was the most influential drinking partner. During this role play each individual tried to influence another member of the group to drink. The smell and sight of the drinks were used as props in the role play. Members were then requested to draw from the memory of their most influential drinking partner. A discussion ended the meeting with the group rehearsing drink refusal techniques. This was typical of how the cue exposure/cognitive therapy exercises were delivered.

Each session began with a "check in" regarding how the members had done at remaining sober over the last few days, and an invitation to discuss any additional issues.

Recording Group Process

The leader planned to video tape each sessions. The purpose of the video tape was to assist the leader to understand and analyzing the group process. This was discontinued soon after the sessions began as members reported that the video taping made them uncomfortable. Because the group sought to teach empowerment skills and control over one's own life, all aspects of the group including format and content were negotiable at members' request.

The group leader received bi-weekly supervision by the student advisor. Written process notes were made after each session and shared with the advisor.

Group Norms

"Group norms are those standards that govern the behavior in the group"(Corey et al, 1992, p.123) and can be implicit or explicit. Implicit norms are the unspoken rules of behavior that the group members bring to the group. Explicit norms are the clear, definitive guidelines for behaviors that have been shared openly with all members.

An implicit norm that the leader learned throughout the sessions was the importance of enjoyment and opportunities for socialization as part of the sessions.

During one session in the working stage of the group, the leader provided examples of potential drinking scenarios and asked members to brainstorm solutions on how to avoid these situations. Members were asked to work as a team without the leader. Ultimately, the group choose not to complete the exercise and instead spent the time socializing. The exercise was completed under the direction of the leader but this reinforced that an important motivator for members was the socialization component. Ensuring that the therapeutic tasks got completed and that the sessions were enjoyable and rewarding was a creative challenge for the leader.

One of the primary goals of the group was to increase members' independent decision making skills. The explicit norm of encouraging independence and self determination was reinforced by the leader throughout the sessions. In one situation, the leader attempted to change dependent behavior by modeling and encouraging a more assertive attitude. When one of the five members left the group, it was used as an opportunity to reinforce with the members that attending the group was each member's choice. The choice of participating in the group or not was a fundamental choice that was respected and reinforced.

Another explicit norm was witnessed in the early stages of a group, and was fueled by the cue exposure exercises and the cognitive therapy exercises. Members were encouraged to openly share personal information with everyone in the session and not in the format of member to leader. Members seemed to accept this explicit norm by session twenty-one when the theme of the session was; "what stands in

our way in leading a life without alcohol?" The discussion focused on change and the anxiety experienced when learning to do something new. All three group members who attended the session were very involved in the discussion and volunteered personal information. The members seemed to own the discussion and things happened spontaneously. This was a change from the first few meetings when members volunteered very little.

Exercises

A weekly theme was developed to increase the structure and organization of the sessions. Part of each session involved exercises intended to educate members about alcohol abuse and relapse prevention. The exercises were often built on the information that was shared at the sessions. Exercises that were included were,

- Draw a picture of your worst drinking experience and include a picture of yourself showing the way that you felt. This was followed by a discussion relevant to the exercise.
- Create a large mural that shows two of your memories from your childhood, one should be your nicest memory, and one should involve drinking, followed with a discussion about how individuals learn to make decisions.
- Draw a body map, a life size outline of your body and include personality traits. Discuss members of our families who may have shared similar traits.

- Discuss and identify what our friends and family gain from spending time with us. This lead to an examination of the motives of some friends and family.
- Identify positive and negative support networks.
- Develop individual plans to stay sober and illustrated these plans on paper.
- Discuss what gets in the way of staying alcohol free.

Other Activities

Other activities that members participated in but were not exercises included,

- Regularly reviewing the many different responses possible when faced with the pressure to drink.
- Spending time in drinking establishments, practicing not to drink.
- Evenings were also spent socializing in non drinking places that offer alternative activities to drinking.

Pregroup meeting (session one)

Prior to the pre group meeting, individual interviews were held to screen potential members and to offer the group to those who met the requirements. Interested persons were then asked to attend an orientation session and make a decision about joining.

The pre group meeting provided potential members with an orientation to the group. It had a number of purposes including introducing potential members to one another, providing them with information about the group, and giving potential members an opportunity to decide if they are interested in making a commitment to the group.

The first session included a discussion about how to hold a group, the location options and group rules. Members came up with additional rules to add to the rules that were already offered. A consent was requested by the group leader which gave permission to use the file information as background data and permission to video tape. If the members were in agreement with the terms, they signed the consent. Five individuals met the criteria for the group and all five came to the pregroup session. Four members completed the group.

Initial stage (sessions two to nine)

The purpose of the initial stage of the group is to introduce the members to the group experience and to explore their issues in relation to the group's purpose. The group establishes norms, or the rules of working together within the group, clarifies their expectation of what they want to happen in the group, explores their feelings of being a member of the group, and decides whether this group is the place they feel safe to talk about their private lives (Corey & Corey, 1992, p.106).

In the beginning the members were very quiet and protective of their own experiences. This group may not have been as quiet as some other groups at this

stage, probably because the group leader had a long established relationship with four of the five members, and was familiar with the fifth member. Nevertheless, they were less verbal in the beginning.

Three of the members were close friends and all five members had worked together in the same workplace at one time. As a result, a getting acquainted period, typically present in the initial stages of group development, was not required. Group cohesion proceeded rapidly. Absenteeism was negligible during the group process except for one member who missed four weeks due to a routine summer vacation. The group decided to take three weeks off in the summer to accommodate holidays. The member who missed three sessions came back to the group when he returned from his holiday. The group members noted his absence but proceeded as usual with group activities. He blended into the group well on his return, perhaps because these four individuals have known each other well and he was very comfortable with the established group before his departure.

There was very little tension among the group members themselves. The members were kind to each other, supportive when it came to problem-solving, and cooperative when working together on exercises. As the sessions went on, members seemed to be enjoying themselves more and were often excited about the next session. Even when members did drink, they continued to return to the group. This may have constituted a risk as typically clients may fear negative consequences by the case manager. The willingness to take such a risk, the obvious continued enjoyment when attending, the positive, emotional atmosphere of the

group, and the willingness to keep returning to the group indicated that a level of safety and group cohesion had been established.

The structure of the group changed at the request of the members. Members seemed reluctant to participate in the early sessions of the group. The group structure was then examined and changed. Initially, it was thought that the group would be more self-directing, in that the members would take control of the meetings early in the sessions. The leader's role would be to provide a structure, format and discussion topics. The expectations for the group had to change to meet members' needs. The sessions turned into teaching exercises and were not as member-directed as first anticipated. The sessions also seemed too long and they needed more structure and planned activity to keep members interested. Early into the sessions it became necessary for the leader to plan out the meetings in detail to ensure structure and purpose. By the forth session the leader began developing a plan for each session, similar to a teaching plan.

The group format also changed in terms of the cue exposure activity. The leader was presented with an opportunity to reinforce self determination and control over one's own life. While at one particular bar that many of the group members had drank at in the past, the members were approached by many different friends. The leader's presence was questioned a number of times. The exercise seemed difficult for most of the members and they agreed afterwards that it was uncomfortable. Eventually, members identified that they were uncomfortable with ordering alcohol and not drinking it. The leader invited them to do what made

them comfortable and reminded them that the group belonged to them. The decision making needed to start shifting from the leader and others around them, to having members make their own decisions free from outside pressure. Here again was an opportunity to provide the group with practice in taking more control over their decision making. A few of the members were invited to drink alcohol with their friends but nobody actually drank. This may have been for a number of reasons. The presence of a social worker itself may have acted as a deterrent. Or, perhaps, fear that others who play a part in controlling the lives of these individuals will be notified of drinking behavior and that this may have some negative repercussions, such as a change in living arrangement or an attempt to control a member's social network. It may also be that the peer pressure from the group may have acted as a deterrent.

Because independent decision making has not been taught through the normal life experiences of these adults, the group was a forum where the leader could reinforce some of this behavior by encouraging members to communicate their wishes. Members often made changes to the group. Examples of this were spontaneous changes in the location of the group, changing the activities during the group, and spontaneous discussions about related topics that were initiated by members. This seemed to increase trust in the leader as members experienced how their wishes were valued and recognized.

Using the direct and indirect feedback received from members regarding certain activities, changes in the format of the group were made. Efforts were

made to include more of the activities that members had responded to positively. The more members enjoyed themselves, the more they responded to the information in the group sessions. It became necessary to gauge members enjoyment levels during the session. The more fun and active the group, the more the members participated and the more it seemed they wanted to return. When it appeared that the activities were slowing down, more interactive activities were suggested.

In the initial stage the leader hoped to create an atmosphere of trust between the members, and with the leader. The cue exposure exercises were experienced by the members as very unusual and not typical of something the case manager had done before. In relation to my role as case manager, members had often tried to hide their drinking as they believed they did not have the right to choose to drink, and that this behavior may get them into trouble. Being a case manager to many of these individuals was an awkward position for the group leader. Part of the role as leader was to encourage members to be around alcohol during the meetings. Having alcohol introduced by a case manager at the meetings was confusing for group members.

Initially, members reacted with discomfort and confusion. Even though there had been a discussion about the presence of alcohol at the meetings, members were still obviously surprised when they first saw liquor as this is not usually present at a treatment meeting. To increase members' comfort with the presence of alcohol the leader often joked about its presence and the cue exposure activity, at the same

time praising members for their ongoing commitment to the group and the activity. Increasingly, the members became more comfortable and trusting as they would openly talk about drinking behavior. This was something they rarely did in my role as case manager. Members started sharing situations that had happened to them in the last week where they had refused to drink. The leader began to feel more secure and comfortable with the group and a greater rapport began to emerge. Obviously a new level of safety and trust had emerged for members.

Another challenge to the trusting relationship that had to be overcome by both the members' and the leader came when the leader overlooked the importance of members personal comfort with the cue exposure activities. These activities were used to establish increased ability to be around alcohol and have the best results if this is reinforced in a natural drinking environment. The difficulty came when the members participated in such an activity in public. In order to see how members would react to the public cue exposure activities, the leader decided to have the first trial in an environment where alcohol was served but not the focus of the setting. The first public session was held in a restaurant where drinks were served as part of the meal. It was anticipated that the activity may result in members feeling stigmatized. Doing the cue exposure while eating a meal may shelter the activity from other members of the public, thus members would not be the targets of uncalled for and perhaps distracting attention. A restaurant met these conditions. There was the sense of being stigmatized by the unusual non drinking behavior. During the session the members were very reluctant to discuss their

drinking or to participate in the cue exposure and cognitive therapy exercises in public. Consequently, the group discussed the feelings about the event briefly on the way home that night, and in the next session. Members revealed that they did not like participating in the cue exposure in public as it made them uncomfortable. To clearly solidify the trusting relationship with the members, in future sessions the leader asked members how comfortable they were with each activity before participating in public cue exposure activities and we rehearsed what was going to be ordered before taking part in the activity.

Transition stage (sessions ten to fourteen)

The transition stage is a period that can be characterized as an uncomfortable but necessary passage into the working stage. Many of the group's difficulties get worked out in the transition stage. Members may experience anxiety, defensiveness, resistance, a struggle for control, conflicts among members, challenges to the leader, and various problem behaviors (Corey et al., 1992).

This treatment group worked through a number of these issues including the issue of conflict, a characteristic that challenged the cohesion of the group. In particular, the conflict that was present in the early stages of the group concerned member E and his conflict about continuing to be a member of the group. The lack of commitment to the group was evident in his disruptive behavior which created some anxiety and discomfort for both the leader and the other members.

Out of the five members who initially joined the group only one member, Member E dropped out of the group. This happened in the eighth session. Member E began the first session with a very open discussion about his drinking history. He was the only group member with dual diagnosis related to mental retardation and mental health. He was also the highest functioning member with an IQ in the borderline range. At the time of our first session he had been sober for a number of months, primarily because of a psychiatric institutionalization. He talked proudly about his accomplishments. He was very talkative in this beginning stage and openly supported a sober lifestyle. After the first few sessions he began to become disruptive. He tried to engage members in outside conversation and often had private conversations during role-plays. He seemed very uncomfortable with the presence of wine at the meeting. Wine was his drink of choice. He spent much of the early meetings looking at the wine bottle and rocking back and forth on his chair. Member E had a history of extreme violence and I thought that the wine may be increasing his anxiety. In order to break the tension during this group session he was asked to run a short errand. By the time he returned the bottle had been moved out of sight. He immediately seemed more relaxed. Because member E received counseling through mental health, his case manager continued to check on his progress. She confirmed that the presence of the wine bottle did indeed cause him increased anxiety even though he had told the leader that this was not a problem. During the remainder of time that member E continued to attend the group, the alcohol was removed from sight after the cue exposure exercise.

Regularly, the group discussed how they felt the sessions were going. The reaction was positive all around, including member E. This is interesting because this was the last session he attended. He would not talk to the leader about leaving the group and avoided the leader when approached. He told his case manager that his reasons for leaving the group was that he found it too difficult to be around the alcohol that was present at the sessions.

It was felt that resistance from this population might manifest differently than in a group with adults of average range intelligence. Typically, adults with intellectual disabilities have little control over their own lives. Often their wishes have not been considered in decision-making. According to Carlson (1997),

> "many adults with mental retardation currently living in community settings have spent portions of their childhood's in institutions or compromised family situations and were poorly prepared for community life." Thus, they may have "limited capacity to cope with the pressures and demands of day to day life" and "may have limited communication, problem-solving, and decision-making skills." (Carlson, 1997, p. 79)

Because of this the leader looked for resistance, instead of waiting for it to appear. What had been member E's reasons for joining the group in the first place? Perhaps he had been pressured to do so. Perhaps he was displaying resistance through his lack of focus or his disruptive behavior. Maybe what he was trying to say through his behavior was something he had never been taught or

encouraged to do, something he had difficulty saying. Perhaps he did not want to be part of the group. Member E's resistance to engaging in group activity and his difficult behavior seemed to make everyone tense. The tension ended when member E quit the group. His resistance to dealing with the group leader directly and the leader's apprehension towards him because of his violent past, led to the conflict being addressed indirectly. In member E's last session the leader feared violence erupting in the group setting and someone being hurt. In order to ensure the safety of all, confrontation about the member's actions was avoided at that moment. Instead a distraction was used to defuse the immediate tension and the session ended without incident. The member was approached a number of times in other settings to discuss his involvement in the group, but he avoided the leader entirely. Without dealing with the leader directly he was still making a choice not to attend and that in keeping with the philosophy of self- determination, his wishes were respected. His case manager confirmed that he no longer wanted to be a part of the group.

After member E left, tensions eased. Member participation during the sessions increased dramatically.

Many of the dynamics that characterize the transitional stage were not present in this group or they were not obvious to the leader. For example, the struggle for control and challenges to the group leader and confrontation were minimal in this group. The passivity and lack of control that are characteristic of this population may have been a factor here.

Much of the reason for this is the traditional disempowering relationship between adults with intellectual disabilities and the rest of society. According to Carlson (1997),

> a number of personality characteristics are reported to be typical of those with developmental disabilities... These factors include high levels of dependency on others, lack of assertiveness, overcompliance, and low self-esteem or poor self-concept. Sobey and Doe (1991) speculate that 'internalized devaluation'....is the destructive result of negative societal stereotyping of people with mental retardation and may account to some extent for low self-esteem and other dysfunctional characteristics such as passivity... (Carlson, 1997, p.80, 81)

Working Stage (sessions fifteen to thirty-eight)

Many of the same issues that are dealt within the first stage of a group continue to be issues in subsequent stages. The working stage can be identified by very distinct characteristics. These include a strong commitment by the members to work on the issues that brought them to the group initially. Members appear willing and open to discuss their personal lives and to look at alternatives to their problems. Members are more comfortable with how the group works and can anticipate many of the behaviors of other members. This stage may also be characterized by a loosening of the traditional structure of the group and an increase in members input in the way the work gets done (Corey et al.,1992).

The treatment group at this stage showed a commitment to explore more significant problems within the confines of the group. Things that members were not comfortable sharing in the initial or transition stage were explored in this stage. Members had reached a level of comfort with each other and could be more focused on their problem.

This working stage and the commitment to work on more personal problems was clear and marked by specific incidents. During one session three of the four members identified that they had been out drinking over the weekend. The leader had had an unrelated opportunity to meet with members earlier in the day. One member said he did not want to return to the group but changed his mind in the end. The tone at the beginning of the session was quiet and member A appeared visibly uncomfortable. Initially he was asked if there was anything wrong. He said no. Then, he was asked if he wanted to leave the session. At first he said yes but again changed his mind. It made sense at this point to discuss and reinforce the successes each member had had over the past few months and to identify the vulnerability to alcohol that they felt. It was hoped that the experience of drinking or relapse, was one that members could learn from. This meant translating the guilt they felt about drinking into strength and determination that would help them formulate a sobriety plan.

What was expected from member A was that he would be very quiet in the session and leave or not return to the next session. However, he stayed and participated and eventually completed the group.

Another characteristic of the working stage is a decrease in structure and intervention required of the group leader in the sessions. This was evidenced in the way the members quickly adapted to the structure of the group and increasingly anticipated the activities that would occur.

For example, in one of the sessions it was suggested that members appoint a leader from amongst themselves to complete an exercise. The group continued to have difficulty getting the activity completed and required more assistance. Interestingly, during one of the leader's absences in this exercise, the members were discussing concern for a friend that they felt had a drinking problem. They felt he would benefit from the group. This event was encouraging as it seemed that the group members were finding the sessions helpful in maintaining their own sobriety. The forward thinking of the members regarding the welfare of a friend confirmed how members were beginning to take some control over the group itself and were less dependent on the leader.

Other examples of members taking more control of the group was with their eagerness to attend the group after a two week absence. The leader was out of town and had to cancel the group sessions. Members agreed to the change in routine but I was concerned about the potential for relapse without the structure and support of the group. It was a possibility that members would lose some commitment to the group. Days before the sessions resumed the leader was approached by three members who excitedly talked about starting the group

again. This helped to solidify the feeling that members were committed to the group.

Group cohesion was evident in the way members supported each other when personal issues were discussed, and also the way they challenged and confronted each other. For example, one session included an activity where members' examined the motivation of friends and family in their involvement in members lives. It was well known that each one of these members has people in their life that have taken advantage of them or their money. This often came by way of an opportunity to drink with "friends," if the member supplies the liquor. The exercise used to illustrate this element had members group friends, family and acquaintances into two categories, those people who want you to drink and those that do not. We then discussed what each individual stands to gain from their request.

This exercise allowed members to visually examine the relationships in their lives and think about the motivation of others. Members often recognized the true motives of people, but when there was resistance, other members gave examples to that member that eventually brought out the realization that they had been exploited. This realization was painful and resistance was high. In the end members decided that in order to remain sober it was wise to surround themselves with people who had their best wishes in mind and to try and avoid individuals who were using them.

The next session continued with an activity where members identified those individuals who helped them make decisions. Members then identified whether each individual usually gave them good or bad advice. The goal of this exercise was to have members examine the motives of others and to think about what was being asked of them. As an increase in independent decision making was one of the primary goals of the group, this was one exercise that hoped to teach and encourage members to take more control over their lives.

One of the behaviors that characterize this stage includes members' level of comfort with disclosure. Members frequently shared a lot of personal information. In one session a member discussed her family's destructive drinking habits. Another member saw his drinking behavior with no negative consequences although there were some, and accepted his past experiences and behavior as part of himself, even though it has threatened his health and stability in the community. His attitude remained constant throughout the entire group but his drinking decreased. The questionnaire showed that over time he did not see a change in the amount he drinks, but the actual incidents of drinking episodes decreased dramatically. His ability to recall the past with accuracy is a limitation of many adults with intellectual disabilities. As Carlson sees it: "the skill deficits typical of people with intellectual impairments can be a contributing factor.....cognitive limitations such as concrete thinking may interfere with one's ability to see possible solutions or to problem-solve effectively...." (Carlson, 1997, p.81). Thus, the

member may recall the past in a way that does not always reflect or consider all the facts.

In another session, one of the members who had been very reluctant to share much family information, made a point of telling the leader privately how much he was enjoying the group sessions.

Group cohesion was evident by the time the group had reached the relapse prevention component of the group. The regular members talked about being proud of their sobriety, even when they occasionally drank. They willingly took risks and openly discussed their participation in the group with non-group members. It seemed clear that the group was positively affecting peoples lives. Everyone attending the sessions seemed to be enjoying themselves. Enjoyment always seemed to be an important factor in motivating the group. Members themselves openly shared the humor they found in the situations and activities we discussed.

The commitment to change by the members was solidified by the beginning of the relapse prevention component. The first session of this phase began by defining relapse as a slip or change from the original plan to remain sober. Individual plans were then developed for remaining sober, which included a relapse goal. Two group members came up with surprisingly long goals, one was nine years and the other ten years. Relapse was identified as getting back to your commitment to sobriety if one does drink. The group seemed to move themselves into a discussion about their own dreams and visions for the future. This worked well as it

reinforced the value of sobriety. The session ended with a brief discussion about what people lose and avoid when they drink.

Termination stage (sessions thirty-nine to forty eight)

The purpose of the termination stage is to clarify the meaning of experiences in the group, to clarify the efforts and successes that clients have made, and to assist clients to transfer their new behavior to the everyday life (Corey et al., 1992). The group began the termination process in the middle section of relapse prevention or around session thirty-five. The exercises and discussions were organized to help members review past information and to assist them to integrate the information into their lives.

In session thirty-five a discussion took place that identified what individuals had to do to avoid drinking and how to change the way members thought about drinking in order to stay sober. There were only two members present at this meeting as the others were away on summer holidays. Both members identified the things they would have to avoid in order to stay sober, but they still had difficulty acknowledging ownership of the decision to drink or not drink. Their feeling of lack of control could be due to the way services are provided to adults with intellectual disabilities and the paternalistic way that these individuals are treated in our society.

In the termination stage of the group it was important that members plan for the future without the regular support and structure of the group. It was hoped that members would recognize the control they had over their own behavior. To

illustrate this members began working on a collage. The theme of the collage was, "what would you have in your life if you could have anything?" The group used a number of different magazines to put together their own ideal life. The process of the exercise was very slow and the members focused on material possessions. Throughout the exercise alternative lifestyles to a drinking lifestyle were discussed. Even after much prompting the group continued to focus on material objects. The limited experience in independent thinking may have affected members ability to complete the exercise or examine the range of choices available to them.

In a later session the collage activity was continued. The theme was slightly changed to "show your dreams on paper, think about the things you want for yourself and draw it." The goal of the exercise was for members to identify their own recent experiences with a sober lifestyle and connect them to changes such as better health, calmer behavior, fewer incidents involving the police or injury and an increased amount of money. Drawing was chosen instead of collage as it had been a more successful tool in the past. The group worked very hard but again the focus seemed to be on material possessions. This may be evidence of members' concrete thinking. A connection was eventually made between being sober and having extra money. The group concluded that drinking is an expensive activity and that it often stands in the way of the life they want to lead and the things they want for themselves. The other connections were not made by the members, but they were acknowledged in the group discussion. The leader gave examples of behavior that she had witnessed in members. Evidence of a change in attitude was seen when

two of the group members talked about visiting their favorite bar over the past weekend and proudly told the group about how comfortable they were about ordering non-alcoholic drinks.

Another session that encouraged the members to look into their future included identifying members dreams to help them connect lifestyle with opportunity. The activity for this meeting was a discussion. The group activity needed to be more interactive and the opportunity to clarify questions was necessary. This discussion was enlightening as members talked about marriage, having children and vocational aspirations. The purpose of this exercise seemed to be achieved as members were able to go further than material possessions. The discussion continued with members identifying their sobriety goals and difficulty in achieving their dreams if all our energy and resources were spent on drinking. The session ended with the group identifying their natural supports.

Members were encouraged to develop support networks and coping strategies. In order to reinforce the positive aspects of a sober lifestyle, we often discussed the things members have given up to remain sober. The group had some difficulty coming up with answers. Alternatively, they were asked, "How has your life changed or what do you do differently since you've stopped drinking?" Still there was little response. Throughout the group sessions it was difficult for the leader to refrain from feeding members the answers to the questions. This is often done with this particular population group. With coaching the group did come up

with a comprehensive list of alternative activities and each member was able to come up with a plan for support.

Soon after members began to use each other as supports without the group leader being involved directly in this process. They confided that they were meeting on their own to support each other, and relayed how three group members got together one weekend for support. It seemed as if they too were preparing themselves for the group to end.

In one of the last sessions of the relapse component, relapse goals were reviewed emphasizing the importance of a long term commitment to sobriety. Group members knew the answers to the questions asked. It was hoped that in the moment of pressure from someone who had too much control over their life, they had a number of useful skills that they could draw from to enhance independent decision making and maintain sobriety. Members showed that they had all encorporated a number of appropriate strategies as evidenced by their responses.

The group sessions ended with a evening out for dinner, a suggestion of the members. A plan to end the group was clear with the group focusing on the future. The formulation of support networks, the exchange of phone numbers, and plans for the last sessions helped make this a gradual process. The termination process was comprehensive as the group covered all that was planned. Monthly follow up sessions continued for four months at the request of the members. Termination continued in these sessions as members became accustomed to being without the group.

Follow up

In addition to the forty-eight sessions the group requested follow-up sessions. The follow up sessions provided members with ongoing support in maintaining sobriety and with continued support and encouragement regarding independent decision making in discussions about everyday life events. Each session was initiated by the members with one or a number of members suggesting a meeting. The rest of the group would be contacted by the leader and asked if they wanted to meet. The meetings were held at member's homes and lasted about an hour. In these sessions we discussed things that had happened since our last meeting that affected the sobriety of the members. For example, members would give examples of how they had chosen not to drink in certain circumstances, and what they would say to people who encouraged them to drink.

In the meeting in December we discussed how to maintain sobriety over the holiday season. The group role played situations that they felt might occur, and practiced the drink refusal techniques that they had learned in the original sessions. The follow up sessions gave members an opportunity to disengage gradually from the group experience in a way that was controlled by members themselves. The sessions were often a review of how to use the skills that had been learned in new circumstances. The last follow up session occurred in January. There were no further requests for follow up sessions after that time.

CHAPTER FIVE

Findings

Independent decision making (IDM)

The mean scores (Table 1) were 11.75 (t1), 11.50(t2) and 13.25 (t3). The member scores show little change across time but indicate that independent decision making decreased slightly six months post group. The collateral mean scores were 14(t1), 12.75 (t2), and 10.75(t3). These scores reflect an increase in IDM. The collateral subjects produced scores that did not vary dramatically but seem to indicate that members were making more decisions independently, and that this behavior improved over the course of time.

The individual scores showed great variation between members. The group leader noticed very little change in independent decision making in Member A during the first four months of the group. Member A recorded a decrease in score initially from 12(t1) to 10(t2) and then an increase to 11(t3).The collateral score for this individual recorded the same results in the first two questionnaires, from 16(t1) to 16(t2) and a decrease to 14(t3). After the first four months the member's drinking was more controlled and the group leader noticed an increase in independent decision making.

Member B showed fierce determination and commitment to controlled drinking behavior. The scores for IDM were 12(t1), 12(t2), and 16(t3). The collateral scores show decrease scores at 11(t1), 11(t2), and 8(t3). The leader saw this member making definitive choices early in the group about whether or not to

drink but an increase in independent decision making did not appear generally in the member's life.

For Member C the scores indicate the individual saw their IDM decrease slightly while the collateral saw the client IDM increase substantially. The IDM increased slightly from a score of 8(t1), to 10(t2), and remained at 10(t3). In contrast the collateral scores were opposite to this trend at 15(t1), 8(t2), and 8(t3). The group leader observed that this member was proficient at making decisions independently from the very first session. There did not appear to be any change in independent decision making throughout the group.

The group leader observed little change in independent decision making in Member D throughout the course of the group. With member D the client records a score that decreases and then increases again at the post 2 questionnaire. The scores are 15(t1), 14(t2), and then 16(t3). The collateral scores show a higher score in post test and then a decrease in post t2 test, 14(t1), 16(t2), and 13(t3).

Alcohol Use (AU)

The members mean scores on the self report scale (Table 1) show a steady decrease over the length of the group at 28(t1), 23.75(t2), and 16.75(t3). The collateral mean scores are similar but not as extreme at 31.25(t1), 22.75(t2) and 20(t3). The AU group scores were reflective of what I witnessed during the group.

Member A reported a score of 27(t1), 26(t2), and 28(t3). The collateral reported scores of 34(t1), 28(t2), and 19(t3). When comparing the two, member

and collateral, we see similar scores, an indication that both the collateral and the member held the same opinion of the drinking habits of this individual although this is not indicated in the frequency data. The collateral scores reflect what the leader witnessed. Some explanations may be that the member may have had difficulty interpreting the questionnaire, or that the frequency data was not correct and that the member had indeed increased his/ her alcohol consumption.

Frequency of incidents were recorded at 18 incidents six months pre group, 6 during the intervention, and 4 drinking incidents six months post intervention, with a steady overall decline. The mean freqency data which was calculated to indicate the mean number of drinking incidents per member per month, also supports this data at 1.6 six months pre group, .6 during the intervention, and .4 six months post intervention. The frequency data supports the collateral interpretation, while the member felt that drinking had increased. A number of explanations are possible. The member may have an impaired interpretation of the past sixteen months. The frequency data could be inaccurate, or the member may have had difficulty recalling the past. Both are a possibility as the frequency data relies on the information of a number of other people involved in the member's life. If these persons have not had contact with the member, their information may be inaccurate. In addition, if the subject does not give an accurate reflection of their behavior, the frequency data will be inaccurate.

Member B recorded a decease in drinking with scores of 26 (t1), 11(t2) and 9(t3). The collateral reported a scores of 20(t1), 21(t2) and 20(t3), almost identical

scores. The frequency data supports a decline as this member decreased the incidents of drinking from 11 pregroup, to 3 postgroup, to 0 six months post. It is unknown why the collateral score reflects a small increase and then a small decrease. This collateral was the primary source of frequency information. This remains questionable as the collateral often commented to the leader on the positive change in the member's drinking habits.

Member C reported scores of 26 (t1), 24(t2), and 23 (t3) while the collateral reported a score of 31(t1), 23(t2), and 19 (t3). Both sets of scores reflect what the group leader witnessed, that there was a steady decrease in drinking. The frequency data indicates that there were 6 drinking incidents recorded in the baseline period, 4 drinking incidents in the post group period, and 4 incidents occurred in the post t2 group period. Interestingly, all four of these incidents occurred in the first month of the post t2 group. For the next five months, there were no drinking incidents reported. This same situation occurs with member A. Coincidentally, these two members began living together in the month that these incidents occurred. Also, the group ended the previous month. Perhaps this behavior indicates a period of adjustment for the members when returning to their life without the regular support of the group.

Member D reported a baseline score of 33(t1), 34(t2), and 7(t3). The collateral scores were 40 (t1), 19(t2) and 22(t3). The collateral baseline score indicates a serious concern regarding drinking behavior. The member's high baseline score of 33 is consistent with the collateral. Member D reports a final

score of 7 post t2 group. This is a considerably lower score than the two previous scores of 33(t1) and 34(t2). The collateral also continues to report a lower score of 22, down from 40(t1) but up from 19(t2). The frequency data supports an overall decrease in drinking incidents at 3 drinking incidents recorded in the baseline period, 4 drinking incidents in the post group period, and 1 incident occurring in the post t2 group The group leader again witnessed a decrease in AU. The collateral shows an increase in AU in the post t2 questionnaire. The collateral also commented on improved sobriety but at this time was experiencing difficulties with member D in the member's home. The collateral often expressed frustration with the member around other issues that may have influenced the scoring. The many inconsistencies in this data may also be explained by the long term behavior of the member. This member had abused alcohol for many years, and the collateral had been a support person for many years, assisting the member with sobriety. The change in drinking over a period of twelve months may have been a notable change over a long period of time even though the frequency data does not seem to indicate much change.

The IDM results do not indicate that members increased their independent decision making skills through attending the treatment program although the program did provide opportunity to practice skills that had not been a regular part of members lives at this time. The AU results do indicate that the group was beneficial to assist members with controling drinking behavior. This was provided

through a non-traditional program that considered empowerment issues and choice in members lives.

TABLE 1
QUESTIONAIRE SCORES

A	Client Questions		Collateral	
	IDM	AU	IDM	AU
Pregroup	12	27	16	34
Post group	10	26	19	25
Post2 group	11	28	14	19

B	Client Questions		Collateral	
	IDM	AU	IDM	AU
Pregroup	12	26	11	20
Post group	12	11	11	21
Post2 group	16	9	6	20

C	Client Questions		Collateral	
	IDM	AU	IDM	AU
Pregroup	8	26	15	31
Post group	10	24	8	23
Post2 group	10	23	6	19

D	Client Questions		Collateral	
	IDM	AU	IDM	AU
Pregroup	15	33	14	40
Post group	14	34	16	19
Post2 group	16	7	13	22

	Client Questions		Collateral	
	IDM	AU	IDM	AU
Mean Group Scores				
Pregroup	11.75	28	14	31.25
Post group	11.5	23.8	12.75	22.75
Post2 group	13.25	16.8	10.75	20

TABLE 2

FREQUENCY OF DRINKING

	1995		1996											1997					
	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
	Pregroup						Intervention Period							Posigroup					
Member A	4	4	2	2	2	4	0	0	1	4	1	0	0	4	0	0	0	0	0
Member B	4	4	2	0	1	0	0	1	0	0	2	0	0	0	0	0	0	0	0
Member C	4	2	0	0	0	0	0	0	1	1	1	0	1	4	0	0	0	0	0
Member D	0	0	1	0	2	0	0	0	2	0	1	1	0	0	0	0	1	0	0
Mean Group Scores			1.6							0.6							0.4		

CHAPTER SIX

DISCUSSION

The results of the group intervention show that some positive change did occur particularly in the area of alcohol use. The frequency mean scores and mean group scores indicates a decrease in drinking behavior during the six month duration of the group and a long term decrease in drinking six months post group. Changes were seen in behavior particularly in terms of choosing not to drink. Before the group began, a common comment to hear from these four members was that someone made them drink. While the group was running these members used this excuse less and would often explain their drinking behavior as a personal defeat hence indicating a perceptual shift around self responsibility and control. Today, three of the four members drink alcohol less, particularly when compared to their pre group behavior. The fourth member has moved from the community and his drinking behavior is currently unknown.

A number of factors contributed to the success of the group. Important considerations include the length of the treatment program that allowed time for repetition and creativity in presenting the information, the consolidation of skill development, and the focus on the development of social skills affording the opportunity to attend and experience a number of activities as any other citizen.These experiences had not been available previously. The focus on independent decision making reinforced the right to choice in life and gave members the opportunity to develop skills exercising choice. Relapse prevention

moved the group from discussions about alcohol abuse into long term planning for sobriety. The cue exposure activities forced the subject of alcohol to move beyond being a subject that was hidden to one that was open and accepted in discussions.

There were trends in the individual AU scoring that did not seem to reflect what I saw transpire over the course of the group. For example, collateral questionaire results did not always coincide with the personal comments of the collateral source. Perhaps the length of time between the questionnaire periods affected the collateral's ability to give comparable results that represented the actual behavior. The difficulties with the collateral questionnaires may have been avoided by having them delivered by a neutral third party instead of having the collateral complete them independently. This may have ensured their interpretation and made the process consistent with the member questionnaires.

Along with a decrease in drinking behavior, the group also worked on increasing their independent decision making skills. Success in this area is not as obvious from the data and cannot be concluded from the results of the questionnaires although in certain areas of their lives members began to state their preferences, dislikes and opinions more often and generally became more involved in decision making, for example becoming more forthright with support workers. Perhaps the minimal change in the IDM scores can be explained by the lifetime experience of members. The idea of controlling one's own life is relatively new to this population group and perhaps was met with some resistance. Service providers are still often skeptical of the idea of independent decision making and

frequently interact with these adults in very disempowering ways, often assuming that they are incapable of making informed decisions. Members themselves may have felt a lack of confidence in exercising independent decision making skills in their everyday lives. To object to direction from someone who has always had control over your life must be a difficult and anxiety provoking experience. Perhaps these skills take more than six months to learn, particularly for a group that has been disempowered for so long and whose learning needs involve special consideration.

The treatment group would be beneficial to continue or run again if there was a desire or need from the client group. If a similar group were to be implemented in the future I would suggest an increased emphasis upon socialization and an expansion of the possible range of enjoyable activities. The group was also very long and intense, six months long and two three hour sessions per week. I would recommend that the sessions be shortened to two hour sessions as this was ample time to complete our activities. During the course of the group sessions were sometimes shortened at the member's request or if the activity was completed early. The group was small, four to five members. I feel that this assisted the formation of the informal ongoing support group that developed naturally. The size of the group could possibly be increased by three or four members without interfering with the completion of activities. It is unknown if the cohesiveness of the group would be jeopardized by the increase in participants.

Flexibility in group structure became a necessity throughout the group process. Members often asked for changes in the length, time and activities in the sessions. Ensuring that activities were enjoyable became an important factor in the sessions. Through these activities group cohesion and trust flourished. Cohesion in the group was confirmed when members formed an informal support network without the assistance of the leader. This support network also provided a needed alternative to the social network available to members via drinking. The treatment group provided an opportunity for members to talk about their struggle with alcohol and to increase independent decision making skills. Members were given the opportunity to discuss, acknowledge and recognize their responsibility and vulnerability to alcohol abuse and coercion which allowed them to be able to recognize their shared vulnerability and responsibility in each other, and to achieve the sobriety goals they had established individually and collectively. I believe this happened because a typically hidden issue was openly discussed and accepted without judgment.

The original format of the group was designed with the expectation that occasional sessions take place in social environments, to reinforce skills learned in the educational sessions. These quickly moved to regular weekly outings that seemed to add more enjoyment and momentum to the group, providing positive reinforcement to maintain group membership. These outings were enjoyable and gave members an opportunity to take part in activities that many of them had never participated in before the group such as visiting the community pool, zoo, library

and restaurants. It also helped to break the barrier of segregation. There are many establishments where the group members did not feel welcome because of the way they were regarded by staff and other patrons. After visiting a number of establishments, members became more comfortable. It is unknown if a change was felt by proprietors and staff as the group rarely visited the same establishment twice.

Termination did not seem problematic for this group. The sessions finished with the knowledge that we would continue to see each other. The group members requested a number of follow-up sessions before ending the program entirely. Three follow up sessions occurred that were each an hour long and consisted of discussions of members sobriety goals, achievements and challenges. The members initiated discussion that often had a social component. Perhaps on-going follow-up sessions need to be a consideration for future treatment programs with adults with intellectual disabilities as this allowed members time to get used to living a sober lifestyle with less frequent group contact but still allowed the group to function as a support.

The dual roles of the leader as case manager and group leader may have caused some difficulty with group cohesion and trust. Traditionally, the case manager has acted as a commentator on lifestyle to the client, making sure societal rules are closely followed and ensuring personal risk is minimal. At the onset of the sessions this traditional role interfered with the creation of an atmosphere of trust, even though the leader acknowledged this and attempted to keep the dual roles

separate. When issues arose in the treatment group that were related to the leader's role as case manager, the leader would ask the individual if it could be followed up the next day during work hours. If issues arose during work hours that related to drinking behavior, these would be followed up at the group session, if the session occurred the same evening. If the issue was critical, it was dealt with immediately. Members gave no indication that they were dissatisfied or uncomfortable with the leader's response to situations. The dual roles of the leader also provided advantages for group development. Members and the leader were well aquainted with each other and had well established relationships. After the initial difficulty with trust this familiarity allowed the group to become comfortable quickly. Group members also established commitment to the group early in the program as was shown in members reliable attendance and minimal drop out rate. This may have been due to the comfort and flexibility of the group. The leader was also familiar with the details of each individuals drinking history which became useful information in the roleplay and cue exposure exercises. Overall, the advantages of the leader's dual roles provided important benefits for the group that outweighed the potential difficulties.

Researchers have just begun to explore alcohol abuse and empowerment issues in adults with intellectual disabilities. These issues have fallen through the cracks as indicated by the sparseness of research conducted in this area. This serious lack of research has made evaluation of this treatment program and other studies difficult. In regards to alcohol abuse Christian and Poling (1997) state there

are no empirically validated "best practices" for detecting, treating, or preventing drug abuse among people with mental retardation. The lack of concrete conclusions and recommendations allows this issue to be ignored by policy makers and treatment programs. A recommendation for increased research in this field must continue to ensure that resources are available for individuals who require/request treatment. Alcohol treatment, like any other service for adults with intellectual disabilities, needs to be provided in a way that encourages independent decision making and autonomy.

In the past, segregation protected adults with intellectual disabilities from being affected by alcohol abuse. With the push toward integration into mainstream society, individuals with disabilities face similar risks of developing addiction problems. Unfortunately, mainstream treatment programs often ignore the particular learning needs of these individuals. Their opportunity to receive support and treatment that meets their particular needs has simply been unavailable. This intervention was conducted in a segregated group format because mainstream programs such as Addictions Foundations of Manitoba and Alcoholics Anonymous had not met the particular cognitive needs of the client group. If full integration is the goal, then this type of group or some of the techniques for teaching should be incorporated into mainstream programs. Issues to be considered by these programs include lengthening programs, including a strong socialization focus, considering the learning needs of this client group by providing information verbally and repetitively ensuring comprehension, providing a lengthy relapse program, having

staff who are knowledgeable about intellectual disabilities, and ensuring that programs are provided in a dignified manner without prejudice or stereotyping.

Because of the demand for increased autonomy, independent decision making, or the practice of these skills are now required to be a part of every intellectually disabled individual's life as they interact with service providers. When we examine the IDM scores, it may be concluded that these individuals may benefit from a longer intervention as this population has been socialized into dependency. Now the law also demands increased independent decision making. I see two primary difficulties in achieving increased independent decision making. First, service providers have long been enabling dependency so that it has become the norm as a way of working with adults with intellectual disabilities. Service providers are often adamant that an individual's potential is determined by their IQ score or age equivalency. This protective stance often comes from caring passionately about the individuals they work with, people they have cared for. Up until now our social environment has not allowed us to see adults with intellectual disabilities as being able to change and grow as the rest of the population does. We have believed that these individuals required others to make decisions for them. The difficulty is then that service providers, families and society have to be educated to encourage/allow for independent decision making and to be a part of the team that teaches these skills. The second issue involves the intellectually disabled who have been thrust into independent decision making with little notice or training. It may take some time before these skills are learned and mistakes will be made. There may also be

resistance to increased independent decision making by individuals based on their lack of confidence and a lifetime of dependency.

Adults with disabilities need to learn independent life skills to survive as equal citizens in society. Independent decision making needs to be taught and reinforced by service providers. Unfortunately, this philosophy has not been embraced by many service providers, and often the struggle for the social worker is to challenge old beliefs. The current push towards more independence has sometimes been criticized as leaving the individual vulnerable in the name of independent decision making. The traditional way of working with this population has always been protection first and personal choice second. Rarely has individual growth been a consideration. Teaching decision making skills does not mean leaving the individual vulnerable, as ideally the teaching of these skills is done methodically and with vulnerability in mind. There must be some concessions given by those who hold control over the lives of adults with intellectual disabilities. If dependent, passive behavior is all we expect from individuals, then we have missed an opportunity to teach adult responsibility and maximize the potential growth and development of this population, characteristics that are necessary to function as equal citizens.

Independent decision making will continue to be a primary push of the provincial government. Encouraging adults with intellectual disabilities to become involved in mainstream programs will assist with acceptance in society in general. These adults have the right to use general services such as treatment facilities and

part of these programs must be to encourage autonomy in making their own decisions, particularly about drinking. Advocacy for insuring that these programs and all other programs are accessible, empowering, and appropriate for this population group is a necessary focus of government, advocacy groups, and concerned citizens.

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APPENDIX I

REGIONAL CONSENT

I ----------, ACTING REGIONAL DIRECTOR OF HEALTH AND FAMILY SERVICES, THOMPSON REGION, GIVE MY CONSENT TO HEATHER FUNK A SOCIAL WORKER WITH REHABILITATION AND COMMUNITY LIVING, FAMILY SERVICES THOMPSON REGION, TO USE OUR FACILITIES AND OUR CLIENTS IN THE PROCESS OF HER MASTERS STUDIES. SHE WILL BE INVOLVED IN A GROUP EXPLORING ISSUES AROUND ALCOHOLISM AND EMPOWERMENT. I KNOW THAT THERE MAY BE SOME INDIVIDUALS INVOLVED IN THE GROUP THAT MAY BE UNDER ORDERS OF SUPERVISION AND I CONSENT TO THEM BEING INVOLVED IN THIS GROUP. I ACKNOWLEDGE THAT THE INFORMATION THAT HEATHER OBTAINS WILL BE ACCESSIBLE TO THE PUBLIC FROM THE UNIVERSITY OF MANITOBA AND MAY BE USED FOR FURTHER RESEARCH PURPOSES IN THE FUTURE. ALL IDENTIFYING INFORMATION WILL BE ABSENT FROM THIS DOCUMENT TO ENSURE CONFIDENTIALITY.

DATE ----------

WITNESS----------

APPENDIX II

PARTICIPANT CONSENT

I HAVE BEEN ASKED TO COME TO A GROUP ABOUT LEARNING HOW TO CONTROL MY DRINKING.

THIS GROUP IS BEING RUN BY HEATHER FUNK WHO IS A SOCIAL WORKER WITH THE DEPARTMENT OF FAMILY SERVICES.

ANY QUESTIONS THAT I MAY HAVE ABOUT ME BEING IN THE GROUP WILL BE ANSWERED BY HEATHER FUNK.

I MAY STOP COMING OR QUIT THE GROUP WHENEVER I WANT AND NO ONE WILL BE ANGRY WITH ME OR HOLD IT AGAINST ME.

I UNDERSTAND THAT THE INFORMATION THAT SHE GETS FROM THE GROUP WILL BE USED IN HER SCHOOL PROJECT AND WILL BE PUT INTO A BOOK THAT WILL BE IN THE LIBRARY AT THE UNIVERSITY OF MANITOBA IN WINNIPEG.

HEATHER WILL MAKE SURE THAT MY NAME IS NOT USED IN THE BOOK SO THAT NO ONE KNOWS THAT I WAS PART OF THE GROUP.

I KNOW THAT THE BOOK MAY BE USED SOME TIME IN THE FUTURE BY OTHER PEOPLE.

NO ONE HAS TALKED ME INTO OR IS FORCING ME TO BE IN THE GROUP.

PARTICIPANT----------

DATE ----------

WITNESS ----------

APPENDIX III

CLIENT QUESTIONAIRE-INDEPENDENT DECISION MAKING

NAME---------- DATE----------

1) Do you make your own decisions about things? (e.g. how to spend your money, who you go out with)

almost never--------- sometimes--------- almost always---------

2) How often are other people making decisions for you? (e.g. how you spend your free time.what you do with your friends)

almost always--------- sometimes--------- almost never---------

3) How often do you go along with the decisions that other people have made for you?

almost never--------- sometimes--------- almost always---------

4) Do you feel other people have too much control over your life? Or do you think that other people are telling you what to do too often?

almost always--------- sometimes--------- almost never---------

The questionaire will be scored as follows;

almost never-one point
sometimes- three points
almost always-five points

INDIVIDUAL'S SCORE----------

The scores will be added up and will provide a baseline score which will be used as a comparison for subsequent questionnaire scores. This questionnaire will be delivered immediately following the intervention and then again six-months post intervention.

APPENDIX IV

COLLATERAL QUESTIONAIRE-INDEPENDENT DECISION MAKING

NAME---------- DATE----------

1) Does the client make their own decisions about things? (e.g. how to spend their money, who they go out with)

almost never--------- once in a while-------- sometimes-------- often---------almost always---

2) How often do other people make decisions for them? (e.g. how they spend their free time, what they do with their friends)

almost always--------- often---------- sometimes-------- once in a while--------almost never----

3) How often do they go along with the decisions that other people have made for them?

almost always-------- often---------- sometimes-------- once in a while-------- alomost never-

4) Do you feel other people have alot of control over their life?

almost never-------- once in a while-------- sometimes-------- often---------- almost always---

The questionnaire will be scored as follows;

almost never-one point
once in a while- two points
sometimes-three points
often- four points
almost always- five points

INDIVIDUAL'S SCORE----------

The scores will be added up and will provide a baseline score which will be used as a comparison for subsequent questionnaire scores. This questionnaire will be delivered immediately following the intervention and then again six-months post intervention.

APPENDIX V

CLIENT QUESTIONNAIRE- ALCOHOL USE

NAME---------- DATE----------

1) Who do you drink with when you drink? (please list all persons involved)----------

2) When do you usually drink? (what time of day and under what circumstances)----------

3) Where do you usually drink?----------

4) What do you usually drink?----------

5) Why do you drink? (What do you like about drinking?)----------

6) How often do you drink?

many times a week---------- once a week---------- less than once a week----------

7) How much do you usually drink when you drink?

1-2 drinks---------- 3-7 drinks---------- > 7----------

8) Has your drinking affected your job in the past year ? (being late for work, too tired or hungover to work)

often---------- once in a while---------- never----------

9) Have you been arrested because of your drinking in the past year?

never---------- a few times---------- many times----------

10) Has your drinking caused you problems with other people in the past year? (arguments, fights)

many times---------- a few times---------- never----------

11) Do you need to drink more alcohol now to have the same effect as a few years ago?

yes--------- a bit--------- no----------

12) Do you go through withdrawal when you have been drinking heavily for a few days and then stop? (sweating, shaking, not being able to sleep, feeling sick, seeing things that are not there, getting mad easily, feeling nervous)

never--------- sometimes--------- always---------

13) Have you wanted to cut down on your drinking in the past year?

always---------- sometimes--------- never---------

14) Do you think that you could cut down on your use of alcohol if you wanted to?

no--------- maybe--------- yes---------

15) Do you believe that you have a drinking problem or that drinking is interfering with your life?

no--------- a little bit--------- a lot---------

A summary score will be obtained using the answers from questions 6-13. The questionaire will be scored as follows:

never/no/none- one point
the middle score- three points
a lot/ yes/often/many times- five points

INDIVIDUAL'S SCORE----------

The scores will be added up and will provide a baseline score which will be used as a comparison for subsequent questionnaire scores. This questionnaire will be delivered immediately following the intervention and then again six-months post intervention.

APPENDIX VI

COLLATERAL QUESTIONNAIRE- ALCOHOL USE

NAME---------- DATE----------

1) Who does the client drink with and when do they drink? (please list all persons involved)------

2) When does the client usually drink? (what time of day and under what circumstances)----------

3) Where do they usually drink?----------

4) What do they usually drink?----------

5) Why do you think they drink? (What do they like about drinking?)----------

6) How often do they drink?

many times/wk-------- couple times/wk---------1/wk--------once every couple weeks-------<1/mnth-------

7) How much do they usually drink when they drink?

1-2.--------- 3-4.----------4-5.--------6-7.-------->7----------

8) Has their drinking affected their job in the past year (e.g. being late for work. too tired or hungover to work)

often---------- sometimes---------- once in a while---------- rarely ---------- never---------

9) Have they been arrested because of their drinking in the past year?

many times---------- often---------- a few times---------- once ---------- never----------

10) Has their drinking caused them problems with other people in the past year? (arguments. fights)

never---------- rarely---------- a few times---------- often---------- many times----------

11) Do they need to drink more alcohol now to have the same effect as a few years ago?

yes--------a bit---------- no---------

12) Do they go through withdrawal when they have been drinking heavily for a few days and then stop? (sweating, shaking, not being able to sleep, feeling sick, seeing things that are not there, getting mad easily, feeling nervous)

never---------- once in a while---------- sometimes-------- often---------- always----------

13) Have they wanted to cut down on their drinking in the past year?

always-------- often---------- sometimes---------- once in a while-------- never----------

14) Do you think that they could cut down on their use of alcohol if they wanted to?

yes-------- probably yes----------maybe-------- probably not---------- no-------

15) Do you believe that they have a drinking problem or that drinking is interfering with their life?

no-------- a little bit-------a lot---------

A summary score will be obtained using the answers from questions 6-13. The questionnaire will be scored as follows;

never/no/none- one points
a little bit/once in a while- two points
the middle score- three points
quite a bit/often- four points
always/alot- five points

INDIVIDUAL'S SCORE----------

The scores will be added up and will provide a baseline score which will be used as a comparison for subsequent questionnaire scores. This questionnaire will be delivered immediately following the intervention and then again six-months post intervention.

APPENDIX VII

WAIVER AND CONSENT
AUDIO AND VIDEO TAPING

1. Permission to make audio and video tapes

I hereby give my permission to Heather Funk, staff of Manitoba Family Services, Thompson Region, to take audio and/or video tape recordings of myself.

2. Use of audio and video tapes

I agree that the audio and/or video tapes referred to above may be used for the purpose of review, and to assist Heather in completing her school project, and to help Heather become a better Social Worker by watching the tapes. I understand that if the referred tapes are to be used for purposes other than those talked about in this paragraph, my further consent is necessary, and will be required.

3. Erasing of tapes

I understand that the audio and/or video tapes will be erased within ninety (90) days of the recording unless my further written consent is provided.

4. Revocation of permission

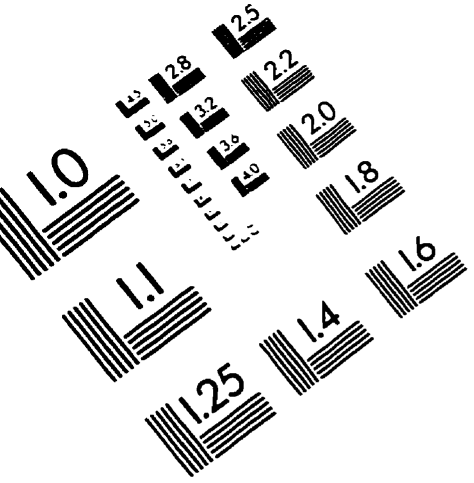
I understand that the consent given herein may be taken away at any time by telling Heather Funk that I no longer want to be taped.

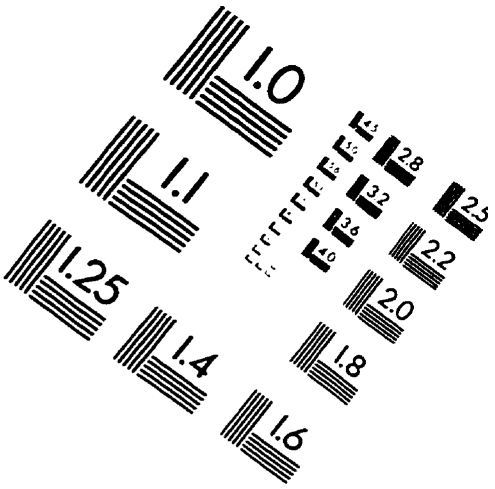
5. I agree that Heather Funk shall be the sole owner of all with regards to the audio and video tape recordings and that I shall receive no financial compensation for taking and use thereof.

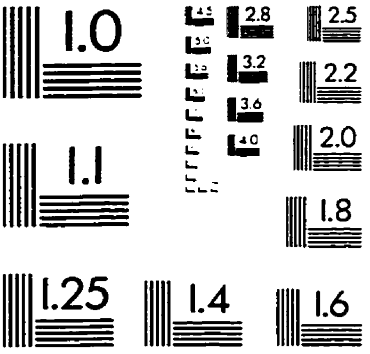
Signed at----------this----------day of----------19----.

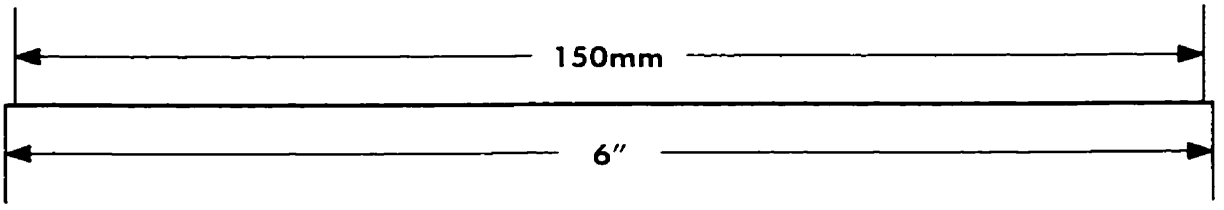
Signature of client

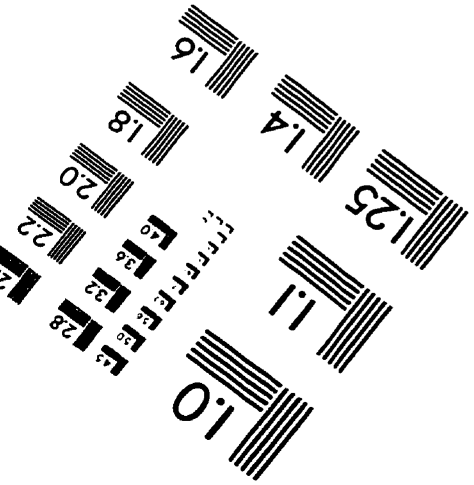
IMAGE EVALUATION
TEST TARGET (QA-3)

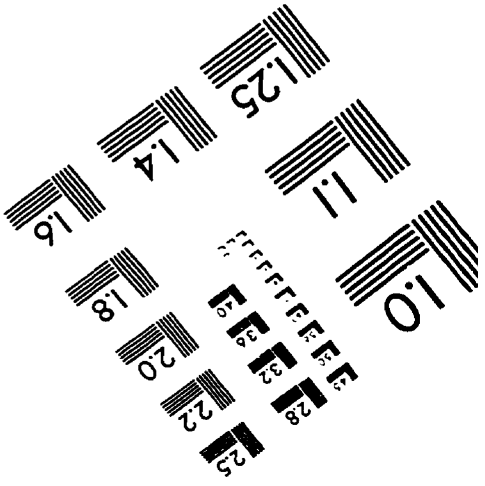












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