REFLECTIONS

NARRATIVES of PROFESSIONAL HELPING

Volume 10, Number 4 Fall 2004

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NARRATIVES OF PROFESSIONAL HELPING

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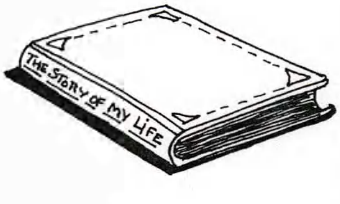
LETTER FROM THE EDITOR

Jillian Jimenez, PhD

By the time you read this issue of ***Reflections***, the 2004 Presidential election will be over, although as in 2000, the final results may not be known. The struggle for the hearts and votes, if not minds, of the United States electorate has been forged through the various narratives each candidate has woven of his disparate and often disjunctive life. Kerry, in particular, has himself offered up to his foes the material for competing narratives of his life: Was he a war hero or an unpatriotic dissembler? Did he stand up to the then enemy or give them aid and comfort during his post war declarations of outrage over American atrocities? Early on he made his Vietnam narrative the linear engine of his campaign (I did it then, I can do it now); his opponents have told a more twisted story and turned this narrative against him. Yet in one sense his story can be read as all of a piece—his character emerged in each situation, differently shaded, but consistently courageous. Insofar as Kerry's story about Vietnam is the story of a generation's journey from idealism to protest, he fully illustrates the postmodern conception of the *self* as consisting of multiple and partial *selves* in flux. His rhetorically shifting positions on the Iraq war parallel the complex braiding of his Vietnam narrative. In neither case does he acknowledge any inconsistency, apparently fully comfortable with his own understanding of himself as dynamic, fluid and responsive to the immediate situation. What holds the fragments together is his narrative about the ways they are connected. In this, Kerry exemplifies the life we live privately, with our various unstable selves made coherent by our self-designed narratives, forging the coherence and the connections for ourselves and our audiences. This is the postmodern understanding of the human personality: it is in our ongoing narrative that we attempt to bridge past selves with current ones and anchor both to our future actions.

But all this is uncomfortable to much of the electorate. George W. Bush is much more the traditional personality, seemingly unified and linear, driving toward a worthy goal (protecting our country), without the complex side trips that we are loathe to acknowledge in our own lives and dislike in our leaders. Since he did not have the advantage of an early war story to tell, his public narrative has been far shorter, beginning on September 11, 2001. His plotline was straightforward, even simple: I have fought the terrorists who did this to us ever since. In an implicit acknowledgement that the past counts and should fit coherently into our current presentation of self, a DVD released in the weeks before the election, titled "George W. Bush: Faith in the White House," ties Bush's past selves, into a narrative of a man saved from his misspent youth and early middle age by faith and a clear moral conviction about the right thing to do in all circumstances. This righteousness may seem an annoying quality to those living with the complexity of the postmodern, not to mention post 9/11 world. But it is quite appealing, even necessary, to a large proportion of the American electorate. John Kerry has a movie too, "Going up River- The Long War of John Kerry," that tells the story of his Vietnam days. The movie's ad proclaims, "Some Men are Changed by History…Others Make It." While the movies in each case were made by others, it is clear that both men were eager to present to the American electorate what they want most: a man whose past and present offer a kind of unified field theory of grittiness and consistency—one who will protect us from harm. By the time you read this, it will be clear whose story was found most compelling.



CALL FOR NARRATIVES

Special Issue

The Spirituality of Human Service
Guest Editor: Edward Canda

This special issue focuses on the role of spirituality in social work and allied human service professions. ***Reflections*** seeks narratives that encompass diverse religious and non-religious spiritual perspectives about such topics as:

- Ethical dilemmas encountered when addressing spirituality in professional service and how they are resolved or lived with
- The sense of spiritual calling to service, how it was heard and responded to
- Spiritual bases of practice wisdom
- Ways that helpers connect their personal spiritual life and traditions together with professional helping contexts
- Applications of explicit spiritually based helping activities in professional work
- Connections between spirituality and practice as a social administrator, community activist, or political and social policy advocate
- Spirituality as a source of resilience, strength, and empowerment for both worker and client/consumer within the helping relationship
- Moral imperatives for compassion and justice in human service
- Experience as an innovator who brought spirituality into clinical practice, macro work, or social work education
- Spirituality in relation to the work of the researcher, teacher, and scholar
- Spiritual wellsprings for theoretical and philosophical innovation in human service

Contributions should blend significant personal stories, accounts of professional work, self-reflective insight, lessons learned that may be helpful to others, and connection to relevant background literature.

Mail manuscripts to: Edward R. Canda, Ph.D., Professor, University of Kansas School of Social Welfare, Twente Hall, 1545 Lilac Lane, Lawrence, Kansas, 66044-3184. Phone: 785-864-8939. Email: edc@ku.edu. Home page: www.socwel.ku.edu/canda.

Manuscripts are due by: February 28, 2005

TALES OF WAR IN RURAL EL SALVADOR: A SOCIAL WORK RESEARCHER'S REMEMBRANCES OF POST-WAR EL SALVADOR

Margaret Oakes, Ph.D., University of Nevada, Las Vegas

As another war explodes, the author recalls her trip to El Salvador where she worked as a research assistant on an international project on the health effects of war in rural El Salvador. The author weaves in stories from native residents with descriptions of the places she visited and her experiences in order to give readers a feel for the environment in which the war took place. It is an attempt to make both people and place take on real characteristics rather than the statistic representations that often are all that remain in our minds after a war.

Before the war in Iraq began, I heard little of how the violence would affect inhabitants of that country. As I watched the war news on television, my mind wandered back to the time I spent in Nicaragua, during a war, and in El Salvador, after a war. I couldn't help thinking of the people of Iraq, those victims, whom neither the press nor the politicians mentioned, who would continue to suffer profoundly from the effects of that war.

As I watched the war against Iraq on television, reporters interviewed our soldiers but made only vague references to the thousands of civilians fearfully awaiting the bombs. My mind wandered back to the three small towns in El Salvador where I had collected data for my dissertation in 1995, three years after the war had ended. I remembered the tormented, plaintive stories of those simple country people, stories told in painful tones, where simple words stretched to wails and moans as they recounted their experiences during a twelve-year war.

San Salvador

As a research assistant on an international investigation of the health effects of war, conducted in part through the Universidad Centroamericana (UCA) in San Salvador, I arrived at the guest house of the university. Next door, I encountered my first reminder of the war so recently ended, the museum set up in the former residence of the four priests killed in the same place towards the end of the war. According to most accounts, death squads with associations to past government forces, who were supported and funded by our government, had carried out this murder. It was an eerie feeling. Standing where it took place I stared at vivid pictures of the crime scene. One of the victims, Ignacio Martin Baró, a priest originating from Spain and a social psychologist, would come up again and again in my research. He served as a priest for a time in one of the towns where I collected data and was deeply loved by those with leanings toward opposition movements during the war. His internationally published writings on the social effects of war became an important explanation of the effects of war, not only on individuals, but on society as a whole.

The second event, although not directly related to war, had links to violence inherent in the aftermath of war. The Department of Public Health, a newly formed department at the university and headquarters for the research project, had a brand new van donated by a German organization. A few days before our scheduled date to travel to the first town along the border of Honduras, armed men hijacked the van. The driver, a professor, managed to escape, leaving her purse and the vehicle behind. Violence and crime continued to escalate in El Salvador three years after the war in 1995. From reports from those recently coming out of El Salvador, it continues to climb.

My trip to the countryside was postponed while new transportation was found, I waited in the guest house watching local television. Two reports of alleged "vampires" appeared on the nightly news. One was an excombatant turned criminal and quite dangerous, while the other was a mentally ill man acting out his delusion by biting prostitutes on the neck. What a strange form of violence, I thought. An eerie feeling crept over me as I knew both had taken place in the countryside, one not far from where I was to travel. Later, as I heard the many stories of mutilated bodies found on the streets and alleys during the war, some form of demonic explanation for such mayhem began to fit better

The Zone of Medium War Conflict

Finally, after the Department of Public Health borrowed a vehicle, we drove through the province of Chalatenango. Descending a winding mountainous road, a white church appeared in the center of an old-fashioned, storybook village, situated in a valley surrounded by mountains on the border of Honduras. The border meandered through a low mountain range in and out of the country of El Salvador. The population of this town had many personal connections to those in Honduras, and many of those relationships had been disrupted by war. Commerce flowed back and forth across the border, and surrounding villages considered this town a place of means, in spite of its extremely modest appearance to a North American eye.

As a guest in the house of two teachers who lived modestly, but well by town standards, I settled into my room off an open patio in the center of the house. A grand flower garden filled the patio, somewhat wild but very beautiful, with pink pillars surrounding it and a hammock strung in the open area of the house next to the garden. We spent nights sitting in *la sala*, the living room, in the front of the house, which opened out onto the patio. It was protected from the quick rains that came down in the afternoon, but allowed the breezes and fresh air to help us live with the heat and humidity. The electricity came and went regularly, and it was best to turn the television on early, as, diminished power later would make it difficult to provide the initial charge it needed.

I had come prepared, having purchased a laptop to record my data. I attempted to hook it up, but as the electricity slowly ebbed and flowed, a computer began to seem quite inappropriate. This was a place where one writes by hand. Life meandered so slowly that the agitated existence associated with computers seemed somewhat unreal.

The professors who had brought me to town situated me in a government health post to conduct my interviews. Staff sent me respondents regularly, and although I continued to insist that this was a research project and not treatment, person after person arrived as if I were a regular part of the clinic. At home I worked as a licensed clinical social worker, but in this small town they called me a psychologist, even as I explained my profession. Social workers were few and never therapists. Most of the people had never seen a mental health professional before and might never see one again. They took the opportunity to consult with someone other than the fledgling doctor just out of medical school, doing his year of social service. Though I advised them over and over that this was research, not a consultation, some asked at the end of the interview how much they owed me.

Most townspeople had relatives who had migrated to North America, mainly to Boston and Montreal, but also to Los Angeles. In a survey I conducted with the high school senior class, 97% of them had relatives in the United States. One could see the influences, especially in the stylized dress of adolescents, with big baggy pants and male earrings.

Townspeople had many connections with San Salvador, and during the war many family members traveled there. They talked of relatives who disappeared or died:

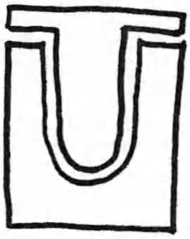
> "My uncle was a student. He was going to get his title to become a lawyer. He came here to visit and we never saw him again. He returned to San Salvador. He didn't arrive at the University. . .Now that the war has ended, we haven't seen anything of him."

On the last day of my stay, I hurriedly prepared to leave the health center to attend the special luncheon my household was preparing for me. Just then, a woman, age 65, ran into the clinic and demanded to speak to me. She then began to talk and didn't stop for two hours, recounting her life—the difficulties of childhood, the problems with her marriage, and the traumas she had experienced during the war. She was a "*comerciante*," a seller of goods, who traveled back and forth from this town to San Salvador on a regular basis. She talked about the bodies she had seen on the road, describing them:

> "... On a bridge, before you arrive in Popa, we saw a girl, well dressed. . .stretched out, very well fixed up. (She began to demonstrate in spatial terms where bodies were placed). Here was a boy. He was there, and she was here, I remember. When we came to the bridge, there were two more dead bodies, a woman and a man, as if they were looking at you. And two other very young boys of 14 or 15 years...Then I got very bad, because I saw a dead child (smaller than the others). . .He was sitting on a bench. He had on a green shirt with red leaves. And a woman with a man's blouse. The child remained with a hand on the ground, with a face painted yellow and black. After the woman, (she came upon another body) a dead man was looking at her. . ."

Then she recounted a story of a child whose father was shot down in front of him and how his mother had fled with him to the States. The child had recently returned to town. I had met a young, English-speaking man in the combination telephone/post office, who had recently returned from San Francisco where he had been living for years. I wondered if he was the child in the story.

At the end of my stay, the local gossip reported that the North American woman would listen to all your problems and then give you medicine. No matter how I had explained things, the word still traveled, their needs and desires contained in the gossip.



The Zone of Low War Conflict

I did not sleep in the second town as it was only a little over an hour's bus ride from San Salvador. Early each morning, I waited for the bus, hoping that a large bus would come. I often had to settle for an ancient school bus, in which I did not fit, and had to hunch over and crowd into the tiny seat. The owner, a neighbor of the woman who hosted me during the day, owned the bus and often parked it on the street, just as a car. Although still a country town, this place had taken on aspects of the city. I saw signs on the walls in two of the neighborhoods of Mara Salvatrucha from a gang in Los Angeles, made up mainly of young Salvadoran immigrants. As people began returning home after the war, they brought with them many trappings of American culture, including youth gangs. I even saw a sign for 18th Street, one of the largest gangs in Los Angeles, in which the majority of the members consisted of those of Mexican descent. In an area where unemployment rates were high, the nearby *zona franca*, or free trade zone, where American factories had been set up, contained the best jobs. The worst jobs could be found on the coffee fincas, where seasonal work paid poorly and the labor was difficult.

Ignacio Martin Baró, or "Nacho," as they affectionately called him, had been a parish priest here. As I heard the stories of him and how those I interviewed had loved this humble, sweet man, pictures of his gory death in the museum next to my residence rose up in my mind. He had tried to apply his form of liberation theology, which they described as developing relationships with the people and maintaining a caring, friendly attitude while developing projects for work and health. They seemed to be describing what social work is, often talking about as its mission. His death had been a communal trauma for those in the town who loved him. As he had written, war causes intense polarizations, so many others did not mourn him. Those who had even sympathized with the rebels lived uncomfortably with neighbors who supported the opposite side. Many, however, had just been nonpolitical victims and onlookers.

There had been no battles in this town but many, many disappearances. Respondents told of hearing morning reports of bodies found. They talked of the death squads, who, during the war, took people out of their homes, never to be seen again. They would sit and wait without moving as they heard the only cars allowed out in the streets after curfew drive by, and would hold their breath in hopes that the cars would not stop at their house. Bodies found became gossip, something people chattered about in the morning. Then they would go to see if the body was someone they knew. Children even began to go for curiosity. A respondent talked about her fear of saying anything about these disappearances to authorities:

"If you had a problem, they could take you away, and you were done for. We walked with a huge fear."

* * *

Another talked about a family member taken away by the authorities or their silent partners, the death squads:

"In my family, a boy died in the *cumbre* (his body was found on the main hilltop or summit in town). They (the authorities or the death squads) went to take him from the house. He wasn't anything. He was just a drunk and, perhaps, the chief of the authorities didn't like him, because they killed all those they didn't like. He was a drunk, no more. Only because he got near a girl of his (relative of someone in authority), and he kissed her, and said something . . and it bothered him (someone in authority)."

Each canton surrounding the main town had a health promoter who helped recruit subjects for my study. Everywhere, recruitment had been facilitated by my connection to the Catholic University. In one of the cantons, I sat around an outdoor table with a group of people: a health promoter, a man with a guitar, other neighbors, and family. They talked of the new priest, of whom they disapproved. He liked to hunt and had been connected to the army during the war. Those who flourished in the church of Ignacio Martin Baró, as did the guitarist, did not feel comfortable with the new priest. He had dismantled much that had been set up in

Martin-Baró's regime, including a sewing project, and had sold the donated machines. The husband of another health promoter, and an ex-military man, had been touching young women inappropriately in the church. The guitarist, the sad, gentle man who sat across from me, had confronted him. The ex-military man had, in turn, threatened his life, so he withdrew from the church. The wife of the ex-military man also helped me recruit in another canton, so I had to guard my information closely. The combination of potential violence left over from war, natural small town differences, and gossip exacerbated by differences in war, caused additional community problems. Even though this town saw no fighting, the trauma of war pervaded it, as this was a civil war, where everyone was suspect and terror methods were used to subdue the population.

The Zone of High War Conflict

The first two towns seemed comfortable, ordinary little towns, could be almost anywhere, compared to the town situated in a major war zone. The road was unpaved and unleveled for at least the twelve years of war and three after it. We traveled up and down hills and around curves on a road that consisted of a path filled with huge buildups of dirt much like tiny hills, boulders, and pieces of pavement sticking up out of the dirt, conditions that would test any shock absorbers. Still, old buses roughed the terrain, and we could feel our brain, stomach, and other organs rattling around on the trip. We arrived at night in the rain, the rain that was to haunt my stay there. Most of the town lacked electricity, but a small generator connected to the Catholic church lit up the plaza and supplied electricity for the TV in the church, where the local children gathered to watch. The constant rainstorms, however, frequently cut off this tiny bit of modernity.

La colonia, a new housing project where I was to stay, could not be reached at night with the rain, as the mud paths were composed of clay, made worse by trucks used in building. The pitch-black night made navigating the road impossible. The clay mud stuck to one's shoes until they became twice as big, and if one wore sandals, as I did at first, a shoe often remained behind in the mud. My hostess, a sixty-five-year-old woman, lived with one of her daughters. The health promoter, another daughter, had found me the arrangements. The senora's husband and son had been killed in the war, the husband by the army because he did not want to leave his land. Thus it became a family of women, all hard working and striving to better themselves and their community. This new cement-block house had one room that functioned as a bedroom, with an open air, covered patio in the back that served as the dining area. It became a meeting place for women in the neighborhood to commiserate and share their problems.

The house sat facing the mountains with a lovely flower garden in between, made even more beautiful by the mountainous backdrop. As I admired the view, I hoped that I had packed my bathing suit so I could wear it to bathe in the stream, as the *colonia* did not have running water or plumbing. The clay soil didn't allow the water to seep into the earth, so latrines became difficult to use. The next phase in the ongoing construction funded mainly by the Catholic Church was the arrival of special latrines for such conditions. The project included reasonable loans that could be paid in ten years by those with very modest incomes. This seemed a far cry from the same church in the United States, much maligned by sexual abuse controversies. Here one saw the progressive side of the church, attempting to help and protect those suffering abuse.

From my backyard view, I could see the corn planted on the mountain. A simple, semiliterate, country people, they had lived in cantons deep in the mountains before the war.

Now, because of their war experience and their politicization, they seemed to have a worldly sophistication and intellect in spite of their simple, rustic manner. They had lived through the *guindas*, the flights during the war, when the army drove them out of their homes and pursued them, circling and slaughtering whatever and whoever moved. Many had died of hunger in these journeys, and those injured or crippled in war had to be abandoned along the way to save others.

One woman, as a young girl, had been lost in a *guinda* and ended up in a refugee camp in Honduras. She returned with a brother who came to get her, only to find that her father had died of hunger in another *guinda*. Ex-guerrillas were everywhere. With the army chasing people and massacring them, men ran to join the guerrillas. Even when safely settled in refugee camps in Honduras, teenagers, both male and female, fled to join the FMLN, the opposition army, often against parents' wishes. One of the respondents, a woman whose house I stayed at when in the center of town, had been one of those adolescents. She had been a nurse in the war, had terrible problems with a pregnancy in midst of a march in the hills, and had a friend unjustly executed. She still suffered from vivid flashbacks of war.

Their stories were overwhelming. It made the work of social work doctoral competition, and harried, tenure-seeking academic activity, seem petty and irrelevant. If a computer seemed out of place in the other town, it was absurd in this setting with gas candles and flashlights being the only nightlights.

At first, few men volunteered to talk, but little by little they came, until I realized I had interviewed more men here than in the other two towns. I missed an appointment with one young man due to a severe rainstorm and mud, and found out later that he had told someone, "I have so much to tell her!" I would have never known by his affect. He appeared a simple peasant, originally from Honduras, young and gawky, with the smile of a Cheshire cat. The men, in spite of their *machismo*, seemed quite shy and reserved. The women, especially those I had most contact with, seemed the more sophisticated and the organizers. Most understood the complications and problems that life brought and wanted to move forward. Feminist ideology had only touched the women. But still, they had to grind the corn and make the tortillas to survive.

Respondents told of many, many accounts of massacres, killings, and dying in flight that happened during the war. A small group of 12, within the larger group of 28, lost 48 relatives in the war.

For those who experienced them, the *guindas* seemed to be the worst experience in the war. A man indicated that he felt much safer when he was mobilized in a guerrilla battalion. Another spoke of seeing the results of the *guindas* and finding the clothes of little children spread out on the trees, the cadavers of little bodies lying around. This he experienced as the worst of war. Older adults were particularly vulnerable during these flights. A woman spoke of her elderly parents running, hiding, spending time without eating so that when they arrived at the Honduran refugee camp, they had stomach problems and both died within a month (Oakes, 1998).

A woman spoke of her little girl who kept asking for sugar or soup or anything, but the soldiers had thrown away their food and there was nothing to eat or drink. The child died of dehydration. Another spoke of a woman traveling with her:

> "Of all the children who were sick, there was a woman who had two children. We said to hug them to keep them warm. In two days the children died." (Oakes, 1998)

A man whose wife became so injured he had to carry her on his back while still having to care for two children, described the final moments of having to abandon her:

"The army was spraying bullets and chasing us. They were going to catch us. Many people were falling around us. I had to carry her because she couldn't walk. It was impossible. We were all going to die. She finally said, "No, you have to leave me. I want my children to survive." At first I couldn't do it. But I knew there was no alternative. If I didn't leave her there, we would all die. So I sat her under a tree and carried the two girls on my shoulder and waist and ran as fast as I could to get away as the army descended on the place. We walked for days, and I saved their lives, but she died." (Oakes, 1998)

The massacre at Sumpul, where the army slaughtered hundreds of people, took place not far from where respondents were fleeing, and many had heard about it (Americas Watch, 1991). From those stories, plus what had taken place before they left, they knew that the same fate awaited them if they were captured. Another talked of traveling with a newborn child suffering hunger and thirst:

"We didn't have anything to eat, and now there were two children...The operative lasted 22 days. We ran. We didn't drink water. I didn't have any milk in my breast. I had to chew leaves of guayaba and put them on my breast so the water would fall in his mouth. Suddenly, here come the soldiers. We had to leave as best we could. Like cats." (Oakes, 1998).

Perhaps, however, the most terrible story I heard I didn't really hear clearly, due to the extreme stress and disorganization of the woman who told it, until I played the tapes at home. She appeared to be one of the most severely affected by events in war. She spoke of a large group of people who were fleeing the army and how they had to make a terrible decision so that some could survive. She even switched from first person plural to third person plural throughout the telling, perhaps unconsciously trying to distance herself from the event:

"There were a lot of children. We were going to leave the children where these huge orasones grew. There they left a multitude of children. The smaller ones they left in the arms of the larger ones. The little ones, only sitting, and others were going to sleep, skinny as they were. They were a multitude of children. The largest sitting, others standing up, and those little ones sleeping. They left these children there, because if they didn't, we were all going to die. The adult people said, we are going to run. Leave them there. Run, because there were mothers there who did not want to leave their children. They forced them to go...In a short while, we heard the gunfire and the children crying. The enemy was killing them. As we climbed, they killed the children. We ran more."

It is hard to imagine that anyone participating in that event could get over it, could somehow resolve it, could come away without terrible trauma that would last a lifetime; neither the mothers who left their children to die, the other adults who organized the abandonment, nor the soldiers who killed the children.

The health worker indicated that all suffered. She, herself, often felt lightheaded and had concentration difficulties. In all the towns, respondents talked of headaches and finally I, too, began to feel them. Perhaps the heat, the smallness of the towns with little means to escape from problems, and the pervasiveness of sorrow caused them. In the high war zone, I often felt the depression hanging in the air, so heavy was the mass weariness. Many, when they could get a chance, would flee to the city, either Chalatanango or San Salvador, to get away from the pervasive gloom. Organized communally, the town attempted to provide services, such as physical therapy and massage, to help alleviate suffering. The daughter of my hostess became the mental health promoter, and a psychologist came from San Salvador to supervise her. The focus, however, centered on organizing adolescents. While in itself a noble idea to avoid future problems, it did not provide those suffering with help. All had depleted psychic energy and thus did not have enough of their own reserve to support those whose coping mechanisms had broken down.

As I left the house of my last interview, before returning to the modernity of San Salvador, the rain continued, the rain that mixed with the clay until you felt as if you were drowning in the rain and mud, the mud that made one's shoes stick to the earth, the mud that made the outhouses nonfunctional. I began to feel as if I were in the Gabriel Garcia Marquez novel *Isabel Viendo Llover en Mocambo*, where the rains came so hard and lasted so long that inhabitants watched as the town floated by and time became distorted (1968). But then the next day the sun shone brightly and the heat enveloped us, unfortunately, without a cool soda in sight, as no ice existed in town.

When I returned to San Salvador, after taking the opportunity to get a ride in a comfortable car, I began to feel guilty for having left without interviewing the young man who had so much to tell me. I had little time left and had to get to the other town to collect data for a survey. Back in San Salvador, I tried to call the telephone/post office, but the phones were down due to the rains. At that moment, I felt that perhaps all this research might be less important than talking to someone and helping him/her through such a difficult time. The social worker in me called, even as I prepared for my career in academia. Now, years later, even the public health staff at the university has not been back to the town, as dangers and travel difficulties mount. I often think about the town and wonder if the outhouses have been built, if running water ever came to the *colonia*, and if the people have ever recuperated from their trauma.

Reflecting Back

As I reflect on the three towns, I remember most vividly the trauma of the high war towns, but also how they had changed. They had seemed, in spite of their illiteracy and simple peasantry, a more worldly wise population. Their town had a communal structure that had built in mechanisms for support, even if not sufficient emotional support. The other two towns had levels of experience and suffering similar to each other. Those who suffered most suffered in silence and isolation, as any other manner could have brought danger to them. Although the suffering did not pervade the community as deeply, they seemed less likely to rise above it and develop new ways of thinking, of being, than those of the high war zone. For a time, those in the high war zone, although terrible victims of war, also stepped out of their victim role to organize, to fight, and to develop new identities that included different ways of seeing themselves in the world. These respondents seemed to have shed their identities of victims. The same was not true, however, of the victims of the two towns who experienced the war more on the sidelines, who were not actively involved and did not participate.

Now eight years later, I have watched our government fund another war based on ideological doctrines, political hegemony, and economic interests, while espousing more noble causes, just as it did in El Salvador so many years ago. In the beginning, our government said the war in Iraq would be of short duration. But as the casualties mount, there is no end of the violence in sight. As we mourn the American soldiers killed, thousands of Iraqi civilians suffer trauma directly. They have watched or will watch others die, fear that the bombs or explosions have killed or will kill or maim themselves or their loved ones, or have seen or will see the dead bodies of their loved ones blown apart. For the Iraqis, memories of this war will last a lifetime and, like the suffering of the Salvadorans, few in the United States will remember or care about their suffering for very long.

Although Iraq is a different, much more urban environment, there are some parallels to El Salvador. Despite the need for talk about trauma in all countries that suffer the effects of war, it is not easy to begin. Resistance is great, and, for some, pushing the past back and not talking helps them go on. For others, that is not possible. Public health campaigns about trauma, its manifestations, and aids in recuperation are important in areas where individual therapy may be impossible and unrealistic. Populations need to understand that what they are feeling is normal, given the abnormal circumstances, and acceptance of such expression in those that continue to suffer needs to be cultivated. That is not easy in populations wearied by war with depleted emotional resources for coping. But the wisdom, and the need to make meaning out of such horrific events that comes from such experience, needs to be tapped into to help others who are suffering. The communal nature of their trauma could aid in recovery.

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CALL FOR NARRATIVES

SPECIAL ISSUE

WORKERS, STUDENTS, FACULTY, AND RESEARCHERS DISCUSS

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Manuscripts are due no later than **MAY 1, 2005.** Early submissions are encouraged.

INTERVIEW WITH MIMI ABRAMOVITZ, DSW, HUNTER COLLEGE, CITY UNIVERSITY OF NEW YORK

In August, 2004, I sat down with Mimi Abramovitz, DSW, at the Policy Conference in Charleston, South Carolina, where she had delivered the keynote address. My interview with her covered a wide range of themes, beginning with the childhood influences that helped form her commitment to social justice which has guided her career as an activist, academic, and researcher. My first introduction to Professor Abramovitz was through the seminal article published in **Social Work** *in 1983, "Everyone's on Welfare: The Role of Redistribution in Social Policy." Her insights were revelatory for a beginning social policy teacher and profoundly influenced a generation of academics and activists. Her analysis was updated in 2001 and appeared in* **Social Work** *as "Everyone is Still on Welfare." In between these articles Professor Abramovitz developed powerful and nuanced analyses of the impact of the welfare state on women in two books:* **Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present**, *published in 1996, and* **Under Attack, Fighting Back: Women and Welfare in the United States**, *published in 2000. She has published many other articles analyzing the family ethic in welfare policy. She is a national leader in the debate over welfare reform and the relationship between gender and poverty. In examining the welfare state through a gender lens, Mimi Abramovitz has made a significant contribution not only to social work, but also to women's studies, social history and sociology. She continues to be active in welfare rights organizations in New York City, where she lives and teaches at Hunter College, CUNY. A hero of mine since I began teaching social policy, Mimi Abramovitz offered a moving and passionate account of a life spent committed to social activism.*

Jillian Jimenez, Ph.D.

JJ: When you look at your background, what do you think were important influences that shaped your professional identity?

MA: I came from a family that did not have a lot of money, and from third grade on I grew up in a very wealthy community. Living there I always felt different from the people I went to school with. My parents explained the differences by saying that our family had different values, that we were not materialistic. I think they were trying to make me feel better, and to ease the difference between my orlon sweaters and the cashmere sweaters of my peers. So that sense of being different, of having less and of knowing it, well, I guess that has shaped my professional identity, given that I ended up in social work and writing about poor women.

Professor Abramovitz, 2004

JJ: Anything else?

MA: I think another event that shaped my thinking over the years was that when I was in second grade, the house that I was living in was "highway" removed. I lived on

Mimi Abramovitz, 1944

the first floor of a two-story, wood-framed house. The family living above us was headed by a male factory worker and his wife and their 12 kids. They were struggling a lot just to make ends meet—and I saw that. But it turned out that the house was in the path of a new expressway that was being built. So the small two-story house along with many others in the Queens New York neighborhood was "highway removed." The state literally lifted the whole house off of its foundation, put it on a flat bed truck, and set it down in a new location—also in Queens.

JJ: That was quite a dislocation, wasn't it?

MA: Yes, and the house was never the same after that. And it was relocated next to a swamp-like marsh. That's when my family left Queens. We moved out to that rich Long Island town that I mentioned. My parents rented one of four small apartments in an attached building. We had 4 and 1/2 rooms. I have one sister so there were 4 of us in these four rooms. Although I went to school with very rich kids, our building was not in the wealthy section of town. We were not on "the other side of the tracks" but there was a real economic difference that could not be missed. It was disruptive to be moved like that and then to be surrounded by so many large homes and people with so many other advantages. I think the contrast between my family's circumstances and the affluence of those around me gave me a (self) consciousness of class.

JJ: It was a *deus ex machina* that pulled you out of Queens and into a privileged neighborhood.

MA: Right. Then four or five years later my parents had moved up economically, but not a whole bunch. But they could afford to buy a small one family house.That my mother was also working I am sure made this possible. I was about to enter junior high school. But that reality also made me feel different—none of my school friends had working mothers and I was self conscious of that.

JJ: Did religion play a big part in your childhood and early life?

MA: Yes and no. I grew up in a Jewish working class family. My family wasn't very religious, they were rather ecumenical. For example, we always invited a non-Jewish friend to our Seder, and the Seder focused more on the fight for freedom than on religion per se. My parents were liberals. They infused us with humanitarian values, a set of beliefs that I think also laid the foundation for my later progressive values. My parents were not very religious in the traditional sense, but they imbued me with respect for the values of social justice that is part of the Jewish religion.

JJ: What about politics?

MA: When I was in high school my mother marched with SANE, against the atomic bomb. When I got to college the civil rights movement was erupting. I now know the difference between being politically formulated and not being formulated. I guess I had these values from my family and had been exposed to some social movements, but I really had not put the ideas together for myself in any coherent way.

JJ: Why did you want to leave New York and your family and go to Michigan to college?

MA: My family always expected me to go to college, but they wanted me to go to a local school—Queens College—which they felt that they could afford. It was a public college and was probably free at the time. The idea was that I would live at home and they would buy me a car, and what 18 year old did not want a car? But something in me—I cannot say what—knew I did not want to do that. I knew I wanted to go away. I really didn't know where I wanted to go. I heard about the University of Michigan from friends of my parents. I applied for early admission and I got accepted in November. It was a simple as that. It was a big school and I guess I felt I could find what I wanted when I got clearer, so I was more comfortable at a big school than at a small school. Even though I knew you could get "lost" in the bigness, I think it seemed safer to me.

JJ: Getting back to politics, you didn't have a political ideology when you started college?

MA: That's right. I had a value system that lead me into the burgeoning civil rights movement on campus. It was a heady time, the rebirth of the student movement too. The Northern students were trying to support the effort to desegregate the lunch counters and the Woolworth's Department store was the target. So I spent a lot of time picketing Woolworths in Ann Arbor, Michigan. This was the time that Tom Hayden was the editor of the college newspaper (*The Michigan Daily)* and Students for a Democratic Society (SDS) was forming on campus. Hayden is probably better known as the California politician he later became. So another major influence on my thinking was the student movement that surrounded me on the campus and then the civil rights movement. It furthered the development of my political consciousness.

JJ: What did you do when you graduated from College?

MA: I was married for a year by the time I was graduated from the University of Michigan. We moved to New Haven so that my husband, Bob, could take a psychiatric residency at the Yale Child Study Center. I took a job at the Connecticut State Welfare Department, but we both continued to do civil rights work in New Haven. The major group that was active in New Haven at the time was a a local chapter of the Congress of Racial Equality (CORE). I spent a good amount of time in the civil rights movement, dealing mostly with local housing issues. During this time, the war in Vietnam was also brewing as the US was becoming more involved. A group of Yale faculty and students formed the Yale Committee Against the War in Vietnam. Some Yale and some community people became involved. I became active in the anti-war movement.

JJ: You were at Yale the same time Kerry was?

MA: Yes, I guess so and Bush too; but we did not hang out together. (smile)

JJ: So your first work after college included political action?

MA: Not my job. I was working for the state welfare department as a caseworker with families receiving Aid To Families With Dependent Children (AFDC). I worked there for two years before I went back for my MSW. But at the same time I got involved in the civil rights movement and the anti-war movement in New Haven, Later I also became active in New Haven's women's movement, which grew out of women's discontent with how they were treated in the other movements of the time. So I was one of the founders in New Haven of what became the local women's movement.

JJ: Did you experience discrimination working in those movements, as Sara Evans talked about in her book, *Personal Politics*[1] ?

MA: Yes I think we all did—we didn't have words for it then, but it happened to every woman—doing the "housework" of the organization. I'm not sure we knew what was happening until afterwards. You need to label these things, and the women's movement put some labels on these practices.

JJ: They seemed like normal, but annoying activities.

MA: Yes, exactly. I was also organizing anti war marches. A group of women from the women's movement organized buses down to Washington to protest the war in addition to the other activities of the women's movement.

JJ: The "sixties" had a big influence on you, didn't it?

MA: In many ways I was a child of the 60's. I feel that I was at the right place at the right time. I feel very fortunate growing up when I did. I think this was a wonderful period, a dynamic, hopeful period and I guess that living through it has shaped my personal, political and professional self. It shows up in my dissertation; it shows up in how I teach now; it shows up in my research.

JJ: How did you get into social work?

MA: In college [at University of Michigan] I was a sociology major. I did not know what I wanted to do career wise. After college with my BA, I worked in New Haven for 2 years as a welfare worker, doing eligibility investigations in the AFDC program. It was a period when the welfare department was being liberalized so you could be a bit more responsive and generous. You could actually get resources for people. But not everyone was of this mind. The first day I got there, this guy who was a schoolteacher and who worked at the welfare department to make extra money during the summer said "Oh, you're new here," I said, "Yes" and he said, "You too will find out they're all whores." That was my introduction to the welfare department! What a thing to say to a new worker -or to anyone for that matter. I was there for two years with a huge caseload of at least 90 families. But in some parts of the neighborhood, I had the same caseload for most of the time. The families in the tightly packed blocks in which I did the home visits got to know me, my black state car and my black notebook— the standard welfare department worker's " equipment." I did my best to help the families that I worked with. That's also where I began to learn how to use departmental manuals full of "do's and don'ts" to help my clients.

My work at the welfare department was one of the events in my life that led me to go to social work school. I was still living in New Haven, so I began commuting to Columbia School of Social Work in New York City.

JJ: What did social work school do for you?

MA: Social work school gave me words, labels, and explanations for what I had been seeing in my work with women on welfare. It also put the whole public assistance program in some kind of historical context, which I loved, and which influenced my work to this day.

JJ: What did you do in your MSW program?

MA: Originally, I was going to be a psychiatric social worker, in part because that is what I thought social work was all about. But during the summer before I entered the program, I met a Columbia graduate who told me about a new program called C.O. (community organizing). It was all new to me. But given what I had been doing in the civil rights and other movements, C.O. seemed to be right up my alley. So when I got to Columbia I took a double major—casework and community organizing. Of course it turns out that I really was a C.O. person. And the C.O. program was going through some changes at the time; it was becoming what it was for the next 20 years, moving from staffing social agencies and federations to organizing "the people." C.O. was deeply influenced by the then new war on poverty—which had a huge impact on social work too, especially the idea of "maximum feasible participation," the mantra of the anti-poverty program—and clearly echoed the fundamental social work values of self-determination.

JJ: What kinds of things did you do as a C.O. student then?

MA: There was a convergence of a lot of things. In my second placement I was in a new community mental health center in New Haven. My job was to organize an advisory board for the neighborhood field station, which I did. Then the chickens came home to roost. Five years later my husband was being considered for a job at the Yale Child Study Center. The job was as a psychiatrist in the Hill Health Center—a federally funded neighborhood health center that was in conjunction with the Yale Child Study Center. So Bob was interviewed by the Hill Health Center's community advisory board; and believe it or not, some of the women that I had organized a few years earlier were now the leaders and they interviewed him.

JJ: What about your first year placement?

MA: My first year's placement was in a public housing project doing tenant organizing. That was an interesting time. One of the biggest problems in the lives of the tenants was arbitrary rules, surveillance, and intimidation by the public housing authority. I thought, wow, this would be an important issue to organize around. But the tenants were terrified to do anything to confront the situation for fear that they would lose their housing—and they were probably right. My field placement was in the office of the anti-poverty program located near to the project. I don't think the poverty program people wanted me to touch the housing authority issue either. In the end, the tenants decided to deal with the fact that the books in the local school only depicted white people, while most of the kids in the school were Black and Latino.

JJ: They say Johnson was horrified when he found out that the money that he had paternalistically given (for the War on Poverty) was being used to fund advocacy programs like welfare rights and legal aid.

MA: That may be true, but who knows? And then I graduated from Columbia School of Social Work and went to work in New Haven. I didn't do traditional social work however. I went into union organizing. The unions were organizing the clerical and technical staff at Yale University. The local women's movement, of which I was a part, became involved with the union drive—virtually all the 3000 clerical and technical employees were women—a mix of student wives and local women. The union began as an independent effort but then affiliated with District 65, a union from New York City. The women's movement was becoming a bigger part of my life while I was union organizing, so it all fit together: organizing women workers to improve their wages and working conditions.

JJ: How did the University react to that?

MA: They fought us tooth and nail. Once we began to make some headway they put professionals up against us. The University talked about us as outside agitators—they used all the tools. But we got enough workers to sign union cards so that we were able to hold an election. We lost, but it was by the smallest margin of several university union elections at the time. Much to my surprise, shortly after the union drive ended, I got a job in the Office of the Dean at the Yale Medical school. It was in the special projects division of the Dean's office that was supposed to develop links between the medical school and the community. Among other things, a colleague and I were assigned to find out about the use of paraprofessionals in the community mental health field. And since we were both in the women's movement they let us pursue a project about the history of women doctors in Connecticut. My colleague and I had stumbled upon some interesting information about this, and the office let us make it part of our work. We left before the project was completed, but I think someone else picked it up and finished the research.

JJ: What made you leave?

MA: The federal and state funding that had supported these community-oriented projects in the medical school ended. This turn of events led me back to graduate school—I had lost my job and was in limbo. I heard about a third-year certificate program that Columbia School of Social Work was offering and thought I'd go back and see what's what. I had been out of school for about seven years. I spoke with Professor Carol Meyer, who had been one of my teachers. I was rather surprised (and pleased) that she remembered me. She said, "You know, I'm still using one of your papers in my class." I was very flattered. It was about interracial adoptions. So she said that the third-year certificate program was really not materializing, so how about a doctoral program? They had a whole new area called "World of Work," and that was being spearheaded by Professor Hy Weiner who had ties to the Amalgamated Worker's Union. It was ideal. I could combine my union work with my professional work! So I went home and sat in the Yale library and wrote my application, and this was March! They took me in right away. In orientation the following fall, I learned that what you did with a doctorate was teach, research, or administration, but mostly teach and research and I thought, oh that's interesting.

So my entry into academia wasn't exactly deliberately planned. But it was the perfect place for me. I enjoyed my doctoral program, and then I got hired to teach at Hunter School of Social Work, and the rest is history.

JJ: Speaking of history, how did you first become interested in historical analysis?

MA: First, I have to say that I hated history in high school. But then I developed a passion for historical analysis, because it is so interesting and also because it explains so much about modern times. Professor Al Kahn taught the history and philosophy of social welfare in the Columbia master's program. I had been a case worker at Connecticut State welfare department before I entered the master's program. This course allowed me to see the historical roots of the public assistance program (AFDC) that I was working in and all that bias about the deserving and undeserving poor. History explained so much about what I had picked up as to how the public viewed poor women relying on welfare benefits and why the government gave them so little. Then there was the history of the two-tiered welfare state—one set of programs for the middle class, another for the poor. This was powerful stuff for me as it put my job, but also wider society, into a different perspective. Dr. Kahn also taught the doctoral version of this course, so I got another historical review when I returned to school. Vera Shlakman, an economist teaching in the Doctoral Program, also loved history and so I picked that up from her too. Interestingly, Vera lives in my neighborhood now—very near Columbia School of Social Work—so I have stayed in touch with her over these years.

JJ: Did your dissertation look at history?

MA: Not surprisingly, my dissertation took a historical twist. It was about the role of business in the campaigns for worker's compensation and health insurance during the Progressive era. I looked at three theories of the state: pluralism, power elite, and structural analysis, and found that all three of them helped explain what was going on in the battle to enact worker's compensation and health insurance before World War I. I found that these theories explained different layers: pluralism explained the interest group competition; the power elite explained the role of the powers-that-be; and the structural theory explained the role of the market and the role of the state. Even since, I have used these theories in my social policy classes. They explain so much. Aren't I fortunate that my dissertation continued to have such relevance for my post-dissertation work!

JJ: When did you begin writing about feminist issues?

MA: I didn't do anything really feminist in academia until I started teaching at Hunter School of Social Work in 1981. This was the start of the Reagan era and a new paradigm was taking hold in the real world. Everything I learned about the history and development of the welfare state was in question. I had to figure out how to teach this new story. So I started using my theories of the state with an ideological grid showing that there were different ideologies embedded in those theories, and that Reagan's or the conservative social policy model reflected a different set of assumptions and values than the liberal social policy that had government for the prior 40 years. I also wanted to break out of the notion that there are only two sides to every story—so I included radical and then feminist theories of the welfare state as well.

I was able to teach the feminist perspective because I was trying to link feminism to social work. In reading about the welfare state I noticed how little was said about women. I decided that the literature needed to be looked at through a gender lens. Around this time, I came up with this concept of the "family ethic," which refers to the idea that women's place is in the home. So much of welfare state policy was about how the welfare state should and did enforce the work ethic. But this sole emphasis on work issues failed to capture the experience of women. As a counterpoint to the work ethic, I began to ask how does the welfare state enforce the family ethic: What does it do about women's gender roles? I had to figure out why it was that the same welfare programs that encouraged middle-class women to stay home, forced poor women on public assistance to work outside the home. I started to write some articles and they were published early on in *Social Service Review*—"The Family Ethic and the Female Pauper" was one.

JJ: Would you say that the relationship between feminism and the welfare state is the central theme of your work?

MA: Yes, that led to my book, *Regulating the Lives of Women.* [2] In it I traced how, since colonial times in American social policy—Social Security, Unemployment Insurance, Public Assistance and other welfare state programs enforced the family ethic—i.e. gender roles. That book was first published in 1988, the year that Reagan passed the first welfare reform legislation: the Family Support Act. I was really enjoying what I was doing with the convergence of welfare policy and my feminist background.

I am happy to say that in 1996, the book came out in a second edition.

JJ: Other scholars like Linda Gordon were writing at that time, unbundling or uncovering the assumptions behind public policies and showing that they were gender based.

MA: Yes. Along the way I discovered the feminist scholars—mostly outside of social work at the time—who were doing fascinating historical research about women and the welfare state. This included the historian Linda Gordon[3], then at the University of Wisconsin in Madison and Alice Kessler-Harris [4], then a professor of history at Hofstra University in New York.

JJ: You really changed the paradigm in social work in terms of looking at welfare and the welfare state. Even though people knew these programs were directed at women, they wrote as though they were directed at men. They were more struck by the fact that the policies excluded able bodied men than by the fact that they focused on women and gender roles.

MA: Yes, the rules and regulations of most social welfare programs rewarded and penalized people based on their work records—but this did not make sense for women who, at the time, it was assumed belonged in the home—full time. Even when they worked for wages, women had the main responsibility for the home, so they moved (and still move) in and out of the workforce in response to family needs. While useful to the family and wider society, this movement in and out of the labor market still disadvantages women on the job.

But it also reduces women's Social Security and Unemployment Insurance benefits. The Social Security program rewards work by providing higher benefits to people with longer work histories and higher wages - a rule that did/does not favor women. Women tend to work in low paid positions and have uneven work histories for the reason I just explained. The family ethic idea also helped to explain the treatment of single mothers. There were/are so many negative assumptions about single motherhood and the AFDC/TANF program was designed originally to help single mothers stay home with their children. But the low benefits always ensured that poor women on welfare had to work. They never had a real chance to live out the family ethic. They rules of AFDC punished them for departing from prescribed wife and mother roles.

JJ: That was a tremendous contribution—to view the entire welfare state through a gender lens. And it hasn't changed at all, it's only gotten more so.

MA: Actually, in some ways things have gone backward. There was an awareness of the gender issues in social welfare policy for a while, but now we are living through a backlash. A focus in "family values" has replaced gender equity concerns.

JJ: One of the problems is that social workers often are not part of the larger community of scholars.

MA: That's right, but we need to work in these areas. I was very flattered when Linda Gordon mentioned my work in her edited collection called *Women, The State and Welfare* [5]. In the introduction she referred to "Regulating The Lives of Women" as the first full length feminist discussion that put a gender lens on the welfare state. I felt frustrated that I had not been exposed to all the feminist scholarship that was being done at the same time that I was writing *Regulating the Lives.* But when I did discover the work of Alice Kessler- Harris and Linda Gordon it deeply influenced my work and their research gave me the courage to continue with a similar kind of analysis.

JJ: Your work has crossed over into other academic areas hasn't it?

MA: My work has crossed over into sociology, history and women's studies, and I am really pleased about this. And though I have gotten to know many of the feminist scholars in these areas since overtime, I think it might have been easier or more fruitful or more interesting if I had been in discourse with them earlier on in my career. I was working by myself, often felt isolated, and did not have the benefit of the wider collective feminist discourse. I think it would have emboldened me even more.

JJ: On the other hand, you did it by yourself that's something to be proud of. I want to ask you about the article "Everyone is on Welfare[6]," which is central to my social policy class and to others elsewhere. How did you come up with the corporate welfare idea?

MA: I guess reading Titmuss while in the doctoral program at Columbia influenced me.[7] He wrote an article on the role of redistribution in social policy in the late 1960s. He talked about social welfare being the tip of the iceberg of social provision. Hidden beneath the surface was the occupational and fiscal welfare system. I drew on and expanded this to talk about corporate welfare. At the time that I wrote the first version of this article there was not all that much data readily available on corporate welfare, and no "google" to help me find it.

JJ: It was hard to find out about wealth, wasn't it, because there were no statistics about wealth.

MA: Yes, I was clipping things out of *The New York Times*! But now there are organizations that track this kind of information, and it's all built into federal budget as the tax expenditures. I think it was in 1974 that they started recording tax expenditures. But it was hard to find—there wasn't an internet. I patched enough of it together so that it was accepted in *Social Work*, which was a thrill because I was just starting out in my second year of teaching.

JJ: It was a profoundly important article, especially compared with most of what is published. And then when you did it again in 2001, many of us were very happy.

MA: Thank you. Actually, the first article has been reprinted in quite a few anthologies. I meet people at conferences and they say, "I use your work all the time," and I say, "Oh, really," thinking they are talking about *Regulating The Lives of Women* or my second book, *Under Attack and Fighting Back: Women and Welfare in the United States.* [8] Instead they say that article! So I slowly realized that it made a big impact. Twenty years later I wanted to redo it. The data was stronger and there was an even stronger need for it, so I submitted it *Social Work*. They reviewed it and published it. [9]

JJ: You received the 2004 CSWE award for Distinguished Contributions to Social Work Education. What are you most proud of in terms of your work?

MA: Well, intellectually I think I'm proud of bringing the gender lens into the history of the welfare state within social work. The work is used widely in social work and outside. I feel like that was a real intellectual insight for me and I was able to translate it into an historical analysis and I feel very proud about this and that so many other people found it useful. I know that you have focused on similar issues in your own work, so that you can understand how interesting these issues are, especially the history.

JJ: When they introduced you at the CSWE Award Session, they spoke of your activism as well.

MA: Yes. I'm proud that when I am introduced at meetings and so on, they describe me as "a scholar and an activist." I'm proud that I didn't just write for the development of knowledge. I think the development of knowledge is very important, don't get me wrong. But I also enjoy using my knowledge and commitments outside the academe. For example, I have worked with the welfare rights groups, both national and local. I have also enjoyed writing for the popular press such as the *Women's Review of Books, The Nation,* and even an op ed in the *New York Times*.

JJ: And you consistently focus on low-income women.

MA: It's interesting that my concern about welfare and poor women has been with me throughout my professional life—from my first job as a welfare worker, to my feminist writing on the welfare state, to my involvement in the welfare reform debate in 1988, and again in 1996 as welfare reform once again became a hot policy issue. I got very active in that debate, was often invited to speak on television and radio shows and to the print media. I guess I became what some refer to as a public scholar. I also worked with welfare rights groups locally, first in New Haven, when I worked for the welfare department, and then in New York at Hunter, which is part of the City University of New York (CUNY). I co-founded the Welfare Rights Initiative (WRI), a student-led organization located at Hunter College that focuses on the educational options for students who are on public assistance. When it was founded several years ago, the New York City administration required women in college to leave school to participate in the City's massive and punitive workfare program. From 28,000 students on public assistance at CUNY, the number plummeted to 18,000, then to 10,000. Since the 1996 welfare reform legislation, the numbers are even less.

WRI is continuing to fight the good fight; they played a lead role in getting state and city legislation passed to make it possible for welfare recipients to stay in school. They also trained a lot of students to become activists. I'm working with them now; they want to do some research on the impact of their program, and I so I'm helping them. So, somehow somewhere since I left College until today welfare has been an issue that…

JJ: …captured you.

MA: Yes. My interest in public policy, my interest in women, my interest in low income women in particular and welfare reform becoming a hot policy issue—I was really able to use myself on all those levels.

JJ: You were relevant all throughout your career in a public sphere. You have a larger public identity than most academics, especially in social work.

MA: Well, I don't know about more than most. I do know that there are many other social work academics that do the same kind of thing, including yourself. Many of us think of it as a professional commitment to work for social justice, and this is one way to do it.

JJ: I guess you're proud of the fact that you didn't become a university scholar, an ivory tower type just spinning off theories. You always connected your theories to the ground.

MA: Yes, but this is not to say that I don't like theory. Actually I think theory is very important. Ask any of my doctoral students! By I also think its makes sense to use theory to understand real life. In my case, I was writing about unpopular groups, like low income women on welfare, and then I tried to apply what I had learned about economics and feminist theories of the state to everyday life. So the theoretical and praxis were combined. And I still do that. The research I have been doing in the past few years is about the history of activism among black and white poor and working class women in 20th century America. My thinking here is that I want to show how low-income activist women—not just the middle class reformers who have been well researched—but how activist working class women shaped the welfare state. My earlier work was on how the welfare state programs shaped women. One of the self criticisms I have of my earlier work is that it really left the clients out. So I've been drawing on case studies of local activism to fill out the picture.

JJ: It completes the picture for you.

MA: Yes, it documents how and why low-income women had agency in the process.

JJ: And that's where the second wave of feminist scholarship went. After the first wave looked at all the bad things that have been done to women and all the institutions that have oppressed them, the second wave looked at women's agency.

MA: I was influenced by that discussion. It was easier to study middle class reformers, because they left a paper trail. But research on working class women is more difficult because of the sources that people had to use, like newspaper articles.

There were no diaries, no letters, and few organizational records. But scholars have written case studies and I am drawing on them to look at a longer time frame. For example, one study reported on the Jewish immigrant women in the lower east side of New York City who protested the rising price of meat at the turn of the 20th century. They were so angry that they could not feed their families that they went into the streets and pushed the meat carts over. The press called it a kosher meat market riot! In the 1930s, in the depth of the Great Depression, housewives were marching in the streets to protest the high cost of living. I never knew about this. All these protests were women led. Once you see that you just can't stop seeing that. It's a completely untold story—the trajectory of low-income women's activism!

JJ: What will you do with the case studies?

MA: I have gathered lots and lots of case studies of all kinds of activism and am working to put it together to see what happened in the 20th century. Right now I am thinking of calling the book "Gendered Obligations," because the women became active - not to gain equal right with men, but to be able to fulfill community defined roles for women which emphasized caregiving and managing consumption. Naturally there is a debate as to whether or not this kind of activism—so tied to women's prescribed role—is feminist or not. To my mind, it is. In the book I will also try to contextualize the activism and its relationship to the welfare state which changed with the changing times. The activism actually began before we even had a welfare state and continues to this day, with women fighting to defend the welfare state against retrenchment.

JJ: You're very excited about this.

MA: I am excited. It's very uplifting to read this history. And in the early twentieth century, the women's demands for food, housing and income actually prefigured the welfare state. Then once the welfare state was formed, they tried to expand its reach, and then when the programs they relied on came under attack in the 1980s, these women defended their right to survive. It's very interesting that the people that write the case studies that I draw on for this research, scholars from history, urban studies, sociology and labor studies—few, if any, link the workplace or community activism directly to the development of the welfare state. Yet so many of the demands of the activists are for greater economic security to be provided by the state. So I almost want to call it social welfare activism; their demands were consistently made first to local and state, and then to the federal government to do something about the issues they were concerned about. You can tell a whole story about this social welfare activism. And that's the way I want to put the story together.

JJ: You can tell this story the way no one else can.

What do you see as the major issues facing social work today?

MA: From the policy perspective, which is what I know best, we have to deal with the attack on the welfare state. A paradigm shift took place around 1980—actually it was already in the air in the late 1970s. At this time, with the election of Ronald Reagan, neo-liberalism took hold.

JJ: What do you mean by neo-liberalism?

MA: Neo-liberalism represents the revival of 19th century economic thinking that rejects active government intervention in the economy. It's better known today as laissez -faire economics. Anyway, in the late 1970s and early 1980s, for a host of complicated reasons, business and government concluded that economic growth required, among other things, a weaker federal government and a smaller welfare state.

JJ: How do you see this affecting social workers?

MA: Since the advent of neo-liberalism, social workers have had to work in a social service environment that is unfriendly to our work and hard on our clients. Welfare reform is one of the harshest examples. But two decades of tax cuts have starved many social service programs. The effort to shift federal responsibility for social welfare to the states (called devolution by policy wonks) has weakened social programs. The states have more control over some parts of the program than they did before, but they often lack enough federal funding to achieve their goals. As a result the states often fall into a deficit. And since most states are required by their constitutions to balance the budget, they end up cutting social programs.

JJ: And when they pick which programs to cut, you can be sure the most vulnerable groups lose out; especially if they are regarded as not among the active voters.

MA: That's exactly how I see it. And another feature of neo-liberalism is privatization or the transfer of responsibility for social programs from the public to the private sector. Social workers are also significantly affected by this effort to weaken the welfare state. That's what education vouchers, and the proposal to privatize Social Security and Medicare are all about. Another way to discredit the public sector is to under fund its programs, making them so inferior that only those without any recourse will use them. Urban public education in some cities may be a case in point here.

JJ: We have been hearing a lot about family values during the past twenty or so years. How does "family values" fit into all of this?

MA: At the same time that the welfare state came under attack by regular conservatives, the religious right got a strong hold on government policy. They were upset by the gains made by women, people of color, lesbians and gays, abortion rights and other social movements. The Right Wing sees the victories by these groups as a threat to the so-called traditional family. So along with the other conservatives, they too want to dismantle the welfare state and go back to policies that foster patriarchal social arrangements and a color-blind society.

JJ: How do you see this move toward family values impacting social work?

MA: Such a program does a disservice to the social work profession that employs so many women and persons of color. Even more important it stigmatizes our clients and deprives them of both needed services and deserved dignity. I think social work has to take on these policy issues even more than we already do. If not us, then who?

JJ: What role do social movements play in all of this?

MA: Social movements have been very important. The trade unions, civil rights, women's liberation, gay and lesbian rights and the disability movement - they all have

played major roles in the expansion of the welfare state. Historically they have always been a strong political force and their victories, especially in the 1930s and 1960s, helped to improve life for so many of us. But since the 1990s when Reagan broke the air controller's strike (as federal employees he was their boss), there has been a distinct effort to weaken the political influence of the social movements. Why? Because they were best positioned to resist the neo-liberal attack on social provision. The movements have been placed on the defensive, but never disappeared. Many people became active on the less visible state and local level, and in the last year the peace movement seems to be gaining some new steam. Many social workers are also active in state and local politics— it's a good area for building a progressive base. The conservatives are way ahead of us on this front. Having built a strong local base they now have many of their people in elected state and city office. But there is no time like the present.

JJ: To write the article on welfare reform, I read all the hearings on the 1996 Personal Responsibility Act and I noticed that there were very few people speaking out against the effort to discipline and punish the welfare mothers. The only one group that went on record was the Children's Defense Fund. You didn't see social work groups, like NASW, testifying against the proposed bill.

MA: That's interesting because I know that both NASW and the National Organization for Women (NOW) did take a stand on at least some of the punitive features of welfare reform. I don't know if they testified at the hearings, but in the mid -1990s, I believe that they were making some noise about the draconian welfare reform bill.

But it is also the case that during the Clinton years, many liberal advocacy groups that took up welfare "reform" moved to the center of the political spectrum. They may have become less confrontational, hoping to secure or maintain access to a seemingly more receptive legislators and the White House. This left militancy to the less resourced welfare rights movement, which also grew and remained active during this period.

JJ : What is happening with welfare reform today, some seven years since the implementation of TANF?

MA: Unfortunately, the program known as welfare reform has become institutionalized, so today the legislative fight is very different. Instead of fighting to prevent the passage of such a punitive law or trying to repeal the one we have, most of the advocacy effort is targeted to what I call "damage control." Given the political configuration of Congress and the White House, few in the advocacy community think that they can accomplish much more. And they may be right. So I guess our job is to try and educate the public about the need for a solid income support system that everyone can benefit from, and then maybe the politicians will take a different stand.

JJ: I wanted to ask you about the idea of "starving the beast"— that there was a deliberate attempt to drive up the deficit through tax cuts and military spending to make sure there would be no money for social programs. Do you think that is what happened?

MA: Well, it goes back to the Reagan years. David Stockman, who was the Budget Director under Reagan, wrote an op ed in *The New York Times* saying that they knew in 1980 that if they lowered taxes and increased military spending, the budget deficit could be used as a hammer, or should I say an ax, on social programs. The deficit would justify the budget cuts. The strategy was no secret. And it's been going on ever since. First, under Reagan, conservatives and liberals too called for balancing the budget. To balance the budget you have either to raise taxes or limit spending; and since no one will dare raise taxes, it always boils down to cutting social programs. And then when under Clinton, the Treasury actually had a budget surplus, instead of restoring spending, the White House and Congress mostly called for new tax cuts! Within a year after Clinton left office the surplus had disappeared. We blinked and it was gone! And now we have a record high deficit. Interest payments on the resulting debt are the second or third largest item in the federal government. Instead of funding programs that help people in need, the Treasury is making interest payments to the foreign governments, large corporations, and wealthy individuals that loaned the United States government money to help pay its bills. These groups are making out ok.

JJ: Tax cuts play a key role in all of this don't they?

MA: I think that the taxes are a major issue that social work could address. Social work advocacy does not often focus on this side of government programs. But I think individual social workers and the profession as a whole need to become more tax literate. I am in the middle of writing a report for the National Council on Research for Women (NCRW) called "Taxes ARE a Women's Issue." In it I trace the declining progressivity of the tax code. Many people do not know about this history. While the tax cuts have been the coup de gras, in fact the tax code has become less and less progressive since the end of World War II. As recently as 1978, there were 25 tax brackets, and the highest income bracket was taxed at 91 percent. Now there are 5 or 6 tax brackets and the top tax rate is 35 percent. So much for collecting taxes on one's ability to pay.

JJ: Talk of taxes may seem dry and boring, but social workers need to pay heed.

MA: Yes. If we do not expose the unfairness of the tax system, the people with less will continue to pay more, and in the long run there will be no money to fund our programs. This affects not only poor people but it affects people across the economic spectrum, because in fact we all depend on government spending for one thing or another. What about transportation, what about libraries? All the other public sector services and infrastructure that we take for granted. My neighborhood library used to be open all day, but now it is open only half of each day. This makes it much harder for me to return books on time without getting a fine. The middle class loses amenities like library services. But the poor and working poor lose their survival income.

And it's not getting any better. Just this week, President Bush put out a feeler—to replace the still mildly progressive income taxes with a regressive flat tax.

JJ: The tax cuts are extremely popular politically, which is another reason why they are passed.

MA: This is where I think the race card comes into the picture. The welfare state has been racialized so that many people wrongly believe that only or mostly people of color receive government benefits. The welfare state opponents have used the race card to turn people against government programs that in fact benefit the middle class as well as the poor by asking them: "Why should you pay for them?" During the heat of the welfare reform debate I was often invited to speak on radio and television shows - you know, the kind that had different viewpoints. The other speakers typically supported welfare reform as did many of the call-ins. Inevitably, the question was asked: "Why should we pay for them?" It was asked was over and over again.

JJ: Like in your article, "Everyone's Still On Welfare." No one seemed to realize that many middle class people receive "welfare benefits" through entitlement programs like Social Security, Medicare and Unemployment Insurance, but even more so from tax credits, deductions and exemptions.

MA: Right. And what homeowner has not received a housing subsidy from the tax deduction for their mortgage interest payment? These tax savings help address basic needs, just as direct spending on social programs does. The tax benefits also deplete the U.S. Treasury because they represent taxes not collected. And it is not just housing. Throughout the tax code the middle class gains access to income support, child care, retirement and health care benefits. In some cases the value of these benefits—that is the "tax expenditures"—is greater than the amount of direct spending on the poor and working poor. Just compare total taxes lost to the mortgage interest deduction with the total amount the government spends on low-income housing in any one year.

JJ: We were talking about why women on welfare are hated so much, and you said that you think race is the real reason.

MA: I don't know if it is the only reason but it is important. No doubt misogyny and hostility to the poor kicks in. But racial stereotypes are very powerful. The public has learned to think that people on welfare are lazy, unmotivated and immoral; characterizations that mirror standard racial stereotypes. Most mainstream discussions of policy today focus on individual values and behavior and ignore the systemic, the underlying or the root causes of poverty such as low wages, high unemployment race and sex discrimination, to name only a few. It is also the case that employers would not like it if there was no unemployment, since unemployment helps to press wages down.

JJ: From my early days in social work, when people would come up to me at parties and say,"What do you say about people on welfare?" I always had to defend welfare. I could see that most people had a racial analysis of welfare. Even correcting them with demographics of the welfare population didn't sink in.

MA: It's a very powerful stereotype; it's going to take a lot to undo it. And now that welfare reform is pushing women off the program, we are finding that white people are leaving the welfare rolls faster than people of color. Once again, labor market discrimination is at play.

JJ: What are you hopeful about?

MA: Deep down, underneath my critique, I am very hopeful about human nature. I do think if the average person has access to accurate information about the causes of social problems, the need for government spending, and the fact that we all depend on government programs of one kind or another, he or she would be less likely to vote against their own interests. I think it's very hard for people to get information given how concentrated and conservative the mass media has become. But I am still an optimist in that regard. I think people can and will see the light in terms of their own interests. If you don't believe that, you can't be an organizer.

Social workers can play a role in putting out correctives. We work with many people in families and communities. When appropriate we can, and I think we should, use our professional selves to offer some correctives to the misinformation that is out there. Academics can certainly do it. Like you, I try to do this in my teaching and writing by exposing students to all points of view.

JJ: It seems that there is a rising critical consciousness. I think Americans have an affinity for the concept of fairness and if you can put things in terms of not being fair, people will respond. I think we see ourselves as fair because of the belief that we have no social classes.

MA: That's right. We are taught that everybody has equal opportunity in the United States. We should at least try to live up to the ideal. Equal opportunity is the American definition of equality. It's not a bad definition, but it only goes so far. A stronger one would focus on equality of result. .

JJ: Yes, and even though we have not yet ensured equal opportunity for all, I think you can appeal to people based on the concept of fairness and move toward a progressive agenda.

MA: Yes, I think that is absolutely right. I'm also optimistic about this election. Usually electoral politics don't make me feel too optimistic because I feel we are always picking the lesser of two evils. And while I think that's still the case, there seems to some kind of awakening. The veils are coming down. I just marched with 500, 000 people in New York City, at the outset of the Republican National Convention. I don't know whether the awakening will translate into electoral votes. I don't want to go overboard, but I sense a new momentum and that change may be more possible now than it has in a long time.

JJ: I want to thank you very much for taking the time to reflect on your life with *Reflections'* readers. I have enjoyed talking with you a great deal and know that this interview will impact our readers deeply.

Mimi Abramovitz in 1973

Books By Mimi Abramovitz

Regulating the Lives of Women: Social Welfare Policy From Colonial Times to the Present. Boston: South End Press, 1996 2nd rev ed

Under Attack, Fighting Back: Women and Welfare in the United States. New York, Monthly Review Press, 2000 (2nd rev ed.)

The Dynamics of Social Welfare Policy. New York: Oxford University Press, 2004 (with Joel Blau) (A social wefare policy text book)

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PERSPECTIVES ON SOCIAL JUSTICE

David G. Gil, Ph.D., Heller School for Advanced Studies in Socail Welfare, Brandeis University, Waltham, Massachusetts

Here the author discusses the differences between "just" and "unjust" societies, and discusses the global human implications for both. David G. Gill is a professor of Social Policy at the Florence Heller School for Advanced Studies in Socail Welfare at Brandeis. He was interviewed in the Winter 2003 issue of **Reflections**.

Introduction

Many advocates of social justice tend not to specify their understanding of this concept. They act as if its meaning was self-evident and, therefore, did not require interpretation. When challenged to specify the meaning of the concept, they tend to hesitate. Leaving the meaning of social justice unspecified may actually be quite useful, for the vagueness of the concept enables people to avoid facing the implications of a clear definition for their accustomed ways of life.

In this narrative, I am sketching my understanding of social justice on three related levels: individual human relations; social institutions and values; and global human relations. I also examine whether, and to what extent, the values, institutions, and culture of the United States are compatible with social justice and how to confront culture-based obstacles towards its realization.

My insights into social justice are not "correct" in an absolute sense. They are merely the meanings the concept conveys for me. I do think, however, that all students and advocates of social justice ought to move beyond an emotional attachment to a vague idea toward an intellectual position, and ought to specify the meaning the concept has for them when they use it in discourse with others. Such specifications seem especially necessary for deliberations on strategies toward the realization of social justice from local to global levels.

Individual Human Relations and Social Justice

The important distinction the philosopher Martin Buber made between "I-Thou" and "I-It" relations suggests, perhaps, the most pithy conceptualization of social justice in individual human relations (Buber, 1937). "I-Thou" human relations mean that everyone is to acknowledge and treat everyone else as an autonomous, authentic subject with equal rights and responsibilities rather than as an object to be used, as is typically done in "I-It" human relations. Gradual expansion of genuine "I-Thou" relations, from local to global levels, could eventually phase out and prevent all kinds of domination and exploitation among people and groups of people.

Buber's insights into social justice were by no means unique. They were foreshadowed in biblical and gospel sources, as illustrated by sayings such as "Love thy neighbor as thyself," and "Do not do onto others what you do not want done to thyself." These illustrations from Judeo-Christian traditions could be matched by similar quotes from the Koran and from sacred scriptures of Buddhists, Hindus, Confucians, and other Asian, African, and (Native-) American traditions.

Social Institutions, Values, and Social Justice

On the level of social institutions and values, social justice means socially established living conditions and ways of life that are conducive to the fulfillment of everyone's intrinsic needs and to the realization of everyone's innate potential, from local to global levels.

Innate human capacities tend to unfold spontaneously when people have opportunities to fulfill their intrinsic needs in their natural and social-cultural environments. Insights into the dynamics of social justice require, therefore, clarification of intrinsic human needs and of the conditions for their fulfillment (Fromm, 1955; Gil, 1992; Maslow, 1970). Human needs include the following inter-related dimensions:

Biological/material needs for survival and development:

- Social/psychological needs for meaningful relations of the "I-Thou" type.
- Productive/creative needs for engagement in meaningful work.
- Security needs derived from trust in stable fulfillment of the above needs.
- Self-actualization needs, to become what one is inherently capable of becoming.
- Spiritual needs, to discover meaning in one's existence in an unknowable cosmos.

Whether natural and social-cultural environments are conducive to the fulfillment of these needs, and the extent to which these needs can actually be met, depends on the value system and social policies, i.e., the institutional context of societies. That context involves the following inter-related dimensions of social life (Gil, 1992):

- Management of natural and human-evolved, productive resources.
- Organization of work and production.
- Distribution of goods and services and of civil, social, and political rights.
- Governance.
- Biological and cultural reproduction, socialization, and social control.

Different societies, at different times and places and at different stages of social, cultural, and technological development, have shaped these essential dimensions of social life in different ways. These variations in policies result in different outcomes for people's circumstances of living, for their relative power, for the quality of their relations, and for the overall quality of life.

Systems of social policies are always results of human choices. However, these choices, in any generation, tend to be influenced and constrained by traditions and beliefs that reflect choices of prior generations. Nevertheless, since people originated all social policies, people, in any generation, can act collectively to change prevailing social policies in order to achieve more desired outcomes. People have often struggled for, and achieved, such changes throughout history, in spite of fierce resistance from social classes interested in preserving established ways of life.

At different times throughout social evolution, human groups have actually created policy systems conducive to meeting the needs of all people, facilitating thus everyone's development. Societies that created such institutional systems in the past did practice "social justice" in accordance with the perspective suggested here. In theory, socially just policy systems could again be pursued and attained in the future.

Socially just societies, whenever and wherever they existed throughout history, have been egalitarian, structurally non-violent, and genuinely democratic (Kanter, 1972; Kropotkin, 1956). "Egalitarian," as used here, is not a mathematical but a social-philosophical notion (Tawney, 1931, 1952).

It means that all people have equal rights, equal responsibilities, and equal opportunities in all spheres of life, including control of resources; organization of work and production; distribution of goods, services, and rights; governance; and reproduction. Equality does not mean that everything is divided and distributed in identical shares, but that distributions are geared thoughtfully to individual differences, and everyone's different needs are acknowledged equally.

Socially just societies do not require "structural violence" by the state, as socially unjust societies do (Gil, 1996). The function of structural violence is to establish and maintain, social, economic, and political inequalities among individuals, social groups, and social classes. Inequalities of rights, responsibilities, and opportunities among people of a society are unlikely to ever be established and maintained voluntarily. Rather, their establishment requires coercion in the form of initiating physical violence which is gradually complemented by a "consciousness of submission" resulting from ideological indoctrination or the "colonization of people's minds."

Socially just societies also tend to practice real, rather than merely ritualistic, democracy. In the context of social, economic, and political equality of socially just societies, no individuals, groups, or social classes can monopolize power over other people and the state by using accumulated wealth to influence the outcome of elections, as is usually done in socially unjust, non-egalitarian societies.

Like social policies, values, too, are products of human choices, but their human origin tends to be disregarded and denied. Their origin tends to be projected onto extra-human sources and their power over human behavior is thus enhanced.

Values are guiding principles for human behavior and social relations derived from judgments of behavioral outcomes. Outcomes judged desirable and worthy of repetition are valued positively, while outcomes judged undesirable and to be avoided are valued negatively. An important issue concerning these judgments is who made them and whose interests are served by beliefs, attitudes, and behaviors shaped by the resulting values.

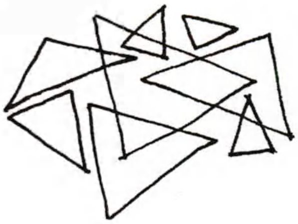
The history of values reveals that, in fragmented societies, the judgments were usually made by dominant classes, and behaviors guided by the values served the interests of these classes. Values, once established in a society, tend to be internalized into the consciousness of most people and to shape their behavior, even when actions shaped by the values do not fit their real interests. An apt illustration of this tendency is the value that men are more worthy than women. That value was often internalized, not only by men whose perceived interests were served by it, but also by women whose interests were hurt.

The values of societies tend to limit the range of possible changes in their policies. Significant changes in social policies and in institutional systems are, therefore, unlikely without prior significant changes in values.

The following value dimmensions differentiate socially just from socially unjust societies:

Just Societies

equality
liberty
individuality
collectivity-orientation and mutualism
cooperation



Unjust Societies

inequality
domination and exploitation
selfishness and individualism
disregard for community
competition

Global Human Relations and Social Justice

Social justice on a scale of global human relations implies a vision of over six billion fully developed people living in fully developed societies and communities. This vision involves extending "I-Thou" relations to all of the world's people and extending the institutional context of social justice from local and national to global levels. And, since living conditions shaped by social justice principles tend to prevent all forms of violence at their source, this vision implies also a peaceful world without structural violence by states and without counter-violence by individuals and groups, including the type of counter-violence labeled "terrorism."

The institutional requirements of social justice would have to be met by sharing the aggregate of productive resources, knowledge, work, goods, and services of the global community in ways conducive to meeting everyone's intrinsic needs and realizing everyone's innate capacities. People everywhere would thus have equal social, economic, and political rights, responsibilities, and opportunities, and no one would be dominated and exploited by others.

Contrary to intuitive assumptions and fears, redistribution of resources, knowledge, work, goods, and services in accordance with principles of global social justice would not cause declines in the quality of life of currently privileged people and nations. For global wealth is not a fixed, zero-sum quantity and quality but could be enhanced both quantitatively and qualitatively as the productive potential of currently underdeveloped people and countries is liberated. Appropriate redistributions would have to be carried out gradually, thoughtfully, and non-coercively once more and more people come to discover that social justice would serve their real needs and interests and would, therefore, enrich everyone.

The quality of life for all would actually be enriched immensely when people everywhere free to develop their innate capacities and are entitled to use necessary productive resources and accumulated knowledge and skills in meaningful, productive endeavors. The "real" wealth of humankind is, after all, not the aggregate of privately controlled concentrations of capital, but the aggregate of realized human potential, the globe's natural and human-created resources, and the aggregate of knowledge and skills generated since early stages of social evolution.

The Culture of the United States and Social Justice

A society's culture is its unique way of life, shaped by its history, beliefs, customs, and traditions, and by its values and social policies. A society's culture determines whether, and to what extent, social justice is attainable for its people, groups and classes. Since cultures are not fixed and can be changed by people, reducing prevailing levels of social injustice is usually possible, though difficult, by changing the values, institutions, and social policies of the culture.

The foregoing sketch of the three related levels of social justice suggests that societies and their cultures are just:

- When they practice "I-Thou" human relations.
- When their institutions enable people to meet intrinsic needs and to unfold innate capacities.
- When their people have equal rights, responsibilities, and opportunities concerning the key dimensions of social life, i.e., resources, work, goods and services, governance, and reproduction.
- When their values stress equality, liberty, individuality, community, mutualism, and cooperation.
- When they are free of structural violence and wars from local to global levels.

- When they practice genuine democracy.
- When their relations and interactions with people and nations all over the globe conform to the principles of social justice.

By applying these criteria, one is forced to conclude that the United States and its culture are not socially just. Its people would have to transform key aspects of their culture in order to reduce the prevailing scope of social injustice and to gradually move toward social justice.

Capitalism, the established economic system of the United States, is based on "I-It" human relations, domestically and globally. Individual and corporate enterprises use people, land, energy, and natural and human-made materials as "factors of production" to be exploited in the pursuit of profits. Employed workers are not treated as autonomous subjects or "masters of production," but as means to the ends of their employers.

Capitalist economies do not aim to match the actual needs of populations but only the "effective demand" of people who are able and willing to pay market prices for goods and services. The people and governments in the United States have usually been reluctant to cover even basic material needs not met by the market, as the people and governments of some other capitalist countries do. As a consequence of the way social, economic, and political institutions function in the United States, people tend not to meet their intrinsic needs and, therefore, cannot unfold their innate capacities. Also, the rights, responsibilities, and opportunities of people concerning resources, work, goods and services, governance, and reproduction tend to vary significantly in relation to social class status, gender, race, ethnicity, and other characteristics.

The "Declaration of Independence," the "Constitution," and other important documents of the United States stress values of equality, liberty, individuality, community, mutualism, and cooperation. However, the values that actually shape the consciousness and behavior of most people of the United States, from local to global levels, are inequality, domination and exploitation, individualism, disregard for community, and competition.

The institutional systems and culture of the United States are permeated by overt and subtle "structural violence" that sustains established, multi-dimensional inequalities and defines diverse manifestations of social injustice such as hunger, poverty, homelessness, and unemployment as "law and order." The messages of structural violence tend to be internalized, not only into the consciousness of beneficiaries of social injustices, but also into the consciousness of their victims. Structural violence, in turn, gives rise to vicious circles of counter-violence by its victims. Acts of counter-violence are usually not directed at the sources, beneficiaries, and agents of injustice, but tend to be displaced onto other targets through domestic violence, rape, crime, addictions, mental ills, suicide, etc.

The public response to counter-violence is usually "repressive structural violence" by the "criminal justice" system against the perpetrators of counter-violence, i.e., the victims of structural violence. The aim and methods of repressive structural violence are to punish, control, and change the perpetrators of counter-violence, to deter others from engaging in counter-violence, and to reinforce conformity to the status quo. The roots of counter-violence in structural violence are usually disregarded and are, therefore, not addressed by the "criminal justice " system.

Wars have been a regular phenomenon throughout the history of the United States, from genocidal wars against native peoples, to wars of conquest across and beyond the North American continent. The "War of Independence," the "Civil War," wars in Latin

America and Asia, "World Wars," and wars of global expansion and domination in the 20th and 21st centuries (Zinn, 1994). Regardless of the official rationales and public perceptions of these many wars, none of them pursued and achieved social justice.

The United States is a constitutional democracy and has consistently practiced ritualistic elections throughout its history. However, the people do not govern themselves democratically in a real sense. Because of constantly expanding, multi-dimensional inequalities, some groups and classes have more economic and social power than others and exert, therefore, disproportionate influence over electoral processes and outcomes.

The above sketch suggests that the culture of the United States is incompatible with social justice in its domestic policies. When examining the role of the United States on a global scale, one cannot avoid a similar conclusion. The same dynamics of the U.S. culture that limit the extent of social justice at home shape also its foreign policies and lead to the same results of comprehensive injustice.

Social justice-oriented aspects of the culture of the United States, like the "Bill of Rights," are results of cultural change processes brought about by social activism over many centuries, going back to the barons' struggle against the English crown that resulted in the "Magna Charta." More recent illustrations of cultural-change efforts in the United States are the unfinished struggles for civil rights of Afro-Americans, Latinos, Native-Americans, immigrants and other groups; for workers' rights; and for women's liberation. Yet in spite of important gains in reducing the scope of social injustice as a result of these struggles, the prevailing culture of the United States continues to be a source of massive social injustice from local to global scales.

Confronting Culture-Based Obstacles to Social Justice

Ways of life of societies, their cultures, and their systems of social policy have never been fixed, although they tend to feel as permanent to people at any point in time. Change is actually a constant aspect of social existence.

Effective action for social and cultural changes to overcome culture-based obstacles to social justice is, inevitably, a lengthy process rather than a brief event of seizing power over the state. There are no known shortcuts to establish cultures of social justice. After all, social injustice has a history and traditions of about ten thousand years.

The history of revolutions aimed at establishing social justice reveals the unlikeliness of achieving just societies quickly by coercive means. A possible solution to this dilemma may be the theory of non-violent social change as advocated and practiced by Mahatma Gandhi, Martin Luther King, and others (Sharp, 1979; King, 1992).

Effective social and cultural changes seem to depend on prior changes in consciousness, values, and perceptions of interest of growing segments of societies. To accomplish such changes of consciousness requires social movements committed to facilitate the spread of critical consciousness through non-violent practice of "dialogical counter-education" as suggested and demonstrated by Paulo Freire and others (Freire, 1970; Gil, 1998; Hooks, 1994).

Movements can also promote and facilitate the creation and development of alternative models of social life such as intentional, cooperative communities, worker-owned enterprises, and various cooperative institutions. In this way "islands of socially just experimental societies" would grow in the midst of established unjust societies, just as early "capitalist islands" emerged in opposition to, within medieval feudal societies. Experiments along such lines are actually already happening in many countries across the globe including some in the United States (Blum, 1968; Buber, 1958; Kanter, 1972; Lindenfeld & Rothschild-Whitt, 1982; Morrison, 1991; Quarter & Melnyk, 1989; Spiro, 1970).

People who wish to involve themselves personally in transformation processes toward social justice can do so by critically examining their ways of life and the quality of their human relations. Based on such self-examinations, they can aim to adjust their relationships with others to the "I-Thou" pattern as far as possible within existing institutional realities, and they can aim to adjust their life styles and production and consumption patterns to requirements of global human development and environmental conservation. They can also join transformation movements and support groups to work cooperatively with others to enhance their critical consciousness and their political practice, and to continuously examine their social change strategies.

Along with the above-sketched long-range strategies to confront culture-based obstacles to social justice, social change activists should support every opportunity for policy change to reduce the prevailing scope and intensity of social injustice in the short range. There is no contradiction between promoting policy "reforms" toward "incremental reductions" of injustice on the one hand, and pursuing, on the other, comprehensive policy transformations focused on eliminating the causes and dynamics of injustice in the fabric of society. Social change activists ought, however, to avoid interpreting and promoting fragmentary reductions of injustice as if they were real solutions toward establishing social justice. They ought to pursue a simultaneous two- track change strategy, combining short-range, symptom-focused and long-range, cause-focused activism.

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MANAGED CARE: WHO MANAGES WHOM?

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This narrative presents dilemmas faced by mental health care practitioners in providing ethical treatment for clients within a managed care environment. As a private practitioner, the author negotiated for many years with managed care companies on behalf of clients. Often he would express frustration to his colleagues over the judgmental and suspicious manner with which he was treated by managed care clinical case managers. When hired as a clinical supervisor of a national managed mental health care company, he gained new understanding of the complexities of managing providers and clients in the delivery and receipt of efficient and effective care.

Note

The reflections of experiences by the author and the narratives of clients, clinical case managers, and providers have been altered only to the extent necessary to protect their identities and privacy. The managed care company is not named to protect the author.

Over 70% of the population of the United States is insured through private insurance, and managed care now dominates the financing of medical care among the non-elderly in the United States (Rosenbaum, Skivington & Praeger, 2002). In 2001, 93% of individuals with employer-sponsored health insurance were enrolled in some form of managed care, and only 7% remained in traditional indemnity plans (Gabel, Levitt, & Pickreign, 2001). Managed care plans promise costs lower than traditional plans largely through case-by-case utilization reviews conducted by clinical case managers (Rosenthal & Newhouse, 2002).

As a licensed mental health provider, employed both in the public sector and in private practice, I dealt with managed care regularly and quickly developed a strong aversion to their method of doing business. I found that decisions made by case managers appeared to be money based and were often at the expense of my client's medically necessary care.

Cost Containment: Who Benefits and Who Pays?

I received the call on the community mental health center crisis line at 4:00 in the afternoon. The caller identified herself, and a quick check on the computer confirmed that she was a client in the outpatient unit of the metropolitan mental health center where I was employed as a senior crisis clinician. Her voice was tense and fearful.

" ...I really don't know what to do. I'm afraid that I'm going to do something that will hurt my daughter...I don't want her hurt...I just don't want her to be hurt... I'm so scared." There was a flatness to her delivery and a slight pressure to her speech that concerned me.

After a brief conversation, it became clear that Cindy was in danger of harming herself. I asked her whether she had harmed herself previously and how she would go about harming herself now. She indicated that she had been involved in a very serious car accident three years ago while very depressed. She now attributed that experience as a suicide attempt.

"When I felt like this before, I ended up in the hospital. They say I was trying to kill myself, but I don't know. I just remember the overpass coming at me and hearing my mother's voice screaming at me about what a bad person I was... she's always telling me how bad I am."

"Was your mother hurt in the accident?" I asked gently.

"No," Cindy hesitated, "she died when I was 13."

Further questioning suggested that Cindy was floridly psychotic and was experiencing command hallucinations—voices telling her, once again, to run her car into the side of an overpass. She appeared to have slipped back into the psychotic depression that had nearly taken her life three years ago. She was afraid for her safety and for the well being of her five-year-old daughter. I did not trust Cindy's ability to control the impulse to 'end it all' and 'stop the pain.' After talking a while more, Cindy was unable to promise me that she would not harm herself and agreed that she needed to be in the hospital for her own safety. She had a health insurance policy that covered inpatient mental health care and asked me to help her receive authorization to go to the hospital. I agreed.

I instructed Cindy to stay where she was, and after confirming that the agency had a release form on file granting us permission to speak with the managed care company I made a call to the case manager. I listened to a muzak version of almost all of "Strawberry Fields" before Paul Smith came on the line. There was no apology for the wait, only a sense of urgency...or was it impatience...as Paul agreed with me that the situation appeared serious and that certainly Cindy should have an assessment to determine the need for more intensive treatment. He assured me that he would consult with the crisis branch of the company to see what could be done. He agreed to call me back shortly.

When no call came within the hour, I called Paul back. He was not available, and another case manager informed me that Cindy had indeed been contacted and instructed to drive *30 miles* to the managed care clinic for a face-to-face evaluation. When I gasped in amazement and suggested that she and her daughter could be dead before they arrived, the case manager stated that it was their policy that a face-to-face evaluation be conducted prior to authorizing days for inpatient hospitalization. I asked to be notified as soon as Cindy arrived for the evaluation. With a sense of dread I called Cindy quickly, only to hear the beep of an answering machine on the other end.

Two hours later, I was surprised when the receptionist called to notify me that there was a walk-in crisis. It was Cindy. I was relieved to see her alive, daughter in hand. Once we settled into the office, she shared with me her past two hours.

"I drove to the center, like I was told, and they told me that I needed to be in the hospital, but they couldn't put me in because it wasn't serious enough yet." She paused, her eyes fixed on mine.

"I nearly stopped twice on the way over. My mother thinks I'm such a bad person. I kept hearing her voice telling me how awful I was, what a mess I had made of my life. I just want to stop her voice. Make her go away. There were five overpasses over to there, and I crawled through each one." Her eyes darted toward her daughter, who sat quietly in the adjacent chair.

"If my Lisa hadn't been there with me, I would have driven into the side of the overpass. There were three more on the way to here." Her eyes were glassy, her plea clear. "Please help me. Why can't someone help...Can you make sure my Lisa is safe?...I can't make my mother go away and I can't listen to her anymore."

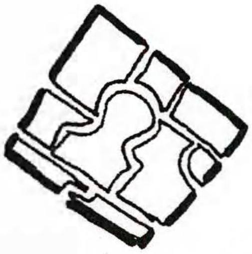
Cindy, highly suicidal and crying out for help, had been put in extreme danger by the actions (or lack of) of the company that managed her health care. Its unwillingness to authorize inpatient treatment for a highly suicidal client forced the community mental health center to involuntarily hospitalize a client who was, in fact, seeking voluntary admission.

With inpatient care denied by the managed care company, the only other option available to provide Cindy a safe environment in which to be assessed and stabilized was involuntary hospitalization. She was clearly a danger to herself and to her child, and was in need of inpatient care.

The treatment implications of involuntary versus voluntary treatment are profound. The sense of empowerment and self-determination that Cindy might have gained by receiving the help she was seeking was destroyed, with the consequence of subsequent inpatient treatment being imposed on her. With involuntary hospitalizations, the State takes on a paternalistic role and grants the mental health industry the right to force inpatient care on clients. The clinician serves as the 'jailer' of the psychiatric institution and holds the keys to a client's freedom; the clinician in the psychiatric hospital assumes a dominant position in the client's life and as such, his/her position as 'expert' is concretized. Given her involuntary admission status, Cindy would be treated as a resistant client, and her protestations to the contrary might be misconstrued and pathologized as the malingering of a manipulative client.

Why did the managed care company refuse treatment? Did they do it to avoid the expense of private hospitalization? The latent function of its negligence resulted in an involuntary hospital admission with the State paying the bill rather than the managed care company. Their actions prevented Cindy from accessing the health care benefits for which she was paying and, indeed, increased the possibility of her death.

What was the outcome of the process with Cindy? She received the care she needed and after two months was discharged from the state hospital. Cindy maintained custody of her daughter and continued outpatient treatment in the managed care outpatient clinic. The managed care company saved a mere several thousand dollars while gambling with Cindy's life, denying authorization for treatment, and forcing the State to pay for inpatient care. The stockholders of the company continued to increase their profits. Cost containment boosted corporate coffers at taxpayer expense...and at the psychological expense of the client, as I witnessed first hand in my office.



Client-in-a-Box

A colleague referred John, 45, to me. A survivor of ongoing childhood sexual abuse at the hands of his father, John had lived with his parents until the death of his father, six months past. He was experiencing clear symptoms of a major depressive episode. After completing the initial intake, I noted that John had insurance with a managed care company with whom I was a provider but with whom I had not previously worked. After reviewing the case with the clinical case manager, I was granted two sessions for the initial assessment. Standard practice. During my second session with John, it became clear that he had symptoms of post-traumatic stress and unresolved issues relating to the sexual perpetration by his father. The major depressive symptoms he was experiencing included thoughts of suicide, and he contracted with me not to act on these thoughts.

During my second contact with the case manager at the managed care company, I was told that I would be authorized four additional sessions to finish treatment with John. I was aghast.

"Do you understand that John has an extensive history of childhood sexual abuse and that he has clear symptoms of posttraumatic stress?" I asked. "You did receive both pages of the treatment plan, didn't you?"

"I understand your concern," she replied, "but it's generally our policy not to encourage the opening up of old traumas. John has lived and adapted to his past history of abuse. While he is scarred from the trauma, we can't support treatment aimed at reopening old wounds. We encourage you to help John with the grief he has over the loss of his father and to point him toward a grief support group...support groups can be quite effective. We want you to view this as an adjustment issue."

"You've got to be kidding me," I blurted out, unable to contain my incredulity. "His father was his perpetrator. John's having flashbacks, nightmares, can't get these intrusive thoughts of death out of his mind...he's hardly slept in a week, and has lost 10 pounds. It's classic symptoms of PTSD."

"I hear that," was the reply. "Nonetheless, we are authorizing you to treat the bereavement issues and adjustment disorder, not the PTSD, and in cases of bereavement and adjustment disorder we authorize an average of six sessions total. It's our policy. You've already had two. You should be able to 'close up' the trauma issues within that time frame and provide some relief for the grief."

I made a couple of phone calls to some colleagues in the managed care business and was appalled to hear that this was standard practice. Managed care companies often have dozens of satellite outpatient care facilities around the country. They conduct analyses of care provided to thier clients at these outpatient clinics. From these analyses, an average number of sessions for treatment is attached to any diagnosis (much like DRGs). This company, therefore, had developed "best practices" expectations based solely on these averages.

While the case manager acknowledged my concerns, she stated that she could not authorize additional sessions unless there were extenuating circumstances. My client fell outside the norm. We had our six sessions, and our requests and appeals for additional sessions were denied. Ultimately, the client and I came to an agreed-upon out-of-pocket fee based on a sliding scale (some managed care companies now include prohibitions against out-of-pocket sliding scales in exchange for membership on their panel). Treatment concluded 18 months later with John beginning to untangle the grief and joy he felt at the death of his father, after having examined the impact the abusive relationship had on life. He had been attending a support group for adult survivors of sexual abuse for several months in town.

Experiences such as these left me with profound questions about the role of managed care in coordinating the providing of mental health services. Has the meaning and quality of human experience been quantified to the point that treatment for individual suffering can be predicted with such accuracy? Are managed care companies forcing providers to put their clients into boxes defined by symptoms, standard treatment models, and 'average' care? What happened to individuality and the unique experience of each client with whom we engage in practice? Are 'depressed' clients all expected to 'do' their depression the same way and respond similarly to treatment? Does the average number of sessions control for attrition? I know of at least one case in which a client committed suicide after one session with a clinician at a managed care clinic—is this considered termination of treatment and entered into the database determining treatment averages?

Into the Belly of the Beast

Like many clinicians, I have many more narratives I could tell relating to how managed care made my life and the lives of my clients miserable. I learned to view managed care clinical case managers with disdain, suspicion, distrust, and even contempt. But, alas, after my frequent lamentations about the evils of managed care and many episodes in which I cursed them soundly, I found myself working for the industry I so hated. How did this come about? I would like to say that I hoped to affect a positive change within the managed care industry by working within the system to effect radical social change, as Saul Alinsky

(1971) would suggest. While not entirely true, this would be the more noble explanation.

My explanation, consistent with the majority of my managed care colleagues at the time, was less noble: finances. Due to the limitations imposed by managed care, my private practice had become increasingly difficult to maintain, and I found myself in need of stable income to support my practice. The radical in me believes that I did affect some change from within the system, and that I served as role model to the case managers to whom I provided supervision. As an insider, I was able to assure ethical clinical decision making. The tension between the corporate bean counters and the clinicians was constant and at times aggressive. They pushed brief treatment aimed at maximizing cost containment; we pushed ethical treatment with a goal of minimizing client recidivism and maximizing client potential. In the end, the values of the clinical case managers won out over those of management, and the satellite shut down after hemorrhaging a quarter of a million dollars a month for nearly two years. Clients received appropriate treatment, but at a cost that the company ultimately could not afford.

In the meantime, I experienced a wealth of experiences that I use to this day in my courses and workshops on ethical treatment in a managed care environment. The following vignettes illustrate my experiences within the managed care industry, and explore ethical dilemmas with which I struggled and, in some cases, resolved within myself.

Conflicting Realities: Truth is in the Eye of the Beholder

The call came at the end of a long day. I had spoken with Dr. Brown on numerous occasions. She was in my catchment area and was known for "trying to squeeze everything she could out of the managed company." She had signed an agreement when she joined the panel of mental health providers that she would provide brief solution-focused treatment to clients. This was surprising because Dr. Brown was a trained psychoanalyst and had been providing psychoanalytically oriented treatment to clients for years in her practice.

I could always depend on hostility, anger, and confrontation when Dr. Brown called. This call was no different, and she wasted no time in ripping into me. She was highly agitated and was requesting authorization to treat a client, Jenny, whom she had been seeing for three years. Jenny had recently switched insurance policies and my company managed her current policy.

"...Jenny is highly suicidal and were it not for my work with her individually she would most certainly need to be hospitalized. Don't you people have a conscience?" she asked, angry at my authorization of only two sessions for assessment.

"I understand your anger, Dr. Brown," I explained patiently. "Jenny's symptoms are distressing and do suggest the need for further treatment. I'm not questioning the symptoms or the concerns around her suicidal thoughts. It's our policy, though, to authorize no more that two sessions for initial assessment and treatment."

Dr. Brown made no attempt to disguise her anger toward the company and me. "It will be on your head if Jenny dies, and there will be no one to blame but you. Don't you realize that she's going to kill herself if we discontinue treatment?"

I breathed deeply and gave a slow, measured reply. "It's important for you to understand that I am in no way denying treatment for Jenny. I'm simply asking for you to submit a treatment plan. I'm authorizing two sessions for you to conduct your assessment and to develop a plan for treatment. At that time we will in all likelihood authorize additional sessions, given the symptoms you've described."

"God damn it, why the hell do I have to beg for sessions two at a time when I have a client who obviously is in need of long-term treatment? And why the hell do I have to explain any of this to you...*you bastard!* Who are you to second guess my clinical judgment?"

I took a deep breath and, as I started to respond, was greeted with a dial tone. Probably for the best I thought as I slid the phone back in the cradle. I sent along the authorization for two sessions and put the call out of my mind...until the next day.

When Jenny first identified herself as a client, I was surprised. It was seldom that I received calls directly from clients. In fact, this was the first in nearly a year. When the caller stated that she was a client of Dr. Brown, I steeled myself for an onslaught of anger directed at me for not authorizing additional sessions. What followed was a shock, as my earlier concerns about Jenny were quickly put to rest and replaced with growing unease about Dr. Brown.

"Hello...are you my case manager? I was hoping that you might be able to provide me with the names of some therapists." When I answered affirmatively, Jenny continued with somewhat more self-assurance.

"I've been with Dr. Brown for three years – she's a psychoanalyst – and I really feel that it is time for me to move on. It's just that I can't really afford to keep seeing her three times a week – it's bankrupting me." Jenny paused. "Is it possible to switch therapists?"

"Of course it's possible" I replied. "My job as your case manager is to make sure that you're getting the best care. Can you tell me what the problem is with Dr. Brown? You've seen her for quite some time. Do you mind helping me to understand what worked with her and what didn't? It may help me make some suggestions of people."

"Well, as I said, I've been seeing Dr. Brown for three years, and I feel as though I've developed a really unhealthy dependence on her." She paused. "She says that the dependence is part of the therapeutic process, and that I'm having this 'healthy transference' toward her as a 'bad object'. I think she just wants more money. I just get so angry when I drive up her driveway and see her beautiful house and her Mercedes while I'm eating peanut butter and jelly sandwiches and can't afford to have lights on at night. I feel like I'm just paying for her trips to the Islands..." Jenny hesitated. "This is confidential, isn't it?"

Assuring Jenny that I would not be speaking with Dr. Brown about the details of our conversation, I probed further. "It sounds like you're really tapped out, financially. I'm impressed that therapy has been so important to you."

"It is important, but I really started because of low self-esteem, and now, in hindsight, I feel that Dr. Brown took advantage of that and purposefully encouraged my dependence on her." She paused again.

"And when I express my worry about the cost of all this, she says that I have an unhealthy relationship with money and that we need to explore the meaning of money in my life, and my using it as an excuse not to do 'my work'...says I'm 'resistant'. She even increased my sessions from two to three per week to increase the tension I feel with money. When I initially said no, she said I was avoiding a deeply rooted problem..."

"I'm at the maximum of all my credit cards and she tells me that if treatment and getting better is really important to me, then I would not worry about the cost and would do whatever is necessary to support my getting healthy. I've become so angry with her, and still feel so dependent on her. Can you please refer me to another therapist?"

We discussed her situation a while longer before I gave her the names of two very well-respected brief therapists who could help her transition from what appeared to be a very unhealthy connection with Dr. Brown. It appeared that the biggest 'problem' in Jenny's life had become therapy itself and what appeared to be an exploitative therapist.

Jenny presented herself as highly intelligent, insightful, and very stable. During our conversation, I could not resist probing for any indications of suicidality. There were absolutely no indications of suicidal thought or intent. Jenny presented as articulate, very clear, and very professional. What a contrast to the irrational tirades of Dr. Brown who presented as angry, irrational, manipulative, and hostile.

Whose reality most closely reflects 'truth'? The provider? The client? The managed care case manager? Why are practitioners so quick to invalidate client experience by labeling it as "resistant" or "avoidant" or some other defense mechanism? When there is dissonance between therapist report and client report, why do we accept the perception of the provider over that of the client? Whose reality is it? In this case the licensing board was contacted and a report made. We discovered the complaint was not the first against this provider.

Through this experience with Jenny and Dr. Brown, I gained a profound appreciation for accepting a client's reality and lived experience over her therapist's interpretation and presentation of client symptomatology. Clients are the true experts of their lives and their experiences, and this needs to be honored. I also learned that while the motives of managed care companies are sometimes suspect, occasionally motives of therapists are equally questionable.

Playing Favorites

Beth was a 34-year-old woman in recovery from alcohol dependence. She had a severe trauma history, including repeated sexual abuse by her foster brother. The provider, Bill, had provided an Axis I diagnosis of Alcohol Dependence. The treatment plan also listed an Axis II diagnosis of Borderline Personality Disorder (BPD) traits. June, the case manager for the case and my supervisee, had been clear that no additional sessions should be authorized. She did not feel that a clear case had been made that Beth still met the criteria of Alcohol Dependence; she was in early full remission and hadn't had a drink in over three months. Additionally, June did not feel that she could authorize sessions for the diagnosis of BPD, as the client did not meet the full criteria for that disorder.

"You really seem to be struggling with this one, June. Why the ambivalence?" I asked.

"It's just that this woman has had so much happen to her in her life, and I really feel that she could benefit from some counseling...it's just that she just doesn't meet the criteria for either Borderline Personality or Alcohol Dependence...and that's what Bill lists as the diagnosis." She paused. "I just feel that she needs something here. I would hate to see her start drinking again. Isn't there some way that we can help her?"

"Well, we can't authorize anything based on Bill's request," I agreed. "Beth's not drinking anymore and she doesn't appear to be 'Borderline.'" I hesitated, as I reviewed the treatment plan further.

"There's some mention in here of early childhood abuse...what's that about? Do you know?" I asked. "Oh... wait a minute, is this the woman you told me about last week who had been molested by her foster brother and was later in a relationship with a violent man...that guy with the anger control problem?"

"Yeah," June replied. "Her brother physically and sexually abused her for quite a while, and her first husband landed her in Pavilion Hospital a couple of times, before she finally left him."

As we continued our discussion of the request for treatment, June shared with me symptoms and behaviors in Beth that were classic signs of PTSD, yet she had hesitated to authorize treatment because the provider had not listed PTSD as a diagnosis. I suggested her that she contact Bill and explore further the trauma history and whether he had considered approaching Beth on working on her trauma issues. I wondered if Bill had misread the behaviors and characteristics of a trauma survivor as Borderline Personality characteristics and behaviors.

After June left, I reflected on what had just transpired in my office. I happened to be familiar with the work of the provider, Bill, and knew that he had a blind spot when it came to trauma. In addition, Bill was in recovery himself and tended to see everything through the 'lens' of recovery. He also had a most disturbing habit of diagnosing many of his 'trauma' clients with Borderline Personality Disorder and /or alcohol dependence. The symptoms on the initial treatment plan clearly suggested a diagnosis of PTSD, yet no mention whatsoever was made of this.

Was it appropriate for me to second guess the provider? Is it the role of the case manager to suggest possibly more appropriate diagnoses and treatment plans? To educate providers? To provide clinical supervision on cases? In both cases, working on trauma issues that each had experienced seemed far more appropriate than focusing on alcohol abuse and/or traits of a personality disorder. Indeed, dealing with the Acute Stress might prevent Pam from developing PTSD, the appropriate diagnosis if the symptoms of the event precipitating the acute stress response continue after one month.

Unfortunately, incompetence and/or inexperience among providers appeared to be as common as not. As a clinician, I chafe at being judged by a managed care case manager; as a past managed care case manager, I shudder at the many cases of unethical practice and incompetence (however well intended) to which I was exposed.

Taking Stock of Stocks

The managed care company attempted to co-opt my clinical judgment in numerous ways. First, I had a vested interest in decreasing utilization. As an employee of the company, I was able to purchase company stocks at 85% of their face value. I was overtly benefiting from the bottom line of a company in which profits in part were directly connected to decreasing utilization of services: 'we make money, you make money.' A conflict of interest thus existed between my clinical responsibility and the potential for my financial gain.

Managed care is a business whose business it is to increase profits and whose values center around money, not people. My company promotions and subsequent pay increases were tied to decreasing utilization and exhibiting good case management abilities (i.e., cost containment). Case managers most likely to be promoted were those willing to take hard stances on service utilization and able to show management that they could decrease utilization in a service area, thereby containing costs. Promotion in managed care is outcomes oriented, and outcome is defined as minimizing utilization without increasing liability. There was a clear benefit and incentive for case managers to deny requests for services.

I watched in amazement as a case manager known for his ruthlessness in denying authorizations was promoted to the position of Clinical Director of the company. The business-oriented company management rewarded productivity, which they defined as decreased utilization of services. Money is made by cost containment, money is lost by service authorization and delivery. The need to compromise one's integrity in order to be 'successful' in the managed care industry is very real.

Do compassionate case managers fall by the wayside and cut throat managers rise to the top? What is the incentive to show compassion to unseen and unknown faces? I watched time and again as those clinicians who shifted their focus from the good of the client to the good of the company were rewarded with bonuses and promotions. Unwilling to compromise my values and integrity to this degree, and frustrated that I could not affect change from within the system, I left managed care after nine months for the academic world.

Lessons Learned

My time as a provider and as a managed care case manager has provided me with many insights. The lessons learned from my experiences are varied. Perhaps the most poignant lesson learned is that there are very powerful latent functions to privately managed mental health care. From frontline case managers to managed care CEOs, there are very real financial incentives to decrease client utilization of services. While the manifest function of managed care is to provide cost-efficient and effective mental health care to consumers, my experiences have made it clear to me that the latent function is individual and corporate profit and promotion.

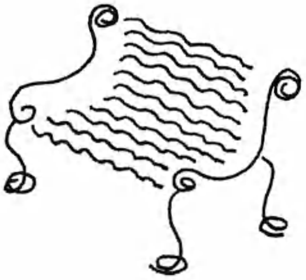
A corollary lesson is that managed care companies will play off the inability of the public sector to refuse treatment as a means of decreasing service utilization. The latent functions of such actions certainly save the managed care company a great deal of money, particularly when the per diem cost of inpatient care, for example, may run upwards of $1,000. Once admitted, a patient is seldom released before a minimum of a two-three day stay. The tension between publicly funded and privately funded mental health care is a powerful incentive for private managed care companies to 'dump' care responsibilities back onto the public agencies and institutions, who are not able to refuse or deny treatment.

Another powerful lesson for me is the nature of the so-called objective review of treatment plans and cases by clinical case managers. Managed care case managers would have us believe that their decisions to authorize sessions are made based on "objective" review of the medical necessity of treatment, when it is clear that treatment is impacted not only by the pressure to decrease utilization outlined above, but by the clinical case manager-provider relationship, by the personality characteristics and personal and professional experiences of the case managers.

Mental health assessment is a subjective process. Research clearly raises questions about the inter-rater reliability and the validity of diagnoses. There is not a single major study that shows that any version of the DSM has been used routinely with high reliability by regular mental health providers (Kutchins & Kirk, 1997). What became clear to me as a clinical case manager is that managed care by its very nature decreases the reliability of diagnoses and the length of treatment authorized. Diagnoses are more a function of what is covered by an individual's insurance policy than 'objective' presentation of client symptoms.

Confidentiality is by no means assured in a managed care environment. Extremely private information is being mailed and faxed around the country. If a wrong fax number is dialed, an individual's entire psychiatric history could be sent to the wrong party. I shudder when I recall the widely reported case in Massachusetts in which the entire psychiatric record of a woman was mailed to her podiatrist where she was seeking an appeal for denial of authorization for routine foot care. In the managed care company I worked with, we had two consultants, each located over a thousand miles away in the Midwest. One of the consultants regularly received faxes from his car fax machine that, he told me in an unguarded moment, his teenage son drove regularly. As managed care companies and health care providers begin to share confidential client records through the Internet, the implications are profound.

A final lesson for me is the 'game' that providers and clients are forced to play as participants in order to receive mental health services. Folks who do not know the rules of the game lose; clients with savvy providers



are more likely to receive treatment, and certainly more likely to receive extended rather than intermittent treatment. Managed care forces 'strategic manipulation' of the system in order to provide ethical services to clients. Managed care might call this insurance fraud; some case managers considered it the lesser of two evils.

Coda

Having experienced managed health care from the perspectives of both provider and clinical case manager, I can state with a fair level of comfort (and disappointment) that were I to choose to seek mental health services, I would not access my managed health plan. I would pay out of pocket. My experiences, as reflected in this article, leave me little confidence in the ability of the insurance industry to manage and coordinate my care. I certainly have not found any evidence that they truly would have my best interests at heart. I am fortunate to be in a position where I would be able to afford to pay out of pocket and not hassle with cost containment, treatment authorizations, case managers, appeals, labels, and the entire bureaucracy of managed care. For many people, especially those with no insurance, this would not be an option.

Is managed care contributing to a three-tiered system of mental health care in the United States: those who have no insurance, those who must use managed care, and those who choose to pay out of pocket? How do treatment and outcomes differ among these groups? Is it possible that those who are able to afford it receive more effective and ethical treatment through an unmanaged process? Perhaps through treatment that is based on a client's lived experience rather than a label required by the managed care industry? If so, then managed care will continue to evolve into an industry whose business is to contain costs through the provision of intermittent care for clients with the ultimate intent of increasing stockholder profits.

As for me, I left the managed care industry disillusioned and disgusted. Working on the inside of managed care convinced me that privately managed health care is untenable. The values inherent in a capitalistic system contradict the values of health and healing inherent in mental health service delivery. I live in the Northeast now, where I serve my penance for having worked in the managed care system by being an aging consumer whose health care services are now coordinated by the unseen faces of corporate managed health care case managers.

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VOICES FROM AN INVISIBLE MOVEMENT: MENTAL HEALTH CONSUMER/SURVIVOR/EX-PATIENT ACTIVISM

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This narrative is the result of the author's long standing interest in the mental health consumer/survivor movement and its implications for social work practice. Her primary purpose is to raise awareness on the part of human service professionals about this movement by giving voice to the experiences and perspectives of consumer/survivors. A number of narratives are woven together, based on in-depth interviews with movement leaders and participants. Implications for social work practice are identified.

Introduction

There is a hidden movement, unknown to most social workers and other mental health professionals. The movement and its participants have gone by a number of names, the most common of which are mental health consumers, psychiatric survivors, and ex-patients, often referred to collectively as C/S/X. The primary purpose of this paper is to raise awareness on the part of non-consumer professionals about this movement and give voice to the experiences and perspectives of some of its participants. For more than 30 years, there has been a network of activists in the U.S. who have rejected the subjugated role of "mental patient" that professionals have thrust upon them. Emerging from the atmosphere of political action and social change of the 1960s, the early movement, beginning around 1970, was organized against involuntary hospitalization, electro-shock treatment (ECT), psychosurgery, and forced medication. The potential for self-help alternatives to professionally controlled services is detailed in Judi Chamberlin's (1978) seminal book *On Our Own: Patient Controlled Alternatives to the Mental Health System.* Chamberlin identified three types of alternative models :

- In the *partnership* model, professionals and nonprofessionals work together to provide services. The recipients of services are told that they , too, are partners in the service. However, the distinction between those who give help and those who receive it remain clearly defined. I consider services based on this model to be alternatives in name only.
- In the *supportive* model, membership is open to all people who want to use the service for mutual support. Non-patients and ex-patients are seen as equals, since everyone has problems at one time or another, and all are capable of helping one another. Professionals are excluded from this model (except in external roles, such as writing letters of support).
- In the *separatist* model, ex-patients provide support for one another and run the service...All non-patients and professionals are excluded because they interfere with consciousness raising and usually have mentalist attitudes.

Indeed, while there has always been a wide range of perspectives among different C/S/X groups regarding the role of non-consumers, the movement during much of the 1970s tended to be characterized by a separatist view, in which the inclusion of non-consumer social workers and other professionals was seen as undermining the efforts of psychiatric survivors to value their own expertise and claim control over their lives. Beginning in the 1980s, with the support and funding of the Community Support Program (CSP) of the National Institute of Mental Health (NIMH), non-consumer professionals, genuinely interested in forging partnerships, have worked with C/S/X activists on policy-making committees, advisory boards, and other aspects of mental health advocacy (McLean,1995). These professionals were trusted by many psychiatric survivors in a context where the professionals were able to provide political access and assistance in obtaining funding for C/S/X projects without seeking to control them.

This exploration of the history, goals, and current strategies of the C/S/X movement will be explored through narratives culled from in-depth, open-ended interviews with movement leaders and other participants.

Terminology

As stated above, participants in this movement have gone by a number of names. The terms "consumer," "psychiatric survivor," "ex-patient," and "ex-inmate" suggest ideological differences. There have been many debates within movement groups as to which descriptor is most appropriate. The term consumer is used by most consumer advocates as well as state mental health officials. Many movement activists object to this term, primarily because it implies a freedom of choice in consumption that survivor/ex-patients do not have. The term has also been rejected because of its association with a market economy, which obfuscates the relationship of the users of these services to the providers. Audrey, an advocate with ties to the movement's leadership, explained the differences in terminology this way:

> "When I was studying the movement, twelve different terms came up, but no one wanted to call themselves consumers. That was really a Department of Mental Health term. My personal favorite is psychiatric survivor...Judi Chamberlin used 'ex-inmate' in the '70s, but almost no one uses it now. 'Ex-patients' denies the subordinate relationship, and the whole medical model paradigm..."

The term "survivor" speaks to an individual's strengths and capacity for recovery as well as to the self-help aspects of the movement. "Ex-inmate" emphasizes the element of incarceration in prison-like hospital environments. So, while it may appear that these terms are being used interchangeably in this paper as they vary from narrative to narrative, they contain different nuances and implications. Certainly the incarcerated inmate whose freedom has been denied connotes a very different image from the mental health consumer choosing freely among a range of voluntary services. Disagreements about terminology have been divisive at times despite attempts to compromise with more inclusive, if cumbersome, terms such as "consumer/survivor/ex-patient" or C/S/X, which reflect commonality among different groups and their ideological perspectives.

My Interest and Methodology

I first met some of the C/S/X advocates in the Boston area in the late 1970s. I was a social worker who later went on to work with people labeled "homeless mentally ill" and the memory of these radical activists stayed with me. I had identified with their political resistance and was intrigued with their view that there could and should be patient-controlled alternatives to the mental health system (Chamberlin, 1978). The homeless, mental health program I supervised was voluntary, but it was professionally controlled with limited avenues for consumer input into programmatic decision making and information control. Chamberlin's critique of "alternative" mental health programs based on an unequal partnership model rang uncomfortably true:

> "…It is clear that true partnership is not possible because the partners are not equal. The staff… keep records on members, consult with others about members, and make decisions members have to abide by. Members, on the other hand, can participate in only the most limited kinds of decision making. They can vote to schedule a bowling night instead of a swimming night, but they cannot vote to fire the executive director…." (1978, p. 92).

Chamberlin's critique raised disquieting questions for me, but I did not pursue these at the time, choosing instead to focus on research concerning homelessness. Many years later, I moved to New England and became involved in a consumer-run, mental health, peer-support center. This particular center is run by a Board of Directors elected by the center's membership, and composed of twelve center members plus a maximum of four "community" members appointed annually by the Board. These distinctions become blurred, as most of the appointed community Board members can also be identified as consumers to one degree or another. They differ from other Board members in that they are not center members, have been appointed because of a particular areas of expertise and cannot run for any of the Board offices. There are clear distinctions drawn between center members and paid staff. The current director is a non-consumer social worker who plays a coordinating role as well as being instrumental in obtaining funding. However, the hiring of the director, like that of all staff, is the responsibility of the Board, which also evaluates the director on an annual basis, and has the power to terminate his employment.

In 1997, I was appointed to one of the center's community seats. My continued involvement in this capacity served to rekindle my early interest in the C/S/X movement. In the late 1990s, I conducted a study of the perceptions of power differentials in the client/worker relationship in more conventional mental health programs (Cohen, 1998). More recently, I conducted a narrative-based study with twelve individuals active in the C/S/X movement. The people I interviewed included three national leaders of the C/S/X movement, four consumer advocates with ties to the movement, four members of the Board of Directors of the above-mentioned peer-support center, and its director. All but the center's director identified as mental health consumers, psychiatric survivors, and/or ex-patients. Participants in these interviews were de-identified for purposes of confidentiality, with the exception of the three national leaders who have been movement spokespersons for many years. They are Judi Chamberlain, Jay Mahler, and Pat Deegan, all of whom readily consented to the use of their names.

[redacted]

Narratives of a Hidden Movement: The Personal Meets the Political

It seems worth commenting that, although each interview began with a very general statement ("I am interested in hearing a bit about your own experiences with advocacy for mental health consumers and survivors"), the majority of people interviewed immediately responded with a recounting of their personal histories in the mental health system as a prelude to their becoming involved in mental health activism:

Pat Deegan, a public spokesperson and author of numerous publications related to C/S/X, responded as follows:

> "My experiences with it, with the consumer/survivor/movement, began while I was in the early years of being incarcerated in mental hospitals. I was a teenager in the 1970s and I was in a mental hospital in Boston that overlooks Brookline Avenue, which isn't

far from Mass Mental Health Center. I think it was maybe only my second or third time in and I think I was 18 by then and looking down the street and actually seeing a demonstration go by...I mean I didn't know what it was. It was a ragtag group, not terribly big, but they were marching on Mass Mental Health Center and holding signs like, 'Lobotomize Shrinks' and 'Shrinks are Nazis.' I just remember catching a glimpse of that and at the same time there was a paper in Boston called the *Phoenix,* and I remember reading about it and that's how I put it together what it was that I had seen, you know...So, that was really my first exposure to it but I didn't really connect at the time. I was very much just trying to survive, but the seed had been planted. At least I knew that there was this group of people out there and that they were somewhere in the Boston area."

Audrey is a psychiatric and trauma survivor with a master's degree in social work who has been employed in a consumer advocacy role in two different state mental health departments. Like Pat, Audrey began our interview by sharing some of her personal experiences:

"I always had a leaning toward activism but never did too well trying stay connected to it. When I was in and out of hospitals in the 1970s, I was aware that there was some critique of the mental health system going on. I read *The Politics of Experience* by R.D. Laing so I knew that there was at least somebody out there who thought that things should be done differently and that was important to me...I was aware in some vague way that what happened to me was more harmful than helpful, but since I kept sort of ending up back in the hospital, I also had the belief that I probably just wasn't the right kind of patient. Meanwhile, it's the '70s and I'm missing the feminist movement. But, I was too busy being a mental patient...Of course nobody was doing anything about trauma then. So I was also one of the many abuse survivors who wasn't even questioned about abuse, and then even when I told people about that part of my life, it was not contextualized at all as sexual abuse...On the unit, they were sending my roommate out for shock treatment...I could see that there was this disgusting, inherent coercion happening that just pissed me off, but I was someone who didn't get angry. I got depressed instead of angry. So when I finally got out of the hospital, I had to figure it out, I had to sort of let go all the stuff about what I would have wanted to do globally and just really focus on what I was gonna do with my life."

Jay Mahler's story further highlights the interconnection between the personal and the political:

"I was active in the Free Speech movement at Berkeley around 1964...Around the same time I had a 'nervous breakdown.' So, I was an activist who became a mental patient, who became a mental health activist. This was in the early days when the movement was more militant. My involvement was focused on the rights of psychiatric inmates, especially the right to be free of involuntary hospitalization, ECT, forced medication. For about ten years I was incarcerated in state hospitals, subjected to shock treatment...But, on and off, I was able to get back to school. In 1972, I was back at Berkeley as an undergraduate. I was active in the movement and also had the opportunity to have a consumer advisory role in a county-level mental health committee. In this role, I went to statewide meetings of county mental health officials, some of whom were progressive and who saw the importance of mental health consumers having a role in designing mental health service policies and the provision of services...In 1976, I helped organize Mental Health Consumer Concerns (MHCC), a mental health advocacy group which advocated for patients' rights to refuse treatment and to get treatment in the least restrictive setting possible. We looked to political activism and began to make connections with activist groups from other parts of the country...We founded the Coalition Against Forced Treatment (CAFT), which engaged in political protest against the use of a medical model in mental health and gave testimony against its worst abuses. We had all been traumatized by the mental health system; we got support from each other and from fighting back; we were political activists and survivors. There were other groups like CAFT around the country which had been organizing national Conferences for Human Rights and Against Psychiatric Oppression since 1972. These annual conferences were initially open to non-consumer professionals, but the leadership role of patients and ex-patients was always acknowledged. In 1976, they threw the radical shrinks out...The separatism in the movement continued for most of the 1970s, and, in fact, in some groups it remains. But there was a move back to partnering with non-consumers, professionals by the late 1970s because there was federal money available through the Community Support Program (CSP) for community mental health programs that had consumer involvement. This provided some opportunities for consumers to have a voice in policy and service planning. At that time, there were some progressive non-consumers with power in the public arena at state and federal levels, so partnerships and alliances were formed. This was how I ended up having some voice in the system...."

Perspectives from the Ground Level

Jay's narrative provided rich historical information about the C/S/X movement in California, where it was particularly strong, as well as the early development of the more loosely woven national movement. My discussion with Judi Chamberlin provides a view from a movement leader on the opposite coast:

"It's interesting because it's gone through so many changes. When it first got started, it was very clearly a civil rights movement, analogous to the women's movement, the black movement, the gay movement. It's about people who are systematically deprived of their rights and their voice. And then over time we kind of got away from the idea that it's about rights. I don't think I ever got away from those ideas but as a group...of organizations that work somewhat in concert with one another, it became much more focused on alternatives and improving treatment and working within the system and all of that...It has been two steps forward and one back, surprising gains in one area and beating yourself against a stone wall in another. The establishment of Offices of Consumer Affairs in the state mental health departments is a good example. Some of them are a total joke but others have done some pretty interesting things, empowering direct users and exposing them to things they wouldn't have been exposed to otherwise. So, there have been incremental changes in that respect...I mean if you look at the organizational charts of how different states have done it, some Directors of Office of Consumer Affairs are in direct line of command and they're really part of senior management, and in other states the same people are stuck off in a cul-de-sac...But we are still fighting against forced treatment, that is still the key. We are legally second-class citizens in that you can do stuff to us that you can't do to anybody else. There is a whole lot less long-term hospitalization than there used to be, although not because of us. There are many more community based housing arrangements and drop-in centers of various kinds, although very few are really integrated...but that confirms the essential truth, that if we get sidetracked into a reformist agenda, we just get put on a treadmill...We need to get back to challenging the real problem which is power distribution and civil rights."

The ex-patients employed as consumer advocates within state mental health bureaucracies generally shared the overarching goals expressed by the movement leadership. However, unlike the national leaders, they were more inclined to emphasize increasing C/S/X voice in the options available to psychiatric survivors within the mental health system, as well as in seeking alternatives. A related goal was having the expertise of patients and ex-patients respected and incorporated into planning by professionals and public officials. Their energies tended to be directed on the immediate concerns before them, which involved ensuring consumer input on specific policies and proposals. While others emphasized the importance of working from outside the system and creating alternatives to it, these individuals put most of their efforts into changing the system from within. This is less of a dichotomy than it may appear. As Pat Deegan commented:

"Right now there are about 35 states that have ex-patients as part of their management structures. That group now has organized themselves nationally and have a president, treasurer, and a little bit of a budget and that in itself becomes powerful...Incremental changes and symbols are important...I think that the people in these positions have recognized that they're going to try to work the system from within, but they need the heat to remain turned on by activists on the outside and, secretly, the people in power, the commissioners, they don't know this, we worked strategically at times with these insiders. They helped us figure out how high to turn that heat, how much the system could handle, what had to be done by outside agitators...I think that when viewed as a whole, at the alliances forged between people who are working it from the inside and working it and agitating it from the outside... then some cool things can start to happen, so long as we can maintain some solidarity. Now the danger becomes if that leadership becomes so entrenched in their position and isolated from the outsiders and begins to view us as unwanted agitators who bust into their meetings and make their job hard, that's when it breaks down and then that's when you have the possibility of co-optation. But I see people working in very creative and good ways."

Lily, employed as a consumer representative within a state mental health department, described the specific goals of the movement as varying widely from group to group. Much of her emphasis was on a strengths-based, peer-oriented approach to recovery, which assumes that survivors and not professionals are experts and can help each other. She also identified as a high priority the goal of increased opportunities for consumer voice in state mental health department decision making:

"I think a lot of folks would say that a couple of goals of the consumer movement would be helping folks move forward in recovery and having opportunities for recovery...You would really have that infusion of recovery and that availability to grow peer support. You never know. It means different things to different people ... peer support is very powerful in that recovery process, that's what we're trying to tap into and that's what we're trying to help people utilize. The other obvious goal is to increase consumer voice, to have consumers be directive, to have their say in the programs they have a stake in. In a nutshell, my job is to bring consumer voice to the department on matters of program development, policy, contract, and to work to increase consumer involvement."

Asked about her perception of encouragement and/or or limitations in her job, Lily responded:

"There is encouragement for what I do because the state needs to show it has consumer input into mental health services. There are federal mandates and the former state commissioner was an ally to consumers. I really haven't felt co-opted in this job, but there have been times recently when I have felt my power to do my job was being undermined. I was in senior management, my position was supposed to be a senior management position. But then the reporting structure changed in a way which diminished my ability to serve as an effective consumer voice."

Audrey, who has strong ties to movement leaders and considerable experiences in consumer advocacy roles in two different state mental health bureaucracies, pointed out several obstacles to meaningful input by psychiatric survivors:

"There has definitely been an attempt to co-opt and limit the movement…They do it in different ways. Some state mental health authorities think they've got it now, like they know what it's about and so therefore they don't have to have consumers at the table anymore or they think it doesn't make any difference who's a consumer and who isn't, because they've taken care of stigma…They don't get why we have to be out of the closet as ex-patients. They say why we shouldn't just assume that everybody is a consumer…or they wouldn't be speaking their mind…So that aids and abets the marginalization of direct consumer voices…it's amazing what discussions aren't even on the table anymore. The other thing that has aided and abetted this marginalization is the state budget situation…There's a way in which these budget crises have given people in authority license to say we don't have time to include people...you know there's this whole thing about what's too much trouble also costs too much, whether that is a realistic assessment or not."

Jay, while aware of his positive impact on the state level also talked about what he sees as the inevitability of co-optation. As he put it:

"*I have met the enemy and it is me.* I am an advocate but I am also a consumer representative on the county mental health management team. Sometimes I find it hard to sustain the identity and values of a consumer. It is hard for me and others in positions like mine not to begin to identify with management. This is true co-optation, when you identify with the oppressor…I feel co-opted *all the time* in my job as consumer representative for the county...I go to meeting after meeting where nothing is accomplished, where I am a token member of the mental health of management team. This is a contradiction I have really struggled with, whether I am making any kind of a difference in this role."

The Board members of the consumer-run peer support center described above tended to view the movement and its goals in very local terms. Several saw advocacy for consumers and survivors mostly in terms of lobbying the state government for funding for the center. Sylvia is a Board member whose view is local but less parochial than many of the others:

"I think the consumer/survivor movement may be stronger in other states; here it is still trying to be born. I know I've watched some of the projects start to come together and unite, but for whatever reason, they don't seem to be working…. while they may be doing it, they're not being listened to by the people in power and so the system doesn't change. I know that our center is trying very hard not just to change the system, but to create a different system...and then, we will need to figure out how the new system relates to the state mental health system and if it doesn't, then money is the major question. And if it does relate to the state system, then a whole bunch of other potential problems come into play...But, the biggest problem is money. You know the state holds the purse strings and they want us to jump through certain hoops in order to get funded and they don't necessarily want to fund consumer initiatives because then they'd lose power. You know, it's like, first we had to get out of the mental institution. Well, now we've gotten out of the mental institutions, but we're stuck in the mental health system and the question is, how do we get out of the system, how do we get what we need?"

Activists working on the ground level have far more than theory and terminology with which to contend. They have to deal with day-to-day issues, compromises, repercussions, and choices of which battles to fight. The concept of being a "consumer representative" is a tricky one as it can become easy to lose sight of which constituency one represents.

The Movement Today

The consensus among most of those interviewed seemed to be that the national C/S/X movement needs to reach out to a broader constituency and find common goals, while overcoming ideological differences. Pat Deegan sees the movement as internally polarized:

"My opinion is that there are these ideological differences and a failure to identify a common ground that we can work together on...The movement is still very polarized. You know, you now have people who proudly call themselves consumers, which means they believe that mental illness really does exist and that psychiatry is okay. Sometimes it's helpful and it's okay to take meds and then there is sort of this other much more clearly anti-psychiatry, pro-choice group that believes that psychiatry is not a legitimate discipline but rather a tool of social oppression...These two groups are really polarized...The one area where I think we are doing very important work, and I'm very pleased with it, is in our cross-disability collaboration and building of partnerships. I think this has been extremely fruitful...For me, that's a natural connection and it really is working out, really well and I think we have a lot to learn from our co-conspirators who are, who come from the other parts of the disability movement."

Judi Chamberlin echoed Pat's excitement about working collaboratively with groups of people with physical and developmental disabilities and agrees that this is an important future direction for the movement:

"For me, in the last five or ten years, the movement has become a lot more focused on cross-disability work and that's where we got back into the rights arena, because the cross-disability aspect of things has focused a lot of ideas, you know, of hey, it's not just us. I guess it began coming together on getting the A.D.A. implemented; we really saw our commonalties. People with disabilities are systematically mistreated and ignored and medicalized and kept out of the mainstream and have their voices taken away and right now, one of my main focuses is working on an international level on this, the U.N. Convention On Human Rights Of People With Disabilities. And that brings it squarely back, this is a human rights issue...There is a history of fighting for fundamental justice for people who are perceived in one way or another as different and defective and not fitting in, and it's really just a joy to do cross-disability work, because people's experiences are different. You know, the particular needs of somebody who uses a wheelchair or somebody who's deaf or somebody who's blind or somebody with a developmental disability or somebody with a psychiatric disability, their particular needs are different in some ways, but the experience of being the outsider, of having other people think they know what's best for you, it's such a powerful commonality."

Jay also saw the future of the movement in broadening its scope:

"...into the community, to form alliances with other groups but, at the same time we don't even really have our own national group. We have information clearing houses, yearly conferences, publications, ... but it is still very regional. We need a stronger national identity, an organization, visibility, a presence. We have done a lot of work at the state level in allying with physical disabilities. I wish we were more a part of the larger disability rights movements, of the various civil rights movements, and really unite all the other disadvantaged and stigmatized groups, groups of poor people for example, under a "rainbow coalition" – unifying all of these groups that have been discriminated against."

Partnership and Implications for Social Work Practice

Judy, Jay, Audrey, Pat, and many of the other movement participants interviewed were in strong consensus that the C/S/X movement needs to be understood first and foremost as a human rights movement, emphasizing an awareness of their commonality with other oppressed groups. This view has important implications for working in partnership with social workers and other human service professionals. In Judi's words:

"We can all work together if all of our expertise is valued. We come from a society that doesn't recognize the value of experiential knowledge. If you've got a Ph.D. in it, you must know something about it...If you've lived it, what the hell do you know, you know, whether it's mental health or anything else?"

Jay expressed his view of partnership with professionals as follows:

"Partnering is necessary. Consumer/survivors just don't have the power to make needed changes in the system alone. They need allies who do have the power even though this frustrates me. I have the experience but not the professional training. As a consumer, my power lies in my ability to influence non-consumer professional allies to advocate for change."

While the traditional worker/client role does not lend itself to the paradigm of the C/S/X movement, there are important practice roles and resources that social workers can offer the movement to help advance its objectives of social justice and self-determination. These are goals which resonate strongly with social work values. Some of the professional roles and skills that social work allies can offer are consultation, assistance with grant writing, linkages to other groups, and concrete and mutual support. We can also provide assistance by publicly allying with the C/S/X movement using our professional legitimacy and power in support of consumer/survivor/ex-patients' rights. Social work educators can play a role by introducing the C/S/X perspective in the classroom, exposing students to C/S/X literature and to guest speakers active in the movement.

Professionals have knowledge and access to resources that can contribute to social change in the mental health system. The strengths perspective in social work (Saleeby, 2002) overlaps with the concept of recovery which many ex-patients see as integral to their work in the movement. A focus on individual and collective strengths makes working for change more humane and provides a bulwark against social oppression.

Two psychiatric survivors, Mead and Copeland (2000), see a potential for infusing treatment-oriented relationships with mutuality and respect for self-determination. In their words:

> "We believe that the need for mutual support extends into clinical settings. Though clinical relationships may never truly be mutual or without some assumptions, we can all work to change our roles with each other in order to discard the kinds of paternalistic relationships some of us have experienced in the past" (p. 318).

The major caveat in the partnering of non-consumer social workers with consumer/survivor/ex-patients is that social workers must remain humble about the expertise that we bring to programs and projects. While professionals have many important contributions to make, it is essential that we not attempt to impose our own solutions when called on by ex-patients to provide assistance. In this context, acting in partnership means making our many skills available, not substituting our professional knowledge for what psychiatric survivors have learned through lived experience.

I believe that one of the challenges for social workers *and* consumer/survivor/ex-patients is transcending the "us" and "them" dichotomy within the context of our different roles. My impression is that most social workers have had some experience as consumers of mental health services. We fall somewhere on a continuum which stretches from involuntary hospitalization and/or outpatient treatment, to voluntary hospitalization and medication, to various forms of voluntary outpatient treatment.

At some point during the course of this research, I found myself identifying with the consumer/survivor/ex-patients, relating to them as "we." In the process of writing this article, I found myself slipping back into my professional voice. In point of fact, while I have not experienced hospitalization or involuntary treatment, I have been a mental health consumer at various points in my life. Since taking part in these interviews, I find myself straddling both identities. I suspect that this kind of potential boundary blurring may account for the hesitation on the part of many social workers to focus on their commonalities with consumer/survivor/ex-patients. There are risks associated with social workers revealing their own experiences in the mental health system. I have seen such disclosure lead to decisions against hiring, to a demotion from a management position following a colleague's hospitalization, and, in my own case, to extreme scrutiny of my job performance following my disclosure that I was being treated for depression. The stigma associated with "mental illness" is powerful, perhaps as much within the social work profession as without. Many of us hesitate to join with psychiatrically labeled people out of fear of risking professional stature and credibility among our peers and employers.

Hesitation exists on both sides. Unless, as social workers, we are fully identified as members of the C/S/X community, we must build our relationships with consumer/survivors carefully through trust and respect, acknowledging and exploring our similarities and differences. Not surprisingly, this parallels how we can work most effectively with members of other oppressed populations, seeing them as experts in their own lives and confident about their abilities and strengths (Breton, 1994; Cohen, 1998; Saleeby, 2002). We need to trust consumer/survivor /ex-patients to be able to choose their own goals and tap into our skills and expertise where necessary. People who have been psychiatrically labeled have experienced great harm from mental health professionals, and we need to take the time for them to experience us differently, thus helping to close the "us" and "them" gap.

My own experiences working as an ally in this movement have been very positive. I have become part of the community at the consumer-run mental health center, and feel honored by this. The participants in the C/S/X movement whom I approached to participate in this narrative project agreed readily, presumably trusting my motives in wanting to give voice to their stories. My earlier experiences talking with homeless and other poor people was very similar (Cohen, 1998). Oppressed people seem to have a keen ability to distinguish between those whose interests lie in equal partnerships and those whose perspectives are clouded by motives of power and control; their survival depends on it.

Closing Thoughts

A few themes begin to emerge from these narratives, including the dehumanizing effects of involuntary treatment and the importance of self-determination. There is a close parallel between the C/S/X movement and other contemporary social movements that emphasize social justice and the civil rights of marginalized groups (Chamberlin, 1995). Historically, as the militancy of the 1960s and 1970s began to ebb, some of the more incremental demands of these movements were met, at the potential cost of co-opting or absorbing the movements' more radical demands.

Most states have some infrastructure for consumer input into mental health services, but this voice has tended to be a muted one. The C/S/X movement has had its impact, at least at the local level, in states that took the mandate to include consumer input seriously. There are still pockets of political resistance in areas where campaigns against the use of restraints, seclusion, and the lack of informed consent continue. The sometimes fragmented and hidden nature of the movement should not mislead us into thinking that this movement is small or easily dismissed. There is a network in the United States, and internationally, that connects many of these regional pockets, however loosely. Support Coalition International, for example, is an international umbrella group with over a hundred sponsors and thousands of members, including many social work allies (*Mind Freedom Journal*, 2003). It publicizes mental health abuses and civil disobedience responses via its website (*Mind Freedom* website), extensive email lists, and the *Mind Freedom Journal.* Moreover, although even the broader disabilities movement has been described as relatively invisible (Shapiro, 1994), the potential for cross-disability organizing and work with professional and non-professional allies seem promising. As a number of the individuals interviewed noted, we may not have changed the system, but the system now knows we are here and we will continue to insist on having a voice in what happens to us.

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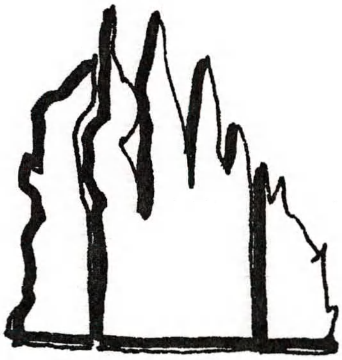


THE REALITY OF ROLE PLAY: PRE- AND POST-9/11 A TEACHABLE MOMENT

Carol L. Langer, Ph.D., University of Nebraska at Omaha

On Monday, September 10, 2001, the author entered her macro social work methods class with a role-play assignment asking the students to be citizens of a rural community in West Virginia. Having given such assignments for more than 15 years, she was comfortable that networking, coalition building, Roberts Rules, and formal processing would be the expected outcomes. They were to meet again on September 12. The world changed on September 11, and the assignment became real in a way that the author could not possibly have anticipated. The learning outcomes also went far beyond her predictions.

I have taught for nearly 17 years, and experiential learning activities are part of my usual repertoire. I rarely use the same materials twice since I typically try to incorporate current events into the classroom activity. The official title of the role play activity I designed for class on Monday, September 10, 2001, was "Planning a Meeting: Part A." On that day, I asked my macro methods social work students to draw their assigned roles from an envelope containing a variety of citizens in a small, rural community in West Virginia. I hoped to use that first class period to build coalitions, practice networking, assess resources and needs, and so forth. The following Wednesday, September 12, the class was to meet again to have a town meeting using Roberts Rules of Order to discuss the issue they had been assigned: an influx of Afghani refugees. My hope was that they would reach some resolution. I was an observer during both sessions, taking notes and watching for teaching moments related to the text information we had read.

The current events for that day included an anti-Arab sentiment that had been growing (in my observation) among my students over the past several years. In addition, I had designed a somewhat stereotypical rural community. Most of my students were familiar with a rural environment, so I was hoping the transition to another state and to a slightly different lifestyle would be easy for them to accomplish in a role play. As with all role plays, there are elements that become real—some are anticipated in the design; some are not. What were unanticipated in this particular design were the events of September 11, 2001. I could not possibly have predicted the enormous consequences of one day's activities on what was supposed to be an ordinary day in the classroom.

Description of the Situation and the Roles Situation

You live in the community of Staples, WV. This community has recently received an influx of refugees from Afghanistan. Very few of them speak English, and of those who do, only one or two speak fluently. They have school-age children (K-12), and they need employment, housing, furnishings, clothing, medical and dental care. The major employer in your community is a chicken farm and processing factory, but there are few openings. You will role play a resident of this community with a particular point of view and role responsibility. Make every effort to stay in that role when you are in COPA class.

Roles

1. You are the mayor and direct all the meetings. You are concerned about getting re-elected and seek a compromise solution that won't cost the community big bucks.

2. You are the owner of the chicken factory/processing center. You don't want to have to spend your time getting people assimilated to America. You just want someone to pluck and cut-up. Your concern is profits. You also want to appear to have the best interests of the community in mind.

3. You are a real estate manager. You know there is limited housing available. You recommend bringing in trailers to house the refugees. You are opposed to building new apartments due to the cost and insecurity of employment of the refugees.

4. You are a school teacher. You want to educate the children, but you are quite concerned about the language barrier.

5. You are a minister. You believe that you should help your fellow man/woman/child. You are supportive of full-fledged community involvement, including seeking contributions from the wealthier segments of the community.

6. You are a member of the city council and run the car dealership. You'd be open to some new residents, but not if they drain the system.

7. You are a member of the city council and own the restaurant. You don't care one way or the other whether new people come to town unless they intend to stay and build the economy.

8. You are a member of the city council, a single-parent mother who has suffered ostracism from the community at various times over your parenting alone by choice. (This community is a very religious community that has shown little tolerance or support—you've been backed primarily by women.)

9. You are a citizen of the town. You are opposed to any immigrants setting up their household in your community because you consider them a drain on the resources of the area (already limited and stretched).

10. You are a citizen of the town. You support refugee placement and services. You are willing to work on housing or whatever issues arise.

11. The rest of the class members are citizens who can do whatever they wished.

Day One: Role-engagement, Networking, and Coalition-building

This class period was spent learning each others' roles and points of view. Coalition building had definitely begun. By the end of the class period, it felt obvious that the community would decide to openly welcome the refugees, developing services and resources that were necessary for their successful integration. The minister was a powerful member of the community and had convinced just about everyone that it was their responsibility and privilege to help someone in need. The community saw nothing as an obstacle, not language, religion, or numbers of immigrants. They were organized into groups who were working on housing, employment, education, and needs for daily living. The future of the immigrants looked assured. However, September 11 intervened.

Day Two: September 12, 2001

After the events of September 11 and hearing of other faculty approaches to the necessity of dialogue, I debated about whether to proceed with the activity as planned. I was leaning toward an open discussion since I had assigned roles that might be difficult to maintain, and there was no guarantee that the underlying thoughts and feelings of individuals would emerge. I know from experience, however, that while role plays are contrived, there are both elements that are real and those that become real. I decided to trust this process and continue with the activity into truly new and uncharted territory. I was fully prepared to be not only professor but counselor, if needed, which is a role I summarily reject. For all intents and purposes, the fictitious West Virginia community was going to be created in our classroom.

When I got to class, students began begging me not to go through with the role play. They wanted an open discussion of the events and their thoughts and feelings. I told them that Roberts Rules would allow us to discuss these painful and complicated issues with an objective format. Inside, I hoped I was right. I also desperately wanted to know that my social work students would be non-judgmental, unbiased, receptive to alternatives, and sensitive to diversity. I was afraid that they would be either too conservative or too close-minded. I had to struggle with my own expectations of student attitudes and behaviors. A part of me, too, was wondering just what might emerge in the course of an hour and a half of the most intense discussion we had entertained up to that point. I questioned my own adequacy to "let it happen." I knew that whatever was said in that classroom needed to be said. I also knew that we had developed relationships and created a safe environment for controversy. My hope was that with little encouragement, the reality of role play would take over.

The mayor called for open discussion of the issues or concerns that citizens felt it necessary to discuss. The first issue was employment. The owner of the chicken factory thought she might be able to employ the refugees if they learned to speak English. The restaurant owner thought she could hire two adults and promote two of her current employees in some way. A citizen suggested a clothing drive. Housing then emerged as an issue, and the real estate agent offered to bring in some trailers for housing. Speaking English began to emerge as a huge issue. A controversy occurred about whether one had to speak English to pluck a chicken. This issue was revisited several times.

Someone then suggested that the community needed to learn more about the refugees before making any decisions. Suggestions included utilizing the Afghanis who lived there to do some cultural education sessions. A visit to the local library was offered. Hosting a chicken feed inviting everyone to encourage interaction was also mentioned. Someone asked why the owner of the chicken factory needed to "get to know them" when she was already giving them a job. The response was, "it's a better working environment if you know your employees." The owner responded, "Not even all of my current employees are all friends. Why do they have to be friends?" A citizen then interrupted, "In light of recent events, could we address safety issues from this population?" The minister responded, "They're refugees fleeing the activities that went on. They weren't involved." The citizen replied, "But there are new issues now between the races. What are we going to do—if—what if the community breaks up and go against each other?" The minister firmly said, "That's why we have to work together."

The chicken factory owner asked, "Do you know for a fact they didn't have anything to do with yesterday?" A citizen exclaimed, "They're refugees! They wouldn't leave their families, their homes..." Tensions were building at this point. I made a note to discuss the issue of the word "races" to describe the observed differences between populations.

The realtor then asked, as if to clarify or stay away from such a volatile topic, "Are we causing them danger from others in this area?" The restaurant owner offered, "It could be the same for all newcomers—Iceland, if I could pick a place." The realtor pursued with

"But they **are** Afghanis and responsible for terrorist attacks. It's just them that are blamed for that." The minister, trying to be reasonable, stated, "Community, let our formal government deal with perpetrators." The chicken factory owner wouldn't accept reason, however. She stated, "We have no clue who to trust. Anyone could be involved." "We have to take into account that they've learned their whole lives that we're bad," said the minister. A citizen agreed. "All the more reason we need to support them—to show them how good we are." Another citizen disagreed, however. "Okay, if those here at the moment are okay, what if our community is known as a safe place for these people—we'll get more and more and more—good and bad."

The teacher said, "Let's not argue value systems. Let's agree on something. How can we provide for our safety? What about police? Help solve my problem—deal with real concerns. How will we deal with these issues?" The minister responded, "We hope to implement a plan where community members—peer mentoring, adult basic education—work with one or two Afghanis." The restaurant owner objected, "You don't have to know English to drive a car. Do you have to know English to cut up a chicken?" The teacher restated her position, "We just need to make sure these people are provided for—that my own children don't get lost. I can slow down, but this is a community effort—as long as parents know I'm slowing down." "Would anyone be willing to tutor/teach these students? I don't want my child to slow down or wait for these kids. That's not fair," said a citizen. "How long will people give and give and give? When will it be taken care of?" I made a mental note to talk about the use of "these people" and the way people were dancing around the elephant in the living room.

The outcome of the role play was that the town decided not to provide any assistance to the refugees. The reasons given were that they could not protect them from angry community members; they might be part of the terrorist network; and the community just "didn't have the resources" to divert to the refugees.

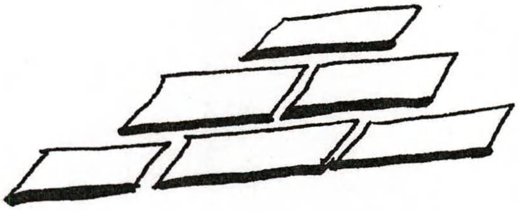
De-briefing

I did not display great wisdom because I did not allow sufficient time for processing what had just happened, and I didn't have to address the elephant in the living room. The students did. They were really emotionally distraught for several reasons. First, they openly admitted that it was extremely difficult to get into their roles. They were surprised at the intensity of their anxiety at the thought of being in a small town that might turn into a pocket of terrorists. The people most open to accepting the refugees admitted they wouldn't have supported their arrival. They kept thinking about the current Afghani residents, wondering if they had a connection to the 9/11 incidents. We spent some time talking about those feelings, trying to understand the reality for people who might "appear" to be from the Middle East, and resolving to be active in urging tolerance, acceptance, and openness. Second, the students were dismayed at their own honest reactions. They had hoped they would be more tolerant, but when their role required opposition, it was easy for them to oppose the arrival of the refugees. Many repeatedly apologized for thinking or saying things that appeared intolerant. The greatest challenge for me was to help them deal with the guilt they expressed about their feelings.

I was surprised at the openness of the communication which continued intermittently for several more class sessions. We talked about the learning value of role play, which up to this point had been marginalized in a macro methods course. We talked about language usage, the influence of the media in shaping our reality(ies), and the difficulties of encountering the other. We also talked about linking theory to practice. It's one thing to read about networking in a textbook and quite another to try it in even a fictional encounter. The students expressed surprise at how this one activity addressed the text and the "real world" in a way that they couldn't have imagined. Several became involved in assisting refugees to the state of Nebraska at a local neighborhood center, directly as a result of this activity.

Obviously, I could not have predicted that this particular activity could become so real. In hindsight, I would have videotaped the entire activity from start to finish. I am also painfully aware of the stereotypical roles I assigned. I didn't really think of this at the time (other than making the minister more "liberal" and having the school teacher worry about bilingualism). I was merely trying to get the students to "think out of the box." In the end, it didn't matter that the role play was supposed to happen in West Virginia. It actually happened in Smalltown, USA—right in that classroom.

I will always be grateful that I had the courage to continue with the role play as assigned. I don't think we could have had a better vehicle to begin to address deeper or hidden feelings and concerns about the recent terrorist events. The role play provided the right amount of structure and freedom that allowed people to vent their views. The real learning happened when students realized that they "were" the minister, the chicken factory owner, the citizen, and so forth. This is the value of role play. I know from subsequent communication with those students that this experience provided a deeper learning than they originally expected. I also learned that it's not enough to trust the process. I had to examine my own beliefs, thoughts, and feelings about the students and the events. Just as the students did, I had to operate on several levels: teacher and citizen, social worker and taxpayer, believer and skeptic. That is when I realized that while most literature on role play emphasizes student learning, instructor revelation should be a part of the processing after the role play, too. There is value beyond the moment in role play as a pedagogical methodology if one takes the time to reflect on the procedure.



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AMY ROSS: BODY STORY OR PERSON STORY?

Elizabeth S. Kelchner, Ph.D., Binghamton University, State University of New York

Physicians' failure to communicate effectively with patients can cause depression, anxiety, and poor adjustment to illness. In this narrative the author shares the story of one woman's communication with physicians while undergoing medical procedures that led to a diagnosis of cancer. Her experience reveals a cold and uncaring medical community, and the impact on her sense of self and quality of life is discussed.

My field of research and practice is gerontology. I conducted interviews for a research project on communication between elders and their physicians in 2001-2002. My interest in the topic came in part from experiences accompanying my mother to various physician appointments; her communication experience with doctors varied and I wondered if that was typical. I found that there were few research studies about physician-patient communication that focused on elders and even fewer that looked at the experience from the older person's perspective.

What we do know from the literature is that when we perceive the person with whom we are communicating to be old, we attribute them with more frailty and vulnerability than if we perceive them to be young (Hummert, Garstka, Shaner, & Strahm, 1995), and that we have a general belief that older adults have more communication difficulties than younger persons do (Giles, Coupland, Coupland, Williams, & Nussbaum, 1992; Hummert et al, 1995). These negative assumptions about the elderly cause us to over-accommodate and communicate in a patronizing manner. Although older patients tend to ask more questions than younger patients do, physicians tend to be less responsive when older patients raise issues. Physician responses to younger patients are considered significantly better than with older patients (65+) in that they are more engaged, respectful, and egalitarian (Greene, Adelman, Charon, & Hoffman, 1986). Additionally, research indicates that physicians do not feel comfortable treating older patients or addressing the chronic problems they present (Béland & Maheux, 1990), and that among medical students, geriatrics ranks lowest compared to other subspecialties (Carmel, Cwikel, & Galinsky, 1992).

From my mother's experiences and the literature I read, I had some suppositions about what I would learn but was not prepared for what I heard from Amy (a self-chosen pseudonym). Amy's story is just that; it is her story, based on her perception and interpretation of events, but that does not mitigate the importance of telling it. As this study was a phenomenological inquiry, I did not have a large sample, interviewing eleven individuals age 70 and older. I was not concerned with being able to generalize the findings; rather, I wanted to understand each participant's experience and the meaning it had for them. Nonetheless, in interpreting the data several themes emerged: issues related to self-disclosure in the medial encounter; depersonalization or being treated as an object or "thing" called "thinging" in health care (Howard, 1975); wanting but not having a sense of control in the relationship with physicians; and wanting but not receiving empathy. Amy's story illustrates each of these themes and best exemplifies the participants' voices in the research I have done. It captures the essence of their experiences communicating with physicians—the need and the desire to have some control over their health, over treatment decisions, and over the care they receive; the need to be heard; and the need to be treated as a person. While this does not reflect the experience of every patient with every physician, that was not the intent of my research.

I met with Amy over the course of nine months. She was very generous with her time, allowing me into her home on three occasions and answering follow-up questions by telephone. Amy wanted physicians to hear her story in the hopes that patient care would improve. I promised Amy that I would do my best to make her story known. Her story is compelling, and I want the reader to have a sense of who Amy was and what she experienced. I don't want to tell her story in a way that is maudlin; Amy was a very direct person, not given to feelings of self-pity. Having learned of her death, I have become convinced that I need to put it down on paper. Changes are needed in our health care system, both in accessibility to and delivery of services. I believe that Amy's story will add to the discourse.

Amy and I met in her living room, a rather large room that was dark despite a generously sized picture window; Amy's illness, along with poor lighting and loosely drawn curtains, contributed to the atmosphere. The artifacts of Amy's life since her diagnosis cluttered the room: an oxygen tank and one extra, so she wouldn't be without; a cot in one corner in case someone needed to stay over; a recliner, as she could no longer sleep lying down. Her diningroom table had been taken over by the numerous bills, statements, and "explanation of benefit" letters she had been receiving related to her medical care. Amy expressed frustration with the volume of mail and was looking for help in sorting it out. She had argued with the suppliers of oxygen about the bill and insurance, trying to explain that she no longer had the energy to figure it all out. If they wanted their bill paid, they would have to call Medicare themselves; after all, she was dying. Amy's back was to the little light that filtered in through the living room window, and her face was in shadow. Although she spoke of having feelings of "rage" towards her physicians and the medical community, her affect was flat.

In addition to sharing her personal story, Amy spoke of other women she had come to know who also had a diagnosis of cancer and their experiences with physicians, and she relayed an experience an older relative had with her physician before she died. Amy spoke about the lack of concern expressed by these physicians; when her friends had chemotherapy treatments, they were called in turn by number, "number 5 is next," rather than by name. She talked about a play she watched on television, *Wit*, a story about a woman with ovarian cancer who had been a college professor. In the movie she is being treated by an intern who was once her student, who is so indifferent that he engages in a one-sided conversation with her, not realizing that she has died. Amy had been reading short stories (she told me that she did not have time to read a novel) about people who have had cancer. She needed to be able to identify with someone else's experience and didn't think that was morbid.

Amy was a retired registered nurse who, for most of her career, worked in a hospital, interacting with physicians on a regular basis. The physician she was seeing when I met her was someone she had worked with for many years and she knew him to be a kind and considerate man. When she began seeing him as a patient she had retired from nursing. Amy was 75 years old when I met her and lived alone, having never married. Her only relatives were a brother and a niece.

In the winter of 2000, Amy was diagnosed with pneumonia. "It was sort of [a] complicated pneumonia, and when I got over it they wanted to do some chest x-rays to see if the pneumonia had cleared." Amy went to the hospital and had the x-ray; shortly after she was asked if she would be willing to have a bronchoscopy. When she asked why, she was told it was a "funny kind of pneumonia." Later she was asked if she would be willing to have a biopsy and was told "we think you might have TB and we want to take some snips." In the end it was clear that it was not an "odd pneumonia" or tuberculosis. Amy had lung cancer. But she didn't know that yet. She saw a pulmonologist who did more tests and then asked to see her.

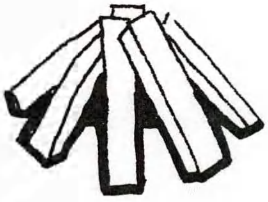
The very first day after he did the lung scan, he wanted me to come in so he could tell me the results. My friend came with me; we were both standing there. He calls us both over (to look at the chest x-ray) and he says, just like this, "This is what I'm concerned about, this cancer right here." We both nearly fell to the floor. The word "cancer" is synonymous with death. Even the worst heart condition, it's still not the same as telling you, "You have cancer." When he said that, I just looked at him. I [said], "What?" "That's what I'm concerned about, see, right here, right here it is. This cancer right here."

Through further testing Amy learned that the cancer had metastasized to the other lung. She was seen by an oncologist and a pulmonologist who both indicated that considering her overall poor health and her age she was not a good candidate for treatment. She was told that chemotherapy would prolong her life for only a few months and that during that time her quality of life would be "horrible."

Amy decided not to seek treatment and was advised to return to her primary physician, but it was not a positive "reunion."

Having known her physician for many years, Amy felt that their relationship had been on a more personal level. She believed that he cared about her as a person. Over the course of several weeks while Amy was having numerous tests, she had expected that her primary physician would call her, especially once he learned of her diagnosis. But he never did. Having been told that there was nothing to be done, she needed to know if her physician was going to "stick with me through this." She decided to confront him with her feelings about his not calling.

My primary physician is somebody I've known for many years, I knew him when I worked at the hospital, and I felt that I knew him, I mean that we had more of a relationship than just, I mean we weren't buddies, but more of a relationship than just doctor and patient. I mean we really knew each other well when I worked with him at the hospital. But in that six or seven weeks that I was having all those tests I really did expect him to call me to say, "Gee, Amy, I'm really sorry to hear your diagnosis." Or, "What's going on?" So, when they told me to go back to my primary physician, I knew I'd go back to him. But before I did I was thinking very seriously about confronting him about just how I felt. Because he was going to be my doctor, I had to find out if he was going to stick with me through this. And so, I decided to confront him with it. And when I did see him, I [said], "I'm really surprised that you didn't call and inquire, that you weren't even interested when you knew I had this diagnosis or was going to have it. And I thought I would hear from you before they ran out of options and had to come back to you." And he said, "Well, what was I going to call you about?" I [said], "Well, just as more than as a doctor, friend, we have had that relationship." He really didn't get it; he kept making excuses. I said, "Well, now I have to find out if you're the only one left." The pulmonary doctor said there's no point in coming back, unless I really needed him for a pulmonary problem. The oncologist said there's no point in coming back. When I was there, he comes right out and says, "I'll give you October of 2000." He says, "You have six months to a year." Just like that. Then I nearly fainted, fell on the floor.



I happened to be alone that day. I have a friend who usually comes with me to these things but she couldn't come. And I didn't think anything like that was going to happen. I said, "Six months to a year?" Well, I don't have to tell you I was in total shock. I mean, the other guys had told me it was no good, and it was aggressive cancer. But they didn't come right out and give me a time.

The response of Amy's physician was one of indifference: "Well, what was I going to call about?" Amy had issued a "call that asks 'Where art thou?'" which "needs to be addressed in a positive manner: 'Here I am!'" Amy's physician had failed the "call of conscience" (Hyde, 2001).

When I asked Amy if, once she had gone back to her physician, she had ever talked to him about her illness and her concerns, or if her physician ever asked how she was doing, she indicated that she did not talk to him. I wondered if she had anyone else she could talk to, someone who might be able to offer some kind of assistance, some support. She told me that she talked to the social worker employed by the housing program where she lived.

Now, I'll tell you the truth. If it weren't for her, I'd be crazy. Because she is a very kind, understanding person. And she is very helpful and I called her when I first found out about it. And she came up and she was very helpful and she gave me all kinds of places I could call, and she said she'd be willing to come up and talk to me. I don't have any family here, no one really to turn to. I cannot tell you how kind and understanding she's been. So when I had that interview, when he told me all that stuff, when I came home, I just knocked on her door and went in and saw her. And all I can say is what a social worker she is. And she has been since. And I truly appreciate that. So when you say, "Did he talk to you?" I talked to her. I don't talk to him about how I really feel.

Amy indicated that she had resigned herself to the cancer diagnosis; she knew she was dying. She wanted to have some control over what time was left but she felt that since her diagnosis her life was not her own. It was taken over by the medical community, one that, for her, often lacked warmth and care. She had been treated not as a person but as a "patient with cancer" and was identified by her test results, not by the person she was. Her physician demonstrated little caring about Amy as an individual, not taking the time to ask how she was feeling, how she was doing emotionally. He treated her disease but not her self.

I just felt abandoned. Especially with this diagnosis. If he were going to abandon me, where am I going to be? I need a doctor. He's never reached out. I feel like I'm not getting full support. I often wish it were different. I often wish I could talk to him. He never once asks, "How are you getting along?" or "How are you taking it?" or "How are you dealing with it?" He never once asked. Now, I don't know if another doctor would take me on. I feel I have to keep him. How many internists take on a cancer patient?

During my last visit with Amy it was clear that her illness had progressed. She was taking more and more pain medication, but there were unpleasant side effects and she occasionally had pain in her hands and feet. She was tired but was unable to get any rest; when she would recline she couldn't breathe so she slept for only brief periods of time.

I made one final phone call to Amy, and she shared with me that she had been feeling more pain recently and more anxiety. A trip to the emergency room resulted in an inpatient stay in the psychiatric unit of a local hospital. She had responded to the emergency room physician's question about depression. Asked if she had feelings of depression and had ever considered suicide, she confirmed that she had, in fact, felt more depressed as the pain worsened, but that although she had considered suicide, she would never act on those feelings. Without being told where she was going she was transported to a locked psychiatric unit and put on "72-hour guard" in a room with a mattress on the floor, no other furniture, and bars on the windows. Amy told me that she was "trying to hold on as tight as I can," but it is a "helpless feeling to feel that you've been trapped in their indifference." When talking about the kind and manner of treatment she was receiving, she indicated that her "expectations [were getting] lower."

Amy's story is about the effect of physician-patient communication and of dying and death on the physician-patient relationship. Communication with elders can have an effect on the individual's sense of her/his own life satisfaction (Allman, Ragan, Newsome, Scoufos, & Nussbaum, 1999) and patient-physician interactions can have important consequences for the quality of life of older patients (Beisecker & Thompson, 1995). As Amy experienced when she was admitted to the psychiatric unit, poor physician communication skills can also lead to costly and inappropriate medical interventions.

How communication between physicians and patients occur and the quality of the interaction can be traced to several factors, including the physicians' medical training. As students progress through medical school, the demands placed on them often cause initial humanistic ideals to be rejected. In observing medical interviews, Kramer, Ber, and Moore found that medical students demonstrated "rejecting behaviors" such as ignoring their patients' emotions, being poor communicators evidenced by not listening to patients' concerns, and avoiding eye contact (as cited in Allman, et al., 1999). Additionally, the attitudes that physicians hold towards older patients can have a negative effect on healthy aging (Grant, 1996).

Researchers have looked at the outcomes of teaching communication skills to medical students (Winefield & Chur-Hansen, 2000; Wolf, Woolliscroft, Calhoun & Boxer, 1987) and the efficacy of physician communication skills with people who have cancer (Ellis & Tattersall, 1999; Maguire, 1999). Medical students have been found to improve their ability to demonstrate empathy through responses to patients after being taught basic communication skills (Winefield & Chur-Hansen, 2000), and those who received both small-group instruction and large-group lectures improved their ability to respond to patients' emotional concerns (Wolf, et al, 1987).

Physicians, trained to treat illness and disease, may have difficulty when their patients are diagnosed with a terminal illness and have revealed that they feel uncomfortable disclosing a diagnosis of cancer (Ellis & Tattersall, 1999). The inability to effectively communicate with patients may cause physicians to feel as though they have "failed the dying patient" (Baile, et al., 1999). As a consequence of poor physician communication skills, patients may feel anxiety and depression, causing them to have a poorer psychological adjustment to their diagnosis (Ellis & Tattersall, 1999), which can influence their quality of life (Maguire, 1999). It seems clear that improved physician communication can have a positive impact on patients' adjustment to illness and to their overall sense of well-being. Some attempts are being made by medical schools to assist medical students in their communication (Tufts e-news, 2003) while a number of medical organizations are calling for "improved training and competence in communication skills" (Lurie, 2003). This emphasis in further education for medical students may help to avoid more stories like Amy's.

Over the months that I met with Amy, I came to know and like her. She seemed to appreciate my interest in hearing her story and my promise to share what I had learned about and from her with others. Most of the individuals I met with for this research project reported negative communication experiences with their physicians. Participants indicated that their physicians objectified them, took complete control of the medical encounter, and demonstrated little or no caring about them as "human beings." I was saddened, depressed, and angry by the stories I heard. At the time I was conducting the research, one of my neighbors was a physician. We talked about what I was hearing, and he shared his frustration that he was "allowed" fifteen minutes for each patient visit, which was supposed to include time for him to dictate his notes. I believe that many, perhaps most, medical students begin their education with lots of energy and visions of providing care and treatment for their patients and end their education feeling tired and rushed and discouraged. The emphasis of medical schools and organizations on physician communication training is a good step in the direction of improving relationships between patients and physicians, and it is something that will benefit all of us. The next step is to return the practice of medicine to physicians and other health care providers.

Amy did not need to read a research report to understand the effects of poor physician communication skills or the lack of empathy on her well-being. She experienced being objectified, and she continued to be a victim, until the end of her life, of a cold and uncaring medical system. Amy died on December 6, 2002.

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NOTES FROM THE MEDIA EDITOR: COMMENTARY ON THE SUMMER OLYMPICS AND MOVIE REVIEW OF *TARNATION*

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The 2004 Summer Olympic Games In Greece, The Human Connection, And The Danger Of Subjective Interpretation: A Commentary

I am not an athlete and I have never excelled in any sport; nonetheless, I have always watched the Olympic Games with great interest and enthusiasm. Every four years, as athletes from every corner of the earth and every kind of background come together to strive for excellence, the Olympic Games become a symbol of our ability to coexist in harmony and peace. International differences in language, attitudes, behavior protocols and food, to mention a few, are overshadowed by awesome athletic mastery and the blending of courage and competition for the Olympic gold medal. In addition to an occasion to admire athletic talent and mastery, I find that the "Olympic experience" provides compelling moments and regenerates my belief in our humanness and ability to accept, respect, and appreciate difference and diversity.

The 2004 Summer Olympic Games are over. These games took place in my birth country, Greece, the nation where they began more than 2,500 years ago in ancient Olympia, and where the modern Olympics were exhumed in 1896. They brought together a gathering of unprecedented athletic talent, illustrated the artistic and creative use of technology to produce spectacular performances during the opening and closing ceremonies, and concluded with no threatening security incidents despite unrelenting terrorism-related security concerns. My reflection on the coverage of the Games has sharpened my awareness of my "dual" ethnic identity and of the need for those who comment upon the host country, as they report on the games, to do so sensitively, objectively, and from a broader cultural perspective.

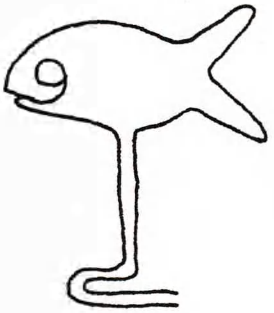
In 1997, the International Olympics Committee in Lausanne, Switzerland, selected Greece as the host country for the 2004 summer Olympic Games. With this selection, the Olympics were to return to the place where they were born thousands of years ago and where they were reclassified as "modern Olympics." This selection also meant that in the course of seven years, Athens, the hub of the Games, needed to build a new airport, a new metro system, stadiums, and roads to accommodate thousands of athletes and visitors. Early on, concerns were raised both domestically and internationally about this small nation's ability to provide all that is required for an undertaking of such magnitude. The tragic events of terrorism in the U.S.A. on September 11, 2001, raised new concerns about the ability of the Greek security forces to be up to the now more enormous task at hand.

As in a self-fulfilling prophesy, preparations for the Games proceeded slowly. The chaotic construction sites in Athens and the still unfinished venues as the date for the commencement of the Games approached, both intensified the concerns of the International Olympic Committee officials and of the international community. Satirical jokes and photos about the slow progress with the preparations started appearing in the media. Mike Penner (*Los Angeles Times*, August 8, 2004) described the situation in what he called "American sporting terms" as follows:

> "Greek organizers spent the first three years sitting on the ball and the next three regrouping before turning the last year into a two-minute drill...Reports of construction delays and operational glitches have become so commonplace, the Athens Olympics Organizing Committee has become an all purpose straight line, with no shortage of punch lines."

Though the media hailed Greece's glorious past, it simultaneously criticized some of the country's more contemporary cultural practices. Beverly Beyette (*Los Angeles Times*, April 18, 2004) described the transformation of Athens from an ancient city of monuments and artifacts to a metropolitan capital with expensive restaurants and deluxe hotels. "But what does not seem to have changed" she continued, "is the Greek mind set" according to which "Greeks do everything at the last moment." Long before the execution of the games, the slow pace of preparations in Greece led to world-wide speculations and predictions that the venues would not be ready on time. Poking fun at long construction delays, the frequently raised question by the American press and media was, "Will Athens pull itself together for the Games?" Countries that had hosted the games in the past were offering to have the games come back to their soil. Predictions of disaster were abundant. The Greek work ethic was scrutinized and Greek life style practices were criticized relentlessly. " 'Now' to the Greeks," concluded Beverly Beyette, "means sooner or later, which tends to explain why only four months before the Olympics piles of rubble sat on partly laid tram tracks."

I visited Greece in April 2004. The grounds of ancient Olympia, the site where the first Games were held in 776 BC, were covered with multicolored wild flowers. The night before, the Olympic flame had been transferred from this site to Athens, a city that was indeed in a state of "construction fever." No Greek, however, seemed to understand, let alone share, the concerns of the international community. They acknowledged the work that still had to be done, but they had no doubts that it would be done on time. They had competed for the honor to host the Games and they were confident that the venues would be completed by the date the Games were to convene. The Greeks that I talked to just could not understand why things needed to be done before that date. To them, it was the final product rather than the process that was important. I questioned their sense of confidence.



As the time for the commencement of the Games approached, Greeks worked fiercely to finish the venues. They finished them under their own terms and at their own pace; practices that those who expected promptness and precision could not understand and were, therefore, eager to criticize. As a bicultural Greek with my own reservations, I felt that judgments by the American media were based more on the work orientation of the critics and less on an understanding and acceptance of the Greek way of operating. Heedless of the danger of subjective interpretation, journalists used language and made predictions that alarmed the world and offended Greeks in Greece and in the diaspora.

As we now know, Greece delivered in grand fashion. Most of the venues were completed on time. Those that could not be declared completed as initially planned, like the roof on the swimming venue, were brought to a state of construction that accommodated the athletes without the risk of jeopardizing their performances. At least no complaints to that effect were registered during and after the Games. Instead, the controversies were over judging mistakes, the fallout from illegal doping and other issues that did not bear a direct relationship to the manner in which the country prepared for the Games. Finally, as Mike Penner (*Los Angeles Times*, August 8, 2004) put it, "after delays, glitches, gridlock and terrorism fears," and an outlay estimated at $12 billion (1.5 billion for 70,000 security personnel) Athens was ready for the Games to begin. The theme was "Welcome Home."

The opening ceremony, a rich spectacle with olive branches and a warm welcome, presented Greece's history from 200 BC through the 20th century. The different phases of her glorious past were paraded in sequence. Technology was used in imaginative ways to create a pageant rich in color, history, promise, and drama. Gianna Angelopoulos-Daskalaki, head of the Athens 2004 Olympic Committee, welcomed the crowd with a promise: "You will be moved, you will be awed, inspired, exhilarated... Greece is going to fire the world's imagination." The procession of thousands of athletes, many in colorful native costumes, created the greatest ethnically diverse and brightest landscape in the new Olympic stadium the world had ever seen. The Olympians of ancient Greece would had felt, I believe, honored with the presence of so many athletes from all over the globe who had gathered in Athens to repeat what they had initiated centuries ago. "The Greek Olympic Committee," wrote Bill Plaschke, created an opening ceremony that "was humble in its welcome, bold in its history, and surprising in its ending" (*Los Angeles Times*, August, 14, 2004).

In the course of seventeen days (August 13 to August 30, 2004), 10,500 athletes from 202 countries, competed in 28 sports and 38 venues. Three hundred and one medal ceremonies took place. The humility of the athletes in an environment of intense competition was penetrating. The manner in which " the best against the best" turned around to congratulate a victorious competitor evoked overwhelming emotions. The closing ceremony depicted the way of life in modern-day Greece. The country's songs and dances, the four-season activities at Greece's different regions, the way in which Greeks toil at work and the way they use leisure time were presented in creative, ingenious and artistic fashion. Athletes and spectators were asked to join in the celebration, dubbed "The biggest, fattest Greek wedding".

"We accomplished what we promised and erased seven years of doubt by delivering flawless Games, reconnecting the Olympic movement to its ancient heritage and introducing the world to the modern accomplishments of the new Greece," declared Gianna Angelopoulos-Daskalaki at the conclusion of the Games. "These Olympic games have shown the world the great things Greeks can do," she continued. Jacques Rogge, the International Olympic Committee president, told the world that these were "unforgettable dream Games." Bill Dwyer (*Los Angeles Times*, August 30th) wrote: "Almost nobody thought they could. Almost every body predicted disaster. Greeks have shown the world the great things they can do." Peter Ueberroth, chairman of the Board of the United States Olympic Committee, declared that "the Greeks are to be congratulated...The first gold medal of these Olympics has already been awarded to the Athens organizers." Michael Phelps, the six gold medal United States swimmer, stated that "Everyone was asking is the place going to be ready? It has been nothing but a great memory." Many other American and international athletes talked of compelling moments they had experienced during their stay in Greece.

I felt pride watching the Americans, the largest contingent of athletes, excel and win the most medals. I also felt pride for the impressive and spectacular outcome of the Athens Games; a first class delivery. For seventeen days I experienced a rapid cycling between my Greek and American selves. I wept during the opening ceremony and during the course of the games. As a Greek, I kept my head high and let my chest thrust forward from pride, the same way when, many years ago, my provincial grade school teacher had convinced me that Greece was the greatest nation on earth. My sense of pride, however, was deluded by guilty feelings for having allowed myself to join the ranks of the critics during the pre-game days and to question my compatriots' ability to meet their Herculean challenge. Nancy Franklin (*New Yorker*, September 6, 2004) reflecting upon the Athens Olympics concluded that "Like every Olympic fortnight, this one produced stories and images that will stay in viewers' minds for years to come." For me, this Olympic fortnight brought an overpowering feeling of pride and rekindled questions about acculturation, assimilation and biculturalism. It also triggered questions about a nation's right to accomplish an endeavor of international magnitude according to its own cultural practices, life styles, and self-expectations, rather than according to externally imposed deadlines. Can the product rather than the process be what really counts, I now ask?

In the eyes of the world, the 2004 summer Olympic Games in Greece, the 28th Olympiad, ended triumphantly. These games also set global TV viewing records, with nearly 4 billion people tuning in. I want to believe that the spirit of human unity that characterized these Games will have a long-term global effect. Furthermore, I want to believe that the "Greek experience" will help increase our trust and confidence in a nation's ability to accomplish Herculean tasks in its own terms.

Movie Review: *Tarnation*

Tarnation debuted at the 2004 Sundance Film Festival as the first feature to be edited completely with Apple's Movie software. It is a movie unlike any other that I have seen. Jonathan Caouette, the 31 year old director, has assembled a lifetime of family photographs, Super-8 home movies, and video diaries to present the cruel absurdities in the life of his trans-generational family, the intensity of his emotional connection to his mentally challenged mother, and his disabling fear of generationally transmitted mental illness.

The movie opens with a distraught Caouette, a resident of New York City, on the phone with an unidentified individual who had called to inform him of his mother's Lithium overdose in a Texas psychiatric hospital. During the following ninety minutes, pictures interwoven with clips from TV shows and various films create a compelling documentary of the director's experiences during childhood, adolescence, and young adulthood. We enter his psychologically turbulent world, and witness his confusion over personal identity, sexual orientation, and betrayal in interpersonal relationships. In an environment full of unpredictability, what remains stable is Caouette's passion for creative expression and his desire to record his life script on film.

By the time Caouette was born, his biological father had left home without ever knowing that his young wife, Renee, was pregnant. We are presented with numerous pictures of Renee from babyhood to middle adulthood. In a series of images we witness Renee's transformation from a beautiful young model to a middle-aged woman in psychotic states, in and out of mental institutions, walking around disheveled and uttering incoherent statements. Paralleling Renee's changes are Couette's transformations from an infant in foster home placement to a young adult in a stable homosexual relationship but haunted by the fear of inescapable mental illness.

Several scenes can have a chilling effect on the viewer. Such is the experience when Caouette appears, at the age of 11, in a dramatic monologue as the abused wife of an alcoholic husband. The words he chooses reveal an upbringing in a world of harrowing experiences and disregard for human dignity. His physical presentation transcends his dramatic talent and gives the impression of a troubled youth affected by hatred and violence. The ferocity with which he loses himself in the act seems to be his way of coping with his life's circumstances that are major deviations from a normal childhood.

The systematic way in which Couette films, from a young age, the interactions among his family members and focuses his camera on their idiosyncratic behaviors, becomes our window to possible unconscious or intentional plans to create a documentary in some future day. A plan to use his voluminous filmed material to expose the disabling effects of mental illness, demonstrates the power of love to transcend feelings of abandonment and rejection, and discloses how the fear of genetic predisposition to mental illness haunts him perpetually.

With camera in hand, Couette follows the toothless Rosemary Davis, his maternal grandmother, and records her often non-conventional dress, senseless statements and outbursts of laughter. He asks Arnold Davis, his maternal grandfather, inquisitive questions about family events and provokes angry reactions and denials. He insists on documenting exchanges with his mother even when the latter is in her psychotic states and finds the task too taxing. One wonders if Couette's obsession to record intra-family scenes was a plan to eventually create the compelling family epic that *Tarnation* indeed is. The young director's statements in reference to his mother at the conclusion of the movie, "I am scared. I don't want to turn out like my mother. At my age she seemed better…" might be reflections of his internal demons of mental illness. Documenting his life in a dysfunctional family might have been the director's attempt to show us how inextricably embedded he believed mental illness was in his life.

In New York City, Caouette succeeds in bringing some normalcy to his existence. He forms a loving and stable relationship with his partner, David Sanin. The two share an apartment where Renee, brain damaged from invasive treatments during her 100 psychiatric hospitalizations, spends time as their house guest. We are touched by Caouette's concern and affection for his mother. "She lives inside me; I cannot escape her…" he utters at the end of the phone conversation when he is informed of Renee's Lithium overdose.

This movie is not entertaining; instead, it is depressing. It is the product of a creative but novice director, who ventures to disentangle a 31-year life experience scathed by violence, perplexity, mental illness, and a perpetual sense of danger. Scenes with this content, in combination with the images of troubled, real-life characters, can make the ninety-minute confinement to a theater seat feel too long. I stayed to watch *Tarnation* from beginning to end because of the promising talent and creativity it reflected in the use of photos and home made videos, the choice of music, and the use of the written dialogue. What captured my interest, however, was Couette's perseverance in the midst of so much aversion, his passion for acting and filming, and his strong emotional connection to a mother who had lost her capacity to reciprocate a long time ago. *Tarnation* is an unconventional and disturbing movie, but worth seeing. I recommend it.

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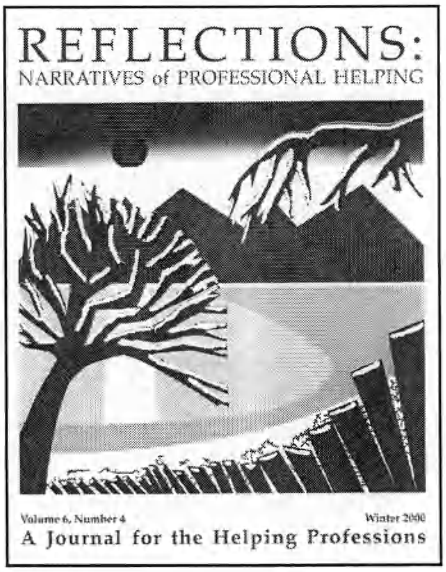

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