REFLECTIONS

NARRATIVES OF PROFESSIONAL HELPING

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THE SUBSTANCE ABUSE FIELD: Discovery and Hope

By Maryann Amodeo

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Jim (Moran) and I wanted to share a few of our thoughts about the topic of substance abuse and why narratives might be an especially effective way of exploring this topic.

Substance abuse is an issue that often evokes strong reactions in clinicians who have not been specifically trained to do the work. It can seem intimidating, stirring up feelings of anxiety, helplessness, hopelessness, fear of being seen as naive or fear of being manipulated. Or the work can seem dangerous, with clients seen as capable of anything when under the influence of drugs or alcohol. Or it can seem futile, with clients who act out and seem to leave a trail of destruction in their wake.

The prevailing stereotype of the clinical work as simplistic and intellectually unchallenging has also contributed to the small number of health, mental health, and social service professionals who identify themselves as substance abuse treaters and experts. This is too bad because the work is complex, important, exciting, and gratifying.

It's a field demanding all our best clinical skills to address conditions that can change the personality, that can be life-threatening, that can cause people to lead double lives and forget who they once were. It's a field with a strong spiritual dimension, where people understand that changing often means self-reflection, insight, and personal transformation.

There is intellectual challenge, given so many myths and misconceptions—I enjoy exploring people's beliefs and convictions, presenting new information, reeducating. It's a field in its infancy in terms of research—there are many discoveries yet to be made on biological, psychological, and sociocultural fronts. There's lots of room for innovation in primary prevention, assessment, intervention, family treatment approaches, and relapse prevention.

As you can probably see, I'm high on the field. Over the years, I've worked with hundreds of clients who quit using alcohol and other drugs and moved into recovery. So in each new client encounter I feel very hopeful.

I began working in the substance abuse field in 1969 just after completing an MSW program. I was hired as the coordinator of the alcoholism clinic at Boston City Hospital, a lively, growing clinic. In those days, there were very few professionals staffing substance

abuse programs—most of the work force was composed of recovering alcoholics and addicts. Whenever we had a job opening, our choices were to hire recovering counselors untrained in clinical methods, or professionals untrained in substance abuse. We decided to develop training programs for counselors to teach them clinical skills. Similarly, to equip professionals with substance abuse skills, we developed internship and residency placements for social workers, psychologists, and psychiatrists.

In training recovering counselors, we learned as much from our students as they learned from us. Thus, I "grew up in the field" and was socialized by the recovering people working in it. I credit them and the clients I treated over the years with much of what I know about substance abuse.

Recovering alcoholics and addicts were the only people available to be hired by the treatment agencies—they were the only employees with sufficient hope about the conditions and sufficient training (limited as it was) to implement treatment. Jobs in the field were seen as low status, even when held by social workers, psychologists or psychiatrists— a case of "derived stigma"—workers being assigned a similar stigma as their negatively regarded clients. Those of us in the field felt like an embattled minority, misunderstood and unappreciated by the larger human services system. And we were.

Now professionals with substance abuse training are viewed with increasing respect, and are actively recruited into the field. A few developments in the past 10-15 years have prompted cross-fertilization or integration between the substance abuse counseling field and other helping professions. Among these developments is an influx of recovering students into the professions of nursing, social work, psychology and medicine. By virtue of their being both recovering substance abusers and human service professionals, they have often been able to improve communication between recovering counselors and non-recovering professionals, thereby reducing the historic distance between the two.

Also, the credentialling process has raised the skill level of many in the substance abuse field, increasing their legitimacy in the eyes of other human service professionals. In addition, substance abuse counselors (like many of the rest of us in the helping professions) have encountered limitations as their cases have increased in complexity, with dual diagnosis, childhood trauma, domestic violence, homelessness, and HIV infection all too common in clients' backgrounds. Mental health and domestic violence experts and those with related areas of expertise have become crucial members of the treatment team.

Unfortunately, training for professionals in all disciplines—nursing, medicine, social work, psychology, occupational therapy, physical therapy—has lacked a strong focus on alcoholism and drug dependence. Even now, most graduate and undergraduate programs in these disciplines offer little substance abuse training. When formal courses are available, they are often electives.

Jim and I both teach in graduate schools of social work and spend a significant portion of our time teaching about substance abuse. We face the daily challenge of helping social work students and colleagues rid themselves of age-old stereotypes and biases and open themselves to the many exciting clinical and research opportunities in the field.

An interesting article in the March 1994 volume of the journal, *Substance Abuse*, speaks to the difficulties many clinicians have in building alliances with their clients. The authors (Mueller & Lewis, 1994) point out that medical students and physicians often have difficulty empathizing with alcohol-and drug-abusing clients—they experience the clients as the "dependent clingers, entitled demanders, manipulative health rejecters and self-destructive deniers" (Groves, 1978; as quoted in Mueller & Lewis, 1994) described in the literature and portrayed in stereotypes.

To address this inability to empathize, Mueller and Lewis (1994) have used short

stories in their teaching of medical students and undergraduates, specifically, "The Sorrows of Gin," by John Cheever, focusing on a young child's perception of parental alcoholism, and "The Navigator," by Susan Minot, about the effects of alcoholism on a larger family constellation.

In teaching substance abuse courses, I have sought similar approaches in an effort to help students see the person behind the addiction. A friend has said she believes that addicts and alcoholics suffer from two profound worries—one, the fear of being found out; and the other, the fear of never being found out and being left to suffer and die alone with the condition.

I invite clients into the classroom each semester to tell their own stories so students can hear directly about the nature of clients' problems, feelings, fears, and solutions. Similarly, students are encouraged to attend open meetings of AA, NA, Al-Anon, Rational Recovery, Women for Sobriety and other mutual aid groups so they can hear first-hand accounts of addiction, relapse, and recovery.

It was this awareness of the power of first-person accounts of change that attracted me to edit this volume of *Reflections*. So often in my own journey of growth as an individual and as a professional, I've been moved by the personal stories of others who have ventured into uncharted territory, struggled to find their way in spite of anxiety and failure, and returned to help others move forward and succeed. These intimate accounts of pain and self-doubt experienced by others have led me to feel hopeful that in time, even the worst of my own difficulties might be resolved and the most improbable of my own dreams might be realized. □

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RESEARCH AND PRACTICE:
The Great Divide in Substance Abuse Treatment

The substance abuse treatment community and empirically oriented academics concerned with substance abuse treatment share the common goal of reducing the harm caused by substance abuse. Yet, these two communities are deeply divided. They tend to see the causes of the problem and its possible solutions in dramatically different ways. This narrative describes my experiences in the terrain between the two communities, first while working for an insurance company as a substance abuse utilization reviewer, and later as a professor teaching substance abuse treatment to graduate students.

By David A. Patterson

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"If you shut your door to all errors truth will be shut out." Rabindranath Tagore, Stray Birds, 1916, (Davis & Mesner, 1994, p. 163)

While completing my doctoral studies in social work, I worked for a nation-wide insurance corporation as a psychiatric and substance abuse utilization reviewer. In this capacity, I spoke with treatment professionals in substance abuse treatment facilities across the country in order to review the medical appropriateness of admissions and the necessity of continuing stay. This was in the late 80's when there was a dramatic nation-wide rise in demand for substance abuse treatment and an equally dramatic increase in non-profit and for-profit inpatient sub-stance abuse treatment facilities.

In response to the soaring cost of inpatient substance abuse treatment, managed care companies, acting on behalf of insurers, were beginning to constrain admissions to, and lengths of stay in, substance abuse treatment facilities in an effort to control costs.

Concurrently, evidence of the lack of efficacy of substance abuse treatment and the findings that inpatient treatment was no more effective than partial hospitalization was beginning to appear in the literature (Annis, 1986; Longabaugh, McCrady, Fink, Stout, McAuley, Dolye, & McNeill, 1983; Vaillant, 1983).

The goal of the company I worked for was to reduce medical costs by preventing unnecessary admissions and reducing the length of stay by transferring care to less restrictive (and less costly) settings when medically appropriate. As a utilization reviewer, I sat in a work-cubicle all day in front of a computer and spoke to representatives of treatment facilities across the country. Essentially, my job was to ask questions such as; "Why does this person need inpatient care as opposed to outpatient care at this time?" "Have there been previous attempts at outpatient treat-ment?" "What types of assessments have you done with this person and what are the findings that support your request for inpatient care?" "What are the goals of treatment that have been individualized for this person based on your assessments?" and finally, "Has your facility evaluated the efficacy of your treatment programs and can you provide me with such documentation?"

My questions were generally not well received. Even in those early days of managed care, calls from a utilization

review worker was not a welcome event. At least once, a physician referred to my colleagues and myself as minions of the insurance company devil. Second, because the questions I asked were shaped by my doctoral training with its emphasis on empirical research of clinical outcomes, they flew in the face of a treatment community that saw itself hard at the task of fighting a deadly disease. In answer to my questions, and almost always regardless of circumstance, I was provided the following answers: "The patient needs inpatient hospitalization because he/she was in denial about his/her disease." Outpatient treatment was inappropriate because the patient needs 28 days of inpatient treatment to break down their denial." "The patient meets DSM-III-R criteria for a substance abuse related disorder and therefore he/she needs inpatient care." "The goal of treatment is for the patient to work the first four steps of AA's 12-steps." and finally, "Our facility has not evaluated our program but we know it works because those patients who continue in aftercare tell our staff it has worked for them."

As my experience grew in reviewing cases with counselors, utilization review nurses, program managers, and physicians in drug treatment facilities across the country, it became apparent that we were not seeing the same information in the same light. Despite attempts on both sides to maintain respectful and cooperative relationships, the interaction would at times become adversarial. In most cases, I was told that what was required for this life-threatening condition was inpatient detoxification and an inpatient stay in which the patient would be educated about the "disease," would receive individual and group therapy, and would begin work on the 12-step program. The inpatient stay followed by weekly aftercare groups and attendance at 90 AA meetings in 90 days. I was familiar, however, with the emerging literature on substance abuse treatment failure rates. Consequently, I had little faith in the treatment plans, time frames, and interventions being proposed. Moreover, reviewing the case by phone and by express-mailed case records from the safety of a work-cubical hundreds or thousands of miles from the actual patient, I was insulated from both the context and the reality of the patient's life and the attendant anxiety it provoked in the treatment staff. One patient, one problem, seen from two worlds apart.

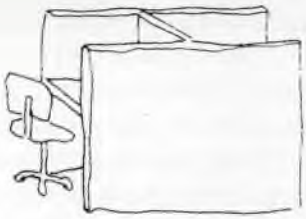
I was continually struck by the indifference expressed by treatment personnel at all levels to both the evaluation of the treatment efficacy of their particular program and to the research literature in general. In a year and a half of daily admission reviews, only one facility was able to provide me with any outcome data on treatment efficacy. This high-cost facility in the western United States had done a single study on the effectiveness of an inpatient cocaine addiction unit in which, not surprisingly, their program appeared to be successful.

My most frequent discussions were with the nurse or social worker responsible for utilization review at the treatment facility. I would often ask, "Why should we pay for a program when you cannot demonstrate it works?" This question usually brought an initial stunned silence and then a shift of subject to the urgency of the case at hand. If pressed on the issue, there was usually an acknowledgment of the need to evaluate the program and the excuse that staff trained in evaluation, nor was there time, or money to carry out such program evaluation. All of which I am sure were true. On a number of occasions, I heard from representatives of treatment facilities that many of the treatment staff were graduates of the treatment program and the success in recovery was clear evidence that the program worked. At the time, I recognized the obvious selection bias in this "evaluation" measure. It was not until some years later that I began to see how such a bias constructs a perception of treatment efficacy dramatically divergent from the

one that emerges in the research literature.

My view of substance abuse treatment during this time was molded by the all too often accounts of repeated treatment failures. When reviewing cases at the time of admission, it was routine to ask about prior treatment. Frequently, the representative of the treatment facility reluctantly acknowledged that the patient had previously been treated one or more times in this program or elsewhere. I read case records with recurrent examples of patients who had been pressured into treatment and then upon discharge, 28 days and thousands of dollar later, resumed their substance abuse. Here, too, was a selection bias. I did not hear, or read, the case histories of those whose lives were dramatically changed by their treatment experience.

My perception of substance abuse treatment was further colored by research literature emerging in the late 80's. One stream of research was beginning to suggest that partial hospitalization programs in substance abuse treatment were at least as effective and more cost efficient than inpatient programs (Alterman, Hayashida, O'Brien, 1988; Annis, 1986; Longabaugh, McCrady, Fink, Stout, McAuley, Dolye, & McNeill, 1983). Despite this growing body of literature supporting the use of partial hospitalization in lieu of inpatient treatment, I encountered no instances in which partial hospitalization was proposed as the first treatment option.



During the same time period, numerous studies were published on the treatment efficacy, across treatment settings, of teaching patients behavioral skills such as social skills training, stress management, and behavioral self-control (Chaney, 1989; Miller & Hester, 1980; Hester, & Miller, 1989; Miller, Taylor, & West, 1980; Prochaska & Diclemente, 1984). In questioning representatives of treatment facilities about what treatment modalities were to be provided to a patient, I never heard that behavioral skills were to be taught. Psychodynamic group psychotherapy, individual counseling, educational groups, and AA 12-step work were the most commonly reported treatment modalities, despite the fact that none of them had empirically demonstrated clinical efficacy (Hester, 1994).

In social work, it has long been known that practitioners seldom read or utilize research literature in guiding their clinical practice (Rosenblatt, 1968; Kirk, Osmalov, & Fischer, 1976; Rosen, 1994). On a number of occasions, I pointed out to physicians and clinical staff that the therapeutic offerings of their programs were at variance with the treatment modalities shown to be effective in the research literature. Invariably, the research literature, (except, interestingly, for the psychopharmacology literature), was dismissed as being out of touch with the realities of hospital practice. Moreover, research findings were discounted as not relevant to the treatment facility's particular treatment population, based on excessively controlled conditions, and treatment methods too complex for the level of training of the facility's counselors. From my own clinical experience in a variety of mental health settings, it appeared that there was an element of truth to all of these reasons. However, in recent years I have begun to believe that this disparity between the worlds of research and practice is formed by the more complex experiential factors that have shaped who we are, how we see that which is before us, and from where we draw our sources of truth.

TEACHING SUBSTANCE ABUSE TREATMENT

For the last four years, I have taught a graduate class in substance abuse treatment.

Despite my lack of direct practice in a substance abuse treatment facility, I was asked to teach the course because the (then) associate dean of the College of Social Work saw in my resume that I had some experience with substance abusers in psychiatric settings and had worked as a utilization reviewer of substance abuse treatment. As is often the case, while not profoundly qualified to teach the subject, I was the most experienced faculty

member available. The job came to me.

The course I developed emphasizes an empirically oriented, biopsychosocial approach to practice. In my class, I focus on trying to have students understand substance abuse as a heterogeneous phenomenon with multiple etiological sources, diverse and changing manifestations, and multiple possible outcomes. Treatment is presented as a collaborative process, individualized for each patient, based on objective and subjective assessment findings, and employing a variety of empirically validated intervention methods.

The course was formed from three streams of information: syllabi from peers at other universities who teach an empirically oriented approach to substance abuse treatment, the research literature, and my utilization review and clinical experience. Initially, two books, Stanton Peele's The Diseasing of America (1989) and Herbert Fingarette's Heavy Drinking (1988), were critical in shaping the focus of my class. Both books provide strong empirically based critiques of the AA /disease model and the limitations of its assumptions about the etiology, course, and proper treatment of substance abuse. So armed with the "truth" of science on my side, I launched into teaching others the "truth" about substance abuse treatment. All the while, I expected that after hearing my "truth," they would embrace it as their "truth."

Over the last four years, the three informational streams of my course, formed on the slopes of the research front, have been joined in the valley of class discussions by a fourth stream. The headwaters of this fourth stream form on the treatment/recovery side of the divide. The first year I taught the class, there was a student, in recovery, who discussed in class how upset he was by the readings that critiqued the AA/disease model. The student said, "I got so mad reading that stuff, I had to put the book down. It's the complete opposite of everything I was told in treatment, everything I believe."

Initially, I was frightened by the response of my student. I was concerned that, somehow, his sobriety would be undermined if the beliefs on which it rested were eroded by new information. I imagined him relapsing and me, the "heretical" junior faculty member, being blamed for the adverse impact of the "lies" I was spreading. Fortunately, my wife, who is a clinical social worker, was able to offer helpful supervision. She pointed out that he had to base his recovery on what worked for him and he needed to defend those beliefs on which his sobriety was based. So when the opportunity presented itself in class, I made the point of stating that, clearly, the AA 12-step approach does work for many people despite its failure in a number of controlled studies (Brandsma, Maultsby, & Welsh, 1980; Ditman, Crawford, Forgy, Moskowitz, & MacAndrew, 1967; Powell, Penick, Read, & Ludwig, 1985; Stimmel, Cohen, Sturiano, Hanbury, Korts, & Jackson, 1983).

Over the last few years, a number of students, who were in recovery themselves and now work in substance abuse facilities, have taken my class and have challenged and felt challenged by the content of the course, much like the previously described student. "Look," they tell me, "I know AA works because it worked for me and saved my life." "Of course, alcoholism is a disease. It was only when I accepted the fact I had a disease that I could finally stop drinking." "Don't tell me the AA/disease model of treatment doesn't work. I see it work all the time for patients who complete our treatment program." "What do you mean that in the natural history of alcoholism many problem drinkers stop or reduce their drinking without treatment. Alcoholism is a progressive disease and the only three outcomes are death, prison, or insanity."

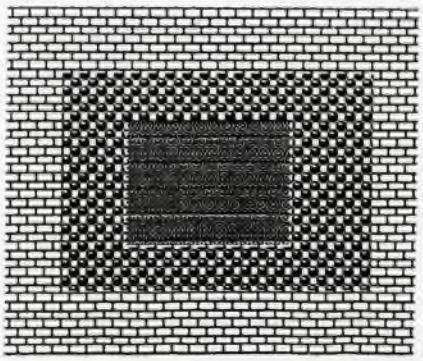
What has continually surprised and baffled me was how these students could read the findings reported in multiple, well-designed studies and yet remain so resistant to changing their beliefs about the causes, outcomes, and treatment of substance abuse. Stated less objectively, "Why couldn't they understand that what they learned while in treatment was simply wrong, that it did not match the world of substance abuse treatment known to and through empirical research?"

The issue finally came to a head for me this year. Our college which has three locations: Memphis, Nashville, and Knoxville. When we recently

began offering courses using interactive television, I volunteered to teach substance abuse treatment utilizing this method. While previously having taught the course to about 15 students each year, I found myself with over 40 students across three locations. Teaching on interactive tele-vision was both challenging and anxiety provoking. Not only was I trying to keep students, in three locations, engaged in the lecture and discussion, but now I had a much larger cohort of students who were in recovery. Many of these students felt personally threatened by the content of the course that challenged the AA./disease model. To make matters worse, I was anxious about responding to these challenges across this new teaching medium.

About three weeks into the course, the class was required to read, as part of their assignment for the week, an article by Miller (1992) in which he first reviews the evidence on treatment approaches, with little or no clinical effectiveness, before going on to report on interventions that suggest cause for optimism in substance abuse treatment. During class I was discussing the lack of empirical evidence supporting the use of AA in the treatment of substance abuse. At that point a student, with considerable treatment experience in one of the remote classrooms, broke in, saying in a tone that was far from deferential, "What do you mean AA does not work? Of course it works. I know lots of people it has worked for, including myself. Sure it works."

I rose to this challenge by quickly pointing out that four articles supporting my position were cited by Miller, which, I was quick to add, was part of this week's readings! I went on to cite possible contraindications for referring patients to AA. At that point, the student did something that truly shocked me. Perhaps not remembering he



was on camera, he mimed being slapped across the face. Students in all three locations saw his response and he made no further comment. I did not pursue the issue of his gesture, partly to avoid embarrassing him, partly because interactive TV did not, at the time, seem conducive to that level of personal inquiry, and partly because I knew that the intensity of my response was indeed a slap in the face. I also knew that during my answer to his chal-lenge, I was angry. My anger was not only toward this student for not reading the assignment, or for his abrupt tone, but also with the fact that so many students in recovery seemed unable to reconsider their beliefs about substance abuse once they were presented with new information. My anger was born from the frustration of not being able to reach, or change, these students and, possibly, from a reservoir of frustration that had accumulated in my days of doing utilization review.

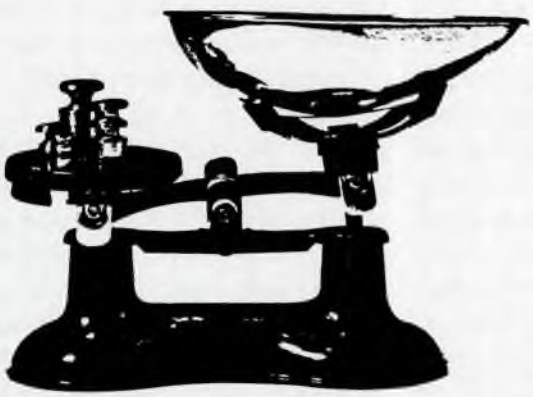
Later that week I had a conversation with a colleague, who is in recovery, about what happened in class. I explained my frustration with the recovering students who seemed unwilling and unable to re-examine their attitudes and beliefs about substance abuse treatment. I told her that it seemed as though these students had come to school only to have their pre-existing world views confirmed. My colleague reminded me of a quote whose origin is unknown to us about four common tasks of all spiritual practices and which are, perhaps, applicable to both the helping and teaching professions. These four common tasks are (a) show up, (b) pay attention, (c) tell the truth, and (d) don't be attached to the results. My colleague suggested that perhaps I was only accomplishing three of the four tasks because I appeared to be attached to both having the students change and to being right. Wanting others to change, and wanting to be right, were themes I had certainly struggled with, both professionally and personally. Upon reflection, it was no surprise that they found their way into my course.

My colleague went on to say that in one of her classes she had observed the same phenomenon of recovering students being very emotionally attached to what they had learned in treatment and practiced in their recovery. She explained that as a person in recovery herself, and

as a scholar of cognitive-behavioral therapy, she thought that she could glimpse both sides of the divide. She went on to say that for many people in recovery, their attachment to the AA/disease model went well beyond a set of beliefs that could be changed by new information. She said the attachment for individuals in recovery was at a deep emotional level, and for many at a spiritual level. She said further that their lives had been transformed, and often saved, by their experiences of receiving hope, support, guidance, and grace as their recovery progressed. She reminded me that many people in recovery have had profound spiritual experiences and that just as one's spiritual beliefs are often immutable to the logic of prevailing science, so too may be one's understanding of the factors that made recovery possible.

Fortunately, the student with whom I had the confrontation, proved to not only be resilient, but also open to learning. Over the semester he asked challenging questions and offered numerous examples from his own clinical experience in support of the class material. One night, toward the end of the course, he shared his own experience in trying to reconcile research and treatment. "Look," he said, "I am starting to appreciate what you have been saying about why people abuse substances, that the reasons are complex and possibly have multiple causes, that treatment should be individualized and include behavioral skills training. But I am working with courtordered, resistant patients in our program. It is a hell of a lot simpler to tell them they have a disease, it won't go away, and they have got to quit drinking."

Like this student who is beginning to value the potential contribution of empirical research to his clinical work, I am slowly beginning hear, acknowledge, and appreciate the reports of students and friends whose lives have been made better by traditional treatment methods. The voices of recovering students, raised in class in objection to research findings, also tell other stories. These voices tell of lives nearly lost to addiction, of rela-tionships ruined, careers left in shambles, and the redemption they found in their recovery. In the telling of their stories, these stu-dents bring to the class and give to their classmates a perspective on the reality of addiction not realizable, in reading the outcome reports of treatment experiments.



Just as quantitative research is enriched when it is augmented by the subjective voice of qualitative findings, so too has my class been enhanced by the contributions of recovering students and their peers who are currently working in treatment facilities. My goal for my students and myself is that we hear and honor the wisdom we each bring to our class. It seems that it is the abandonment of our attach-ments to right and wrong that enables us to move into the place of being most able to learn.

The image of a great divide that separates substance abuse treatment into two camps loses its metaphorical power if one expands his/her vision to see the common valley that unites the two sides. It is in this common valley that the resolution of the opposing sides of the divide occurs. It is my wish that my students and I may inhabit this common ground and draw upon the knowledge and wisdom accumulated on both sides of the divide. I suspect that we will not be alone. Increasingly, I am hearing from experienced substance abuse clinicians of their use of research findings to develop treatment programs in what were formerly very traditional treatment settings. As an academic, I believe that my colleagues and I must move to enrich our work by listening to the many voices that can inform our teaching. In essence, this may be the rent we all must pay to inhabit this common ground. □

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SEQUENTIAL NETWORK THERAPY: Evolving a Training Model to Treat Alcoholism at an American Indian Pueblo

Sequential network therapy, as a treatment approach to alcoholism , has the potential for use by many different ethnic communities because of its grass roots and community organization thrust. Our intent within the Zuni Pueblo was to involve alcohol counselors and more networks from the Pueblo in therapy efforts. We confronted significant obstacles in our work during the six years we were involved. Confronted with the realization that the utility of our framework was perceived quite differently by the Pueblo members, we found ourselves unknowingly violating the boundary issue of spirituality. Fortunate to work in a Pueblo, considered the most traditional and secretive of all the desert and river pueblos, we believe the Zuni counselors learned the basic approach from us, and will adopt it in their own way.

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In the Summer of 1985, we decided to see if it was possible to utilize our social work skills to help substance abusing Native Americans. The two of us were social work teachers and practitioners living in Denver, Colorado. We planned to present our ideas to the mental health staff of the Zuni Pueblo. Our five hundred mile trip was in vain, however, since the entire staff was gone. They thought we were coming a week later! This missed com-munication was a periodic theme during the training project that eventually began six years later. This paper is a description of our saga.

The Zuni Trip was not totally wasted because it served as our initial acquaintance with the Pueblo Indian culture. From the beginning, we anticipated that the process of developing trust and engaging Indian interest in our model of sequen-tial network therapy would be difficult. Little did we know that it would take us six years of exploration, extending feelers to different tribes; and that when we finally found a point of entry we would have to spend four more years promoting our model and seeing it modified as we Anglos interacted and worked with our Indian colleagues.

The director of the Zuni mental health clinic, who had been gone on the occasion of our 500 mile trip, eventually returned from Albuquerque and welcomed us into his home. An Anglo married to a Navaho woman, he had gradually immersed himself in Zuni tribal customs, rituals, and religious ways during the three years he had lived there. In time, he built his own hogan and started a family. He served as a valuable resource introducing us to Pueblo and Navaho ways.

THE SEQUENTIAL NET WORK MODEL

We hoped to interest Pueblo alcohol counselors in our new approach to the persistent problem of alcoholism among adult Indians living on reservations. We named the approach "The Sequential Net-

Model," since it focused on work with the alcoholic's support system and involved them in varying combinations. The goal was to modify the social environment whether or not the alcoholic was ready for serious sobriety. It made sense to us that the nature of reservation life, involving a high degree of social interdependence was ready-made for a network therapy approach. Carol Attneave had written about similar efforts among one of the northern tribes and we hoped that the stability of Pueblo life would allow the approach to work here as well.

Our form of "sequential" differed from Attneave's—hers required a team of family therapy professionals working with a sizable group of extended family, neighbors and friends. We planned, instead, to teach the approach to paraprofessionals who had limited or no family therapy experience. For paraprofessionals, just as for many professionals, working as a part of a team and with multiple family members can be overwhelming. Thus, our sequential emphasis involved smaller combinations of members of a client's support system. Briefly described, the sequential network approach consisted of the following activities:

1. Identifying significant people in the client's social system, both positive and negative;

2. Planning how to neutralize the effects of those reinforcing drinking, while strengthening the roles of those supportive of sobriety;

3. After the initial session with the alcoholic or family member seeking help, deciding who to include in the next meeting. Each subsequent meeting then reveals the combination of people to be invited to the next session. Sometimes this is someone new, and at other times it is someone who has already been seen. Seldom are more than two or three people seen in any one session, although as termination nears a larger assembly of people who have been previously involved might occur.

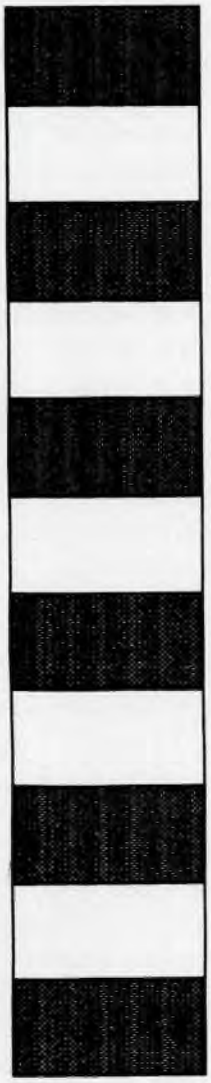
4. Strengthening and possibly expanding the support system of the alcoholic. This can include immediate and extended family members, friends, and others in helping and roles acquainted with the alcoholic. Their impact as "supporters" is strengthened by clarifying the nature of the alcoholic's struggles and identifying ways they might constructively influence him or her.

The sequence of individuals asked to participate often shifts and varies on the basis of what was most recently learned in the interview, or problematic development. For instance, after the counselor sees an alcoholic who reports conflict with his wife, the wife might be invited to join the client at the next session. In this session the discussion might reveal that a child or the grandparents are also reacting strongly to the client's drinking. The counselor might then decide to see either the mother and child together, or the grandparents, with or without the alcoholic in the next interview. The sequence of network combinations is commonly planned from one session to the next.

Following our six years of exploration, we linked up with one Pueblo but it took two and a half years of preliminary work before our training began. This work included meetings with the alcohol counselors, politicking with the tribal counsel, and searching out funding sources. The training itself was accom-plished in ten seminars over a period of eighteen months. Most of the trainees were Indian alcohol counselors—one drug counselor was also involved and occasionally there would be drop-in visitors from other helping programs of the Pueblo. Drop-ins sometimes included alcoholics who were still in the process of drying out, since meetings were held at the center where alcoholics usually came for counseling and AA groups. Each session was a day long and most occurred at six-week intervals.

What was intriguing about our work was a two-fold challenge. The first was overcoming the barrier of ethnic distrust. The second was establishing legitimacy as teachers among people who were highly ambivalent about being in student roles with us. Many were not convinced that they needed to learn anything new on the subject of alcohol treatment.

Boundary Writers



APPLYING THE SEQUENTIAL NETWORK MODEL

An important difference between the Sequential Network model and traditional alcohol counseling approaches is that the treater does not need to begin with the drinker. Even when the alcoholic is involved, the counselor is careful not to engage him or her in a power struggle aimed at a decision to stop drinking.

The treater also recognizes that an alcoholic, whose primary allegiance is to his drinking peers, may be temporarily inaccessible to a personal commitment to counseling. The game of "dry out" is often a revolving door with the alcoholic bouncing back and forth between treatment center and drinking buddies. Nevertheless there are frequently other members of the system, sharing the pain and frustration of the client's drinking melodramas, who are potentially accessible to counseling.

The assessment process begins with whoever is feeling the need for help. The counselor listens and helps them specify the kind of help sought, and is avidly interested in discovering the important people in the drinker's life. Inquiries are made about immediate family, relatives, neighbors, friends, support groups, employer, fellow workers, and people who have served in the helping role in the past. The counselor is also interested in the spiritual resources utilized previously. If the person seeking help is the alcoholic, information is obtained about the importance of his or her peer group and whether this group includes sober people, such as AA members. For some, the peer group will remain of primary importance even after sobriety, while connections with family may be distant, highly conflicted, or abandoned.

In the assessment of both the problem of concern and the relationship system, an attempt is made to determine who has the problem or, problems. Here the counselor's interest broadens out to other concerns and difficulties in the alcoholic's life which may or may not be related to the presenting problem. For example, the wife of an alcoholic client might reveal her worry about a teenage son who has been involved in peer drinking. This situation may generate interest in involving more people in the assessment process.

A major task of a Sequential Network assessment is to build a team of helpers or support people from the existing network of immediate and extended family members, friends, and significant others who may be able to promote an atmosphere conducive to healing and change. The counselor must assess who the people are in the client's life who actually reinforce his/her drinking patterns—peer "drinking buddies," family members, friends or co-workers whose attitudes unwittingly support the alcoholic's behavior.

The therapeutic challenges are to neutralize the effects of those people reinforcing drinking, while strengthening the impact of those people wanting to help the alcoholic in constructive ways. This latter group becomes the empowering, helping team, utilized in various combinations by the counselor. This network group conveys specific values, hopes and promises, confronts and shares the pain. A mounting tension occurs as this empowering-helping group conveys acceptance and a valuing of the alcoholic, while at the same time pointing out how the alcoholic's

attitudes and behavior are impeding his or her role functioning. Group members offer varied suggestions or concrete help if the alcoholic wishes to make use of them. The group offers advice to members of the relationship system in an effort to facilitate and mobilize a more active helping network. Those who reinforce the problem are not always other alcoholics. They may be relatives, neighbors or peers who are hostile, controlling, or threatened by change. They may gradually be neutralized as the empowering-helping group gains enhanced importance in the eyes of the person in need.

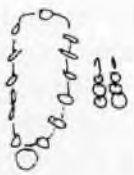
The nature of the problem determines the combination of the resources used. There may even be a shifting of who is doing the helping and who is receiving the help. Helpers may include not only the counselors themselves but sometimes natural helpers and para-professionals who are part of the client's support network. At times, persons formerly seen as negative reinforcers, whose influence was neutralized, may become receivers of help or actually helpers themselves.

BUILDING RELATIONSHIPS WITH THE PUEBLO

Following the failed meeting with the Zuni Pueblo mentioned previously, we did a presentation at the New Mexico Public Health Service's Annual Conference in 1986. This was a description and role play demonstration of our Sequential Network Therapy Model. Ours was one among many seminars, but we had several Native Americans present and we were encouraged by their response. So when we eventually met with the Director of the Indian Health Service in Albuquerque, we felt confident that our model was a viable one. But it quickly became apparent that training programs were in place already and there was no interest in funding our project.

We made sporadic trips during the next five years visiting three other Pueblos and having discussions of our approach with alcohol counselors. There was apparent interest, but no funding. We also made some return visits to Zuni Pueblo. Once we spent the day talking with several Pueblo people about the use of medicine men by the tribal people. Another time we did a day-long workshop sponsored by the Zuni Social Services where they presented cases, and we discussed them from our sequential network perspective. The excited response to our ideas by the varied group of Zuni helping professionals and para-professionals once again raised our hopes. We were invited back. However, administrative changes had occurred at the social services department by the time our second visit was to occur, so our return engagement was canceled.

Then, quite by happenstance, we discovered in Santa Fe two non-Native Americans who had business arrangements with the Pueblo that was to become our home for the training. They provided introductions and informally indicated to the Tribal leadership of the Pueblo that we were decent and competent people. We also found that valuing and purchasing pottery and jewelry was a critical symbolic gesture of cultural appreciation (over 70% of the tribe is involved in jewelry production).



Our initial steps then were volunteering to talk about family therapy, meeting with tribal officials and elders, and forming social relationships over mutton, chili and frybread dinners. Even then, much patience was called for. There was a change of directors in the alcohol program and new doubts and suspicions toward us surfaced. On one scheduled visit with the new director, we were turned away at the Pueblo entrance because the tribal counsel had declared the day off-limits to non-Pueblo people—no one had notified us of this. Once again we had to call upon our "business resource" who arranged a meeting between the governor of the Pueblo, and the new director the next day. Considerable discussion was needed to gain a tentative acceptance by this director so that we could meet again with him and his staff.

We had high hopes for

connection between our ideas and other innovative work on alcoholism among Indians: The Alkali Lake Project. This project had been an informal, spontaneous effort by tribal members at Alkali Lake in British Columbia, Canada. Primarily a grass-roots community organization effort, within ten years, it reduced the rate of alcoholism in the tribe from 90% to about 10%. While this model had been taught to other tribes, we learned that few seemed able to utilize it because of the special blends of leadership and tribal commitment required. We hoped that by having alcohol counselors involve more and more networks of people in their therapy efforts, a gradual re-education of the tribe might occur regarding the social components of alcoholism and its destructive effects on the community. We hoped too, that after one group of Indian alcohol counselors was trained, those individuals could become the trainers for other Pueblo Tribes. We might then write a training manual and provide consultation.

These ideas were presented in a three-year research and training project proposal for federal funding through the U.S. Public Health Division on Alcoholism. The proposal was rejected because of the Public Health Division's shift in interest toward funding programs for the youth. Committed, we limped along on church contributions which barely covered a year of training visits in which we were only paid enough for our auto transportation and food. Along with this shift in funding we lowered our expectations. We planned to do a pilot project in which we would teach our model to the counselors and assess their ability to use these new methods and ideas. Successful results could promote further funding. The Pueblo was unable to compensate us and we believed they would value our services more if we were doing our work for pay. In due time we were able to secure small grants from a second church organization and from an independent foundation in Denver.

UNDERSTANDING CULTURAL DIFFERENCES

A critical aspect of our work with the Pueblo was understanding tribal political and cultural processes. We were particularly interested in how Pueblo members formed trusting relationships with the outside world. We found that we were spending far more time attempting to understand the interplay of political and cultural matters affecting the thinking of the alcohol counselors than we were in planning the content for our training sessions. We were not dealing with a generalized "culture of the Pueblos" but rather with the unique style and traditions of this particular Pueblo. We were also constantly readjusting the "fit" between the personalities and skill levels of the alcohol counselors and those of ouselves.

We learned that their fears toward us centered upon two central themes: that we wanted to learn and exploit their spiritual and healing practices, and that we might impose our cultural traditions upon the tribe Also ever present was the uneasiness that we would undertake hurtful clinical experiments. Understandably, Pueblo Indians are deeply distrustful of health providers. These feelings had to be taken into account in order to facilitate an ongoing welcome and openness to new ideas.

We speculated that an additional barrier in establishing a trusting professional relationship was the current romanticization of Native Americans as possessing spiritual keys to contemporary life. We needed to divest ourselves so the stereotypes of Native Americans as stoic, artistic, and heroic that have often led White America to approach Indians as "museum pieces" to be studied, collected, cataloged, and marginalized.

We had already learned something useful about the role of medicine men in our Zuni visits. There was a place for both medicine men and professional physicians and psychothera-

pists. Medicine men were used in two primary ways. If people believed the cause of their ailment was spiritual (or the effects of evil forces) they would seek out the help of medicine men instead of professional helpers. If, on the other hand, they had first sought help from the professionals, but healing was not forthcoming, people would commonly seek the help of medicine men or some tribal ritual that involved a community healing process.

A routine event, symbolic of the psychological and cultural need of Pueblo members to carefully control the flow of information, was their habit of "breaking into" their Tewa language whenever sensitive matters arose. This appeared to be a well-established practice which we realized would have to be accepted if we were to continue to be guests of the Pueblo, however infantilizing and insulting the action felt.

When we were children we had both experienced such language switching among some of our adult relatives. One of us had listened to "Pennsylvania Dutch" (really German), and the other had heard "Yiddish." Now, hearing multiple exchanges in Tewa—sometimes even heated interactions, left us feeling that old suspicion that there were adult "matters of consequence" being discussed to which we were not privy. Were they "secrets," or simply ordinary conversation, or a reminder that we were "outsiders?" We would sit respectfully waiting to be readmitted to the conversation and later we would speculate together about the conversation. In due time we were comfortable enough to inquire about the general theme being discussed. One of the Pueblo members would then make a brief summary statement about the nature of their discussion.

In time friendships and trust grew and visits by some tribal families were made to Colorado where jewelry shows were sponsored by us. We obtained camp scholarships for several Pueblo youngsters to further demonstrate our personal interest to tribal members. There was one other personal gesture that soon became a pleasant routine. One of us was an amateur magician and would entertain the counselors with one or two tricks during our afternoon break period. Magic has overtones of more profound meaning to Pueblo Indians than to Anglo audiences, but at the level of entertainment the puzzled smiles and chuckles were much the same.

ASSESSING RESPONSES TO THE TRAINING

Eighteen months ago the training began. The group attending the day long seminars averaged seven or eight. There were seven people who attended, as visiting paraprofessionals, only once or twice. Of the alcohol counselors, six were regulars and three attended about half of the sessions. The sharing of problems began in a cautious manner, as might be expected, with the focus on general problems related to their roles in the community and how they perceived their relationships to the tribal counsel. Sharing of both case material and personal difficulties with their

HARMONY

own family situations increased as time went on. During the first five meetings, one counselor dominated the discussions. After this, more counselors began speaking about cases, as well as of their own anxieties and self-doubts.

Early on, we assured them that our interest was not in learning private information about their religious beliefs, ceremonies and traditions, but rather in helping them see how they could make use of this new model. We also stressed that we would be learning from them and that we all needed to be looking for a mutual "fit" of ideas and methods. We were somewhat surprised in the second session to learn that counselors never discussed religious matters with clients. This was considered an entirely private matter.

During the first four meetings we presented the Sequential Network perspective by using our own cases for illustration. Here we concentrated on identifying how a presenting problem, usually that of alcoholism, was related to family or marriage difficulties. We also identified what individuals were important figures in the client's life, for example, his or her friends, immediate and extended family, neighbors, and AA members. We also identified which people seemed to encourage the problem and who might be potential supports for change and sobriety.

We inquired about the referral process, how alcoholics came to seek help from the counselors. The counselors described common problems they encountered with clients not wanting to involve family members. We talked about the frequent enabling roles of spouses. Counselors also spoke of their own dilemmas related to knowing many of the families as neighbors and friends in the Pueblo community and the boundary and confidentiality problems presented.

We also addressed the matter of involving two counselors at the same time—this was possible when a helping professional from another agency (school, social services, visiting nurse) was already involved with a family. Even the role of the tribal counsel was discussed, for example, the tribal counsel could reach out to a particular family to clarify Pueblo traditions and the need for adherence to them in relation to some personal difficulty.

We raised the question of how alcoholism was viewed by the Pueblo community and variations among alcohol counselors in how they thought of the problem. All alcohol counselors were alcoholics themselves with varying periods of sobriety. Alcoholism was usually seen in the context of the AA perspective, as both a disease and evidence of an individual's problematic life style. Yet some of the counselors saw such problems as reflecting troubled family relationships as well.

By our fifth meeting, a few counselors had begun talking to other family members of individual clients on their caseloads. They remained reluctant to see more than one person at a time, so they were adopting their own version of sequential interviewing. We then focused on specific skills and purposes of seeing a family together for the first time.

In this fifth meeting we were also privy to a rather unique occurrence. One of the counselors was discussing his own family difficulties. He had been divorced and remarried and his teenage son had recently gone outside the Pueblo to live with his natural mother and in-laws. The move had resulted from mounting rebellion of the 17-year-old toward his step-mother. He was refusing to do his chores and homework. He was flunking his courses at high school and skipping classes. The father was experiencing a growing distance with his son. There was also a resurgence of conflicts between the father and his former wife. She and her parents were both blaming the father and step-mother for the boy's misbehavior. The son seemed to be playing one set of family members against the other.

The group's discussion of this family problem focused on whether the 17-year-old son should be making the choice about where he lived. Some group members felt that the parents should be deciding this instead of the youth, but since there was strong conflict between these divorced parents and their extended family members, how could they reach an agreement? Someone proposed that a counselor from outside the Pueblo work with

outside the Pueblo work with these two divorced parents. At this point, a member of the tribal counsel happened by. Listening to the problems we were discussing, he spoke up. He spoke in Tewa, taking over the meeting with the other counselors. As observers for about 30 minutes, we listened to an animated discussion by the group. They conveyed considerable respect to the tribal counsel member. He also happened to be a relative of the counselor talking about his family matters. When they finally resumed in English, they had decided how to handle the problem based upon tribal traditions that referred specifically to the dilemmas being discussed. Both divorced parents needed to meet with tribal counsel members who would advise the parents on the basis of tribal tradition. In this case the boy would probably need to stay with the parent in the Pueblo community and the other parent would need to abide by this. This was a demonstration to us of both the interconnectedness of people in the Pueblo and the power and use of tribal tradition in settling certain family disputes.

During the next two meetings we discussed the family life cycle and patterns of problematic triangulation among extended family members. A common family norm emerged that seemed related to drinking patterns of young married men. When a young man married, he would often continue to live in the home of his parents, along with his wife and children. The man's mother would help her daughter-in-law with the grandchild. The young man's father would remain the adult leader of the household in terms of most decision-making. Thus, the young man had a very limited role in his family, living out the varied roles of husband, son, and father, yet with limited authority. This situation would often continue until he could afford to buy or build a home in the Pueblo for his wife and children. In some cases there were more than one set of grandchildren living under the same roof. These young men would often seek the company of their male peers outside the home, and this commonly involved drinking. If his drinking became excessive, this was looked upon by the family as his illness, or problem, rather than an expression of family chaos, role confusion, or submerged conflict. Grand-parents would sometimes act as "enablers" because they benefited financially from having the adult children remain in the home and contribute to the upkeep. The young wives tended to be pulled into an alliance with their mothers-in-law, since they were

dependent upon them in numerous ways, while growing emotionally distant from their husbands.

As we delved into these extended family complexities, focused more of our teaching on how to strengthen a spouse's role, given her husband's alcoholism. This would require that the counselor establish a strong therapeutic relationship with the alcoholic's wife, so we emphasized the components of relationship-building as a counseling skill.

During the last three meetings, we strongly encouraged the counselors to see families or couples together, but we had very modest success. There was hesitancy to do this, or to share the results when they attempted it. Instead, they talked of their own lack of confidence, limited skills, and fear of intruding upon a family who did not want to be involved in counseling. It was also apparent that the counselors accepted the family's definition of the alcoholic's "individual problem" and were not about to dispute this. We also sought to clarify "boundary" issues—counselors sometimes had difficulty seeing and establishing their own professional roles as separate from those of a friend, neighbor, or fellow community member.

REFLECTING ON THE ISSUE OF SPIRITUALITY

In our final meeting, we found ourselves unknowingly violating a boundary issue between ourselves and the group of counselors. A new counselor had joined the group. There had been a longer interval than usual since our last visit due to funding arrangements. We were "going the rounds" so each person could report on the state of his workload. The new counselor talked about his way of working with clients that had spiritual overtones. We picked up on this and elaborated on the theme in terms of our personal beliefs about the mind-spirit process as it sometimes can be experienced in counseling. Then a second counselor, one who had been with our training from the beginning, spoke up. He customarily wore colorful bracelets and a necklace and a headband, but seldom talked. Now he contributed some of his own strong beliefs about how a counselor might deal with the spiritual realm.

Both of us had a strong interest in spirituality and the varied ways this topic might play out in the counseling process. The concepts related to the statements "Healing is in revealing," and "It is not what you know, but who you are," had spiritual overtones and we had sensed similar views in what these two counselors were saying. We had clarified this apparent linkage of thought between them and us just before lunch break.

But we were in for a surprise. When the group reconvened, two of the older members spoke out critically saying there would be no further talk about spirituality here, as this was a person's private business. Then one of them went on to question us as to why we were coming all the way from Denver to do this sort of training. He also stated that he was not learning anything from us and thought we should be telling them how we did our work with families back in Denver, rather than inquiring about their work with their people. The remainder of the group was quiet, as if in tacit approval. As of this writing (June, 1995) it is unclear how training will resume other than another planned visit. As has been true throughout our work, trust is fragile at best.

We don't know the meaning of what occurred in this last meeting. It is possible that the counselors were sensing a split among themselves in relation to us. The two men who had spoken about spiritual matters may have been perceived as investing too much trust in us by sharing these more personal and "secret" matters. After all we had been warned in the second meeting that religious matters were most private and were never discussed with clients. Here were two counselors sharing some spiritual beliefs with us and finding us both responsive. We may have been perceived as becoming too inquisitive or as assuming our own views of spirituality were akin to theirs.

Our critic was one of the older members of the group and was not a counselor himself, but served more of an educative role in the community. This man had joined the group in our sixth meeting so had not been there for our early groundwork session. He may not have understood

that the training was meant to be a two way process, including feedback on their efforts to utilize our ideas. It was obvious he experienced us as intrusive. He was also an elder toward whom the others showed respect. He may have believed that we had already shared what knowledge we had and it was better to terminate than to have us press the group to share more.

Our original high hopes of an expanding project have been tempered by our growing awareness of the combination of cultural, socio-economic, and educational barriers between us and the counselors. We were fortunate to have had the opportunity to work with this particular Pueblo, since it is considered the most traditional and secretive of all the desert and river pueblos. Considering this tribal conservatism, the final tension-filled session was not surprising. The counselors had learned the basic model from us and will now adapt it in their own way. Perhaps it is time for us to go down the road and leave them to grow in their own way.

An important realization for us was that the utility of our framework was perceived quite differently by us and by the counselors. Their roles within the Pueblo, their personal associations with the Pueblo families, and their knowledge of their own traditions resulted in integrating and reshaping our educational offerings in their own ways. Fortunately, we were able to "bend with the big wind." It is possible that we will continue our work with this Pueblo, shifting our focus in teaching. If not, we hope this experience opens doors for similar teaching efforts with other Pueblo tribes. The cultural interchange has itself proven invaluable. □

REMEMBERING AL

Al was my first client at a detoxification center. In my youth I tried to save him, but did not. I did learn from Al about humility and boundaries. I now use the story about working with AL in my teaching. It captures the disappointment I felt in me and my client, and built within me a new place to explore the balance between heart and mind.

by Diane B. Byington

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Al was my first client as a beginning social work intern. He was an alcoholic, and he taught me many things. I was sent, somewhat unwillingly, to an unfamiliar town to intern in a county-sponsored substance abuse treatment program for four months. I had never worked with substance abusers before and hadn't yet in my young life known anybody with an alcohol or other drug problem. I was ripe for a great learning experience, and Al provided it.

Al was assigned to me as a client when he first entered the detoxification facility. I was a middle-class white woman in my early 20's, and he was a white man who looked ancient to me but was probably only in his late 50's. He was intoxicated when I met him that first night, but very polite nonetheless, and seemed embarrassed to be seen in his current situation. I was impressed by his courtly manners, because he wasn't what my stereotypes of an alcoholic had led me to expect.

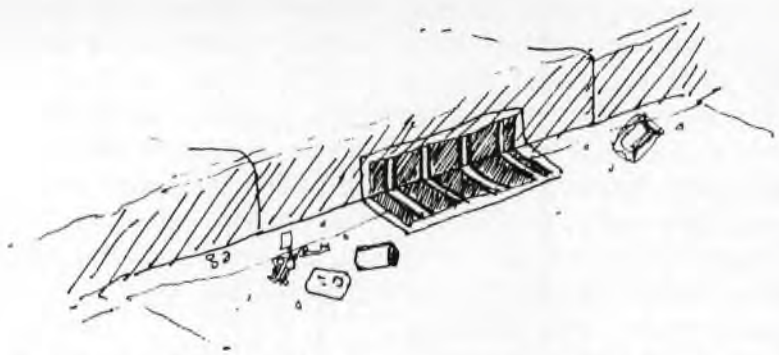
Al had a great story to tell a person such as myself who was new to taking psychosocial histories. He said he was a college graduate and had been an engineer for many years in a neighboring state. He had a family, a sister who would take him in if he could only get to where she lived. He just couldn't remember her telephone number or her married name, but he was sure he could find her house if he was in the area. Most importantly, he had a safe deposit box containing quite a lot of money, but the box was in a bank in the town where his sister lived, and he needed cash to get there. When I naively asked why he didn't just have someone get the cash and send it to him, he patiently explained, as if to a child, that the bank wouldn't release the box to anyone but him.

He explained that his life had just somehow gone astray. He had lost his job, through no fault of his own, and his wife had kicked him out; she was a misunderstanding bitch. His kids had turned their backs on him, because they had been poisoned by their mother. He spoke eloquently of a fascinating life. He seemed to be a victim of circumstance, who had turned to alcohol completely by accident and was bewildered by where the journey had taken him.

I believed him. I believed every word the man said for nearly four months. The agency didn't have money to send him back to his family, and he had none of his own, so he stayed on with us. Al became my personal project and I worked very hard to "save" him. I saw him every day while he was in the detoxification center. He seemed motivated to get his life back together, and I regarded myself

as the agent of his return to sobriety. He played his part in this process admirably. He told me over and over how much I was helping him. It was wonderful for him to have someone understanding to talk with who believed his story, fantastic as it was. Other people hadn't seen the real person underneath the out-of-control drinker. He felt that he had a chance now to succeed, thanks to me. He laid it on thick, and I lapped it up. I had a need to be helpful, and he needed to be helped. Al and I moved together very well in our dance.

My supervisor and other agency staff warned me not to be gullible, not to believe everything a client told me. After all, these seasoned workers said, most of our clients live on the streets, and they become skilled at survival. By the time they got to us, they were pretty far down in their slide from middle-class to skid row. Because of the nature of the program as a county service center, we rarely received clients who were attached to conventional society. Mostly, the detoxification center served as a way-station for people to gather their strength, dry out before the next binge, and reconsider the idea of arresting their slide. Most of them would be dead before long, my colleagues told me, because alcoholism is a killer disease. Every now and then someone "dried out" and stayed sober, really changing, but nearly all of the clients were too far gone to do more than verbally express their desire to change. I needed to understand the reality of the



situation, the staff told me, so I wouldn't be too disappointed when Al disappeared to get drunk.

I listened politely to their warnings, but privately I thought the staff to be burned out, and it was no wonder that the clients didn't recover, given this cynicism. I thought that I, with my youth and good intentions, armed with my new social work knowledge, could beat the odds. Maybe I couldn't "save" every client who came through detox, but I was convinced that I could "save" Al.

I got Al admitted into our halfway house facility following detoxification, and he was exceedingly grateful to have such a nice place to live. He was still physically weak, but he said he was determined to stay away from alcohol and to recover from this terrible disease that had claimed him for many years. He enthusiastically participated in group therapy, Alcoholics Anonymous meetings, and other program components, and he even tried to play volley-ball, although he was no natural athlete and years of drinking had wrecked his coordination. I continued to see him daily for individual therapy. Mostly, I listened to his stories.

For a few months things appeared to be going very well with Al. Most of my other clients had joined the revolving door, entering detoxification for a few days and then leaving, only to return within a couple of weeks. They were always sheepish about seeing me again, drunk, after having only days before proclaimed their desire never to touch another drop. After a while I caught on: my part was to fill out forms and offer talk therapy, as they spent several days recovering from a seriously debilitating episode of uncontrolled drinking. The truth was, they wanted to quit but couldn't, and the resources at my disposal were inadequate to help them resist the overwhelming compulsion that had them in its grip. All we could really offer them was "three hots and a cot," as well as some human caring, and hope that something someone would say or do would stop the seemingly inevitable slide.

I could accept this frustrating reality with all of my clients except Al. I wanted Al to be the exception. Together, we

built elaborate plans to get him back to his money and his family, to keep him sober, and even to get him another job. Finally, after months of effort, I found an organization that would buy him a bus ticket to the neighboring state, and I dropped him off at the bus station. I thought he was gone for good, and I felt great about my ability to "save" at least one person.

My months at the substance abuse treatment program were at an end. I had evolved from thinking I could "save" all of my clients to thinking I could only "save" a few of them. I had gained an appreciation for the goodness in the souls of my clients, who seemed always ready to offer a helping hand to someone else but appeared to lack insight into their own conditions. I had attended funerals for several of them, and had watched as a couple became sober and shakily entered a new phase of life. I had learned how valuable Alcoholics Anonymous and its unconditional support can be to many people. And I better understood the allure of the dark side of alcoholism, how the bottle became the best friend of most of my clients. I had developed a few tools in working with alcoholics, but I knew I still had much to learn, and I felt optimistic about my developing skills.

On my way out of town, with my car packed, I stopped at the detoxification center to say goodby to the staff who had become my good friends during the past months. When I walked in, I was absolutely stricken to find that Al had been admitted a few hours earlier. He was drunk and overbearing. As I stared at him, aghast at seeing him again in this condition, and with such a different personality than I had experienced before, he came over to me with his hand out for a handshake.

"Hello, I'm Sam. And who are you?"

"Al, don't you remember me? I'm Diane, and I worked with you for months."

"Diane, no, I don't remember a Diane. You must have mistaken me for someone else. My name is Sam."

The other staff didn't know how to comfort me in my distress, but they confirmed that he definitely was the person I had known as Al. This new personality, Sam, had an entirely different story, not at all similar to the one told to me when he was Al. I drove away, numbed and in shock at the difference in the man and the reality of my failure, shaking my head in dismay. I never saw Al, or Sam, or whoever he was, again. I presume he is dead, because he was far into his addiction when I met him and he probably didn't have long to live even then. The few months that he stayed sober at the treatment center were probably a good respite from drinking, but were likely not enough to stop the deterioration. In talking with my supervisor, we agreed that he probably had organic brain syndrome as a result of chronic alcoholism, and it was difficult to tell which, if either, of these personalities was indicative of the real person.

I was devastated. Al's return to drinking meant that I had failed completely in my mission to "save" him, to return him to society as a productive member. What had all of my hard work meant, then, to these clients I couldn't save? Was I really cut out to be a social worker, if I couldn't even save one person?

It took years to recognize and internalize the learning from this experience, and from Al. In many ways, Al was a comfortable person for me to work with, because he was somewhat similar to me and to my family. He spoke well, and I believe that he could have been a college graduate. He might even have been an engineer at one time. His eloquent use of language and his obvious middle-class background were things I could relate to, and I clung to them as evidence that he was worthy of being "saved." I think my prejudice was that he was more worthy of my efforts than many of the other clients who were of different races, with blue-collar backgrounds, were less articulate, and, most of all, didn't tell me what I wanted to hear.

I don't think I ever had the slightest idea of who Al was as a person. I doubt if even he knew. He had been on the streets for many years, I think, and he knew how to read people and tell them what they wanted to hear. This was his gift in exchange for a place to stay for a while, hot food, and safety. It seemed to be a worthy exchange, because it made me feel useful and needed.

It didn't ultimately help him, though, nor did it ultimately aid me to develop my helping skills. So our interpersonal dance, although comfortable for both of us, was at best a waste of time. The harsh reality that I finally came to understand is that I can't "save" anybody. On this essentially spiritual level, we are all responsible for saving ourselves. Other people can be there for support and guidance, but the ultimate responsibility is ours alone. Al punctured my God-complex and helped me to realize the limits of my influence.

In my ensuing years in the field, I came to believe that the clients at this detoxification center were the most challenging I would meet. My colleagues had understood better than I the value of human caring, of providing a respite from drinking, of nourishing the body with good food and rest, and of offering at least a vision of a different way of life. They were willing to settle for this contribution, and they respected the clients as unique individuals, without needing to see a change to enhance their own image as effective social workers.

I remember Al fondly, after nearly 20 years. He was a loving, caring person who was caught in the throes of a terrible disease process and who did the best he could in very difficult circumstances. He certainly had the gift of gab, entertaining me with wonderful stories, and he stayed sober for nearly four months. In the end, the addiction recalled him, but I hope that those four months helped him to last longer than he would have otherwise.

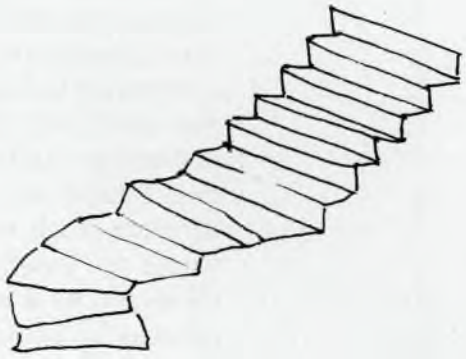
Because of Al, I learned not to take it personally when a client relapsed. Relapse isn't about me and my failure to "save." It's a reality of the disease or condition of addiction. Realizing the limits of my power helped me to accept clients wherever they were and allowed me to focus on shoring up their own sense of power to help themselves.

Al taught me a lot about myself and my blind spots. Because of him, I began to learn about humility. He helped me to distinguish boundaries, the difference between myself and somebody else. He also helped me to understand that, when somebody's story seems too good to be true, it probably isn't. What I should be focusing on instead is why the person feels a need to tell me such a fantastic story. I certainly don't need to reject automatically whatever a person tells me, but I don't need to accept it either. I can walk a middle road, remembering that part of the addiction process for many people involves telling other people what they want to hear. I became much more effective when I learned to confront unlikely stories while making it safe for clients to examine the truth. Working with alcoholics was a constant barometer of my own need to be needed, and it helped me to keep my priorities straight.

Eventually, I moved on to other areas of social work, although I truly enjoyed my years in the addictions field. Now that most of my work is with MSW students, I often have opportunities to remind myself of the lessons I first learned with Al, and to pass them on to other naive students who want to "save" the world.

Al provided me with a hard but very effective learning experience, and I smile now when I think of him. I am especially grateful that I was around long enough to see more than one aspect of his addiction. Even though I was shocked and dismayed to see him drunk again after all my hard work, that was the best part of the lesson. What if I had been allowed to think that I had successfully "saved" him?

I suspect that I grew a great deal more from our experiences together than he did. Wherever he is, I thank him. □



GRAPPLING WITH SEXUALITY in a Women's Recovery House: My Own and My Agency's Journey

Confronting and working with both same-sex and opposite-sex intimacy issues in a residential women's chemical dependency recovery agency setting can be fraught with difficulty. This article describes my own journey and that of my agency as we explored and improved our capacity for providing respectful recovery services which recognized and worked with women's individual sexuality issues.

by Elizabeth Twining Blue

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For five years, from 1984 through 1989, I was the director of a halfway house for chemically dependent women, located in a small urban area in northern Minnesota. During this time, in the chemical depend-ency field there was a growing concern about how sexual behavior and sexuality impacted recovery and relapse. Increasingly, chemical dependency professionals had begun to address client sexuality as part of recovery planning and services. However, in our locale this openness did not, as a rule, extend to frankness and sensitivity in treating gay and lesbian issues. As an agency and as a staff, the "hottest," most provocative challenge we faced was how to work with the full range of women's sexuality as part of the overall recovery process.

Sexuality was an issue about which residents were often confused and in pain, about which our staff had varying degrees of comfort, about which many persons in the local sober community had strong opinions, and about which the halfway house was under intense scrutiny. I came into the position as director, with my own set of values and emotional and social blinders. As it turned out, the process of personal and professional growth we all went through at that time was one of the most intense, far-reaching and rewarding ones I have experienced.

During the process, our staff was consumed with "uncovering, discovering, and discarding" those things in our responses to sexuality that were unhelpful and/or harmful to the women and to one another. It was not until I was leaving the agency that I was able to reflect adequately on the entire process.

I was asked in the fall of 1989 to make a presentation at a state-wide women's recovery conference. By agreeing to discuss my own and the agency's experience with this issue, I had to reflect upon those events in a fashion that would allow me to talk about them to people who had not gone through the process with us. When I hung up the phone after agreeing to give the address, I got scared, really scared. I had just volunteered to talk about a process that was not just my story, that had undergone a painful and frightening evolution, about which I still felt some personal vulnerability.

The story was a personal and organizational chronicle of the agency's struggle to respond

to client sexuality issues, especially those related to lesbians. As a staff and an agency, we emerged from a complicated challenge, able to work with sexuality as a recovery issue.

Imagine that you are about to start a new supervisory position in a women's recovery agency. You are excited, full of anticipation and energy. You have feelings of trepidation because there have been serious problems about which you are unclear. On the plus side, you inherited an experienced and dynamic staff, and have support from the executive director and board.

During the first week, you and the experienced staff look over the program, and get to know one another. You begin to get a clearer picture of the problems. An experienced staff person has been singled out by people in the recovering community because she is a lesbian. She feels personally attacked and unappreciated for her considerable contributions to the agency and wonders what working with you will be like. You tell her that you are prepared to deal with public perceptions and concerns about the agency and that your expectation is that she continue to do her job.

During your second week, a board member tells you that you should fire this staff person because she is a lesbian. A community volunteer comes into your office and picks up a picture of you with a male friend and says, "Oh good, you have a boyfriend." Several people go out of their way to tell you about your new agency's "lesbian" image and ask you what you are going to do about it. Another chemical dependency professional complains that the agency sponsors a sexuality group for clients and that "a lesbian is leading the group."

I was angry, threatened and afraid, and imagined all sorts of catastrophes arising from this scenario. This fantasy was my initial reality when taking on the directorship of this women's recovery home.

My first response was to appoint myself the agency heterosexual. In that role, whenever anyone pointed to us and said, "Lesbians!!!!" I essentially said, "No, she just works for me; I'm straight." I put on the heterosexual hat and spoke for us all. Whenever a client reacted homophobically to staff or another resident, I said both behaviorally and verbally, "Follow my lead. You don't have to approve to accept. It'll be all right I'm here to keep the faith." This response, driven by fear, was supported by my own ignorance and lack of awareness. I was saying to the community that my "clean" skirt could cover us all. This reaction gave the impression to a critical community that I was really one of them and was making the best of a bad situation.

My fears were constant. On a daily basis, I was terrified that the house would be shut down by community disapproval. The house had been closed for some months before I came. Community perception was that it was closed because of the lesbians, and this perception was a concern to my supervisor and others. However, a host of dynamics had interacted to produce the closing. One recovering staff person had relapsed; one former staff person had kept this secret, and a current staff member had been kept in the dark about it. Referral sources found that our intake process required too much background material and too much time for pre-placement visits. Thus, they sent fewer prospective clients and the census dropped. Further, of those clients accepted, many were young residents who established a pattern of running away in groups.

In hindsight, I have come to believe that some of the low census and negative community press was the result of the our agency being oppressed and "punished" by the larger community for being a staff of assertive women, for daring to respond to female sexuality as a recovery issue, and, most of all, for having a counseling staff of both heterosexual and openly lesbian women. During my tenure as director, frequently there were more lesbians than non-lesbians on staff. Our besetting sin, as I now see it, was that we, especially me , became apologetic and defensive about what we were doing out of fear of the community's response. I operated out of a mixture of my own homophobic fear and a false sense of responsibility for

"saving" the house. Much of my energy was spent defending something that wasn't wrong and didn't need defending.

Our agency staff (including me) and the clients spent much "air time" preoccupied with both our own and other people's homophobia. This, in turn, served as an effective diversion that interfered with client exploration of intimacy issues related to recovery. When members of the staff and residents spent serious amounts of time reacting to someone's sexual identity or to someone else's reaction, that interrupted and delayed the healing clients needed to do to support their recovery: facing feelings about being a woman; examining how to establish, conduct and maintain relationships; and addressing needed changes in sexual and intimate behavior. Keeping homophobia stirred up, alive and unsettled, blocked our agency in its efforts to assist all women in all areas of recovery.

Early on, I was told by various lesbians I knew that, if we continued to accept community perceptions and expectations as gospel, we would stay in a defensive mode. I realized this truth later. I remember the sense of em-powerment I experienced when the executive director and I finally agreed to treat this unfounded story like the gossip it was; it was not deserving of our energy and attention. Previously, reacting and over-reacting had had the effect of making rumors and innuendo loom larger. Slowly, I began to see that community perceptions could be corrected, if we responded thoughtfully and openly, and not reacting defensively. When, with the support and encouragement of staff, I refused to treat sexual orientation issues as if they were shameful secrets, something interesting occurred. We experienced more calm as a staff, there was less oppositional noise from the community, and referral sources stayed with us. It became part of my normal practice to share potentially explosive issues with the executive director, he was then able to support our program and to defuse gossip brought to his attention by "well-meaning" folk in the community. Each time community perceptions or expectations became an issue, I had to repeat this process of deciding not to react or defend.

As an agency, we implemented measures to minimize future invectives and to maximize communication with potential referral sources and clients. I asked area treatment centers to let me come to talk about what occurred at a women's halfway house and what the experience was like for the women who lived there. I began to lecture monthly throughout the region. I deliberately exposed myths and misinformation about women's recovery experience in this kind of a setting. I talked about the house being a safe place for lesbians and straight women, and said that both heterosexual and lesbians lived and worked at the house. My talks at local treatment centers increased our visibility as a house; more importantly, it provided the opportunity to give an accurate and positive picture of the halfway house experience.

In residential programs

there is a kind of enforced intimacy because residents go through programs in cohorts, sharing limited space, having only a relatively brief stay that can be counted in weeks or a few short months, and living close to one another's experiences. Sorting out intimacy issues is often a priority for recovering people because intimacy had been so disrupted in the past; and relationship-building is a powerful tool to use for the recovery process. The house became a microcosm of the world outside its door, but the experience was intensified and compressed. Discussion and decision-making about sexuality and sexual identity in this atmosphere required that staff be prepared to interact personally with the women, and assist the women in negotiating their interpersonal relationships with one another. In a house of women, staffed by women, we encountered the sexual issues of when, with whom, and how safe. The discussions and situations involving lesbians generated the greatest heat.

We decided early on that we needed to define and announce boundaries between staff and residents, staff and ex-

residents, and among residents. Many revised policies and procedures came out of this decision. The first was called the "Staff-Resident/Ex-Resident Boundary Policy;" it laid out the policy that staff would not be buddies, twelve step program sponsors, landlords, or have other such personal relationships wearing confusing "hats." The policy was a starting point for discussions about how the women could best get their needs met by expanding their relationships and learning new self-care skills. While not directly addressing sexuality, it was an important first step. The policy also served to reassure the community that appropriate boundaries were being maintained between staff and residents.

The new policies said that there would be: a) no using of mind-altering drugs, b) no violence, and c) no sexual involvement with other women in the house while living at the house. While a number of potential residents were taken aback by this frankness, and some decided not to enter the house, many residents let us know that these limits increased their sense of safety. We outlined grievance procedures and clients' rights and stated boundaries and expectations about sexual and other behaviors. For example, if a resident hid a weapon in her room or on her person, she was discharged. While non-sexual physical expressions of affection were encouraged, sexual fondling was grounds for referral or discharge.

The first severe test of the campaign for openness came when I received a call from a referral source intimating that we had a staff person sexually involved with a resident. After conducting an investigation, the executive director and I dismissed the staff person for modeling and maintaining inappropriate boundaries with a client. Residents were kept informed as to what was alleged, what our response had been, and what actually transpired. Even though a few residents left, we followed through with agency standards while leaving a positive impression. I responded to questions from the referral source without discussing specific staff or resident information. At inservice training sessions delivered to programs in the immediate area, I also announced we had a staff change. I told them what had been alleged and what our response had been. This served to inform them of our process, and to halt gossip before it had expanded exponentially.

Our staff had differences of opinion about intimacy issues. We defined intimacy differently based on our personal histories and cultures. In response, during the first year, we initiated staff development groups to clarify our thinking. We brought in an outside therapist to facilitate our groups. It became the norm that whenever there was an internal staff crisis, we would bring in a therapist — women from a local mental health clinic, with strong feminist ideals, and group process experience. We used the group to confront intimacy issues, to express personal and professional concerns, and to open communication. As a result, we created the expectation that crises would not be avoided and differences would not be buried.

As the organization grew more complex, we met monthly.

Any staff behavior which might impact or interfere with client recovery or staff boundaries, was discussed and resolved through compromise and negotiation. Using these facilitated groups and practicing direct communication in regular staff meetings allowed staff members to confront a misguided sense of responsibility for one another's and clients' behaviors; we celebrated the coming out of a lesbian staff person and shared her evolution through that experience. We established when and under what circumstances we shared our personal experiences about sexuality, with one another and with the women in the house. We confronted one another on heterosexist thinking and on overreacting and feeding homo-phobic reactions in clients.

Facing the challenge of acknowledging clients as sexual beings, we developed a house philosophy about how to respond to sexual concerns and behaviors. Sexual attraction and feelings were normal elements of the recovery process, so the fact of sexual attraction was to be

treated with calm and honesty, regardless of whether it involved same-sex or opposite-sex relationships. Getting the staff to do this was not the problem; my own commitment and follow-through had been the biggest obstacle. Stepping out from behind my role and into that group arena was frightening. I felt exposed and vulnerable.

In counseling sessions and groups for clients, we selected non-shaming approaches to address intimacy issues and sexual acting out. Exercises and approaches were designed to help the women establish positive personal identities and focused on teaching them how to be intimate in healthy ways with other women. Many of the women entered the house mistrusting and competing with other women. Quite often we learned that the women had grown up in alcoholic and/or drug abusing families where appropriate gender and sexual role modeling was missing. Large numbers of the women had experienced sexual violation at the hands of family members, long-term partners, and casual sexual partners. Some had been abusive themselves to the men, women, or children in their lives during their drinking or drug using periods. We wanted them to learn how to deal with intimacy in its myriad forms, for example, to learn that genital intimacy, albeit important, was only one of many intimacies. Our goal was to make it possible for them to discover non-sexual intimacy with other women in jointly completing tasks, expressing feelings, enjoying activities together, and sharing confidences.

One approach the therapist used with staff groups was art, such as mask-making. Each woman helped another to make a plaster strip mask of her own face and decorate them. Women were invited but not required to participate. It was a means for sharing non-sexual intimate activity and non-sexual loving touch. Another such activity was the bag exercise: women cut out pictures and sayings from various printed media or drew something of their own and placed them inside the bag; some were made into a collage on the outside of the bag. This activity fostered self-clarification about how they saw themselves inside, which was only shared with the group if they wished. The outside represented how they presented themselves to others; explaining the outside collage opened avenues of mutual questioning and communication. They examined their own congruence by comparing the insides and outsides; the exercise also aided them in surfacing hidden issues with others when they were ready to do so.

In groups counselors employed non-verbal exercises like "sculpting power" and other relationship dynamics. Exercises in mutual problem-solving and role rehearsal prepared the women to resolve situations they might encounter in and out of the house. The women were also encouraged to identify and express what they observed about relationships with one another. In doing this, they learned to trust their own perceptions.

Both in and out of client groups, when there was sexual energy and attraction between clients, it was acknowledged and solutions were tried. We did not give the women permission to behave in an overtly sexual way with one another. Women who tried to establish exclusive relationships were required to spend time separately from one another, learning to include other people in their lives. If they persisted in unhealthy exclusivity or in pursuing one another sexually, we discharged and/or referred them elsewhere. When two women in the house had sexual energy between them, it was not treated as if it were a "secret" to be stuffed away or ignored. Rather, we supported each woman in finding appropriate ways to work out how she felt, without acting it out. We learned that, we had to discharge and/or refer women who did become sexually active with one another while living in the house. We found that once that leap had been made in a relationship, it indelibly affected the entire group. Its effects on the women involved and the others with whom they lived could not be undone.

The women in the house reacted when two women fell in love or became sexually involved. Reactions usually ran the gamut from disgust to extreme anxiety. The house was supposed to offer a safe place; safety was a big issue because of the abuse, neglect, and

abandonment many had experienced before they entered recovery. In addition, a good many of these women had acted out sexually as part of their drug using careers, for example: prostitution for money or drugs or acceptance; multiple sexual partners; and group sexual activity. Many women looked at their recoveries as a second chance, a sexual time out, a once-in-a-lifetime opportunity to explore, disclose, and be vulnerable. For some women, the falling-in-love situation caught at their own uncertainties about sexual identity, safety, and lack of personal boundaries. If a woman had been victimized during her drinking or drug using career, it called up the fear of being re-victimized, only this time by women.

Some women that had sexual experiences with other women when they were drinking or using drugs had unsettled thoughts and feelings about this previous behavior. Did this mean they were lesbians-in-waiting? For some women, this concern was exacerbated by their homophobia, confirming stereotypes they held about lesbians and lesbian relationships. Would this make them vulnerable to being "preyed upon" by other women in the house, they worried. Other women were jealous of the exclusivity of the intimate relationship between two peers. They felt shut out and, sometimes angry because they could not "compete" fairly if unwilling to be sexual themselves. The disgust reaction was attributed by many of them to the values instilled in them during their childhoods. This was a very religious part of the country. Same-sex behavior went against everything they had been taught by their families and churches.

When there was sexual or romantic energy between a client and staff person, that, too, was acknowledged and diffused. Sometimes it was as simple as

calling the energy by its proper name and by having the staff person clarify with the resident what the actual relationship and boundaries were. Sometimes a resident was reassigned to another staff person. On one occasion, when the energy was mutual and obvious, it was acknowledged, and boundaries and expectations were clearly defined and followed by all parties.

Not all of this openness was conducted easily and with sweetness and light. We were very concerned with how sexual matters were perceived and at times twisted by the women; for many of them, having a safe opportunity to identify and work on a sexuality issue was necessary to achieve and maintain recovery. I think that people who work with recovering addicts and alcoholics delude themselves if they think that sexual thinking and behavior somehow take a sabbatical while clients are in residence in a facility. More often than not, whatever the dynamic in the house, the women and their grapevine had possession of it long before the staff; it had usually been chewed over and distorted by the time we came into the equation. In addition, every woman came into the house with her own world view, experiences, and values regarding sexuality. As candid and genuine as we tried to be, some women probably did not believe or trust us. I also believe that, however disturbing and frightening it was for staff to be forthright and authentic in matters sexual within the house milieu, it was many times more difficult for residents. As staff, we were open with them because not doing so created worse difficulties. At one point, I underwent a confrontation that was a personal milestone for me. A lesbian resident told me how my assumptions about her sexuality had affected her. She took the risk of telling me how she experienced my hetero-sexism and homophobia while living in the house. It was difficult for me to understand and hear her. I operated from a "self-centric" perspective where, if I didn't "get" it, then it was not a genuine problem. I screened other people's reality through my assumptions and defenses, or not at all. This was especially true if I were struggle to come out and be true to

herself. She did not feel safe to be real with me.

I was very ashamed because I was raised cross-culturally and knew something of being defined as "other." Thus, I had prided myself on my acceptance of others. However, my version of acceptance in this instance was bounded by my ignorance, my unintended and unconscious judgments, and my lack of bona fide openness to dialog. My mind, rooted in heterosexist thinking, did not change rapidly. However, once I could see the negative effect on someone else I valued, I changed. As the director and supervisor, my attitudes and assumptions bled through to the house population to which they reacted. Discovering that I could be so righteously blind appalled me and provided me with a powerful impetus to change. Every step of the way, I had to break down my own defenses, develop new understandings of situations, learn new behavior, and rehearse it until it became mine.

The decision our agency made to quit being defensive and ultra careful not to offend the sensibilities of homophobic residents and community people was a wise one. No matter how "nice" or "careful" or "sensitive" we were, we and the women we served were the ones who had continued to pay a price. However, our decision was more easily made than actually accomplished. Lesbian staff people continued at times to feel attacked and unsafe. As a house, we had spent a lot of time giving people the opportunity to air their homophobia and their attendant feelings, and in the process, the homophobic fears had somehow been given more expression, and thus, more validity.

Rather than forbidding dating, we eventually decided that the women needed encouragement to talk honestly about relationships and we no longer pretended that they didn't enter them. We allowed women to date people who were not members of the household after an initial orientation period. When restrictions were placed on relationships, they were made in terms of the woman's individual history and vulnerability around issues like sexual abuse and being male- or female-de-pendent. Permission to date, for example, was not necessarily an issue of longevity in the house; it was an issue of personal choice, fit, and priorities. We expected them to take re-sponsibility for the conse- quences of their sexual and intimate behaviors. We taught them that it wasn't a matter of us telling them what they could and couldn't do, so much as it was about them learning to live with the consequences if they did harmful things to themselves in pursuing relationships. We reflected their patterns and our concerns back to them. We were clear when we did not support a behavior, but did not attempt to control or restrict unless we saw the situation as life-threatening.

In our interviews of prospective staff, we asked tough questions about intimacy and attitudes on promiscuity and sexual orientation. We encouraged staff to take inservice training on intimacy issues of all kinds.

As an organization, we had to work from the inside out to find some of these solutions. We were aided in this by several factors. We had a supportive executive director. As a supervisor, I was a team player. While the overall agency had a hierarchical structure, the women's program was a team, working from a collegial model. Our team had a coherent, agreed-upon treatment philosophy to center our efforts.

As an organization, we had to work from the inside out in order to find some of these solutions. We were aided in this by several factors: We had a supportive executive director, and I was a team player. While the overall agency operated in a hierarchical structure, the women's program was a team working from a collegial model, with a coherent, agreed-upon treatment philosophy to center our efforts. We utilized the principles of Alcoholics Anonymous and a philosophy related to the unique aspects of women's intepersonal and growth processes. We had balance in age and sexual orientation and almost all staff had long-term sobriety and a commitment to our process. Each staff person, in the final analysis, was willing to do her own personal, self-reflective work as she went through this process. This meant

anything from self-inventorying to seeking out additional support in therapy.

Stability was another supporting factor. Because we were also a long-term residential setting (women were in residence six to nine months), we had the time and opportunity to work on deeply rooted issues. Throughout this five-year period, we had relatively little staff turnover. Finally, we had fine local women's resources available, and created a budget to support the process.

As I looked back on this five year experience, I did some serious personal soul-searching around dealing with sexuality within the agency. To my surprise, I discovered new feelings related to the entire experience which I had buried at a deeper level, new feelings. I felt exposed, vulnerable, and resentful that I had to learn and practice sensitivity about other people's sexuality; I felt resentful that I had been put in a position where I had to examine my intimacy issues, which I believed were no one's business but my own; I felt resentful because I seemed to be the token non-lesbian in certain situations; I felt resentful because I sometimes felt outnumbered and scapegoated; I felt resentful that I couldn't "belong" and was, at some level, always on the outside; I felt resentful that I had to check myself to see if I was being "correct;" I felt resentful at living in a recovering community fishbowl and being vulnerable to others' opinions.

When this pain about my resentment sank in, I had a powerful insight — lesbian women and women of color in this society have to contend on a daily basis with this type of pain, fear, and resentment from being marginalized.

In retrospect, I am grateful for having had to deal with sexuality as an agency issue. I appreciate the diversity in my life, and see what an asset being "different" can be. I was and am grateful to the lesbians who took the time to invest, teach, and bear with me. Out of their risking, I gained tremendous experience in exploring and establishing my professional limits and boundaries. I now know that I am able to stand behind and for something I believe in, not just give it lip service. □

THESE CAMPS WERE DIFFERENT

This article provides a narrative account of my experience with The Camp Approach for treating alcohol dependent individuals in rural India. The major themes that emerged were the differences and the similarities between work in rural and urban areas; the active participation of families and everyone that lived in the village in supporting the person's sobriety; and the clients, families and villagers reverence, and conformity to the social worker, as a motivating force for sobriety.

By Jayashree Venkataraman

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BACKGROUND

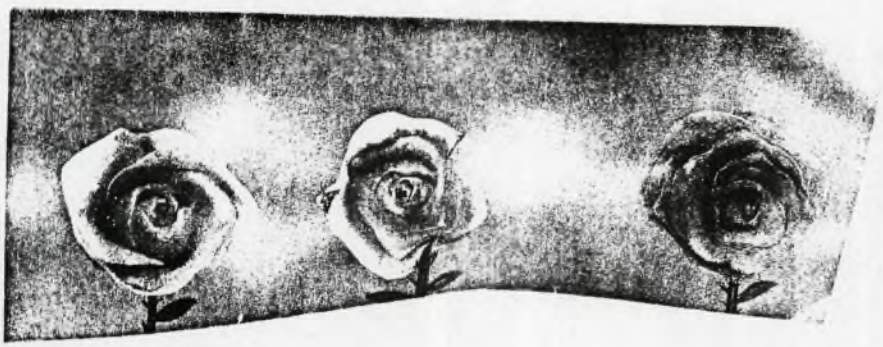
Before coming to the United States to pursue a doctoral degree in a large university in the midwest, I worked for 4 years as a social worker in an alcoholism treatment agency, the T. T. Ranganathan Clinical Research Foundation in Madras, Southern India. It had evolved a new approach to alcoholism in rural India.

The Foundation, founded in 1980 by Mrs. Shanthi Ranganathan, a social worker, had been the wife of an alcohol-dependent husband. Mr. Ranganathan had traveled to the United States for treatment, but did not get adequate aftercare or recovery-group treatment. When he returned, he resumed drinking and subsequently died. The reaction to this final pattern of behavior was typical for Indian society: some blamed his upbringing, his affluence, his lack of orthodoxy, some even placed the blame on his immediate family (Cherian, 1986; 1989).

During her visit to the United States with her husband, Mrs. Ranganathan became convinced of the validity of the disease concept, and total abstinence as a goal for recovery.

Mrs. Ranganathan dedicated her life to the treatment of alcohol and drug dependent individuals, and within a year of her husbands death, she established the treatment center in his memory. The hospital, now 15 years old, based on the Minnesota model for alcoholism treatment (Cook, 1988) adapted to suit local cultural needs: An inpatient facility with 55 beds that can accommodate clients for 4-week stays; and a week of detoxification, followed by 3 weeks of psychological therapy, consisting of re-educational lectures, group therapy, individual counseling, relaxation, AA meetings, and recreation (Cherian, 1986; 1989).

Finding that alcohol dependent persons would not travel to the city for treatment, an effort was made to encourage professionals to travel to the rural areas.



THE CAMP APPROACH

The "Camp Approach" began in August 1989, when the director of the Foundation was invited to conduct a 2-day awareness program at the Swami Dayanand Saraswathi School, in Manjakuddi, a village in South India. Following the presentation, the teachers, unanimously said "you cannot leave without giving us any solution, it is very frustrating." They described how alcohol dependence had touched their lives:

"Everyday in the morning, when the teachers come for work, they see half a dozen children sleeping in the corridors of the school. These children were driven away from home the previous night as the father would have consumed alcohol, came home late, typically abusing his wife, beating her, shouting foul language, threatening to beat the children, and causing embarrassment in the neighborhood. These children had no where else to go, and thus, came to the school to sleep in the corridors or under the trees. At dawn, they got up, went back home, had a bath, and returned to attend classes."

Everyone had similarly heartbreaking stories: a child had climbed down into a well to escape his father, who was about to beat him; children dropped out of school to work so their families could afford to eat a single meal a day. The teachers told Mrs. Ranganathan, "You have to do something for the alcoholics and we will give you all the help we can." The camp approach" was the direct result of these urgent requests for help.

There appears to be no precedent to this kind of treatment, i.e. take a full-fledged professional detoxification and therapy routine outside hospital boundaries. The clinic's director, and a team of professionals condensed and indigenized their treatment program to suit the context of the village, bundled themselves into an ambulance with the necessary equipment, and headed to the village. The director recounted the program's initiation:

"Going to the community seemed right to me. We cannot go on building hospitals like the Foundation. I had no idea as to whether it would work, how long should this treatment be, or what components should be there . . . It was Bhagwan [God], who guided me in this endeavor."

My initiation into the camp approach came later, in another village in South India. It began with an 8 hour ambulance ride. We drove down a muddy road, drawing curious looks from people standing on the roadside. As we entered the camp, held in a kalyana madapam, (a marriage hall, which is usually rented to celebrate weddings and other special events), we were welcomed by the village leaders. Along with the air of excitement, there was the distinct smell of arrack, (locally brewed liquor) suggesting that a good part of the crowd might be prospective clients. The physician and the nurse immediately busied themselves screening the patients while the rest of us unloaded the van and set up the makeshift hospital. One leader commented:

"Motivating people to attend the camp was difficult. Villagers spread tales among the would-be patients saying that their blood or their organs would be removed. Because of such propaganda, the whole batch of alcoholics we [hoped to motivate] had not showed up. The volunteers [had] gone on a trek to the surrounding villages to bring those who have shied away."

As the physician examined the patients and inquired about their drinking history, the crowd outside the room, peeked in and listened to the conversation between the doctor and the patient. Each client was accompanied by many family members, and a typical interview would begin:

"When was your last drink?" asked the physician. "Two days ago," the client would quickly reply. The wife looked on helplessly, crushing her hands, the words written on her face, "That is a lie." As she deliberated whether to say this, a voice piped from the on looking crowd, "Ah . . . last night you were with me at the arrack shop . . . Why do you want to hide facts from a doctor?" The physician looked at the client again, and with a sheepish look the client nodded his head in agreement.

I would meet with the client and family to explain the program, and discuss their expectations. I explained:

"You have to stay here with us for a period of 2 weeks. You cannot leave the premises during the treatment time. Your family has to attend the treatment classes every day. Your family does not have to stay here, but has to come every day. If your family does not show up for

3 consecutive days without informing us or giving valid reasons, you will be discharged."

In response they nodded in agreement, with their hands folded across their chest as a symbol of respect of their humbleness before me. The day was spent in screening prospective clients and admitting those with less serious physical complications. Twenty-five such clients were admitted. Detoxification with IV fluids and required medication was started.

Our objectives were:

- Identify and provide treatment to alcoholics living in rural areas.
- Use the existing community support to strengthen the recovery of patients.
- Create greater awareness about the problem of alcoholism and its ill effects among the rural population (Ranganathan, 1994).

FEATURES OF THE TREATMENT PROGRAM

The 2 week program included: 3 days of detoxification and 12 days of psychological therapy consisting of structured activities: prayer, educational classes, group therapy, physical exercises, and individual counseling. Accommodation, food, medical care, therapy, and follow-up care were free of charge.

PRAYER

The director recorded: *"The first camp was held in December, which is the marghazi month for us. So I used to do a lot of pooja. So the patients joined me in these pooja. So having regular pooja, aarthi, chanting of bhajans became a regular feature every day, both in the mornings and evenings."*

Rituals surrounding this activity were elaborate and systematic. There was a designated place as the pooja room, where all the pictures of Gods and Goddesses were hung. Flowers were collected and strung, the surrounding area of the pooja room was cleaned and auspicious kolams were designed. The lamp was cleaned, fresh wick and oil added regularly, a supply of vibhuthi (sacred ash) and kukkum (sacred powder, a mixture of tumeric and other ingredients) was maintained in trays, and prasadam in the form of kalkandu (sugar nuggets) was supplied regularly. Although the patients reported that they had lost faith in God during their drinking period, the rituals seemed to retrack them. There was also subtle peer pressure to adhere to the routine, so through rituals, faith was rekindled.

Throughout, we did not abstract the notion of a higher power. The term "higher power" seemed equivalent to God, and God was a concrete idol that people worship—whatever form this may be.

EDUCATIONAL LECTURES

Social workers gave daily lectures on issues related to alcoholism: on the disease concept, the need for total abstinence, required lifestyle changes, ways to stay away from alcohol, or on the serious damages that alcohol can cause. The lectures were used to help the clients identify the issues present in his/her personal life. Among the clients, there was a high level of interaction and an exchange of personal information.

The lectures focused on what the individual had done as an alcoholic and on the specific recovery steps. Constructive themes were repeated frequently: disease, total abstinence, loss of control, avoiding high-risk feelings such as being hungry, angry, lonely and tired, the importance of antabuse, and follow-up. For example, an extract from one of my lectures:

"When you are on an empty stomach, there is a tendency to develop craving. So if you feel an urge to drink, go home and eat whatever is available, or go to the temple and sit there for a few hours till the craving goes away, go to [some specific] person's house when you have [a] craving. Is that clear? So what will you do when you have [a] craving?" The patients would repeat what they have been told.

Instruction was simple and repetitive as most of the clients were illiterate. There was no reflection on the underlying philosophy, we simply gave directions on the nature of the disease, how to recognize symptoms, and how to overcome the symptoms. In-depth understanding of these issues was not important to the process. The overall theme was: since simple instructions work, why not limit the program to simple, instructional content?

STORYTELLING

Every evening we told moral-based stories from the Hindu scriptures and the Bible. The director told the following story:

"In the first camp, patients were just sitting around doing nothing. Their family would have left for home and they were just hanging out. So I started telling stories. The clients seemed to enjoy [this], and I found them to be attentive. So I continued that in every camp. In the rural areas, these stories have been effective in helping the client to understand important values like care for the family, importance of hard work, trust in God, importance of savings, etc." We have now developed a file of collected stories. Each counselor takes a turn on rotation and every day, at least two stories are narrated. After the story is told, what they learned is emphasized.

I too told a story to the clients: My boat–story.

Ravi was 12 years old. Even at this age he was skillful in making toys out of wood. He used to make beautiful toys and that was his hobby. His father was of good help to him. He used to help his son to buy the materials required to make his toys. One day, Ravi made a beautiful boat. It was planned very well, the finishing was good, and it looked very beautiful. His father had all praises for his son's work. Ravi also was also proud of his boat. One day after heavy rains, water was flowing in a little stream near Ravi's house. Seeing that, Ravi wanted to float his boat in the running water. He pushed his boat onto the gushing water and he was playing with it. Suddenly there was a gush of water and his boat got swept away. Ravi ran behind it to retrieve it but in vain. He was dejected. He looked for it for days but he could not find it. He was preoccupied by this and was not eating or sleeping properly. The following week Ravi went to the market with his father. He saw a boat that was bright red in color in one of the shops. He ran to the shop and urged his father to buy that boat for him. When the shop keeper took the boat from the showcase, Ravi screamed 'Appa that is my boat, I made it. It has only been painted red.' Obviously, the shopkeeper did not look happy with what Ravi said. He asked Ravi to prove that this was his boat. 'Oh sure.' He just flipped the boat around and showed his name engraved on it. The shopkeeper was convinced and he gave the boat to Ravi. The little boy was happy: My boat-theme

The Boat represents the character/values we have built from out childhood. Our values have been built with great care. But one day, like the boat, we got lost in the water; our values were lost in alcohol. Now, during the treatment, we alone can recover our values, just as Ravi alone could identify his boat because he had made it – even though the boat was painted and remodeled. Similarly, even though we had lost out good character, we could find it because it was ours earlier.

GROUP THERAPY

Group therapy, with three groups of 8 members each, was held every day for an hour and half. The group counselor was also the individual counselor of each group member.

The members sat in a circle on the floor, under a tree, in the shade of the building, or in the sand. The rules of group therapy and its purpose were briefly explained to help clients understand their powerlessness over alcohol, verbalize their adverse behavior, and learn new skills to maintain sobriety (Ranganathan, 1994). To facilitate the sharing each day a topic was introduced, such as, worst drinking episode, incidence of blackout, methods tried to give up alcohol, recovery plans, etc.

Denial, the classic defense mechanism was almost absent or minimal in the group. A colleague of mine shared her observations:

"Denial is low or none. I think this is because the whole community is here. Even if a client tells me that he had been drinking heavily for 1 or 2 years, another client might say, You and [I] have been drinking for 5 years, so I think you have been drinking heavily for 5 years." Also the village culture is to speak the truth, and they do not tell anything different.

Counselors took a directive role. Clients, if they were silent were called by name to share. The social worker summarized, and gave the final word about what to do about the difficulty in stopping drinking, clients would say *"You tell us what to do now."*

INDIVIDUAL SESSIONS

Individual sessions were held every other day over 2 weeks with both the husband and the wife, or other significant family members. Information about the length and consequences of alcohol abuse was gathered extensively. The social circumstances that influenced the attempt to gain sobriety, were evaluated and discussed, like: getting back to the job, having regular eating and sleeping pattern, praying to God in the morning, taking antabuse every day, and interacting with family. Focusing on the "here and now" and concrete suggestions on "what to do" helped strengthen their motivation for sobriety.

Mrs. Ranganathan shared her experience and apprehension in working with clients individually in the first camp:

"On the first sessions with my clients in the first camp at Manjakkudi, I was shocked and anxious. I told the other counselor who had come with me I really do not know what we have ventured into. In one of my patient's family there has been five suicides–you can imagine–and the patient has also attempted suicide. In another patient, his daughter committed suicide because she was engaged to be married and the bridegroom's family heard that the bride's father was an alcoholic and stopped the wedding. A third patient shared that he had started drinking because his wife [had] an affair with another man. Even though this had stopped he did not forgive her. When I heard all these stories on the first day of the first camp, you can imagine how scared I was. God where will I start, what will I deal with and where will I go in these 12 days! But, at the end of the camp we had worked on these issues and everyone was sober, without any relapse within the past 5 years. With the client whose wife had an extramarital affair, after certain understanding he forgave her and let go. With the first client I described, we started him on antidepressants and he responded very well. With the other client whose daughter had committed suicide, he had a lot of associated guilt too, so we started him on antidepressants and moved him to a relative's house where he stayed for a while and improved.

FAMILY PROGRAM

In the first camp the family members expressed a desire to visit the client every day. Capitalizing on this motivation we designed an 11 half-day family program. Parents, brothers, sisters-in-law, parents-in-law, and a wide array of relatives visiting the camp were willing to do anything to aid recovery.

There were several constraints in the program: women had to work for (per diem) wages so attending the program meant foregoing daily income and groceries for the evening meal. Families of field laborers in rural India (often paid minimum wages) bought groceries in small quantities every evening to cook the only meal of the day, dinner. Consequently the program was planned for 2 weeks, as a morning session. The ambulance picked up spouses in the morning who had to travel long distances or rely on local buses, and dropped off them in the afternoon. They could have a meal in the afternoon in the camp site. This support encouraged spouses to attend the program regularly, and gave a boost to the client, who felt that "they are doing so much for me, I have to work on my sobriety." The program, a community meeting, lecture, and group therapy served all of the clients' family members.

SOCIAL SUPPORT PROGRAM

The heart of the camp approach was the social support network that was already available. The social support program held for a half a day extended to the whole community. Friends and rela-tives attended the function which took on a festive atmosphere. Women wore their finest saris and men their dothis. Women wore traditional bindhis (red dot on forehead, chappals and big smiles).

Apart from friends and relatives, the local organization that helps the Foundation run the camp also acted as the social support network. In the camp I attended, a college with a department of social work gave a lot of support. In other instances, local welfare agencies or school teachers pitched in. One of the social workers elaborated on her experience in working with the support people:

"Family here means not only the spouse but everybody: uncles, aunts, friends, wives' relatives. They all know about addiction and that he has to take medicine to recover along with regular follow-ups with the counselor. Even if some of the relatives do not come in direct contact, they would still be aware that the client is going through this program. This support system is something that is precious to us. Our success is high simply because of such a social system which provides a lot of emotional, social, and financial support for a patient who has got admitted here."

RECOVERING ALCOHOLICS SHARING

When the first camp was held, clients who had been to the main hospital at Madras and lived around the area of camp site were contacted to motivate potential clients for the camp. The clients from previous camp sessions could recommend a certain number of clients. The director believes this method helped increase the self-esteem of the old client, who gained the respect of the village because he was on the "selection board." Moreover, they felt responsible for looking after the people he had recommended, which also reinforced his commitment to sobriety. The old patients from the previous camps were encouraged to share their experience and to give the message to the new clients that the program was successful, i.e., that someone from your very own community has done it, so why not you?

CHILDREN'S PROGRAM

Every client had at least four, and often as many as 11 children. Every day in the camp, the children gathered to visit their fathers. Usually these children would stop by after school to "check" to see if their fathers were okay. The fathers, on the other hand, would reserve some treat for the children. If there were a snack served at tea time, some would take an extra helping to share with their children. These were the same children who had previously run away from their fathers. In the camp, the natural relationship began to take hold, even without the social worker's intervention. The children saw their fathers through the period of recovery.

FOLLOW-UP PROGRAM

Follow-up lasted 1 year. A social worker visited the village every month, met with all the clients, gave a re-educational lecture session on recovery, met with the client and family members, and distributed medicines. Relapses were also handled during follow up. The support systems were mobilized, the local physician was contacted, and the client was motivated and detoxified by the local physician.

In addition, an informal network of people kept an eye on clients. The first was the local department of social work. Both the teachers and the students in the department visited the clients regularly. The physician also did an informal follow-up when the clients visited him for other reasons, or asked the neighbors if the client was doing "all right." Support persons who had attended the program also took it as their responsibility and thus did their part as they had been instructed.

REFLECTIONS

Several pertinent themes from this narrative reflect the nature of social work practice with alcohol dependents in a village in India.

Informal Atmosphere

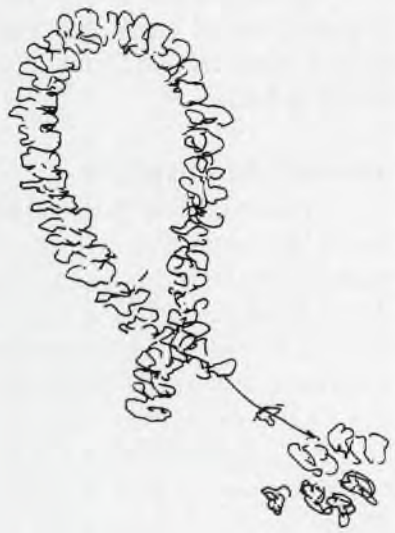
An essential theme that struck me was the informal atmosphere at the camp site. For all practical purposes it was a hospital, or rather an inpatient alcoholism treatment program, yet there was an air of casualness, informality to it. The style of life was similar to home. Clients wore clothes worn at home (dothi and banian), staff wore casual clothes, simple cotton saris and chappals. Situated in the village also led to its informal nature.

The nature of the relationship with the clients

seemed to strengthen the informal atmosphere, and by the fact, staff spent almost 15 hours a day at the camp.

Trust And Confidence

Because of the time spent, the commitment expressed by the staff, the clients developed an immense trust and confidence in what the staff said or asked them to do in just a couple of days. The director reflected : *"Yes, major issues get resolved. If I have assessed something with a patient, I can identify some of the ways of handling the problem. So I tell them these are the ways you can handle the problem. Are you ready to act upon these issues immediately? . . . And they agree and accept whatever I say. They do not go above this, assimilate, ponder, do I have to do this way or not. They just accept it."*



Gratitude

Gratitude ran high among all patients, the families, and the village for the needed treatment, and also because the entire treatment was free, including room and board. There is a Tamil (the local language) saying, uppitavarai ullalavum ninai, literally "You must have gratitude to people who have given you salt (food)." The clients also expressed gratitude for the pleasant nature, the kindness and affection, and the genuine concern of the staff toward them. They felt that the staff had sacrificed much in giving up the comforts of city life to stay in the same place, eat the same food, wash their own plates and utensils, in short, to share the condition and situation of the village. In the words of one client:

"You come all the way from Madras, and stay with us, tell us through your affectionate words that we should not drink, you have given up so much of your time with your family to be with us. How can we drink; the trust which you have placed on me will be broken, so I will do my best to stop drinking."

Social Stigma

A fascinating aspect of the program was the absence of the social stigma commonly associated with the alcoholic. The clients seemed to have nothing to hide, even though it was clear that this was a de-addiction camp and extended this support. The whole community was aware why some of the people from the village were in the camp. This public knowledge and acceptance took the pressure off the alcoholic, and contributed significantly to the recovery. As one of the staff put it, "There are that many pairs of eyes watching the alcoholics." The community seemed willing to believe, have faith in the recovering alcoholics, have hope and think unanimously, that, "Even if this person was bad before, he has changed now."

Disease Concept

There was a lot of input about the disease concept, how much was understood and internalized was questionable. The community's responses seemed to center on the issue of "will power." As mentioned earlier, the community saw the person as "bad," but changing now.

Shame And Guilt

The response to a relapse was intense shame and guilt. The community did stigmatize relapse, which might work positively. The social support systems were immediately mobilized to help the alcoholic get on track again. The client experienced the pressure from the community and cooperated in taking action to deal with the possible relapse. The whole community knew that clients took treatment so there were no subsequent invitations to drink, and the alcoholic was not allowed to wander around arrack shops or places where alcohol was served.

Willingness To Share And Be Honest

There was a willingness of clients to talk about issues openly and honestly. These people had never been to a social worker before and knew nothing about counseling, but when told

that they could talk about their greatest personal problems, the clients prioritized their issues and there seemed to be clarity in their thinking. They were able to accept the alternatives given, and implement them in their daily lives. This faith in the treatment staff worked wonders!

Action-Oriented Approach

Alcoholism is seen often as a disease of feelings. However, the approach here was not one of dealing with feelings. The strategy was action-oriented, and focused more on methods to recover. The director noted:

"I agree that this is a disease of feelings. I will have to agree with you that we are not working on a feeling level. I do not see the relevance of focusing too much on feelings and using feeling talk with our population."

Several concepts were repeated and emphasized over others:

- *I should not drink for one day; that is today. Every day in the morning I have to pray to God and take this medicine they have given me. If I drink again, I will die.*
- *Every day I have to go for work.*
- *If I feel like drinking, I should buy some food, eat it and fill my stomach and go and sit in a place where there is no alcohol.*
- *Come regularly for follow-up.*

These repeated messages helped the individual understand what to do.

Surrender To Bhagwan (God)

A strong theme that emerged was the emphasis and ease about surrendering to Bhagwan (God). From childhood, members of this culture have heard the message to Bhagwan kite vendyko (request or ask God). The rituals that go with this surrender and the emphasis on prayer twice a day convinced the clients to make prayer an essential part of their everyday lifestyle.

Role Of The Local People

The local people played a crucial role in the camp. For example, in one camp site, the school teachers (from a school run by a religious group) played a major role. The religious leader (founder of the school) had a major influence on the lives of the people in this village and those surrounding it. Because of the swamiji's powerful image, the school teachers also assumed highly respected positions in the community. In the camp I attended, the department of school of social work and the image of the college (which was run by a Catholic missionary) filled this role. The priest, who was the head of the department of social work, had a major impact in the local community.

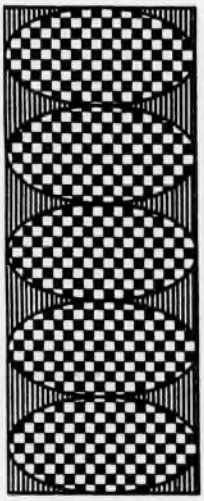
AFTER-WORDS

These camps have meant a lot to me and my family. My father was in the liquor business in the early 70s. He subsequently closed business because of prohibition in Madras. My education as a social worker and work with alcohol dependent individuals has been seen as my 'karma.' Since my father had sold liquor, earned the curses of many ruined families, here I was his daughter to do the evil away!

The director of T.T. Ranganathan Clinical Research Foundation requested me to go to the camp. When I was asked to go I was nervous and excited for several reasons. I had heard that it was an intense experience and required different skills than the ones we use at the urban center. My work in the urban center was only with clients and issues surrounding clients. In the camp, as a senior social worker I was also responsible for coordinating all the camp activities — fund raising, buying groceries, working with the kitchen staff, maintaining accounts, coordinating with the local agencies, propaganda, motivating clients and co-ordinating the treatment program! This required more skills than just being empathic and listening to the client! I needed administrative and managerial skills. One voice in me said that this was a challenge whereas the other one frightened me with dreams of the worst case scenarios, especially what if a client dies!

From the time I arrived at the camp site I was amazed at the simplicity and gullibility of the village people. I thought they were gullible because they seemed uncontaminated by the fastness of city life, their hospitality was genuine, and they were naive. They hardly knew me, yet they had so much faith from the word go, and would follow my instructions carefully. I reflected on the compliance exhibited by this group of people, and wondered

if it this was a good indicator for motivation or not. This compliance seems to be an important feature in increasing motivation and being successful in achieving and maintaining sobriety.



In the urban center there is a lot of respect for the social worker and I was used to being put on a pedestal. Still in the village setting reverence made me feel uncomfortable. I was looked upon as GOD. Clients would want my photograph to keep in their pooja room! Talking to colleagues helped me understand that this was part of the foundation of the client-worker relationship in rural India and that it was "normal." It may be an essential feature in achieving sobriety because they feel obligated to remain sober, and not let me down.

I felt uncomfortable about the instructive and directive role we took on. Also I wondered about how much the clients understood my role as a social worker as they have never been to one before. But the directive role that I had to take helped in this process. I explained my role as a social worker to the client and bingo, clients talked about issues, understood instructions, families cooperated and goals were set! After the assessment the next step was to find ways to handle the problem rather than looking at the issue in-depth. This frightened me. I wondered if my approach would have negative consequences. Talking to the director and other colleagues with experience reassured me.

A Note on the Use of Stories

Storytelling was never my cup of tea. I had apprehensions about this responsibility. All staff took turns each day in storytelling. I wondered if this really helped as I have always thought that stories were for kids. Here, I was to tell stories to clients who were older than I was. Clients later shared that they liked stories and enjoyed learning through stories. This was a discovery for me and I still use this modality in my teaching. Today I teach students research and practice courses through stories.

I have been to at least six such camps in India. Every experience was unique and challenging. I was more comfortable in the later camps, I knew what to expect and I felt like a "BARE-FOOTED SOCIAL WORKER" and loved it! □

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CHAINED OPEN

The struggle with alcoholism changed my life. This narrative explains how I dismissed charges of alcoholism at my first, second, and third excellent annual academic evaluations. By the fourth year the charges were made with increased intensity, and my teacher evaluation rating was mediocre. I tried and dismissed Alcohol Anonymous; and finally, after some authoritative and caring persuasion , I entered a treatment center to placate everyone. I was certain I would not be diagnosed as an alcoholic. The narrative tells about my experience at the center, my recovery and return to the University community. I found that confrontation elicited my defensiveness, and that self-realization, in the context of pain and suffering, led me to "recovering."

by Michael Beechem

Michael Beechem, MSW, Ph.D. is Assistant Professor, School of Social Work, South Florida State University, FL.

Like many upwardly mobile Americans, I was caught up in a fast-paced lifestyle. After 12 years as a social work practitioner, I entered a Ph.D. program in my quest for a university teaching position. I wanted to teach more than anything.

A few weeks before graduation, I accepted a tenure-track faculty position in the social work department at a southwestern regional university. Soon thereafter, my wife Ruth with our two children, arrived on campus in a 22-foot-long Ryder truck packed with all our possessions, intrigued about the prospects of beginning a new life in this small town of 11,000 (with a university enrollment of 7500).

Soon after the Fall semester began, I was immersed in teaching, and community activities. At the end of the first academic year, I felt positive about overall developments. Our children made the transition smoothly, and my first annual evaluation was positive. The only disconcerting event was a meeting with an administrator who suggested I had a serious drinking problem. I dismissed the accusation as a reflection of jealousy in what could be a competitive relationship.

I established a reputation as an active community leader by my third academic year. Enjoying the small-town atmosphere and my faculty position, I savored every minute. It was a heady experience to sense ideas catching fire among students in my various classes. I knew teaching was my profession. My classes were jampacked and the students were enthusiastic. The annual evaluations from the Dean for my second and third academic years were excellent. Periodic charges of alcohol abuse persisted from the same administrator, but I learned to co-exist in the environment in spite of the unpleasantness of the accusation.

By the end of the fourth academic year, the administrator's complaints were incessant. At the meeting with the Dean for my annual evaluation the administrator was present. In response to charges of alcoholism, the Dean suggested I consider attendance at the local Alcoholics Anonymous (AA) group. This time my evaluation rating was mediocre.

An otherwise unblemished record was tarnished by

charges of alcoholism. I agreed to cooperate, and a few days later, a faculty member invited me to attend AA with him.

From the latter part of June through October, I attended bi-weekly AA meetings. My intent was to placate my superiors even though I did not believe I was an alcoholic. The meetings seemed silly. Zealous recovering alcoholics relished the opportunity to unashamedly, if not brazenly, disclose their alcoholic behavior. I was uncomfortable at the AA setting, but continued to attend meetings regularly while my heavy drinking continued on the weekends.

When the administrator told me that students had smelled alcohol on my breath, I avoided drinking during the week. Although I never drank during the day, people still detected the smell. I learned that the smell of alcohol from excessive drinking seeps through the pores of the skin. I tried breath freshners and mouth washes to conceal the scent.

I felt it wise to refrain from drinking during the week, but counted the days, and hours before I could resume heavy weekend drinking. This recovery facade continued into October.

One day, Bob, a new social work faculty member and a recovering alcoholic from the AA network told me about his personal experiences. "Mike, your job is on the line," he said, " but more importantly your life is at stake. You need to get into a residential treatment program now."

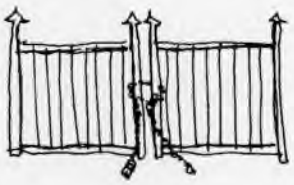
"But I need to finish the semester," I countered. "Man, you don't have the luxury of time if you want to live. I've talked with the Dean, and offered to cover your classes."

If not for the intervention of someone whom I held in high regard as a professional and as a recovering alcoholic, I would have flatly refused to seek residential treatment. I continued to deny my alcoholism and thought I could prove to all of them that I wasn't an alcoholic. "That's it," I rationalized. "A professional diagnosis from a treatment center will settle these false accusations once and for all."

For the next two days, I was on the phone with prospective treatment centers, calling them from a list Bob had compiled. The typical cost ranged from $12,000 to $20,000 a month for residential treatment. Insurance would pay 80 percent after I paid the $425 deductible. For me living from paycheck to paycheck, my share seemed exorbitant.

After two frustrating days, Bob suggested that I call Valley Hope in Oklahoma where he had been on two occasions. "Look, Mike, don't worry about the cost, we'll work with you on the finances. The main concern is to get you here," urged Susan, the Valley Hope representative. "Now don't be alarmed by the imposing metal fence and chained gate. Our policy is to leave the gate chained open because we don't want people to be forced to stay here; we try to maintain a loving and supportive environment." I responded, that I'd be there in a week hence, after settling some business affairs.

I called a few friends and my parents to tell them of the developments. I needed support during this unsettling period. I recall my mother's advice:



"Look, I think you're really smart to do this." Feeding into my denial, she continued, "What a rare opportunity to write about an unusual experience, an experience that concerns more and more people. If I were you, I would be sure to get everything down on paper and don't worry about editing. That can come later."

I made a point of sharing my plans for treatment with students in my classes. I explained how essential it was for all of us to identify personal shortcomings and work toward improvement. I stated that an honest self appraisal is the foundation for becoming a professional social worker. While altogether forthright, I needed a plausible explanation for my impending 30-day medical leave. I recognized the drinking problem, but had not yet internalized that I was an alcoholic. I was fully prepared to go to any length —even entering treatment—to prove to the administrator that I was not an alcoholic. I was convinced that Valley Hope would not diagnose me as such.

While reading the newspaper in the student center, Dick, the unofficial leader of recovering students, joined me. Dick, a 35-year-old recipient of a student disability grant for alcoholism, had previously been featured on a television program on alcoholism. As television cameras followed him for a day, he was filmed with me during my lectures. I recall how hypocritical I felt being with him considering my drinking problem, which he might have recognized but had never discussed. He would simply remark, "It's really a great relief to be able to own up to one's alcoholism," as he looked directly at me.

This time he spoke directly, "Mike, I want you to know how much it means to the recovering students that you have taken this courageous stand to enter treatment. You will serve as a role model for a lot of people." Feeling especially guilty about my deceitful efforts to pacify the administrator and the dean, I felt like a full-blown phony.

Apprehension was building for Wednesday, November 1st.

DAY ONE

3:30 p.m.: Ruth and I arrived at Valley Hope. Scared and humble, I entered the admissions office where an intake worker interrogated me with questions ranging from annual income and manner of payments to drinking behaviors.

"What were your drinks of choice?"

"How much liquor did you consume in a week?"

"What times of the day did you usually start drinking?

"How long have you been drinking?"

"When did it become a problem?"

After an hour of answering grueling questions and signing forms, I was led into the nurses' station to begin yet another session of questioning, mostly about my medical history and, again, drinking behavior. The nurse checked my blood pressure, which registered 150/112 with a pulse of 80. She walked to the medicine cabinet and advised me, matter-of-factly, that I was "withdrawing" as she administered 50 milligrams of Librium and 50 milligrams of Dilantin, an anticonvulsant.

5:00 p.m.: After another hour of information gathering, it was meal time at Valley Hope. We were introduced to two youthful patients, Jeff and Shannon, who invited us to join them for dinner in the cafeteria. Jeff, friendly and outgoing, proudly announced that treatment helped him change from being "introverted and withdrawn" to becoming "outgoing and involved." Shannon, an attractive and engaging young woman, wanted to know about our two children. The meal was interspersed with anecdotes about the success of the program and how it had changed their lives. Jeff asked me what I did for a living and, I noted a disguised look of surprise, that a university professor of social work would check himself into a substance abuse treatment center.

Sad, with tears swelling in my eyes, I was barely able to answer. Our new friends appeared uncomfortable and changed the subject.

After dinner, Jeff and Shannon showed us the facilities, and then we walked back to the main building, "the mansion." Once a monastery, it was donated to Valley Hope to be used as a treatment center. Thanking Shannon and Jeff, we departed for the "recovery room," a euphemism for the detoxification area where the nurse monitored physical withdrawal symptoms. I shared this room with two other new patients.

Ruth and I were making plans for future visits when I abruptly asked to be alone. I would break down if she stayed longer, something she also sensed. Ruth replied in a voice as unsteady as my own. "What a contradiction! We social workers encourage our clients to ventilate, to get in touch with feelings, yet, we experience the same difficulty in sharing feelings."

After Ruth left, I attended a one-hour meeting in the lecture room to hear the testimonies of local AA members. There were about 50 patients ranging in age from 15 to 70. I was told that most of the younger patients were addicted to hard drugs; however, I was too preoccupied with my own thoughts to feel empathy for them. As Day One concluded, the expression "one day at a time" assumed a new meaning. Day One was a

struggle, but it marked a new beginning.

DAY TWO

12:15 a.m. Day Two started early as the nurse again took my blood pressure — it had risen from 150/112 to 170/110 in a mere 7 hours and 20 minutes. I began to feel panic. She handed me two capsules of tranquilizers (100 milligrams) with a cup of water, and said I'd feel drowsy in about 40 minutes.

2:25 a.m. The nurse took my blood pressure and it had been reduced to 130/96 from 170/110. What a relief!

6:00 a.m. With only 4-5 hours of sleep, it was time for breakfast. My blood pressure had again increased to 150/100, with a pulse of 76. I then stood in line at the nurses' station for a meal ticket and prescribed meds.

DAYS FOUR-FIVE

The next few days were traumatic and taxed my adaptive skills. Our regimen consisted of classes on substance abuse, daily small group and individual counseling sessions and testimonies from recovering AA members who were invited into the facility to sponsor groups for us. We were encouraged to attend AA meetings twice a week in the outside community.

As one week of treatment concluded, it seemed like several weeks had past. My whole life was taken up with treatment and group living, and I felt comfortable in my new surroundings.

DAYS EIGHT -TEN

My counselor, Mark, expressed concern that I was unwilling to relinquish the social worker role; that, when not providing support to a fellow client, I was writing in my journal rather than facing my own demons. Actually, I felt introspective and mindful of loss.

By the eighth day, I had come to accept on an emotional level—I was an alcoholic. Steadfastly, I had denied my alcoholism. "I simply drink too much," On the day after the nurse rushed to the medicine cabinet for anti-convulsant medication, I began to admit, that I was an alcoholic. (Counseling sessions, classes, and peer support continue.)

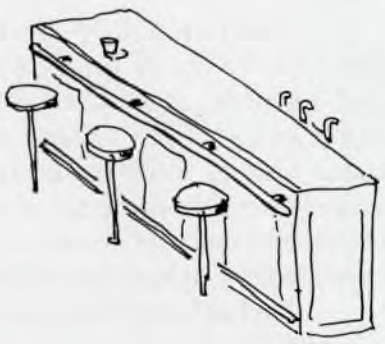
DAY ELEVEN

There now seems less of a need for an emotional outpouring. Physically it's like a new lease on life with increased energy. I was relieved that years of heavy drinking had not destroyed my liver and other major organs. Now able to sit through a "Patient Talk" — whereby a new patient shares his/her substance abuse history with the Valley Hope community — without choking back tears, I could focus more on the content than on my feelings. The abrupt transition from a drinking lifestyle to sobriety necessitated grieving.

I received a week-end pass to spend with Ruth at a local motel. The cafeteria fare of cheese and noodles seemed unappetizing so we drove 25 miles for seafood. The restaurant was also a popular drinking hole for college students and faculty. My attention focused on what appeared to be a college-age coed sipping a draft beer. I was careful not to be noticed as I studied her every move. Sipping her beer deliberately and infrequently, she couldn't be an alcoholic, I thought, not even a "problem drinker," because she lacked the compulsiveness so characteristic of alcoholics. Enviously, I thought that she could handle alcohol.

DAY FOURTEEN

What a role reversal! For 6-7 years, I had provided psychotherapy and, had taught students substance abuse intervention techniques; but now, was relegated to the role of a patient in an alcoholism treatment institution. Paralleling my feelings of shame, I knew I was right in coming here, accepting that I am an alcoholic in need of treatment. "I'm going to lick this problem once and for all!"



DAYS FIFTEEN THROUGH THIRTY

Weeks two, three and four passed slowly. Treatment continued to progress in spite of the continued concerns of staff and my counselor Mark, that I hadn't fully relinquished the professor role and taken the patient role.

I was only two days away from the "cup hanging" ceremony (to symbolize the completion of thirty days of sobriety) and graduation from Valley Hope. Traditionally, each patient designed his/her coffee cup with water colors. I painted six circles on my cup, with each representing a significant system in my life - physical, emotional, social, spiritual, familial, and occupational. An artistic patient drew a stereotypical professor in the center of the six systems. Lines were drawn to represent how I was now interacting with each system: _____ smooth, _ _ _ _ tenuous, and _/_/_/_/ conflict.

I looked forward to the ceremony, but hated to see this experience come to an end. I had become quite comfortable at Valley Hope and savored many emotionally-intimate patient relationships. I felt intimidated by the prospect of leaving this protective environment, and determined to remain sober.

DAY THIRTY-ONE

The "cup hanging" ceremony for the three Valley Hope graduates started at 9:40 a.m. as counselor Craig, holding a microphone, announced me. I was proud to be graduating and motioned to Ruth to join me on the stage, as I reflected on her support. Craig shared how I had worked the program ..."but it was a real challenge for him because Mike is used to helping people; then he had to agree to a role reversal and work on himself. I love Mike and am optimistic that he will be successful in recovery."

I began my talk by recalling the week preceding my admission spent contacting residential treatment centers. While many of the programs seemed intent upon enforcing stringent policies, Susan of Valley Hope, had emphasized the need for me to be in a "loving and supportive environment." I recalled her statement that the heavy metal entrance gate was "unchained."

In expressing my appreciation to the staff, I explained that, "much of the therapy I received was from the patients and I'll always feel a sense of gratitude to you for helping me through some very difficult times." I concluded by displaying my painted cup.

Following the ceremony, Ruth and I departed to celebrate a new chapter in our lives — undoubtedly the most important one in my life.

POST TREATMENT

After a year of sobriety, I noticed changes in my teaching. I felt confident, had more energy, worked harder to prepare lectures and was more patient with students. With more reflection and insight I was able to make better decisions. I could not recall every having such an abundance of physical and mental energy. In the days of drinking, I would tire at about noon—now its seems possible to go on forever. Student advising improved since I was being less hurried and more relaxed and the students were less rushed and more at ease. Soon after returning to campus, a number of recovering alcoholics, disenchanted with the local AA group for reasons ranging from confidentiality, that was sometimes breached, to an interest in organizing a campus group that was homogenous and geographically accessible. A colleague and I agreed to work on it. About 7 recovering alcoholics were at the first planning meeting. Some did not want the typical A. A. structure, others wanted the group to be free of a religious orientation, and an "agnostic" expressed the view that "any religion tends to turn off people who aren't religious."

We agreed that there would be no reference to the "serenity prayer," the "higher power," and the "12-step program." This group would remain a loosely organized and informal support group. Our

initial group of seven —two faculty professors, one mid-level staff, and four students increased to about 15 members in six months. One of the students, a long-time AA member , and now active in the campus group, commented that, "I really didn't expect to get support for my sobriety in a group without a formal structure, but I was certainly wrong on that."

I soon understood that Ruth and the children had assumed the heavy burden of concealing my alcoholism from others. The children had avoided inviting friends over, for fear of the embarrassment of finding me drinking. Ruth would tell people that I was sick with the flu or that my back was acting up so she could break social engagements. As I reflect on what happened, I am deeply saddened that they had to handle such an onerous responsibility.

Ruth and I noticed a distinct difference in how people treated us on a social basis. The first party we were invited to following treatment, was the annual New Year's Eve celebration hosted by long-time friends. At the party, guests appeared uncomfortable in our presence, they simply were not as gregarious or outgoing as previously. In March, invited to a St. Patrick's Day party, we found that anytime we sat with others, they did not drink alcohol. Randy, the host, was surprised that we had even attended. "We weren't sure we should invite you because we were afraid it might tempt you," he remarked. Most of our drinking friends no longer invited us to social events. Ruth later remarked that we were treated like we had an illness, a plague. We wanted to be treated as we had been before, but nothing was or would be the same as before.

ANNIVERSARY (ONE YEAR LATER)

A sense of freedom was in the air on this warm fall day as Ruth and I drove to Valley Hope for my first anniversary, an important milestone in my post-treatment life.

While driving I reflected on a year of sobriety, and the prospects of being recognized at Valley Hope. There would be a formal ceremony involving the staff and patients, complete with a cake. I was going to address the group about my "new life of sobriety."

I thought that "Perhaps, I could tell them that sobriety alone is not a panacea; it was simply the first of many new challenges." The book, *I Never Promised You a Rose Garden,* occupied my mind as we continued to speed ahead. Startled by a siren, a State Trooper appeared in the rear view mirror. Pulling over to the shoulder of the road, I lowered my window.

"May I see your driver's license, Sir?"

"Yes, officer," as I handed it to him.

"You realize that you're doing 85 in a 55 MPH zone, don't you?"

"Yes, officer, I became aware of that as soon as I heard your siren. I have no excuse. I was hurrying to make a 9:30 meeting at Valley Hope Treatment Center to celebrate my first year of sobriety."

I hoped that explanation might appease him, as I'm sure that traffic cops become weary of the number of drunk drivers on the road. My hunch paid off. I thanked him profusely and, this time, we slowly resumed our journey. There was some irony to the high speed — I have a reputation for very conservative driving, probably compensating for driving under the influence on an almost daily basis for years.

As we approached the "chained open" entrance gate leading to the "mansion," I was at ease seeing the beautiful grounds, and the gaudy mansion which offered a sense of security. I did not feel like an outsider, Valley Hope had been my home for thirty days.

Warmly greeted by the administrative secretary, she assured us that everyone was expecting us for the anniversary celebration. Excitement surged through my body, a natural high no longer masked by the lobotomizing effects of alcohol. As we sat down in the classroom, everyone's attention focused on us.

Mary introduced me. She told how difficult it had been for me to "resign my professor role and just be a patient." She con-cluded by announcing that, much to the staff's chagrin, I had kept a journal during treatment.

My brief talk related to the need to grieve the loss of one's old drinking self, in order to stay sober. At the conclusion the patients enthusiastically applauded.

I felt I'd completed a "right of passage. " At the time of my one-year "anniversary" I knew few successful recovering alcoholics. I felt tremendous warmth and acceptance from the Valley Hope community and proud of my successful recovery, so far.

EIGHT YEARS OF RECOVERY

I celebrated eight years of sobriety in November. In the midst of my fifth academic year at the University of West Florida I am now the Director of the Center on Aging, and teach courses in the social work department on death and dying, gerontology, and substance abuse. Yes, even a substance abuse course, which I would never have taught during my active drinking days. I continue to enjoy teaching, and the enjoyment has increased along with my teaching effectiveness. With improved organizational skills, I have more time to be involved in student-related activities. For the first time I complete research projects that I start. I lacked the concentration to do research and complete an article. Now I publish.

My new-found energy has changed my life style dramatically. Recovery has dramatically improved our finances. No longer do we incur expenditures of $500-600 monthly for alcoholic beverages and I also do more of the household chores.

I enjoy my family and have come to understand and appreciate their uniqueness; I spend more time with them than when drinking occupied my time. Instead of listening superficially, I can be attentive and listen with genuine concern.

I find myself actively engaged in the recovery process, aware of the insidious nature of alcoholism and how a small voice within me can threaten to coax me into indulging in "just one drink" to help during a stressful situation.

It seems that most people are casual about drinking and often forget that I'm recovering. A university administrator and close friend recently suggested that we go out and "tip a few." I was annoyed that he'd forgotten that I'm recovering. While I want people to be sensitive to my recovery, I want them to treat me like anyone else. Perhaps I can't have both.

The composition of my substance abuse classes includes a wide spectrum of students with varying interests. Some are recovering students, others have friends and/or relatives who are substance abusers and they look for answers about intervention strategies. A challenge I often face is establishing a balance between experiential (self disclosure) and theoretical content. On the one hand, I encourage the recovering students to share personal anecdotes but realize that if overdone, they distract and anger the non-recovering students. I usually curtail lengthy personal narratives in class and encourage the student to meet with me. Self-disclosures are cathartic for those who have hidden their addictions, perhaps for several years.

I have not confronted others with drinking problems; instead, individuals have sought me out to express concerns about their drinking or the drinking of friends and relatives. I've not had much success in personal confrontation because typically people become defensive, as I did. It has been my experience that people are more receptive to treatment when they are faced with trouble, pain, and suffering, caused by the alcoholic behavior, than when someone makes observations about their drinking.

Sobriety has resulted in an overall improved quality of life. □

ERRATUM

Due to a printing error two columns in the section TEACHING were left out of "REFLECTION" by Carol H. Meyer Vol. 2#1, 1995 (pp. 47,48). The entire article is reprinted here.

REFLECTION

This is a narrative of my 50 years in social work. The stories told are intended to reflect the times and the then current issues. Through this device, I have discussed my practice and academic career with a view toward finding my own coherence and offering to others a sense of hope and vision.

By Carol H. Meyer

Carol H. Meyer, D.S.W is Ruth Harris Ottman Professor of Family and Child Welfare, The Columbia University School of Social Work, New York, N.Y.

"All writing derives from, is the product of, helps to construct, lives... autobio-graphical writing centres the knowing subject and makes the basis of its knowledge-claims available for analytic scrutiny." [i]

"I yam what I yam." [ii]
WHO, ME?

Reflections on what? My critiques of the profession? My obsession with preserving practice? My impatience with pretension? My rebellious conceits? Perhaps these quibbles are all threads in the same weave, and as I reflect upon them and see how they all played out in my practice, teaching, and writing, I will learn something about myself. A few things I know already, and I learned them the hard way. One of my work evaluations included the comment that "she doesn't suffer fools gladly." I resented that criticism a lot, and it still rankles, although it was said eons ago. But it is probably true. The flip side of that idea is my impatience, always wanting to move on even before an idea has been digested. This flaw probably explains why I have always been a little "outside" of the professional mainstream. Then (and certainly not finally...) there is my tendency to make light of things, to joke when things are serious. For those who do not know me, this can create some misunderstanding.

This is the context of what follows. I am glad to tell this story, because it allows me to derive some personal and professional coherence from looking backward. I also want to offer to the person who reads this the assurance that one can span 50 years in the profession of social work and come out of it only slightly scathed, not burned-out, and still hopeful. If that reader connects with some ideas, gains some of her or his own insights, and finds courage to push on, then these reflections will have been worthwhile.

NOTE

REFLECTIONS invited Dr. Meyer to write this "Brief Reflection."

THE PROFESSIONAL JOURNEY

Contrary to the experience of almost everyone I know, my school and work experiences were always unplanned, and happened mostly through accident. I am not even sure that I can dignify my professional journey as one where I took advantage of opportunities. This view of the randomness in life experience has led me to pose the question "Who, me?" when I have been favored with chances... some of which I took. It was not so much luck as it was the unfolding of new discoveries; something always seemed to lead me to something else. Perhaps, as I re-trace my steps here, I will find an explanation... but I doubt it. I tend to believe in accidents and unintended consequences; there is too much uncertainty in the world for one to be able to plan very much. Also, I think it is one of the joys in life that there are always surprises around the bend, and that we cannot foretell the future. My comfort with unpredictability has allowed me to take (safe) risks, never really knowing where my choices would lead. This is definitely a non-linear way to live one's life.

SCHOOL AND BEYOND

I was a college drop-out before it was common to be one. Erik Erikson spoke of the "adolescent moratorium," and that offers me a socially acceptable excuse if I were to need one. The truth is that it took me three universities before I found it possible to remain long enough to graduate. I went to New York University[NYU] (briefly) and got a job at Greenwich House (one of the earliest settlement houses), where I was a kind of gopher for the director Mary Simkovitch. Among other things, I led my first group, of 10 year old boys, helping them to make model airplanes, and I delivered milk to people living in tenements in Greenwich Village. No one told me this was social work, perhaps because Mrs. Simkovitch was not too kindly inclined toward social workers. It was at The University of Pittsburgh that I accidentally discovered professional social work. Ruth Smalley, a leading scholar of the Functional approach to social casework, then Dean of the School of Social Work, gave some lectures on Human Behavior in the Social Environment in one of my undergraduate college courses, and that did it! I became one of the student groupies of a house in which lived some of the leading social workers of the World War II era. My strongest memory of Pittsburgh is the taste of the soup Gertrude Wilson (a professor of group work) always had hot on the stove. I worked as a group worker at Soho Community House, where I thought then that I had learned everything there was to know. Part of my job was to bring food to the steel workers who were on strike. I suppose that in the beginning, social work meant to me distributing food; come to think of it, that isn't a bad definition.

Before I was graduated, Dean Smalley invited me in for an admissions interview for The University of Pennsylvania School of Social Work, where she would soon become the Dean. Ever since then I have had as an intellectual hobby the study of Functional Casework. My admissions interview was surely "an experience in form" as the Functionalists might say. It was intended to take the applicant (student, practitioner) through the "pain" of taking help so as to develop empathy for one's clients. In that admissions interview, I cried, I laughed, I perspired, I regressed and matured in the space of an hour or two, and when I was finished (or when Dean Smalley was finished with me), I took to my bed. It may have been cowardice, but I decided upon the New York School of Social Work(NYSSW). A footnote on the incomparable Ruth Smalley: Twenty years later I wrote my first book and she was asked by the publisher to review the manuscript. I received a copy of her six handwritten page response,and although her name was cut off, I recognized her tough, analytic thinking and her inimitable prose. The following year I met her at a conference and asked her if she were the one, and I had guessed right. No ambiguity there; she was a person who left

her mark!

Perhaps I should have gone to Pennsylvania, because it was just after the War, and the NYSSW was over-stocked with returning veterans. I was turned down several times, never considering the preference given to male veterans as a contentious issue. The School was on the quarter system then, so I reapplied four times all within the same year, and was told to "go away and grow up." First I worked at the National Recreation Association as a program developer and copy editor, but it was boring. I returned to the summer camp where I had been a counselor, and placed an ad in

The Survey. (Then, the only journal of social welfare that I knew of.) It said something like... "wanted... job in a social agency; will do anything." To my surprise, Elizabeth Chichester, the director of The Bridgeport (Connecticut) Family Society answered, and through this accident, I became entrenched in the field of family and children's services. I remember my salary... $1800. I commuted to the NYSSW for a part-time course in Public Welfare, given by Alpha Pepper (who had once been a police woman). I was seriously hooked on social work then, and so began my torturing of the admissions committee. I was totally untrained in social work, having majored in history and sociology, and having had only peripheral jobs in settlement houses. The professional staff of the Bridgeport agency were role models, and I tried to copy them. This was a community based agency, so I generally "walked over" to my clients' houses. Why is it we remember our first clients so well? My favorite activity was the evening hours when the agency took on the Travelers' Aid Society function and we chased runaway kids (to save them) who were on the train from New York City.

After a year, the NYSSW succumbed to the regular pressure of my applications, and my real intellectual life began. In the time I attended the school (1947-49 and 54-56), among the great teachers were: Gordon Hamilton, Lucille Austin, Florence Hollis, Fern Lowry, Eveline Burns, Virginia Bellsmith, Marion Kenworthy, Clara Kaiser, Mitchell Ginsberg,Herman Stein, Alfred Kahn...and the brilliant curmudgeon Philip Klein. I can never over-estimate their influence on me. They were so committed to developing social work theory and practice, so insistent upon standards, so demanding that students think, that there was no room in our minds for anything but applying ourselves totally to the task. But more, each of them was a philosopher of his or her subject: a humanist? a romanticist? a scholar? Each intermingled his or her interests with those of others. Their professional and intellectual boundaries were permeable; it was social work purpose and knowledge, not only methodology, that were deemed important. Later, I will comment on social work education today; here the reader should note the way it used to be, and cannot be again.

My field work experiences also were formative, changing the direction of my interests and commitments in life. First, I was placed in what was lamely called The New York Section (of the Council of Jewish Women). This was a social agency that focused on immigration problems of Jewish refugees from the Holocaust in Europe. There were three students there, and we firmly believed that unless an agency had the titles of family, children, or psychiatric as part of its name, it just wasn't a social agency. So we complained to our field advisor and asked to be replaced. Our "hearing" took about one minute, and we were returned without discussion to "The Section." Such peremptory

advisement would be unthinkable in today'sstudent-as-consumer environment. How fortunate it was! Our clients opened up the real world for us, and we grew up.

Just as I was leaving the placement, I met a French social worker from Oeuvres de Secours des Enfants (OSE) who was accompanying boatloads of orphaned refugee children and adolescents to their American relatives. All of these substitute family arrangements did not

work out of course, for after their concentration camp experiences, the children were under-developed, uneducated, and almost totally lacking in social skills. It was obvious that they needed social and psychiatric services, and they wanted to stay together. I was asked (who, me?) to work with them as a group... a group that kept growing as more children arrived. I happened to be taking a group work class with the director of the Bronx (NYC) YMHA, and he agreed to offer the Y's facilities for the group to meet. I had never been to the Bronx before, I could not speak half of the languages the group members spoke, my field placement was over and I had no direct supervision, and I was almost overwhelmed by the children's Holocaust narratives. Their family adjustment and psychiatric problems were severe, and there were few resources available to them. Through some mixture of youthful naiveté and desperation, I called upon the New York Psychoanalytic Institute for help, and the first person who came to the Bronx on a Sunday morning was the famed psychoanalyst Ernst Kris. He was so moved by the experience that he induced a dozen or so other members of the Institute to join him, and they volunteered countless hours of their time, talking with the children there at the YMHA in the Bronx on Sunday mornings in the summer.

This refugee group became my masters thesis project. I interviewed them and discovered that the United Services for New Americans (USNA), the agency that was working with their families (their aunts and uncles and cousins), had overlooked the particular needs of the children...now in their teens. The families often felt guilty and inadequate to the task of relating to the children, and the children felt alienated. The thing I am most proud of in my professional life is that I presented my masters thesis to USNA's director, and convinced him to develop an independent youth service. I was beginning to understand what it meant to be a social worker.

My second field experience was at the Neurological Institute of Presbyterian Hospital. There, I was in a student group that included, among others, a Catholic Priest, a Baptist Minister, and a Reform Jewish Rabbi. In 1949 we were in the middle of the psychiatric deluge, and my memory is more of seminars than of clients. This was a rigorous experience, and it probably served as the foundation of my clinical knowledge. Yet, I knew that hospital/clinical work was not to be my future. I missed the messier, generic world of family and children's services, with its undefined problems, its uncertainties, and its diversity. Also, I didn't like it when physicians and psychiatrists had the last word in my cases.

THE WORLD OF WORK

After graduating, I got a job as a beginning caseworker at the Community Service Society

(CSS). Rumor had it that it was a very traditional, proper, and "lady-like" place, but also that it was an agency where the "best of casework" was practiced. (It was all of these things.) Having once been the primary training agency for the NYSSW, it seemed like the logical place for me to continue my learning for a while. My first day there was representational of the next five years. I arrived at the Riverside District Office to meet my supervisor, the unrivaled Frances Scherz. I had been mildly terrorized by the restrictive atmosphere I had already detected in my "downtown" hiring interviews, and I didn't know who Frances Scherz was. (She was to become one of the first theorists of family therapy, but more importantly, she was a brilliant renegade.) She asked me how things went downtown, and I remember saying "I am not going to wear hats and gloves here. They are not going to make me into a lady." "O.K., " she said, as she put on one of her famous hats and her gloves as she went out to lunch.

At the time I went to the CSS, it was just giving up its relief function, and it was still supporting selected clients who were motivated to "use" casework. I had an aged client who had been supported in this way for several years, and it was my task to help her turn to the Welfare Department. She was a very proud woman, a refugee from Germany, and a doctor's wife, although he had not practiced in America. When her husband died, she was terrified of his having to be buried as a pauper. I

asked a family friend who owned a funeral parlor to take care of the funeral, and I found a German Landsman group to donate a cemetery plot. The agency sent flowers. A year later it was time for a stone to be placed at the grave. I knew the agency would not absorb this cost, so I called a stonemaker and talked him into making a tax deductible charitable contribution. I was impressed that he was so agreeable, but when the stone was ready he called to arrange for his picture to be taken with the client for the newspaper. I had to tell my supervisor, because confidentiality was a religion at the CSS. I was sent downtown to an administrative council, where I was all but tarred and feathered. The agency paid for the stone, and five dollars was withheld from my paycheck forever more. My salary was $5,500.

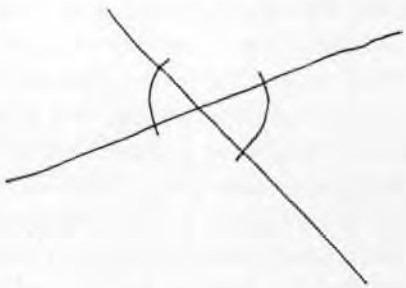
BACK TO SCHOOL

While I was a field instructor at CSS, I talked with the School's field advisor, Dorothy Sumner, about the profession and what I ought to be doing. She said off-handedly, "Why not take a course, it might give you some ideas." So I took an anthropology course at Columbia University, and got a C+. Perhaps a course closer to my line of work? Then, surprisingly, I received a letter from Lucille Austin telling me that I could have an National Institute of Mental Health Fellowship (NIMH) if I applied to the Columbia University School of Social Work (the erstwhile NYSSW) doctoral program. Who, me? There were no casework doctoral candidates, and I guess they wanted to use up the fellowship they received. I left CSS and took my retirement money with me. I think I left the agency with my unpaid and permanent five dollar debt. I had no idea what a doctoral program was about, nor why I would be attending one.

Neither the profession nor social work education were quite ready for a caseworker in a Doctor of Social Welfare program. As the first laboratory rat, so to speak, I was subject to some curious tests, when measured by today's doctoral educational processes. For example, there was a matriculation conference where 17 faculty members attended to determine if I were qualified to continue past the first term. I remember that it was the time of some important Public Welfare Amendments, the announcement of which was front page news on the morning of my matriculation conference. Eveline Burns was the Chair, and naturally, she asked my opinion of the

amendments.(I had remembered Dr. Burns from my masters seminar seven years earlier, when, as an economist, she had just joined the faculty and really didn't know the answer when she asked me, "Casework? What is that?") I had not read the newspaper that fateful morning, but I had done the crossword puzzle, and I explained that to Dr. Burns. Philip Klein, a philosopher and researcher was my advisor, and he was sitting next to me trying to help. He whispered to me, "Tell her you did the puzzle in ink." I did, and I passed the examination. I still can't imagine why. At my final oral comprehensive examination, the same 17 faculty members attended, probably two thirds of whom were still skeptical of the validity of casework in a doctoral program. I still have nightmares recalling how Forence Hollis (perhaps wanting me to demonstrate my grasp of casework theory) asked a question I have never overcome. "Name two concepts and trace them historically." What? First, I couldn't bring to mind what a concept was, so of course I couldn't answer the second part either. It was the longest silence I have ever participated in. The committee murmured things like "blocking? anxious?" The Chair later explained to me that I had passed the examination, because they knew that if I couldn't talk about something there had to be an unusual organic reason.

My dissertation was about the development and application of the concept of "complementarity" in casework practice. This term was used by the physicist Robert Oppenheimer, and I had become interested in the idea of interactional "fit" that it conveyed. (Concrete examples of the term complementarity might be a railroad coupling, the two halves of a fountain pen, or the intertwining of the fingers of both hands.) I remember the best library experience I ever had when I did my search for literature on the terms "complementarity," " fit," " balance," or anything comparable. (Systems thinking was not yet in the mainstream literature, although von Bertalanffy had already published his General Systems Theory. I had not then discerned an association of complementarity with systems thinking.)



The School was then housed in the Carnegie Mansion, and the best thing about that place was Andrew Carnegie's personal library space, which contained a most comprehensive social science, social work, and social welfare collection. Remember, this was decades before computers, and it was also long before the card catalogue listed any topics related to my idea. Thus, I spent a summer looking directly in books, any book that might harbor an idea that was even tangentially associated with complementarity. I experienced the joy of discovery, almost feeling like an archeologist turning over the earth to come upon an antiquity. When I was able to define my project, I was fortunate to have Florence Hollis as my Chair and Nathan Ackerman, then an adjunct faculty member at the school, as a consultant. He was then involved with his own definitions of family interaction, and we had a lot in common. I applied the concept of complementarity in the analysis of cases of marital conflict, and found it to be a useful tool in the assessment of why combative couples stayed together....because their needs met each other, even when they were irrational (or as we used to say then, "neurotic.") When I passed my dissertation defense, I went to teach a class at NYU, and my students presented me with a child's toy doctor's bag. What I remember most about my graduation was that it was in the garden of the Carnegie Mansion, and that Gordon Hamilton was honored because she retired that evening.

While I was in the doctoral program I was asked by a funding agency to take a position as director of a small children's residency, for the express pur-

pose of finding evidence that would close it. (Who, me?) I found that the director was a bookie. (I figured that out when I saw the telephone bank in his office) and that conspiring with his board of directors, he was keeping about a dozen little girls there who might have been returned to their parents. Both the Bureau of Child Welfare and the voluntary funding agency were supporting this program, but they were suspicious of the enterprise. I worked with the girls, visited their parents, and with the help of a placement agency, finally emptied the agency. Most of the children went home, and the rest went into foster care. At my exit interview, the director naturally refused to write a reference for me, and in fact told me he would kill me if he ever saw me again. Thus, I waited 30 years before I put that position on my Curriculum Vita, although we will see that the connection to this agency later legitimized my standing as a child welfare worker.

ACADEMIC DISILLUSIONMENT

My first teaching job was at the brand new Graduate School of Social Work at NYU. One summer in this period I taught at Smith College School of Social Work, but I found city life to be more interesting. The NYU experience was very exciting because it was new and the small faculty had a strong sense of mission. Among the faculty were Tessie Berkman, Ralph Pumphrey, Samuel Mencher, Jean Maxwell, Rose Segal, and the noble Esther Hilton. But it was a troubled school in those days, because it was then part of (and competitive with) the School of Public Administration. My three years there were exciting, but they ended in disaster. The cold war between the two schools was concretized in the shared brownstone building, where "they" (2 full-time faculty) got the air-conditioned front, and "we" (15 full-time faculty) got one big, hot room in the back. New students were told to take "their" catalogue instead of "ours," and so on. The Council on Social Work Education had its finest hour in the year that Fidele Faurie, then the Dean of The University of Chicago School of Social Administration, served as chair of the accrediting committee. When the committee heard our story, they investigated the situation, and heeding our pleas, refused to accredit the school. This meant that it was over, that all but one of us would lose our jobs. (The one person, Tessie Berkman, stayed on to hire new faculty and to continue the program through what proved to be the second of three or four later generations of new faculty.) The decision we made to expose an unethical situation and a bad educational environment, and thus to lose our jobs, was probably one of the most principled and unselfish actions any group of people have ever taken. However, the loss of accreditation meant that the second year students would be in danger of losing the value of their diplomas. A second principled action occurred when The Columbia University School of Social Work offered the students the opportunity to attend Columbia, without admissions interviews. Columbia's Acting Dean Sidney Berengarten knew an ethical issue when he saw it, and managed the complicated transfer of the students who chose to leave NYU. The day I packed up and left NYU, I was certain that I would never again teach in a school of social work.

THE REAL WORLD OF WORK

I decided to begin my career all over again, to work in public welfare where a social-worker could do real things with real people. I needed to reassure myself that social work was about something besides petty politics, competition, and personal aggrandizement. I was desperate for a social purpose in my life, so I called the personnel department of the New York City Department of Welfare to find out what was required to get a job as a social investigator. I was told that I was over-qualified for the job; too many academic degrees. I had the impression that this was not a legal requirement...to be non-educated. Irate, I put in a call to the Commissioner's office to see if I could use his influence to get an entry level job in his agency. I had known

the Commissioner, James Dumpson, as an adjunct professor at the now defunct NYU Graduate School of Social Work , and I felt that he would understand. To my surprise (Who me?) his secretary told me that Dr. Dumpson had been trying to reach me for weeks, to propose a position. It turned out that the United States Children's Bureau wanted to fund a staff development program in the Bureau of Child Welfare(BCW) , and when their representatives talked with me, they said it was my "child welfare experience" (!) along with other things that qualified me. After two years at the BCW, I was promoted to Assistant Commissioner in charge of staff development for the Department of Welfare. James Dumpson may have been the most enabling "boss" I have ever had. His administrative gift was his absolute confidence in the professionals who worked for him, so that whether we made good or faulty decisions, he stayed with us and never wavered. One day I met Eveline Burns waiting to see the Commissioner, and the first thing she asked was, "Have you found out what casework is yet?"

My years at that public agency were the most interesting and fulfilling in my career. (I wrote a book about the experience. [iii]) Although I lived on valium and was in serious combat with senior civil servants and the police department's "training program," I discovered how even a small intervention can have a ripple effect in a system. I think that one of the most significant things I accomplished there was the removal of the time clock on one floor. In those days, the Children's Bureau gave full scholarships...tuition, board and travel expenses...to workers who wanted to attend graduate schools of social work. This meant that people who had never been away from New York City could attend school in California if they chose to do so. Never before or since was I able, through the distribution of these awards, to make such a marked difference in people's lives. My job there included development of all of the staff, and I was able to accomplish an extraordinary thing when I helped a receptionist at the central office to stop thumbing her nose at clients. I had found my calling again.

A NEW BEGINNING

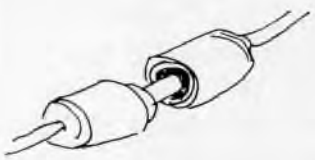
In 1962 I attended a meeting one evening at the Columbia University School of Social Work(CUSSW). I was not prepared (Who, me?) when Dean Fred DelliQuadri and Associate Dean Mitchell Ginsberg took me aside, each holding one of my hands, to ask me if I would like to join their faculty. Knowing that politics usually reigned in academia, I stupidly asked if Lucille Austin and Florence Hollis knew they were asking me,(as if a hiring decision could be made without them). Earlier that year I had shared an airplane ride with Isabel Stamm, a member of the CUSSW faculty search committee, going to a social work conference. I didn't realize then that our conversation was actually an interview, but I later learned that my appointment was held up while the casework faculty considered whether or not it would be "safe" to hire someone who was "either too impulsive or too compulsive." At least I didn't have to hide the fact that I was some kind of activist, even though it wasn't clear which "ive" I was afflicted with. So began the rest of my social work career, with a decrease from my munificent Department of Welfare salary of $11,000 to $9, 000 as an associate professor.

Being an academic in a professional school may be the best of all worlds, for it allows for a life of breadth and autonomy, the two features of a work life that have significance to me. Autonomy has meant the freedom to be myself, to be mobile, inventive, and when necessary, lazy. It took a while for me to realize that there was no one (but myself) to whom I was accountable. In the early years, I would telephone my secretary regularly to report on my whereabouts, probably confusing her with a supervisor or a boss. Then I discovered that I was my severest supervisor, and that I could be trusted to work on my own...an important quality for a faculty member at Columbia. In the course of my work as Chairs of the Council on Social Work Education's Commissions on Educational Planning and Commission on Specialization, I visited many schools of social work throughout the country and abroad, so I have had opportunities to compare the CUSSW with other places. Columbia is best understood as being reflective of its location in New York City. Thereby, it suf-

fers some of the same criticisms as does the City. Too fast, too noisy, too big, too pushy. If these things are so, then it requires a certain kind of toughness to be a part of it. More than anything, it demands of faculty members that they know who they are, what they believe in, what they want to ac-complish...it is not an easy place in which to feel insecure. Once on the faculty though, it is a place where academic freedom is taken very seriously, and this covers one's pursuit of possibilities, the freedom to take a wrong turn, the institutional support of one's work, and a healthy collegiality. The price one might pay for this open system of thought and action is that it can be professionally lonesome at times (if everyone enjoys autonomy). Here, as I try to sort out the threads in my professional life, I realize that it is because I was left alone that I could branch out into so many interesting activities.

ROAMING IN THE PROFESSION

In almost four decades I have lectured; conferred; given workshops; and trained at approximately 150 social agencies, universities and conferences. Reflecting on these occasions, it is interesting that while I don't remember all of the subject matter I covered, I can recall special things about many of the visits. For example, I remember some of the people who have driven me to and from airports, tours in Utah, Arizona, and New Orleans; campuses like Tuskeegee, Sherbrooke in Canada, and Sussex in England. I remember a bomb scare on the plane on my way to University of Southern California, and I still mourn for the school that was dismantled between the times of my invitation and my (forgotten) arrival. Mostly, I remember the New York State Welfare Conference in Buffalo, when we learned after lunch that President Kennedy was killed. Traveling to other places for professional reasons is something like being a field work advisor... you make connections with new people, and you have experiences that teach you new things and enrich your life. Also, it gives reassurance that you are indeed part of a unique and definable profession, when social workers talk the same language and consider exactly the same issues everywhere you go.



I took my turn on the Board and chaired several Commissions of the Council on Social Work Education during the years just before the expansion of BSW programs. Generally speaking (as this narrative has already shown), I am not a joiner. I am not patient enough with organizational politics, nor do I do well when committees detour from their assigned tasks, or when members have hidden agendas. These may be structural features of committee life, so it is just as well that I have come to terms with the fact that there are just some things I shouldn't do.

On the other hand, when Ann Minahan and Bea Saunders spoke to me about becoming the Book Review Editor of *Social Work* (Who, me?) I reveled in that opportunity. When it came time to select books for review, the staff would place them all on a huge table, spines up, in double rows. I had mixed feelings...one of power, where I could actually decide which books were to be chosen, and another of guilt, where I complained of feeling like a murderer when I didn't choose a book. The entire process was wonderful...skimming the books, corresponding with reviewers, seeing the completed reviews. Perhaps it had something to do with the beginning, middle, and end idea and the fact that there was a finished product, and of course, that it all had to do with books.

The invitation by the NASW to be the Editor-in-Chief of *Social Work* (Who,me?) was another wonderful surprise, and although it was hard and tedious work, it engaged me with authors' new ideas (and delicate egos), and the spectacular NASW publishing staff. My strongest impression of those years is of Linda Beebe, in the editorial department then, and her ubiquitous coca colas. I soon discovered that writing editorials was a serious risk-taking affair, and that any editorial decision could appear to be a life or death matter. Nothing in life is without its politics, and editing a professional journal is no

more sanguine a job than is committee work or teaching. The scariest thing about participating in putting out a professional journal is that once it is published, there is no way to erase anything.

AFFILIA

Soon after leaving that post I was asked by the Editorial Board of *AFFILIA: The Journal of Women and Social Work* to join them, and a few years later to be the Editor-in-Chief. (Of course, who, me?) I had no idea then that I was a feminist, and in fact I had been reprimanded by some members of the first NASW Women's Conference for a paper I had written that was deemed to be critical of the women's movement.[iv] (It wasn't true.) Members of *AFFILIA* , particularly Naomi Gottlieb and Diane Bernard, convinced me that I had feminist leanings, and in fact I immediately realized that it was only through a feminist lens that I could make sense of my personal life history. The *AFFILIA* adventure has been unique for me. The Board is the only committee I know where people fight to remain on it, and where I, the non-joiner, have had the most enlightening, educative, and life-affirming experiences of my career. I am not entirely sure even now how I would define feminism, because I think it has many different meanings depending upon context/standpoint/situation. But my association with the *AFFILIA* Board has convinced me that there is such a "universal" as being a feminist, if it can be likened to equality, fairness, and consideration. When the editorship becomes taxing in caring for the details, inevitably, some member of the Board will offer help or carry out the task. When mistakes are made, the members sympathize rather than criticize. This feminist thread, although a fairly new addition to the tapestry I am weaving here, has provided a certain kind of platform, where standing on tiptoes and leaning over, I can peer down on the career I am trying to describe, and begin to find some explanations for things that went right and wrong. That feminist analysis of my professional career will have to wait for me to re-think my professional trajectory...a story always left unfinished. As I mentioned earlier, the feminist lens has helped me to re-interpret my personal history, but that is not exactly the topic here.

POLITICS

Politics governs everything we do and to not consider them is to travel on a deceptive high road. Things are not looking too encouraging for social work in today's political atmosphere, and as always, the consequences are being felt within and without the profession. The attacks on the poor, on racial minorities, and on women are outrageous, and before this country returns to its senses and to a more humane politic, many people are going to be badly hurt by the cuts in social welfare, health, and education. It is hard to know what any professional group can do in this reactionary environment, where the Congress knows right from wrong, and is deliberately choosing the wrong. This Congress doesn't need education; it needs to be voted out.

I was fortunate to have entered social work after World War II, when the reactionary political forces were ineffective in overthrowing The New Deal. Racism, classism, sexism, and ageism were certainly rampant, but there was, after the War, always a sense of hope and possibility. Social work was more valued as a profession, perhaps because it flourished in the shadow of Roosevelt and Truman, and because veterans (men) entered it on the GI Bill of Rights. Social workers like Bertha Reynolds were active in the labor movement, and as a student at the NYSSW I was part of a vocal political majority (even though I was Co-editor of the student newspaper called "The Id"). We once invited Bertha Reynolds to speak at school, expecting an imposing and aggressive figure to match her activist reputation. I was shocked to see a diminutive figure, wearing a tiny straw hat with a flower in front that bobbed when she spoke in a New England whisper. When the Community Service Society, then one of the most powerful social agencies in New York City, had its 75th anniversary, there was some labor strife, and students and faculty marched on a picket line around the Roosevelt Hotel

in the mornings, and in the afternoons we all attended the professional meetings. Everything we did made sense to us at the time.

"The 60's" (and 70's) were different. Nothing made sense...the assassinations of the Kennedys, Martin Luther King, and Medgar Evers, for example. The protests for Civil Rights and against the Vietnam War...these were clear issues in which we could actively join, but the students' struggle against "the establishment" was a problem for me. I was a professor at the Columbia University School of Social Work then, and I was part of the establishment! Again, who, me? Students threw themselves in front of my classrooms and wouldn't let others in. We held classes in our homes, and students accused me of bribing them into submission when I passed around cookies. Sometimes on picket lines, other times peeking out through windows at the mayhem on the campus, I felt that I flunked "The 60's and 70's," perhaps because I could not identify with the students' assaults upon me (!) who was on their side.

Then came the 80's and the 90's, and I found my voice again, and have complained because students haven't reacted strongly enough against "the establishment." Did I learn from the 60's test through which I had suffered? Was my academic perch so comfortable that I could afford to be radical? Were the lines drawn between progressive and reactionary more clearly defined? Were the issues more local and manageable? Perhaps this time around, the attacks on health, welfare, and education resonated so sharply with the time I began in social work, when it was certain that government had a necessary role in enhancing the social and economic fabric. I think this idea is built into my character. When I was 20 years old, I told my father that I wanted to be a social worker, and he said" I always knew you would become a socialist." I am not sure I knew what it meant then.

The politics of feminism were concealed from me in the beginning of my career. I didn't know until as late as the 1980's that there were alternate (sexist) explanations for my own construction of my personal and professional worlds. Upon reflection, I now recognize that men controlled the terms of debates, and that it was a given that men would be in charge of most things. It is hard to believe now, that early on we never questioned that. Further, in the beginning, before Brown vs. The Board of Education and the Civil Rights movement, racism was not defined as something to be addressed, although we all recognized its presence. McCarthyism and the activities of the House Un-American Activities Committee radicalized me, and my first public political protest was to join thousands of others at Union Square in New York City at a vigil when the Rosenbergs were put to death. Thereafter, there have been many (Civil Rights, Women's Rights, the Vietnam War) vigils in Washington, and I now realize that although these actions do not have an immediate effect, they always leave an impression...to resonate later

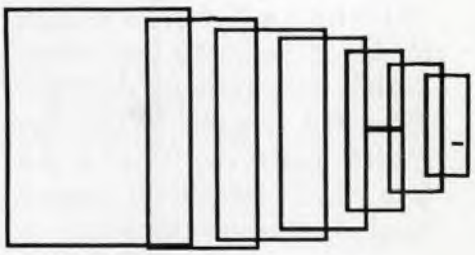
TEACHING

So much has been written about teaching that I am not sure that there is much that I can add to be helpful to anyone. I remember that before my first class at NYU, I was having coffee at Nedicks, and someone I knew sat next to me and asked about my thoughts on teaching. Distance from the occasion allows me to repeat what I said then..."My vision is of students as little birds with their beaks open, waiting for me to drop in worms of knowledge, but I don't know what to tell them." I don't know where such an idea could have come from, because I had had wonderful teachers, and I had never had such a patronizing teacher. Since then, after many years of experience and after two worn out copies of Bertha Reynolds' *Learning and Teaching*, I know that if students are birds, they are more likely to be diving hawks than hungry fledglings. Teaching has always been two-edged for me. Because I have been teaching social work, I have cared deeply that students think critically and learn well so that they would do well; thus, I have been a no-nonsense, demanding, content-oriented

teacher. "They have to use their minds! They have to know this!" On the other hand, teaching is fun, and like clinical practice, it is a way of knowing others. Thus, I have also been process-oriented, more patient in the classroom than elsewhere, waiting for students to "get there." I know that the classroom environment has to allow for students to learn in their style and at their pace, and that they must be active participants in their learning. I also know that such a learning environment is one of the most difficult educational purposes to achieve.

I used to have higher standards in my classroom, but I have learned to accommodate to a new generation of students who are television-oriented, although they do not always admit it. I have forced myself to show videos and to not complain when students don't read enough. I do badly at role play, although I try because the students love it. Why should students "enjoy" their classes? Why shouldn't they take notes? Why must teachers be popular? I often compare social work to medical school courses. Would student doctors dare to complain because their professors didn't make their anatomy class exciting enough? I wouldn't go to a physician who had learned about disease through role play. (You be the germ and I'll be the tummy.) Often, when I look out at a classroom of students, I think of their clients who need them to be competent, and then I get serious. I don't know if it works for all students, but I generally "teach to the top" so as to induce students to reach, and reach more. There is no universal way of learning, and we don't always know which approach is best for a single student or a classroom. That's why teaching is fun; after every class when I think that if only I had done it this or that way...there is always the next class to try it differently.

Education in social work has changed radically since I was a student, and although it isn't relevant to make comparisons, it does sharpen the focus of analysis. Earlier I mentioned the holistic orientation of my teachers at the NYSSW For example, it was Gordon Hamilton, a major casework theorist, who analyzed and supported the idea of entitlements in public assistance in her editorials in *Social Work*.. Philip Klein made research so integral to practice, that one could hardly distinguish between them. Lucille Austin, known as a casework theorist/ practitioner, introduced social sciences along with Freud into her classes. In the decades since, social workers have necessarily become more specialized, because areas of practice have proliferated, knowledge has increased, funding for research is sectored, and research methodology in particular has taken off on a trajectory of its own. It is no longer easy, if it is at all possible, for either academics or practitioners to have generic competence, or broad interests. Perhaps it is true that we are coming to know more and more about less and less, but this is inevitable when there is so much to know, and when we are paying so little attention to the purposes and meanings of it all. Dinosaur-like, I continue to press for those purposes and meanings in the books and articles that I write, and I am well aware that I may be among the last of those who still seek the messiness of real-world practice, and who revel in the idea of the unknowable. As my story, told thus far, should make clear, I am not a strong believer



in predictability; I care more about processes than outcomes; I am perhaps over-cautious about social workers being authorities about the "objective" world; I don't think that there are "truths" out there that can be found if we were only to polish the lenses on our microscopes. Also, I am not convinced that acquiring knowledge (endlessly and a-contextually) is the best way to engage social workers in effective and meaningful practice.

A final thought on social work education is a sad one for me. I foresee (in an all too near future) the "down-sizing" if not the elimination of masters level programs. Ph.D.'s will be emphasizing research, and BSW s are already outnumbering MSW programs. Entry to practice will be at the BSW level, and (as in psychology) the next level will be

the Ph.D. How the Profession itself has created this pending scenario is a topic for another article. I am continuing to struggle with the origins and meanings of this shift in educational focus, but I fear that the outcome is inevitable, no matter the causes. I once took a doctoral course in administration and chose as the topic for my term paper the story of an administrator I knew who had behaved badly in her job, which itself was probably set up for her to fail, and was subsequently fired. I entitled the paper "Was She Jumped or Did She Push?" Perhaps that will be the title for my epitaph on masters level social work education.

WRITING

All social workers do not write, although I wish they would, because it is the only way to spread the word about what practitioners do. Academics call this disseminating knowledge, and now that scholarship is so closely tied to numbers of reading references cited and to statistical sophistication, it has become intimidating to those who have something to say, but do not have the academic skills. I regret that we do not hear the practitioner's voice, because I have always used writing and publishing as an outlet for my ideas and convictions. It is as if I cannot help myself; writing is a way of sorting things out, of talking to colleagues, of framing debates, of arguing issues. Practitioners' experiences, ideas, and convictions must be equally pressing, but they are inhibited by "official" writers, who may have less vital or interesting things to say. Writing often seems to me like playing the piano; when one has mastered the score, the music just goes through one's fingers onto the keys. It is almost an unconscious process (not mastering the ideas, or the piano score) that the words come because they insist upon it. So, since 1959, when I wrote my first article, [v] I used publishing as one might use a log to write about what was important to me in social work.

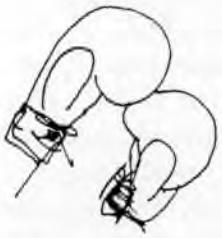
Writing these "reflections" has caused me to look at what I have written in over four decades. It is not easy to do such a review. Times and ideas have changed, and it isn't possible to take anything back. Could I have been that concerned about so much in social work? Are there contradictions? Did my articles get better or worse? The list seems long when compared to its impact on the profession. Six books, 46 articles and chapters, uncounted editorials, and about a dozen monographs, in addition to the drawer full of speeches and articles that didn't get published. So why didn't social work always do what I wrote about? I conclude that writing...even publishing...is a private matter. It has everything to do with self-expression, and that is why it is gratifying. Beware of the illusion that anyone listens!

Reflecting upon what I have chosen to write about, I am not sure of the impetus. Sometimes it had to do with what I was doing or thinking at the time, or with my response to another's work. Once in a while someone would ask for something. So, there are the staff development articles, [vi] and the work in child welfare, [vii] and a variety of subjects that were "hot" at the time, but that I did not pursue further. My field of practice interest was always family and children's service, and as in all the other social work fields of practice, the arena changed, and changed, and changed. What does stay the same in social work? Always its purposes and values, and its psychosocial emphasis. When these components are stable, then the profession can adapt to changes in society, family structure, lifestyles, diverse populations, and problem definitions. My preoccupations have been more with the application of those stable components to a range of substantive matters. In other words, I have argued on behalf of some aspects of practice theory in many different contexts.[viii] The invention of the eco-systems perspective was a way of extending my interest in the "psychosocial" focus of practice.[ix] It took a very long time for the idea to take hold, partly because it framed a way to look at cases and it didn't tell practitioners what to do, and partly because it was at first viewed as "anti-clinical." (This caused me to respond with a book that would challenge that criticism.)[x] It has often seemed to me that going public through writing is, like a crisis, as much a hazard as an opportunity.

PICKING FIGHTS

Each of us muses about the way we would like things to be. Some of us are more patient

than others about the direction and pace of change, and whether or not we should enter public debates. Perhaps because I have always been "hooked" on social work and have wanted it to be "right," I have been one of the impatient musers and have entered debates perhaps too often. The first one I remember was about the once popular idea that poor people should be called "muti-problem families." I have always been impatient with undocumented, over-generalized labeling of people. Euphemisms so often serve as escape hatches and distort reality, and I prefer to confront things as they are. [xi]



Of another order, a long-standing debate has been about private practice. This has been sort of a "fools walk in..." effort, and the debates in the journals [xiii] were often carried over into personal exchanges. My concerns about private practice in social work are of two kinds ...ideological and practical. As for the ideological issues, they are not provable, and my values can only share space with the values of private practitioners. I believe that social work's historical mission has been to ameliorate the condition of the poor, those who have been discriminated against, and those who need supports so as to cope with social and economic failures in society. Private practice in social work, by definition, means that fees are charged and this has to exclude many of the very people social workers are supposed to serve. Also, in order to be a viable for-profit enterprise, private practice must "cream" the help-seeking population for clients who are healthier, are more motivated, have more self-defined problems, and so on...leaving out many of the very people social workers are supposed to be serving. Finally, as a consequence of for-profit practice and the "creaming" I mentioned, social work private practice inevitably comes to resemble psychotherapy. (If one leaves out clientele who have environ-mental difficulties, then what is left are cases often defined as having "only" psychological problems.) This process narrows the focus of intervention, and redefines the purposes of social work. Given the proliferation of private practitioners, it is obvious that perhaps most of my professional colleagues do not share my beliefs.

This leads to my view of the practical implications of private practice in social work. When comparisons are made to medicine, which offers the model of private practice, we should look more closely at what the profession of medicine does. I am not referring to individual physicians, but to their profession, which is accountable for the health care of the public. In over hundreds of years physicians have carved out their domain, which today covers a broad range of health care services from public health to brain surgery. Whether the medical profession does this well or not is not at issue here; what is important is that the public expects it to, and the profession claims its universal domain. Turning to social work, let us assume that the profession is accountable for providing social services to the public, and that (would it were so) the public expects this and turns to social workers to address the psycho-social needs of people in a range of areas. Does the profession meet this obligation? Does the public turn to skilled social workers to deal effectively with problems in these fields? When social work is visible, as in public child welfare, are there any professional social workers left there? My practical point is that social workers in private practice have skipped the necessary step in the process of "maturing" into private practice (if that is how it is perceived) and that until the profession assumes responsibility for social services that are delivered, recognizable, and valued by the public, then there will be no core professional identity to which private practitioners can be attached. In this political era when social work services are being cut it has been difficult to convince the public that social workers are necessary. Can we imagine the public questioning the value of physicians? The invisibility of highly trained professional practitioners in the central public and voluntary service institutions in this country will not promote the future of professional social work. There will always be a need for social services, but we are already not-

ing that non-professional practitioners are functioning with lowered educational standards and with titles such as human service workers. Will the profession of social work ever take back its function? And will there be any professionally educated practitioners left?

Any social worker who has worked in organizations knows how hard it is to practice well in a bureaucracy, and it is probably this more than any other reason that has driven practitioners into private practice. But this is an organizational world (ask any physician in a hospital or teacher in a school)) and agencies will remain a fact of life. So social workers will have to learn how to manage them just as have physicians. My practical concerns are based upon data, not ideology, and ironically, it is toward the goal of their self-preservation that I have been nagging at practitioners to think hard about the erosion of professional social work. It has been a career-long struggle to make the case for the profession, but I now feel great sadness when I view the down-grading of organizational social services, the trend toward using non-MSW practitioners, and the parallel up-grading of individual private practice of psychotherapy. There may not be a direct causal connection between these phenomena, but there does seem to be a reciprocal contributory effect.

CHANGE WAS COMING

"The 60's " introduced radical changes in society, and social work needed to find new ways to adapt to those changes. The professional literature addressed many aspects of the impending changes, and naturally, I worried a lot about the future of practice. [xiii] Social workers were still focusing narrowly on intra-psychic change, and in my view, many did not notice that the client population was become culturally diverse, that once-overlooked poor people were becoming articulate about wanting social services, and that the emerging public and academic interest in social phenomena was having an impact on all professions. In 1970 I wrote a book about broadening the scope of casework practice and its methodology of study, diagnosis and treatment. I proposed changing the terminology and substance, to call it social work practice and exploration, assessment, and intervention. My intention was to encourage practitioners to be more inclusive of client problems, and less medicalized in their thinking. This book[xiv] did not interest many people at first, and in fact, a close colleague complained to me that "You don't tell practitioners what to do." (That has always true of my writing...and my teaching. I am a strong believer in framing the topic, identifying choices, and relying on people to be guided by their own judgment, values, and experience. That is the only way I have ever learned to do anything.)

The response to the book that had the greatest effect upon me came in an experience that reflected the very reasons that I had written the book in the first place. Florence Hollis and I went to lunch one day (in 1970) so that she could find out why I had written the book, which she thought would be damaging to practice...while I, in my missionary's zeal, believed that I was trying to save practice. As we were returning to school across Broadway (a six lane avenue with an island in the middle), I noted that on the south island there was a large group of Columbia students, some of whom were carrying placards, while others were throwing tomatoes. Their target was what seemed to be a small battalion of New York City policemen on horses, lined up on the north island. Florence Hollis and I were deep in conversation about the book....she asking, "What social changes?," and my saying hesitantly, "Everything..." (Professor Hollis had been my mentor and was a senior colleague, so this was not a comfortable conversation for me.) As we crossed the street, we dodged tomatoes, but kept on talking. I don't believe that she noticed the students' demonstration, and I remain convinced that she did not understand my reasons for writing the book.

Six years later I wrote a second book about practice, this time introducing systems theory and eco maps, in hopes that theory would help to support my point about the necessity for practice to become more adaptive to the real world.[xv] This time the response was slightly better, and it laid the foundation for later writing on the eco-systems perspective. I am certain that

many colleagues still believe that I have been "anti-clinical" in my writing, and I have argued that my attention to individualizing practice is clinical, and all that I have done has been to broaden the definition of clinical to include individuals' environments. I also remain a Freudian, in my belief in the unconscious and in the structure and functions of the ego. Perhaps the criticism of my clinical treachery has more to do with my nettling about private practice. In my recent book on assessment [xvi] I hope I have laid to rest some of the criticisms, for we all want to be liked. After these years of writing, wherein one puts one's ideas out for public review, analysis, and criticism, I am pretty much convinced that the academic's motto should be "Publish and perish!"

CODA

There are always new frontiers in which professionals can find issues ripe for debate. Currently, shifting epistemologies as they affect feminism and research are among the most interesting. As for feminism, it is encouraging that feminists, since 1973, have recognized that feminism is not only about white middle class women, that poor women's bread and butter issues are deserving of attention, and that there must be common cause with the plight of women throughout the world. The directions to be taken in social work research are less certain.[xvii] Will there ever be more attention paid to discovery than to proof? Will research move toward more holistic and denser models and become less fragmented and narrow in its focus? Will the language of research become more comprehensible? Will statistics become the servant rather than the mistress of projects? Will practice become the mistress rather than the servant of research? Will we ever give up the search for absolute validity? As one who has always insisted upon viewing events and processes in context, I cannot imagine what universal, objective "truths" would look like if they were not situated.

And that applies to this narrative. The "truth" of my story is not universal; it can only be recognized as a reflection of my life and the times in which I lived. When I entered social work, I thought that it was about settlement houses and concrete services, but when I went to graduate school, I discovered that practice theory, heavily influenced by Freudian thought, was more influential than the ideology of social activism. All was not lost, however; Gordon Hamilton taught and lived out her commitment to psychosocial practice, and as she was undoubtedly the greatest intellectual influence upon me, this idea probably kept me centered. I have never found it necessary (or even possible) to think separately about clients' motives and feelings and the provision of services. Because of my grounding in social casework (albeit narrowly defined in the 1940's), its approach to problems...study/explore, diagnose/assess, treat/intervene...has served me in each professional situation, even when it was not a clinical one. I used it to figure out all of my experiences with the OSE children, the bookie's agency, the NYU debacle, the glorious clutter of the Department of Welfare, the organizational work I did, editorial problems, and even daily life at Columbia. Social work values cannot be overlooked, either, for the role they have played in my life. Although we have not always used it as a governing principle, the Golden Rule...do unto others as you would have others do unto you...has always guided me. Its observance could account for my impatience with those who disrespectfully remove children from their parents, who tell people how to lead their lives, or who relate to others as if they were objects.

I have learned something from writing these reflections. I have recognized a kind of coherence in my social work career. Often I think that I have both practiced and written the same things over and over again, although at different times, about different topics, in different places. I have also been pretty much the same person no matter when or where. Does this depict stubbornness or commitment? Perhaps both. I have lived through a lot of change in the world and in the profession, and I am often surprised at how easy it was to adapt. Happily, I have

do unto others as you would have others do unto you

kept most of my friends and I have never, ever been bored or have felt that I chose the wrong path in becoming a social worker. For this I have to thank the entire cast of characters in this play. □

August 1995

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ATTRACTION NOT PROMOTION

The power of narratives used in twelve step speakers' meetings can frequently break through insurmountable denial of substance abuse. The narrative retelling of life experiences can be powerfully attracting and reassuring to newcomers as well as the speakers themselves. The "drunkalogues" can teach recovering participants that the "rotten personalities" that emerged during drinking and drugging can and do change.

By Ted Ernst

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There is probably nothing that better illustrates the power of narratives than storytelling, and some of the best examples are the stories that are told in twelve step speakers' meetings, variously known as "speaking," "qualifying," or "giving the lead." Guidelines are minimal but precise: tell "What it used to be like, what happened, and what it is like now. These are also the same guidelines for visiting and "sharing the message" with a practicing alcoholic or addict, hence "attraction not promotion."

The power is in the hearer's response and can often break through otherwise insurmountable denial. "Yeh, that's what happened to me, too" (comparing in) rather than "That hasn't happened to me...yet" (comparing out). It is in hearing others that newcomers learn that they are not terminally unique, nor crazy, nor unforgivably bad, and they are told, "If you didn't hear your story tonight, keep coming back." I know a recovering alcoholic who began sobriety in his mid-fifties, but finally heard his own story a few years later out of the mouths of a nurse in her sixties, whose drinking and perilous detoxification were similar to his own and from a fifteen year old young woman whose use of prescription uppers exactly paralleled his own. It is in these stories, too, that newcomers begin to recognize the emotional and intellectual augmentation in their own past lives. The extremely exaggerated emotional and thinking responses that have been brought about by minds augmented by mood-altering chemicals that have been both bizarre and destructive.

One of the saving/healing graces of such stories is that they are often wildly improbably and/or humorous...I one heard a speaker recount nearly being arrested for piracy for attempting to "borrow" a sailboat in the Annapolis tow harbor only to have a teenage newcomer share with him that he had actually been arrested there for stealing a rowboat, both incidents part of drinking episodes. I once heard a speaker describe hiding empty bottles in closets throughout a seminar dormitory. A newcomer shared with him that he had heard the same story among a group of old testament scholars around the campfire at an archeological dig in Israel. I have heard of an entire trainload of coal being stolen in Germany and sold to locals a few miles down the track, and of a young women crawling on hands and knees through an airline terminal pushing a suitcase. While

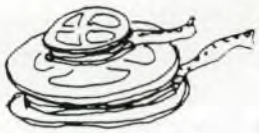
many are funny, the point of these examples is that newcomers learn that they are no worse or no better than others like themselves and thereby may begin to bond to sobriety and to "stick with the winners."

Narrative retelling of life experiences can be powerfully attracting and reassuring to newcomers as well as to the speakers themselves. "What it's like now" often speaks of the forgiveness of self and others that can occur when clean and sober. These narratives are often referred to as "Dunkalogues." But they teach recovering participants that the "rotten" personalities that emerged during active drinking and drugging can and do change, that the deterioration that has been the source of shame and guilt can be repaired, and these narratives often include instructive accounts of amends that have been made. They may be powerfully cathartic and healing for the speaker and hearer, with the seed of forgiving self and others.

Usually, sponsors or local groups require a certain time in sobriety before " telling your story" but this varies. The instructions remain the same: " What it used to be like, what happened and what it's like now. If the speaker has done the fifth step (shared a "searching and fearless moral inventory with themselves, with God, and with another person), speaking often brings up "memory bubbles" and speaking becomes an appendix or addition to that inventory.

For many it is a way of sharing that may attract another to sobriety. Speakers experience again the unconditional acceptance of these groups. Speaking is the classic example of "sharing the message," as the twelfth step indicates. Speakers are often anxious beforehand; seldom afterwards. It may well be that twelve step groups have produced more successful public speakers than any other method.

It is an ultimate experience in "storytelling," almost always a new experience no matter how often repeated, and groups seldom mind at all when they hear a story a second time or oftener. Although "drunkalog" stories may focus almost too much on "what it used to be like, the gold...attraction for newcomers is more often in the "what it's like now" portion, that is the outcome...the rewards... of sobriety, no matter how difficult to achieve. One often hears, speakers say that in the beginning they "wanted what you people had," which they very likely heard at a speakers meeting, as well as saw and experienced in the fellowship. Meetings, they learn, are the fellowship; the steps are the program, and occasionally speakers will include how they worked the steps as part of their stories. □



VIDEO REVIEW: "When A Man Loves a Woman,

Featuring Meg Ryan and Andy Garcia. Directed by Luis Mandoki. Touchstone Pictures (1994).

BY PAMELA K. METZ,

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This film shatters the stereotype of the alcoholic as old, male and poor. Meg Ryan in the role of a young, white, middle class woman is married to Andy Garcia, who plays an airline pilot. They have two children, both girls. The eldest is Meg's daughter from a previous relationship, and the younger is a child from her marriage with Garcia.

The early part of the film depicts Ryan as a "social drinker." Several beginning scenes show her being playful and silly while celebrating their wedding anniversary. Ryan is then seen as a counselor in a school setting where a co-worker invites her to to an "end of day winery" to talk about the co-worker's problems. Ryan forgets to call home and returns late. Drunk and self-denigrating, she says" she screwed up again" as she bangs her head against the wall. Garcia and the children soon show the cumulative effects of Ryan's use of heavy alcohol. This family episode is in stark contrast to the seemingly harmless effects of intoxication in the parental relationship in the opening scenes.

Garcia decides that a trip to Mexico to get away from the stress of home and work would help her. Again the social drinker, Ryan stands up in a row boat off the Mexican resort and falls into deep water. Garcia rescues her and says prophetically, "Wringing you out at the end of an evening is not as much fun as it used to be." Ryan responds with the good intentions of the addicted drinker, "I'm going to stop drinking so much; I promise you – I promise me."

An important character in this film is Amy, the Asian-American baby sitter who takes care of the house and children while the parents are away. Amy is aware of the patterns of drinking but does nothing until the day when Ryan comes in late, obviously drunk. Denying her own need for assistance, she sends Amy away. Slapping her child, Ryan then downs aspirin with vodka. She gets into the shower, passes out,cutting herself as she falls through the full length glass door onto the floor. Jess, the older child, is frightened and thinks her mother is dead. She calls her father at work and he directs rescue people to the home.

With Ryan in the hospital and then in a residential treatment center, Garcia begins to understand what the children have known all along: his wife is an alcoholic. The young girls tell their father that Mommy cries a lot in the bathroom. When he finds a bottle in her clothing drawer, he goes to the liquor cabinet and throws out all the liquor in the house. Again, the older child tells him he should wrap the bottles in a paper bag like Mommy does. He understands the child's need to be a part of this ritual cleansing and invites her to join him in smashing the bottles in the trashcan.

The viewers see a few scenes of Ryan at the treatment center. Upon arrival, her bags are searched as part of the "routine" checking

in process. She is shown to a room in what appears to be a large home. Ryan goes through the detoxification process with the support of an African-American woman counselor. When Garcia comes for his first visit, Ryan says to him as he views the diversity of people in treatment, "Whatever you think of these people, think of me. I'm just like them." The film depicts some of the people at the treatment center in extreme characterizations and panders to people's fears about who goes to treatment centers. Two of of the people that talked to Garcia were bizarre and threatening; in high contrast to Ryan's cheer leader image. (The film in some measure does not accurately represent the different kinds of people found at residential treatment centers.)

While his wife is at the center, Garcia begins to experience the challenge of being a single parent. The girls are acting out; Amy, the baby sitter is filling in; and his work schedule as a pilot has become more demanding. Chaos and crisis mount at home as he takes his frustrations out on Amy, who refuses to become the scapegoat. She walks out, leaving him to deal with these problems.

Garcia swallows his pride and anger and approaches Amy, seated among her many relatives as they share a meal together in their restaurant. He asks her if she will stay with the children while he meets the demands of his flight schedule. His airline company is downsizing and he does not have the flexibility to stay home while his wife is in the treatment facility. He may lose his job or be transferred if he cannot work this trip. Amy agrees to return to care for the children in his absence.

When Ryan returns home after drying out, she tries to re-establish her relationship with the two young girls. When Garcia is home, again he steps in and takes over while she is working with the children. This initiates new tension between them as she recreates her life without alcohol. They see a marriage counselor and Garcia eventually moves out of the house. He begins to attend Al-Anon meetings and initially calls them a bunch of losers who feel sorry for themselves. She attends AA meetings and, while not drinking, continues making new friends with people that attend her meetings.

He is transferred to Denver and it appears that, although they love each other, the changes they both need to make may be too much to deal with while living together and remaining married.

Ryan invites him to a six-month anniversary meeting where she will stand up and tell the story of her drinking career. It appears that he will not be able to attend. She tells her story celebrating 184 days of sobriety, adding that each day is difficult. A moment of drama occurs as she ends her story: Garcia, standing in the back of the room, hears what she has said. They embrace, and we believe, as the film makers wanted, they are reunited.

The film gives the uninformed viewer a sanitized introduction to alcohol addiction. Because of the socio-economic status and physical attractiveness of the actors, the film it is easy viewing. The more important messages about alcohol abuse and how it affects others become evident through the lives of the children. The scenes that depict the increasing damage to the children send messages to parents about how their use of alcohol negatively affect their children.

A friend who viewed this video reported that this was like her family when she was a child. The film warns the viewers that, although a family might look fine from the outside, the children of alcoholic parents may suffer long-term scars.

The film also gives the husband an opportunity to ask why he didn't see the problems sooner. When Ryan replies that she hid it from him, she confirms how this can happen even in a marriage where partners are close to one another. In this relationship, Garcia's love for his wife took the form of protector and rescuer, disallowing Ryan's realization of her own competencies. As an airline pilot his schedule allowed him to be absent from daily routines, and their time together was often like dating, with easy access to vacations and resort living. They escaped whenever there was difficulty. In fact, during the post-treatment tension and abstinence at home, Garcia suggests getting away. Meg Ryan's sober response is "Maybe I should learn to live in reality before I try to escape it again." □

BOOK REVIEW

Michael Dorris

A Yellow Raft In Blue Water
Warner: Little Brown & Co. Inc.: Boston MA , 1987, 343 pages. $16.95

By Charlotte Goodluck

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Braiding hair with three different and separate colored strands is the metaphor used by the author of *A Yellow Raft in Blue Water* to unwind the stories of three strong, sensitive and struggling American Indian women. Dorris, a member of the Modoc tribe, sets the novel as a trilogy capturing each person's voice over a three generation span. Rayona a bi-racial (American Indian and African-American) teenager returns to the reservation to find out about her culture and traditions. She is the third generation. Abandoned by her mother, she tries to reconnect with her grandmother who lives on the reservation. Sexually abused by a trusted assistant priest, she struggles with the idea of returning to the city. Christine, the mother, the second generation, lives in Seattle enduring the stress of an impoverished life. Alcohol provides consolation and companionship. Harboring resentment toward her reservation's extended family, Christine spends her days recalling the joyful times when she was young. Ida, the grandmother (the first generation) and cultural matriarch, holds many secrets and weaves the conclusion of the story into one of both betrayal and loyalty to one's extended family.

While the apparent protagonist is Rayona, the mixed bi-racial daughter, within the inter-generational dynamics of American Indian families, Ida is the true protagonist. Ida's personality, values, culture, and traditions flow through each generation, and reveal themselves in each character. Substance abuse is a strand which colors and filters the reader's impressions of the three characters. The maternal grandmother and the granddaughter both live alcohol and drug free lives despite their troubled experiences. However, Christine uses alcohol excessively and eventually suffers serious health problems. The mix of non-use and excessive use of alcohol among the central characters is an accurate reflection of reality; pointing out many of the problems alcohol creates in Indian communities, without surrendering to the popular but inaccurate stereotype that "all Indians drink."

This novel helps readers to understand much about substance abuse among American Indians, and how culture plays a role to counter the destructive forces. Numerous factors such as oppression, poverty and racism propel Christine to alcohol for friendship and emotional support, while other cultural traditions and American Indian values moderate that pressure. Christine, represents the person in the middle of culture change, moving to the city away from her Indian roots and extended family.

The city represents a spiritual vacuum and isolation from her traditions. She frequents Indian bars for a social life, and falls in love with an African American man: from that union Rayona is born.

Curiously, Rayona's conception takes place at Point Defiance. This underlying theme of Christine's life represents other American Indians' internal and external struggle with understanding "the American Way." Anger, resistance, withdrawl, rage and depression are all points of personal defiance against changing one's identity and culture. Christine uses alcohol to soften the hurt,pain, and rejection of her own experiences as she struggles to find her place in a large city. Despite these problems, she retains a history of her own people. She has a rich extended family on the reservation with whom she visits occasionally, and she tries to teach her daughter her native language. Christine is caught in the "in between" generation, half in and half out, she is half on and off the reservation. Such an isolating position and emotional devastating place for the heart, mind, and spirit. As professional helpers , we could assist her as an individual, focusing only on the issue of alcoholism , or we could use our knowledge to understand her context and see the story in its entirety.

The color yellow symbolizes hidden dimensions. Yellow, a sacred color of the American Indian people, represents the spiritual domain of the life giving sun, corn, and sunrise. One character says, " I'm stopped, halfway down the trail, with my eyes fixed on the empty yellow raft floating in the blue waters of Bearpaw Lake. Somewhere in my mind I've decided that if I stare at it hard enough it will launch me out of my present troubles." (p. 104) Yellow, from the Indian perspective, is part of the spiritual core and goes to our traditional values and beliefs. Each main character, Ida, Christine, and Rayona have juxtaposed relationships with traditional spiritual ties to their culture. Each family member uses their spiritual memories, traditions, customs, and practices as both symbolic and concrete places to hold on to in the personal struggles of living in "two worlds".

Dorris' novel is a rich resource. The book can serve as an important supplement for educators teaching about Substance Abuse. It can also be used as a tool to look into the world of American Indian women. For all helpers, it is a place to begin a conversation on the issues of substance abuse, race, culture and gender. □