WHAT'S SPECIAL ABOUT JEWISH FAMILY SERVICE ALCOHOLISM TREATMENT?

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To the Jewish families with alcoholism problems we've opened the door of the central address for the Jew in trouble. They can experience the special support that we believe most Jewish families feel—consciously or unconsciously—when they come "home" to the agency that belongs to them, for help with whatever problem.

DENIAL OF JEWISH ALCOHOLISM

Jewish family service agencies have long been in the forefront of family service programming, always providing innovative services to meet constantly changing needs of the Jewish family in a complex society. Why, then, has there been a dearth of services provided to the Jewish alcoholic and his family? Alcoholism treatment services in recent years have been a major growth area in both the for-profit, and not-for-profit sectors in the human services, but not in Jewish communal service.

Although we have an increasing number of Jewish communities that are beginning to cope with the issue of community consciousness-raising, still only a handful of Jewish family agencies are offering any direct treatment service to this population. Is it because there are no Jewish alcoholics, or that there are so few that Jewish agencies really do not need to provide services? This is highly unlikely; a conservative estimate based on population projections would indicate that as many as one million Jews nationally are affected, either because they themselves or their family members have a problem with alcohol.[1]

Perhaps the most awesome issue facing not only the Jewish alcoholic, but the Jewish community as well is that of denial. Denial is the most critical defense mechanism in alcoholism and is one of the major obstacles to overcome in treatment of alcoholism. Denial is pervasive on all levels, from the individual, to the family, to the community. As to Jewish alcoholism, there is a cherished belief that Jews escape it altogether. The Yiddish song, *Shikker Vie Ein Goy*, reflects the traditional community values that set up an identity conflict resulting in either denial ("Since I am a Jew I can't be an alcoholic") or disaffiliation ("Since I am an alcoholic, I'm not really much of a Jew"). Individuals must come to grips not only with the issues of being an alcoholic, but also the additional burden of being a Jewish alcoholic. Thus the "double whammy" for the personal aspect of Jewish alcoholism.

The family also operates within this system of denial or disaffiliation. The family supports the denial about the alcoholism so that the alcoholic is either overprotected or rejected by his family. For the Jewish family, this is even more true. "What would our Jewish relatives and neighbors think? We can't have an alcoholic in *our* family."

The Jewish denial is further increased on the community level. Here the group says: "What would the gentile community think of us, if we are just like the goyim? We have got to be superior. Jews cannot

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1. "Proposal: Coordinated Services to Reach Out to Alcoholics and Their Families," Jewish Family Service Association of Cleveland, 1983.

have this kind of problem. Therefore, it does not exist in our community. No one in our community can be alcoholic."

And Jewish Family Service Association of Cleveland is a part of this community. As in most communities the Jewish family service is known as "the central address for the Jew in trouble." Like most agencies, we have been developing services with an outreach thrust—to reach out and include in our services client populations who appear to be isolated or alienated from the mainstream of Jewish community life: the elderly, chronically mentally ill, retarded, physically disabled and single parent families. But little has been done for Jewish alcoholics and their families. The Jewish alcoholic, then has suffered not only from his own and his family's denial, but from exclusion from many Jewish communal agencies.

For example: Alcoholics Anonymous and Alanon meetings are often held in churches, not in temples or synagogues; JFSA has referred alcoholics where the disease was seen as primary, to community alcoholism agencies; our staff gave barely polite attention in 1979 to our Regional Alcoholism Council director's challenge to inquire about alcohol use in all our cases, and wished that she would not continue to bother us with her insistence—when we are so busy with more relevant and complex problems—that we were missing the boat.

From our long experience in working with Jewish families, particularly those who are isolated and alienated from the Jewish community, we know the special impact that feeling disconnected from the community has for Jews, because of the familial dynamics that operate in the Jewish community. Exclusion has serious consequences for erosion of a secure identity and self-esteem. Although JFSA of Cleveland has prided itself on its tradition of *tzedakah* and *chesed*, and although our community agencies have *not* had the tradition of *excluding* the Jew in trouble, our traditions have not been honored in the case of alcoholism where the exclusion has been, at the very least, by omission.

BREAKING THROUGH OUR OWN DENIAL: A DEMONSTRATION PROJECT:

When a family comes to JFSA for help with its problem, often a long-standing one, we always find it essential to understand "why now"? What was the particular convergence of elements that led to a change in our point of view about our obligation to provide help to alcoholics and their families at JFSA of Cleveland, to do something different about *our* problem?

For us, the change began to be noticeable in 1982. We were involved in program development and promotion in a new suburban satellite office with a particular goal of reaching more families with children, families who had moved to suburbs further east, and one of our avenues of outreach was through several suburban school systems.

We learned that the schools' focus in most of their counseling and pupil personnel services was chemical dependency, that they were heavily involved in staff training and in-school models for identifying chemical dependency problems in students, countering denial and enabling in families, referring to treatment sources, and even providing aftercare support groups. They noted, however, as did a neighboring teen Rap/Art Center a block from our home office, that while there were many support groups for teens in schools, AA, and Alateen, there was little individualized counseling, particularly longer term outpatient counseling for families.

Many teens were being sent for 28-day inpatient treatment to Minnesota or Baton Rouge, but they, and especially their families, had insufficient individualized support after their return home. We determined to "check out" the Minnesota model—to gain credibility, to be able to

speak the language with the school people, if nothing else, we told ourselves.

We sent a satellite office outreach worker, whose background included experience in psychoanalytic child therapy and treatment of adolescents, for a one-week Johnson Institute Training Program in chemical dependency that was being offered in Akron, the "introductory course" designed primarily for school personnel. I remember cautioning her to try to keep an open mind, but not to be caught up in what I feared might be a faddish and perhaps self-serving sales/evangelism of this "treatment movement." She came back shaken and impressed, convinced about her own denial of addictive behavior and ready to share her experience in a very serious and convincing way with other staff, as well as to begin to see youngsters and families who might be referred by schools at the suburban office.

A pivotal event (perhaps the "precipitating event") in our consciousness-raising occurred when our executive director attended a session at the CJCS conference in 1982 about Jewish alcoholism. He brought back to the administrative staff group and to the Executive Committee of the Board, his conviction that we could no longer be negligent about the major Jewish family problem of alcoholism and chemical dependency, particularly alcoholism in Jewish adults, and that we needed to think in terms of a comprehensive agency alcoholism program.

An ad-hoc advisory Committee—made up of concerned persons in the community as well as agency Board members—and the agency administration staff worked for almost two years with Federation, The Congregational Plenum, The Regional Council on Alcoholism to explore the dimensions of the problem of Jewish alcoholism in Cleveland and to advocate for the JFSA demonstration project.

The proposal for the demonstration project stated:

> Although alcoholism is the third largest health problem in this country, and is recognized as an illness destructive to family life, no family service agency in Cleveland offers alcoholism treatment as one of its clinical programs. Furthermore, although population projections indicate that a significant number of Jews suffer from this illness, the traditional stigma about alcoholism in the Jewish community has resulted in a critical gap in services, i.e., no Jewish agency currently has sufficient expertise to treat alcoholic Jews and their families.

This demonstration project had two major goals:

1. To counteract the Jewish community's denial of alcoholism as an illness affecting Jewish families.
2. To enable alcoholic Jews and their families to achieve healthy functioning without the use of alcohol and other drugs, while *staying or becoming connected to the Jewish community."*

Foundation funding sources were approached, with support from the Jewish Community Federation and the Regional Council on Alcoholism, and the agency received funding for a major, three-year demonstration project to provide for the following services:

- Community education and consciousness raising about alcoholism as an illness which affects Jewish familes.
- Training professional staff at JFSA and other Jewish communal agencies in identifying the symptoms of alcoholism within an individual or family.
- Treatment at JFSA for Jewish alcoholics, coordinating family counseling with the Alcoholics Anonymous model for recovery.

Our formal alcoholism program began in July, 1984, when its director, a graduate social worker, joined the JFSA staff. She

had been in the alcoholism and chemical dependency field for over ten years and had well-established relationships with the AA community, as well as experience in both individual and group alcoholism counseling. Her earlier experience in Jewish group work agencies gave her knowledge of and familiarity with the Jewish community and with Jewish communal service, which we felt was essential for our program.

Long before the formal program began, the very process of breaking through our own denial, developing lay leadership, and obtaining Board, staff and community support on many levels had already launched us in a beginning way in each of three program services: community education and consciousness-raising, staff training in identifying alcoholism in individuals and families, and treatment at JFSA that appreciated the value of AA, and coordinated closely with it.

The very important service elements of community education and consciousness-raising will not be addressed here in order to concentrate on the treatment program and staff development issues. However, just a word, in passing—as with all agency programs, the very fact that the Jewish family agency has a defined program for treating Jewish alcoholics and families, in itself, makes a statement that heightens the community's perception of the problem, and contributes to changing the atmosphere of alienation for Jewish alcoholics and their families within the community.

TREATMENT AT JFSA FOR JEWISH ALCOHOLICS AND FAMILIES

From the outset of our planning, we determined that our alcoholism treatment service at JFSA should not be just an "add-on," separate from the basic JFSA clinical services. The antipathy that has developed between the mental health and alcoholism treatment communities is well-known. Moreover, one of the funding sources, a local foundation, was interested in the proposal to integrate a family-oriented mental health service with an AA-alcoholism-as-a-disease approach. We, therefore, planned a variety of elements in our program that would utilize the specialized skills of the alcoholism counselors and the family practice skills of our generalist counseling staff.

The alcoholism counselors are experts in chemical dependency evaluation, countering the many faces of denial, "enabling," educating about the disease; in methods of confrontation and influencing acceptance of abstinence, in facilitating connection to AA and Alanon and counseling in a mode that utilizes AA concepts and speaks in the language of "program" and quality twelve-step recovery. They also have experience in determining how far-progressed and chronic the disease is, when referral for inpatient treatment is advisable, when hospitalization for de-tox is necessary, what are expectable experiences in recovery, and the use and value of short-term behavorial goals in treatment—one day at a time.

The practice of our generalist counseling staff is grounded in a psychodynamic approach to individual treatment; in-depth understanding of intimate family relationship issues; and family life-cycle and systems theory. As a result of continuous staff development attention to the Jewish dimension in practice, JFSA staff have "in their bones" a sensitivity to and understanding of Jewish identity issues and Jewish family experience and dynamics. They are experienced in engaging the client—whatever the request—in a joined process of problem solving to facilitate coping with a myriad of dilemmas in living.

They are a varied, relatively experienced and sophisticated group, who strive for superior quality of treatment. Among them they have skills in crisis-intervention,

individual psychotherapy, marial counseling, parent guidance, child therapy, family therapy and group treatment (support-group, family-life workshops, or group therapy). They are familiar with using psychiatric consultation that includes a DSM-III diagnosis and a clinical treatment plan based on that diagnosis, often including work with family members in various combinations. They have skills in assessment and case management in situations needing life-supportive services for elderly and handicapped and delivering counseling and support services to the chronically mentally ill and the mentally retarded and their families.

In order to provide for the greatest flexibility in utilizing the skills of the alcoholism specialists *and* the family practitioners, we have avoided—as much as possible in this age of checklist accreditation—rigid rules about format and about who should provide treatment to alcoholics and their families. We have encouraged experimentation based on our best matching of staff skills with careful assessment of the needs of the individual family. Cases can be assessed and treated by the alcoholism counselor alone, usually when the request is specifically related to an alcoholism/CD problem.

Sometimes the family urgently needs counseling for other problems, e.g., about a child, concurrently with alcoholism counseling, and a co-op case is set up, with frequent consultation between the two workers. In several cases family treatment with co-therapists (alcoholism counselor and family practitioner) has seemed most appropriate. A frequent model is the use of the alcoholism counselor for consultation in a case where the family comes in about a different problem and the worker recognizes the alcoholism and asks for help in discussing and dealing with it. The consultation may lead to an in-person evaluation by the alcoholism counselor, often with the family worker sitting in.

In the first 18 months of the program we have seen 85 families who were carried by the alcoholism counselors as primary workers, and 78 with the family practitioner as the primary worker, using consultation from the alcoholism counselor. To strengthen the decision-making about how cases should be carried and to enhance the process of integration, the overall supervision of the clinical practice in the alcoholism treatment program has been assigned to a supervising practitioner with many years of experience in JFSA family practice.

As the individualized family treatment has gotten established, we've developed some group services. We presently have a supportive therapy group for adult children of alcoholics, have had two 10-session family life workshop groups for children with an alcoholic parent and one group for parents of these children. We are hoping to expand group support and treatment services within the remaining year-and-a-half of the demonstration project.

In addition to the clinical program, an important element has been the two annual weekend retreats, one just completed, for Jewish alcoholics and this year, their "significant others." Using the model developed by the JACS Foundation of New York,[2] the retreat provides an opportunity for sharing experiences with other Jewish persons recovering from alcoholism/chemical dependency, for reconnecting with their Jewish spiritual roots, discussing how to understand the twelve steps within the context of Judaism, and strengthening their recovery in AA. The program was planned with a committee of recovering Jewish AA and Alanon members. In 1985 there were 14 participants in the retreat, the following year, 46, including two rabbis and two JFSA staff.

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2. Jewish Alcoholics, Chemically Dependent Persons and Significant Others Foundation of New York City.

The participants' evaluations over and over emphasize a deep appreciation for the fellowship with other Jewish alcoholics, some version of reconnecting with Judaism, and the support this provided to their AA program. One participant put it well in answer to "What did you like most about the weekend?": The joyful experience of coming to grips with my heritage and religion, and the community!" There was enthusiastic support for having another annual retreat, perhaps more than one, and several people asked to be on the Planning Committee. While only 12 of the participants were JFSA clients or former clients, there is little question that the retreats are a meaningful support to the recovery of all participants, and can certainly be viewed as a treatment service.

STAFF DEVELOPMENT: BEYOND TRAINING

Staff development is a key factor in the success of any program; because staff have been so much a "part of the problem" of the denial and "enabling" of Jewish alcoholism, staff development is even more crucial to a JFS alcoholism treatment program.

One of our project goals called for training staff at JFSA in identifying the symptoms of alcoholism within an individual or family. In addition to that goal, however, our determination to integrate alcoholism counseling with family practice has been a complex task, and has required utilizing every aspect of our staff development structure. Detailing the process—which has been fascinating—is outside the scope of this paper, but it has included two three-session series for the total staff planned by the Staff Planning Committee with the alcoholism program director, an alcoholism study group of selected staff that meets twice a month to discuss cases, and attention at one time or another in every staff study group even in the two groups that focus on practice with the elderly. Our experience is that not only do staff identify many more cases now, but that they identify the problem earlier and identify more cases in the early stages of the disease. The staff's interest now clearly goes beyond issues of identification to issues of treatment.

The flexible and readily available consultation described earlier provides for a two-way staff development: alcoholism consultation for family caseworkers and learning about Jewish family agency cases and family casework for the alcoholism counselor. We believe we have a solid base for a truly integrated treatment service for alcoholics and their families.

Now comes the question—"What's Special About Jewish Family Service Alcoholism Treatment?"

We believe there is much that's unique about this program that is specific to its being a *Jewish family service agency program.*

First of all, to the Jewish families with alcoholism problems we've opened the door of the central address for the Jew in trouble. They can experience the special support that we believe most Jewish families feel, consciously or unconsciously, when they come "home" to the agency that belongs to them, for help with whatever problem. To the alcoholic Jew who has lived with *shikker vie ein goy* this has enormous healing power for the shame and alienation that are major barriers to recovery. At JFSA we can also lend the authority of our communal mandate and our reputation for clinical know-how to our conviction and message that denial is *not* the thing to do.

Second, they can find at JFSA a treatment service that supports their involvement in AA/Alanon. But one that goes farther, that connects them with other Jews in AA, that understands their desire to interpret its spiritual emphasis in a Jewish context, that understands some of the conflict they feel in an organization

with Protestant evangelical roots which is so good for them, yet sometimes feels so strange.

Third, besides good alcoholism counseling they can have counseling based on an in-depth understanding of their family, their particular ways of being that work for or against family health, family patterns that may enable alcoholism in one member, depression in another, and deliquency in a third. Their counselor will also understand the complicated issues surrounding Jewish identity that may effect their recovery. This is the counseling product that comes from the agency's repository of clinical Jewish family practice knowledge and expertise.

Fourth, they can get help in connecting with a variety of other supportive and treatment services, all family-oriented, that respects their need to concentrate on recovery while recognizing that they are likely to have other situations in their lives that may need help, alcoholism-related or not. And their counselor/case manager will be there to help them utilize these services effectively.

Finally, they can have the opportunity to participate in planning and support of agency services, through advisory and other committee participation. When they do this within the JFSA, they fulfill a Jewish obligation and responsibly join in the mainstream of Jewish community life.

Recently we had the following Intake call:

> Mr. R. called. His sponsor suggested some counseling for him; he has family and individual problems. He has rejected his Judaism, which makes it difficult with his family, as well as being alcoholic. He has been sober 16 months (following inpatient treatment at L____Institute where he was referred by an EAP counselor). He goes to *10* meetings a week. (7 AA and 3 OA). He said he looked up *Jewish* in the phone book. He prefers to be called at the office for an appointment."

Although we have many, many questions unanswered, lots of wrinkles to iron out, and work to do, we now can say, with conviction to Mr. R: "How right you were to call JFSA! Come right on in."

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