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An exploratory study of two Chicana therapists working with Chicano/Mexicano alcoholic clients and their families with special emphasis on treatment modality, barriers and success

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AN EXPLORATORY STUDY OF TWO CHICANA THERAPISTS WORKING WITH CHICANO/MEXICANO ALCOHOLIC CLIENTS AND THEIR FAMILIES WITH SPECIAL EMPHASIS ON TREATMENT MODALITY, BARRIERS AND SUCCESS.

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CHAPTER I: INTRODUCTION

DESCRIPTION OF ALCOHOLISM IN THE UNITED STATES:

Alcohol is an accepted aspect of our society, with strong social, economic and political roots. Alcohol is used to enhance social occasions, to promote relaxation, as a compliment to food, as a component of religious ceremonies and in medical treatment.

Historically, alcohol was part of this country's heritage, beginning with the pilgrims landing at Plymouth Rock to brew beer, followed by the rum trade, frontier distilled corn liquor, homemade wine and bathtub gin during prohibition. Today, three out of four adults in the United States drink alcohol and it is considered a normal and acceptable practice.

Our society does not forbid alcohol consumption but rather encourages moderation and often abstinence. Therefore, in order to protect our own alcohol use, drunkennes is often ignored and an alcoholic is often defined as a "skid row bum." Not until recently, with the anti-drunk driver campaign and laws resulting in increased public awareness of alcohol related problems, has the use or abuse of alcohol been considered a social problem and threat to this country's general welfare.

In the past the alcoholic was often ignored or viewed as a nuisance; today he is viewed as a threat to society. He is a drain on the economy, costing billions of dollars a year due to car accidents, insurance settlements, court costs, lost productivity, medical and social services and crime.

Alcoholism can be described as a problem that effects not only the alcoholic but penetrates into all the areas of the alcoholic's

relationships and functioning. An alcoholic can be described as anyone who experiences problems in life as a consequence of alcohol abuse. These problems may be in one or more of the following areas: family - divorce, social relationships - isolation from non-drinking friends, work - loss of job, education - school drop out, health - cirrhosis of the liver, legal - drunk driving arrests, financial - as a result of job loss and legal problems, and self identity - low self esteem.

Alcoholism can be defined in a variety of different ways. These definitions not only define who is an alcoholic but usually prescribe a treatment approach. The legal definition sees alcoholism as a threat to law and order; often views the alcoholic as a criminal and prescribes treatment through the criminal justice system. A social definition may view the alcoholic as a social deviant, define alcoholism as a social disease, a threat to family and community and provide treatment through groups and community oriented organizations. A psychological definition may see alcoholism as a personality or developmental disorder and define the alcoholic as an oral or passive dependent individual and provide treatment through psychoanalysis. The biological definition sees alcoholism as a physical malfunctioning disease or genetic predisposition and define the alcoholic as a patient in need of medical treatment. And last, a socio-cultural definition views alcoholism as a result of cultural factors especially values, expectations, customs, and stress, often focuses on oppression and alienation. The alcoholic is seen as a product of these factors and the recommended approach to treatment is correcting the system, not the individual. Often these various definitions are intertwined to present alcoholism as a complex sociological, psychological and biological phenomenon.

On the other hand, alcohol is quite often defined as a psycho-active drug. It is perhaps the most powerful, legal, self regulated and administered drug available without a prescription. Treatment of alcholism in this perspective focus on stopping alcohol distribution and usage.

There are many conflicting figures as to how many alcoholics are in the United States. Two of the most common reasons for this are the confusion regarding who is an alcoholic and second, the tendancy of denial of an alcohol problem or of the troubles resulting from alcohol abuse. This denial is not only by the alcoholic himself but also frequently by the alcoholic's family and friends.

Although approximately two out of three Americans drink, the most common conservative estimate of alcoholics in this country, is approximately one alcoholic in every twenty or twenty-five persons. This figure is supported by a 1959 health survey which estimated 5,500,000 alcoholics, about 4,200 per 100,000 general population over twenty years of age.[1]

Often the effects of alcoholism are measured in dollars and lives. Dollar measurements are often used:

cost of lost productivity - $19 billion
cost of automobile accidents - $5 billion
cost of social, medical and health services - $14 billion
cost of violent crimes - $3 billion[2]

Lives are used as a measurement not only in terms of deaths or alcoholics as a result of their alcohol use (ie, cirrhosis), but also in terms of people killed by alcoholics, especially in car accidents. In fatal crashes, according to a study by Perrine, Waller and Harris 54% of the fatally injured drivers showed a blood alcohol content, of those 42% were above the legally drunk limit of .10%.[3]

THE ALCOHOLIC'S EFFECT ON THE FAMILY:

The true victims of alcoholism are the families of the alcoholics. These family members are not only victims but also play the roles of buffers and protectors of the alcoholic. The family has the greatest suffering since the alcoholic is often anesthetized by alcohol. Family members are frequently caught in a double bind situation, dependent on the alcoholic for support, love and security, while denying the alcohol problem or the troubles it creates in their lives as well as the life of the alcoholic. At the same time, family members may act as enabler for the alcoholic to avoid responsibility and consequences of his life and alcohol abuse.

As a result of the family system's dysfunctioning, confusion and conflict may first become evident through a "symptom bearer" other than the alcoholic. Often this is demonstrated in a child whose normal psycho-social development is inhibited resulting in dysfunctional behavior within his social cultural environment. An example of dysfunctional behavior common with children of alcoholics is truancy.

Unfortunately, this country is seeing an alarming increase of alcohol abuse among young people. Alcohol is the most widely used drug among teenagers today and its use is on the increase. There is a high correlation between juvenile alcohol abuse and parental (especially father's) alcohol abuse. The family usually provides the primary role models and socialization of the child as well as defines what is and isn't acceptable behavior. Furthermore, the home environment often provides the child's first access to liquor. It is very sad but true that these helpless victims all too often become alcoholics themselves or marry alcoholics and perpetuate the problem.

In a family setting the alcoholic's drinking is often done in the isolation of the home. As long as the alcoholic's problem behavior is not evident in public or considered a threat to work, to the family or the home it is often ignored or sanctioned. Being a closet drinker is much more difficult for the alcoholic breadwinner who must spend much time outside of the home, in the work place. The alcoholic spouse is often fearful of losing the partner, children and secure home if there is an admitted alcohol problem.

All too often in the quest for recovery the individual must confront societal and cultural role, as well as personal self identity, values, and expectations. The barriers of denial of alcoholism by both the alcoholic and others must also be broken down to gain insight and begin the recovery process. Denial is not easily broken since it has become a way of life, is easy to continue and socially acceptable.

THE DUAL STATUS OF BEING MINORITY AND ALCOHOLIC:

The Chicano/Mexicano faces all of the aforementioned alcohol related problems, but they are compounded by the dual status of being an alcoholic and a cultural minority. As a cultural minority the Chicano/Mexicano is often in a lower social and economic stratum in our society. The Chicano/Mexicano often faces unequal availability and accessability to justice, money, education, employment and housing. The result of the unequal availability and accessability to resources and services is often defined by the individual as a lack of power. Furthermore, as a member of a minority the individual is frequently also experiencing a confusion about self identity and cultural awareness.

The Chicano/Mexicano alcoholic's family often put the alcoholic in a double bind situation. On the one hand there is strong denial of the alcoholic's drinking as a problem since it reflects on the cultural expectations of strength and control. When the alcoholic is defined as a problem, it is usually dealt with-in the family, by the family and defined as a family or personal problem. Once defined as a family or personal problem the role of alcohol abuse is frequently denied as being at the root of the manifesting problems.

Unfortunately, the social and economic status and family factors are often ignored by the dominant culture when viewing alcohol problems within a minority such as Mexicano/Chicano. As a result, an incomplete data base is often used in developing cultural theories and theoretical concepts about Chicano/Mexicano alcoholism. These theories and theoretical concepts inevitably "blame the victim" for the alcohol problem. Some of these theoretical concepts will be discussed in Chapter II.

Against this background the primary investigators interests are to focus on how the therapeutic needs of the Chicano alcoholic family are being met. In particular, how are these needs being met by Chicana therapists? What are the theories and treatment modalities being used to guide the therapists? What works? How is success defined? What are the barriers in treatment?

CHAPTER II: LITERATURE REVIEW

The following chapter is a review of the studies and works that are related to the main subjects of this special project.

ALCOHOLIC DEFINED:

Alcoholics Anonymous' definition of an alcoholic is anyone who experiences problems in his/her life as a consequence of his alcohol abuse. This can be compared to the clinical classification as found in the Diagnostic Statistical Manual III (D.S.M. III). The two main sections and criteria of the classification are:

Section 305.0x Alcohol Abuse

A. pattern of pathological alcohol use

B. impairment in social or occupational functioning due to alcohol use

C. duration of disturbance at least one month

Section 303.9x Alcohol Dependence

A. either a pattern of pathological use or impairment in social or occupational functioning due to alcohol use

B. either tolerance or withdrawal.[4]

Alcoholism knows no social, economic, educational, racial, ethnic, cultural or sex barriers. Perhaps one of the largest and most inclusive studies of alcohol use in the United States was presented by Harold Mulford in 1963. This study took into consideration regions, sex, age, education, community residence size, religion, income, marital status, occupation, while focusing on alcohol usage and related problems of the respondents. In Mulford's study it is interesting to note some of the following findings:

1. The higher the income the higher the percentage of drinkers and the lower the percentage who quit drinking.
2. The marital status figures show single persons drink more than married, divorced or widowed, yet the majority of people having problems with alcohol are the divorced.
3. Occupation figures show the largest number of (100%) drinkers were professionals including dentists, lawyers, judges and physicians. Their responses indicated awareness of experiencing the highest percentage of alcohol related problems of any group of respondents polled.

(Author's note: Perhaps some reasons for this might be the stress and responsibility associated with their jobs; they often handle painful, intimidating situations while also having a "god-like self image." They often represent and care for the problems of other alcoholics, therefore, might have an even stronger awareness of alcohol related problems in their lives.)

4. Education figures show college graduates drink more than any other category yet respondents with less than 7 years of school experienced the most drinking related problems.

(Author's note: Could this represent a dual system of problem handling for the more educated (ie: reprimand or warning) and the less education (ie: arrest and judicial system) in our society).

5. It also might be expected that respondents under age 39 drink more than the other categories.
6. Regarding religion, Jewish and Catholic have the highest percentage of drinkers, yet the small Protestant denominations and Baptist have the smallest number of drinkers yet have the most problems.

(Author's note: It is interesting to note that alcohol plays a ceremonial role in both Catholic and Jewish ceremonies).

7. It is not surprising that there are more male than female drinkers, nor that males experience more problems.[5]

In consideration of alcohol's effect on behavior response and affective mood in male and female, it is interesting to note the following; McClelland's (1972) study reported "power fantasies (machismo)," in males and "feelings of womanliness," in females. Second, women who have problems with alcohol more often than men have or have had a problem drinking model (ie: father or husband).[6] Third, Edward's (1973) study regarding motivation for male and female drinking shows ataractic (anxiety reducing or calming) reasons appeared most important to both males and females.[7] Lastly, peer pressure seems to play an equally important role in both male and female alcohol use.

Rimmer's (1971) hospitalized alcoholic study showed some significant differences between female and male alcoholics. In comparing the sexes, males showed:

1. earlier onset of alcohol problems
2. younger age at first drink
3. more daily and morning drinking
4. more weekly consumption of over 32 ounces of distilled spirits
5. more bender drinking
6. more history of delirium tremens
7. more blackouts
8. more loss of job and friends because of drinking
9. more history of school problems
10. more "reckless youth"
11. more alcohol related arrests
12. fewer suicide attempts[8]

CROSS CULTURAL STUDIES:

Minority populations are often viewed as high risks of alcoholism. Some reasons suggested for this are: poverty, lack of mobility, under employment, discrimination, greater availability of alcohol, and conflicts as a result of acculturation and assimilation especially in terms of self esteem and identity.

In 1976, Donald Cahalan did a study showing various ethnic, religious/ minority alcohol use frequency.[9] The frequency, high maximum usage (referring to weekly drinking, at times 5 drinks or more) for males and females are:

	male	females
Chicanos	43%	16%
Black	16	13
White Protestant	22	11
White Catholic	36	15
Jewish	not available	12

Abstainers (no alcohol intake for the past year) showed:

Chicanos	3%	29%
Black	11	44
White Protestant	17	21
White Catholic	5	13
Jewish	not available	12

Another interesting study of alcohol abuse offers statistics on cirrhotic deaths. This study was done by Edmonson from 1970 to 1975 (longitudinal). It studied the deaths in the University of Southern California Medical Center in Los Angeles County.[10] The results were:

	male	females
Mexican American	26%	7.3%
White	18.8	12.1
Black	17.7	8.5

The California Department of Justice provides yet another perspective of alcohol use among youths you were committed to California Youth Authority

(CYA).[11] Youths who had used alcohol prior to or during the offense for which they were committed to CYA in 1975 reflects the following breakdown:

Mexican American	50%
Anglo	33%
Black	20%

Also in 1975, although Mexican Americans comprised about 16% of California's population, Mexican Americans represented about 23% of all arrests for public drunkeness and drunk driving.[12]

At this point it might be beneficial to point out some possible weaknesses in these types of studies. For example, the samples of the studies might not be true indicators of the population at large. In the study referring to cirrhosis of the liver, the study was made in a county hospital. Middle and upper class Americans often have insurance or can afford private hospitals and would, therefore, not be satisfactorily represented in this study. In the Criminal Justice survey it is interesting to point out the more frequent patroling of minority neighborhoods and often different handling of the residents of barrios than a middle class neighborhood. Often too, the values of the residents of the neighborhood can effect the proportion of arrests, especially if they do not confirm the dominant society's views.

THEORIES OF ALCOHOLISM:

There are many theories of alcoholism. First, alcoholism may be defined as a disease. A disease as described in Dorlands Illustrated Medical Dictionary, 24 edition is "a definite morbid process having a characteristic train of symptoms; it may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown."[13]

The biological theory asserts:

1. The possibility of alcohol producing tetrahydroisoquinolines (THQ), a morphine like substance in certain individuals' brain which creates an alcohol addiction is being explored, therefore, suggesting a biochemical cause of alcoholism.[14]
2. It is sometimes suggested that the metabolism of sugar or carbohydrate in an abnormal manner creates a pre-alcoholic condition that leads to alcoholism.[15]
3. The food allergy approach suggests that ethanol or foods used to make alcohol (ie: grain) leads to alcoholism development.[16,17]

Genetic factors are also possible, suggesting that alcoholism or a pre-disposition to alcoholism runs in families, but needs more research.[18]

There are several psychological theories, including:

1. The tension reduction hypothesis (Tamerin and Mendelson)[19] may reflect more "selective remembering" of the good effects while forgetting the adverse effects of alcohol rather than actual tension reduction.[20]
2. The Reinforcement Theory (Bandura, Roebuck, and Kessler) suggests people drink because the drinking behavior is reinforced or rewarded,[21] therefore, suggesting drinking is a learned behavior.[22]
3. Transactional Theory (Steiner) suggest communication problems (double messages, excuses) are believed to be a contributing factor in alcoholism.[23]

The psychoanalytic theory, (Freud) in the classical analytical approach may refer to the alcoholic as a passive dependent or oral individual. It suggests connections between alcoholism and latent homosexuality, self destruction and narcissism.[24]

The following are examples of psychodynamic theories regarding alcoholism:

1. The birth order (Schuckit) is also sometimes considered a contributor to alcoholism; the last born's early insulated environment may create a high degree of dependency, therefore, the individual may be viewed as more prone to drink.[25]
2. The use of alcohol may be to gain a feeling of power or improved self-esteem (McCord).[26]

Theories concerning personality are abundant. Perhaps one of the most interesting is the anti-social personality theory of Feighner which refers to the anti-social behavior beginning before age 15 in most areas of life, before the onset of drinking. Therefore, alcoholism may be considered a result of an anti-social personality and not vice versa.[27]

Theories which focus on social cultural aspects include the following:

1. Supracultural level (Bacon) sees alcoholism in a society as a result of a lack of indulgence of children and a demanding attitude towards achievement with a restrictive view of dependent adult behavior.[28]
2. Other considerations are cultural stress placed on the individual, lack of equal opportunity as a result of culture, minority status, and/or sex roles.[29]

Erikson's developmental theory when applied may demonstrate negative learning and failure to acquire the appropriate life skills. This approach seems most appropriate when applied to women alcoholics who often display mistrust and overcontrol (vs. basic trust and intimacy), shame, low self confidence, inferiority and incompetence.[30] Bem takes this sex role approach a little further with his androgymous and undifferentiated subgroups.[31]

Erikson's early adolescence appears to be the most critical stage in many alcoholics lives. A 1972 study of 7,414 tenth, eleventh and twelth graders shows 85% reported using alcohol.[32] Some connections between alcohol use and the early adolescence stage may revolve around:

1. physical development and heightened body awareness and sensations
2. escape from difficult or painful self image, environment and relationships
3. peer pressure and peer group membership
4. inducing emerging altered consciousness and, last
5. a capacity for self destruction.[33]

Sutherland's "Principal of Differential Association," may add a different perspective to alcohol use and learning, especially when its use is defined as illegal or deviant behavior. Basically Sutherland says criminal deviant behavior is learned through communication and interaction in small intimate personal groups (peer groups). The learned behavior includes techniques and special direction of attitudes, motives, rationalization and drives by defining as favorable or unfavorable legal (and social) codes. The individual becomes delinquent/deviant when he accepts as favorable, codes in violation of the law (or social norms) (this is the core of "Differential Association"). This way of thinking and behavior may vary in intensity, frequency, priority and duration. The learning of deviant behavior uses the same learning mechanisms used in all other learning. Lastly, deviant behavior expresses the same general values and needs as any other behavior.[34]

EIGHT MODELS OF ALCOHOLISM TREATMENT:

Siegler, Osmond and Newell, in their article "Models of Alcoholism," discuss eight models of alcoholism and treatment. They will be presented here with special focus on etiology, the alcoholics' behavior, treatment, prognosis and the role of the family and society.

The Impaired Model: In this model the cause of alcoholism is not known. The alcoholic is viewed as behaving as a skid row bum. No treatment

is considered successful and the prognosis is hopeless. The family role is to "keep" the alcoholic at home or "send him away." Society is expected to only provide basic survival needs.

The Dry Moral Model: Views alcoholism as a result of drinking and the alcoholic's behavior is viewed as immoral. Behavioral therapy, aversion therapy and/or jail are considered appropriate treatment. Prognosis is poor. The family's role is to maintain a "moral" home for the alcoholic. The preferred society role would be prohibition and education.

The Wet Moral Model: States the reason is not known why some drinkers become alcoholics and others don't. The alcoholic's behavior is labeled as an unacceptable form of drinking behavior. The best treatment suggested is reward and punishment. Prognosis is "gloomy." The family role is to get the alcoholic to drink "normally" with control. Society's function is to keep the alcoholic within acceptable limits.

The Alcoholics Anonymous Model: Views alcoholism as an incurable, progressive, fatal disease ("physical, mental, spiritual malaise"), involving an emotional impairment and defective body chemistry resulting in addiction. Treatment includes possible hospitalization to "dry out" and total involvement in A.A. It is felt alcoholism can be arrested but not cured. The family is encouraged to become involved in A.A. Society's role should be to recognize alcoholism as a disease but society should not be responsible for the alcoholic's bills.

The Psycho-Analytic Model: Preceives alcoholism as a symptom of neurosis, plus an addictive personality, as a result of early emotional experiences. The alcoholic's behavior is seen as an expression of an unconscious conflict. Treatment is through psychotherapy, possibly in a hospital therapeutic milieu environment. The prognosis is not encouraging

without extensive therapy. The family's role is to help the alcoholic "grow up." Society's role is to provide affordable psychotherapy.

The Family Interaction Model: Sees alcoholism in terms of family games and roles. The etiology is viewed as a basic personality inadequacy transmitted from generation to generation, and often focusing on a dependent or incorrigible child. The alcoholic's and co-alcoholic's behavior is seen in terms of a "family game." The treatment prefered is possible hospitalization of the patient to detox and restore health, to be used in conjunction with family therapy. Prognosis is good. Family has a role to participate in treatment and society has a duty to provide family therapy services.

The Old Medical Model: Views alcoholism as a progressive fatal disease as a result of excessive drinking. The reason for loss of control is unknown. The alcoholic's behavior is viewed as immoral. The treatment suggested is hospitalization to meet the alcoholic's physical needs as an acutely physically ill patient in a state of detoxing, malnutrition and with physical disease and deterioration, for example, cirrhosis of the liver. Prognosis is poor. The family's role is to help control the alcoholic's drinking and possibly total abstinence. Society's role is to censure the alcoholic.

The New Medical Model: Also views alcoholism as a progressive fatal illness, possibly hereditary. The etiology is considered a defect in metabolism with socio-cultural and physical factors. The alcoholic's behavior is viewed in terms of controlling withdrawal symptoms. Hospitalization is seen as necessary to detox, restore health and providing rehabilitation services including psychotherapy and social case work. Antibuse is often prescribed to help the patient abstain. The prognosis is considered grave. The family role revolves around the alcoholic being viewed as a gravely

ill person. Society's role is to see alcoholism as a disease and provide appropriate services.[35]

THEORETICAL CONCEPTS REGARDING HISPANIC ALCOHOLISM:

The following cultural theoretical concepts address Chicanos, Mexican Americans and Spanish American alcoholism.

Acculturation is often considered an issue in the Mexican American/ Chicanos alcohol use. If acculturation is defined as the adapting to a new culture and cultural shock as a social economic state with lowered effective coping ability because of unfamiliarity with language, morals, traditions and customs, behavior disorders such as alcoholism can be viewed as a result of the acculturation and the culture shock process.[36] This is especially interesting when considered in regards to Madsen's "agringado theory," which refers to Chicanos who are assimilated into the Anglo culture. The highest risk of alcoholism among Chicanos is in the lower class acculturating Chicano, which represents the largest number of Chicanos in the United States.[37]

Grave's study showed the Spanish American to have the higher rate of drinking and deviant behavior of the three groups studied (Indians, Spanish Americans and Anglo Americans). The non-accultured Spanish American had the lower rates of alcoholism as a result of family and religious controls.[38]

It is unfortunate in the Chicano community, the cultural and political approach to the Chicanos alcohol use and treatment is often ignored. Often the "cucaracha" approach, as defined in Rubios article, is dominant in which the Chicano's drug and/or alcohol use is viewed as an individual who abuses substances in order to cope with life in an attempt to survive without consideration of the environment.[39]

The concept of "machismo" also plays a role in the denial of alcoholism because of the perception of alcoholism as a character weakness vs. the

ability to hold one's liquor. Identification and treatment of alcoholism is often further complicated by family pride which all too often leads to denial or ostracism.[40]

These schools of thought are often attacked by Chicano leaders for several reasons. First, they are often accused of stereotyping. Many times these theoretical concepts are a result of problem solving approach, that is, seeking to pinpoint a cause, and extrapolate information from unappropriate sources or previous studies. Furthermore, cultural minorities are often viewed as static with a single major model, not considering the full implications of social economic status, individual experiences and background. There is definitely a need for more empirical studies to demythologize this area and provide a more factual perspective.

These theories also illustrate the need of culturally orientated therapists to work with Chicano/Mexican, Americano/Mexicano clients within a culturally orientated program in order to accurately perceive and meet the client's special needs and expectations in a realistic, unbiased manner.

HISPANIC USE OF MENTAL HEALTH AND ALCOHOL SERVICES

It has only been within the last few years that alcohol services have been established as a distinct department in Santa Clara County. Prior to this, alcohol services were included as part of the mental health services. Therefore, in considering the following studies, it is important to consider that they also applied to alcohol services, since at the time these studies were made, mental health and alcohol services were under the same department, Santa Clara County Department of Mental Health.

In 1969, a California study by Karno and Edgerton found that the Mexican American population (according to the California Census figures in 1962-63) represented only 9 to 10 percent of the California total

population. Yet not more than 3.4 percent of the Mexican American population were represented in psychiatric facilities.[41] The results indicated that the Mexican Americans under-utilized the mental health services. From these results, one might conclude that Mexican Americans are a mentally healthy group of individuals. Yet Padilla, Ruiz and Alvarez do not agree. They suggest that Spanish speaking/Spanish surname people in fact need more mental health services because they are:

> "...partially acculturated and marginally integrated economically and, as a consequence, are subject to a number of "high stress" indicators. These indicators, known to be correlated with personality disintegration and subsequent need for treatment intervention, include (a) poor communication skills in English; (b) the poverty cycle--limited education, lower income, depressed social status, deteriorated housing, and minimal political influence; (c) the survival of traits from a rural-agrarian society; (d) the necessity of seasonal migration (for some); and (e) the very stressful problem of acculturation to a society which appears prejudicial, hostile and rejecting."[42]

There are several reasons for this under-utilization of services. Perhaps the most often cited is discrimination practices by the system itself. In order to eliminate these discriminatory practices, Gibson states, "Title VI of the Civil Right Act of 1964 prohibits recipients of federal funds from discriminating against patients on the grounds of race, color, or national origin...(but)...more subtle factors may impair the accomplishments of program goals." Some of the major factors cited were the low percentage of minority staff members, limited outreach services to minorities, the lack of bilingual staff, and inaccessibility of services.[43]

Madsen suggests that Spanish speaking clients often use curanderos and folk healers instead of mental health services.[44] Karno and Edgerton (1979) suggest family physicians are replacing services traditionally provided by mental health.[45]

Torrey (1970) suggests Mexican Americans do not use mental health services because they are irrelevant to their needs in many ways, including language differences, class and cultural boundaries and inaccessibility.[46]

Burruel and Chavez (1975) not only suggest the service centers are inaccessible, but also lack bilingual/bicultural staff and the procedures are too bureaucratic.[47]

In 1976, Engleman and Associates made a report to the California Commission on Alcoholism for the Spanish speaking, stating that there were only a few services available to the Spanish speaking individual with alcohol problems. Furthermore, these services were limited, understaffed, underfunded and often inaccessible. Service providers frequently failed to consider the Spanish speaking client's socio-cultural factors.[48]

A study of randomly selected Mexican American soldiers showed that the respondents preferred counseling services offered by a therapist of their own ethnicity. Furthermore, they stated they would be more likely to go to the military clinic if services were offered by a Mexican American staff member.[49] In a 1966 study of Mexican American high school students, a preference was expressed for Chicano counselors rather than Anglo.[50]

The findings of Lorion, in a 1974 study, showed that Hispanic clients were more self exploratory in the beginning stages of therapy with Hispanic therapists, especially if the therapist and client shared a similar socio-economic class.[51]

In a 1976 study in East Los Angeles (Miranda, Audujo, Caballero, Guerro, and Ramos) found that less acculturated clients were more apt to discontinue therapy after two visits or less, regardless if the therapist was bilingual/bicultural or not.[52]

A library search done in April 1983 at San Jose State University was unsuccessful in locating literature concerning Chicana therapists working with Mexican alcoholic families. It could be that the search was too specific, or that the wrong identifying code words were used.

"The Chicano Family: A Review of Research," (1973) by Miguel Montiel states that Chicanos alone are not responsible for their difficulties. The American society especially schools and government agencies, have played a major part in creating these problems.

Montiel refers to the focus of past studies as being on disadvantage, causation, and stress of deprivation, while equating the Chicano culture with poverty or lower class.

In future studies Montiel encourages an appreciative, holistic, analytical framework of the Chicano family. Special themes of future studies should include viewing of the Chicano as a viable and distinct individual with a realization and awareness of self determination within a cultural pluralistic environment. Second, there are many variations in the Chicano family life as a result of rural to urban lifestyle changes. Third, when the Chicano reaches middle class, he is often considered assimilated by the dominant culture, but Montiel stresses that the Chicano has not lost his culture.[53]

FAMILY THERAPY: RESEARCHERS AND TREATMENT DEVELOPMENT

Perhaps the first significant application of family therapy to the problem of alcoholism was in the late 1930's when Knight and Chassell focused on the relationship between the etiology of alcoholism and family factors. In the 1950's Futterman and Jackson explored the alcoholic's wife role in maintaining the alcoholic's behavior. The 1950's through Ewing and Smith's work, the improved success rate of alcohol treatment as a result of

couple concurrent group therapy was explored. The 1960 and 1970's brought about increased awareness of the role of the alcoholic's environment in the systems theory, through Bowen's concept of homeostatis within the alcoholic's system. Davis in 1974 suggested alcoholism as a family problem solving mechanism which he called "alcohol maintenance." This illuminated alcoholism as having a function within the family. This view supports the use of the alcoholic's family as a helper in the recovery process.

The alcoholic's family was no longer seen as separate, but as an asset in assessment and treatment and continued sobriety of the alcoholic.

FAMILY STRUCTURAL SYSTEMS APPROACH AND THE ALCOHOLIC FAMILY

Structural family therapy is action oriented with confrontive, educative and supportive components based on the family's functional and developmental stages as affected by multi-generational influences. Minuchin's family map is a very useful diagnostic and intervention tool, leading to treatment goals.

A short explanation of the Family Structural System approach based on Nancy Taylor's article, "Structural Family Therapy: The Sanchez Family,"[54] follows. The individual is an interacting component of his environmental system which influences his inner psychic processes.

The therapist as a part of this system causes change by restructuring the family's patterns of transactions including rules and the family's internal and external relationships, thus affecting the individuals sense of self. In an alcoholic family system, the family responds to stress created by the alcoholic by reinforcing rigid transactional patterns, thereby avoiding change. This may delay the crisis but it also inhibits conflict resolution. Anxiety levels rise with entrenched patterns, creating a closed and isolated system, not only externally but also internally. In

other words, denial leads to control. Control leads to covering up which results in withdrawal.

The family system has subsystems, reflecting sex, generation, function and interest, that transmit cultural norms and provide psycho, social and physical protection. In the alcoholic family role reversal (alcoholic parent to child/co-alcoholic child to parent) often occurs, creating confused and inconsistent subsystem boundries and functions.

In order for the family to address functional demands it organizes and creates a structure. In the alcoholic family structure system this often results in disengagement from the alcoholic or restructuring the family around the alcoholic.

Sub-systems are differentiated by boundries. The degree of clarity determines if the family's interaction will be functional (clear) or dysfunctional (rigid, enmeshed). The alcoholic family's boundries may become rigid or enmeshed and communication (verbal, non-verbal and behavioral) may become predictable and rigid as a result of increased inconsistency in rules, sanctions and discipline.

A system bearer often becomes the scapegoat, carries the family's pain, guilt, helplessness and hopelessness, which is often manifested as behavioral (ie, a child's truancy) or somatic (a wife's headaches). The dysfunction at first may appear to be in one individual, thereby providing a smoke screen to the family's dysfunction. It is important to remember that alcoholism is a progressive disease not only for the alcoholic but also for the family. The alcohlic is often anesthetized, therefore, avoids responsibility and blame which family members may gradually accept.

THERAPIST'S ROLE:

The role of therapist is primarily a change agent. The therapist becomes part of the family system. By creating disequilibrium, the therapist creates the opportunity for and fosters positive change in the family transactional patterns, boundry permeability and sub-system differentiation.

In an alcoholic family the therapist may remove the identified client/family scapegoat from the triangulation position in the center of the conflict to be replaced by the hidden alcohol problem. At the same time it is usually necessary to promote intervention in the scapegoat's identified problem area (ie. truancy). Thus the family map is changed. At this point change may begin in several areas: sub-system differentiation, creating clear boundries, improving sub-system functioning, communication and rule development while facilitating conflict resolution. At the same time the family is provided with education about alcohol and the role it played in the family's dysfunction.

The alcoholic is also being supported towards his goal for recovery. Towards this goal several services/resources may be employed including Alcoholics Anonymous, medical or social detoxification centers and community residential treatment programs. Other family members may also be encouraged in attending and participating in such programs as Alanon, Alateen, or other therapy programs such as groups.

In the previous chapter, a general review of alcohol studies, theories, and treatment approaches with special focus on family therapy has been presented. The next chapter will focus on methodology.

CHAPTER III: RESEARCH METHODOLOGY

PURPOSE OF THE STUDY

The purpose of the study was to expand the deepen the current body of knowledge about special thereapy for the treatment of Chicano Alcoholics and their families.

In the past, alcohol therapy has focused mainly on the Anglo, middle class family member, or on the skid-row alcoholic. Treatment approaches based on a cultural perspective have not been studied or reported in the literature.

The objective of the study was to provide an educational tool that could convey the increasing knowledge about alcohol and alcoholism, showing the therapist's role in intervention from the Chicana perspective with a Hispanic population.

The focis of this study is on the Chicana therapist, and on the culturally sensitive family treatment method as used with Chicano and Mexican alcoholic clients. Special consideration was paid to the barriers of treatment and the therapist's success.

RATIONALE OF THE METHODOLOGY

An exploratory study was deemed most appropriate to the subject, as this form of research is concerned with gaining new information about, or insight into a phenomenon with the intent of developing a more precise formulation of the problem for further research, or a clearer hypothesis for testing. The lack of clinically focused studies on Chicano alcohol therapy led to the researchers interest in this area. Too little information has been reported on Chicano alcohol therapy to warrant the testing of a specific hypothesis. Therefore, the exploratory form appeared

the most appropriate type of study to conduct.

The use of the video taped interview was chosen because of the exploratory nature of the subject matter. Therefore, the two interviews and the culturally oriented family therapy role play sessions were video-taped. The video-taping depicts real therapists at their actual work sites. Although the therapy session is simulated, it showed an actual intervention method and portrayed good visual body-language and communication. These interactions were valuable because they cannot be expressed through the written word.

As a by-product of the video taping, the respondents planned to have the film used as a visual educational tool.

THE INTERVIEW SCHEDULE

In order to collect information on the methods of treatment and issues in the therapy of Chicano Alcoholics, the researchers conducted structured interviews with two Chicana therapists who specialize in alcohol therapy. The interview consisted of open-ended questions. The questions were designed to explore three areas of research:

a.) Treatment Styles

b.) Successes

c.) Barriers in Chicano Alcohol Therapy

In addition, several "profile questions" were used to elaborate the two respondent's qualifications and experience in the area of work with Chicano alcoholics.

SELECTION OF RESPONDENTS:

The respondents were chosen because of their reputation as alcohol therapists with a Hispanic perspective. Both women had participated in an

alcohol conference at San Jose State University, sponsored by the School of Social Work.

The first respondent, Ms. Daniella Gomez, is an alcohol therapist working in the community based program at Clinton House in Redwood City, California. Ms. Gomez is a Chicana and a graduate of San Jose State University, School of Social Work. She is currently conducting individual and family therapy with Hispanic alcoholics.

The other therapist chosen was Mrs. Josie Romero, currently employed by Santa Clara County as a Mental Health Administrator and part-time therapist at South County Mental Health Center. Mrs. Romero is also an MSW graduate of the School of Social Work, San Jose State University.

These two women were chosen for their similar backgrounds; however, they utilized different setting and approaches to alcohol therapy.

VIDEO TAPING

The services of Robert Reynolds (Producer, Director of Instructional Television, San Jose State University), were solicitated by the study's primary investigators. Mr. Reynolds created the video tape for this project.

This project was facilitated through Manuel Fimbres, School of Social Work, San Jose State University.

The interviews and role play were filmed on three separate occasions. Mrs. Daniella Gomez' interview was filmed at Clinton House, Redwood City, California, on April 26, 1983. Ms. Josie Romero's interview was filmed at Central Mental Health, San Jose, California, on April 27, 1983, and the final session of role play was filmed at Central Mental Health on May 10, 1983. In addition to the interviews of the therapists, the therapists chose to participate in role playing, a situation using students of the school as

volunteers. Role playing was used in order to illustrate certain techniques. One technique chosen was that of conocimientos which consists of getting to know the clients better by making a list of commonalities and differences between the clients. The therapist also shares her background.

The couple role-play explained the intervention technique, "conocimientos," a treatment modality. The participants were Ms. Josie Romero, therapist, Ms. Carolina Flores a co-alcoholic, and Mr. Ernesto Victoria as the alcoholic (both graduate students at San Jose State University, School of Social Work).

SIGNIFICANCE OF THE STUDY

The significance of this study touches many areas. It is a compliment to the San Jose State University School of Social Work Mission:

> "The School of Social Work is founded to train people committed and able to work with oppressed people everywhere, but particularly with those Spanish speaking people who are Chicanos."[55]
>
> Bulletin School of Social Work
> San Jose State University, 1978-80.

For the Social Work profession, the study provided additional knowledge and insight into developing and broadening the knowledge of treatment modalities with the Chicano alcoholic client focused on his cultural and familial environmental factors and strengths.

Since there appears to be so little information and research finding in this area, it is hoped that with the implementation of this knowledge and these techniques through direct intervention, the effectiveness of alcohol treatment will be increased. This in effect will provide more appropriate service to the target population, the Chicano and Mexicano alcohol client. At the same time the non-target population, the general

public, will also benefit. Some of the benefits would be a decrease in death and injuries as a result of the alcoholic's behavior, lower cost of social, legal and medical services paid by tax dollars. But perhaps the most important benefit would be the improved general welfare and functioning of the alcoholic's family members.

It is further hoped that this project will stimulate interest and material for further research projects and studies.

DEFINITION OF THE TERM

Because this study was exploratory and does not involve an experimental design, it was not the intent of the researchers to arrive at a measureable difinition of alcoholic. Rather, our intent was to establish operational guidelines.

Nevertheless, some definitions in the video-taping must be addressed. These definitions fall into the categories of cultural therapy terms and general words used specifically in the treatment of Chicano alcoholics.

In the video-taping both Ms. Gomez and Ms. Romero referred to such terms in cultural therapy as the client/therapist relationship.

The client/therapist relationship is an equalizing method that demystifies the power hierarchy inherent in the therapeutic situation. In order to be more equal with the client, the therapist works toward being open about her own values and attitudes.[56]

Both therapists also referred frequently to the term, "use of self." Use of self is a social work technique in which the therapist uses herself in a helping way, whether this is as an enabler, advocate, nurturer or as a resource locator. Use of self can also be the process whereby the therapist becomes a role model for the client.

The term Chicano refers to various groups such as Mexican Americans, Mexicans, Tejanos, Californios and Nuevo Mexicanos, in an effort to unify

their various orientations and life experiences. Identification as a Chicano can also mean awareness of the hierarchial relationship between the majority and minority populations that determine the allocation of rewards and access to vehicles of opportunity, a commitment to social change, exploration of alternatives to existing lifestyles and a positive self-perception through pride in culture, language and Indian ancestry.[57]

The questionnaire that was used in the video-taping for information gathering used several important terms. The term alcoholic refers to a person who is suffering from the disease of alcoholism. The symptoms include physical dependency on the drug alcohol and, most notably, pschological dependency: loss of control over drinking, including when, in what form, how much and why; and interference with normal functioning in one or all such areas as family, work friendships and community activity. A counselor may assume that a person shifts from social drinking to alcoholism when the elements of dependency, loss of control and interference with normal functioning are present in his drinking pattern.

The definition of success was very difficult to define quantitatively and qualitatively. It is important to remember that as individuals we all have our own perceptions, definitions and expectations of success. In this project, success was not defined, but was explained. The individual therapists were asked what they considered success.

The definition of barriers was also dependent on the perspective and treatment modality of the therapist, resulting often in different, or sometimes similar approaches to successful intervention. However, several barriers were identified.

In order to appreciate the specifics of the research question, there was a need to understand broader concepts; therefore, the following are Spanich terms used in both interviews to describe treatment issues.

Conocimiento literally translated means an "awareness of."[58] However, in the context of this presentation it was expanded to mean a method of becoming aware of, and getting to know a person. The understanding of the person is within the context of their family and their culture.

The term respeto connotes having respect, relation or reference for the client.[59] The term confianza means confidence, trust, familiarity, informality.[60] Another important term used was ambiente which literally means atmosphere: environment; but for the purposes of the therapeutic relationship, meant creating an atmosphere conducive to therapy.[61] An ambiente means a pleasant atmosphere that engages the client in a therapeutic relationship.

A structured interview was conducted with each therapist. These interviews covered the areas of treatment methods, success, and barriers. A sample of the questions used in the structural interviews are found in the appendix. The questions listed in the appendix are not necessarily listed in the order in which they were used.

CHAPTER IV: DATA PRESENTATION AND ANALYSIS

RESPONDENTS DEFINITION OF ALCOHOLISM

Ms. Gomez defined alcoholism as a psycholgoical, physical, social dependence on a drug/chemical. The individual begins using alcohol in a social environment as a part of traditional and cultural celebrations. Use leads to dependence to cope with frustrations, such as low economic status and adjustment. Alcoholism is a progressive dependence that leads to total dependence and death with continued use.

Ms. Romero defined alcoholism as a disease involving an abuse of a substance that is destructive in a majority of the cases. Alcoholism impacts not only the individual but the family and employment as well.

THE RESPONDENT'S CLIENT POPULATION

Ms. Gomez began the Spanish speaking alcohol counseling program at Clinton House. Presently about 35% of Clinton House's clients are Spanish speaking. The greatest percentage of Ms. Gomez' clients are Mexicano, usually first generation and undocumented males who are referred by the probation department. The probation department is defined as the legal authority needed to get the clients into treatment.

At intake, Ms. Gomez described the Mexicano alcoholic client as often having feelings of standing naked before society who says that he is bad. He feels caught and frightened but doesn't know why. At this point she would listen to their concerns and empathize. This begins a process of confianza (developing trust, confidence and rapport). Treatment duration usually lasts from 3 to 6 months. When the family joins the therapy

process they are encouraged to join Clinton House's co-alcoholic couples and children's groups also.

Ninety-nine percent of Ms. Romero's direct practice cases are monolingual Hispanics, the majority which are families. Ms. Romero stated the typical client who seeks help at Santa Clara County Mental Health were described as primarily mothers. They are referred by school, doctors or probation, because it had been determined that they had low coping abilities. There are several indicators used in making this determination. For example, the children may be out of control, the client may be in a low economic situation, unemployed, with a low educational level and faces a language barrier which limits use of services. Often the mother is on tranquilizers for depression. Her husband is frequently drinking and unemployed.

Ms. Romero estimates that in 80 to 90% of the cases there is an alcohol factor in addition to stress related problems as a result of school, employment, housing, financial or medical concerns. Yet the majority of clients stated they come for other reasons than alcohol caused or related problems.

The treatment duration, according to Santa Clara County Mental Health's guidelines, is 8 sessions; however, Ms. Romero qualifies this by saying it varies with the client's needs and that "the doors are not closed." In other words, she encourages the clients to come back as new needs arise, if they cannot cope or handle them alone.

Both Ms. Gomez and Ms. Romero encourage and use recovering alcoholics as role models, support system and educators with new clients.

THE RESPONDENTS' PERCEPTION OF THEIR IMPACT ON THEIR CLIENTS

Ms. Gomez related that normally Mexicano males have a stereotype image of women. Furthermore, the Mexicano clients usually don't discuss alcohol

use and problems with people outside of their family, except with their compadres. Yet Ms. Gomez feels the Chicana therapist plays a very important role with these clients, although she expresses an ideal therapy team would be male and female co-therapists.

One of the major barriers consists of cultural perceptions. Male chicanos perceives women as being in the home and not as a professional. Furthermore, he often feels women are not his equals and, therefore, may resent or resist a female counselors intervention. Ms. Gomez' method to deal with this is to use male experts such as doctors, lawyers and recovering alcoholics in group settings in the initial stage of treatment to get the client involved in treatment in an easily acceptable manner while the therapist at the same time provides an atmosphere of acceptance and trust establishing her reputation.

On the other hand, Ms. Gomez feels there are specific advantages to Chicana therapist/Mexicano client relationship including role modeling. Ms. Gomez sees herself as acting as a rule model for the Mexicano alcoholic male's wife to think for herself. Furthermore, Ms. Gomez is an enabler, helps the wife become involved in co-alcoholic support systems and shares her experiences as a minority woman in the United States. Thus she further facilitates a change not only in the Mexicano male but also his female's role and attitudes.

Ms. Romero not only views her sex but also her age as sometimes impacting the client/therapist relationship. When she becomes aware that as a young woman she is not fulfilling the male client's role expectations, she acknowledges the client's discomfort. For example, she might say something like this: I know you feel wisdom, knowledge and skill come with age, but I would like to be your friend. Age and sex doesn't matter becuase I respect your feelings and concerns.

and political environment to achieve the utmost impact. Ms. Romero addresses the family as a whole to provide the opportunity and impact for change, knowledge and growth.

Ms. Romero also uses the Social Action Model. She defined the Social Action Model philosophy by saying she doesn't "therapize" people, especially the oppressed Chicanos. Instead she sees her function as teaching her clients (both the alcoholic and his family) to interface independently with society. The method employed to achieve independent interfacing is to learn and use concrete skills of exercising rights with society's institutions, for example, welfare and schools, for the purpose of self-sufficiency.

Ms. Romero applied the Social Action Model to the alcoholic by saying she focused on redirecting the individual's activities in a constructive way to develop self-worth through validation, fulfillment and acknowledgement. The family, she felt, should also be educated in the physical and health factors of alcoholism and to recognize the characteristics of an individual likely to abuse alcohol.

Ms. Romero didn't limit her treatment approaches to the cross-cultural or Social Action Model, but said she used an eclectic theoretical approach in order to meet clients expectations. Ms. Romero expressed role expectations as the most integral part of the therapeutic process. She stressed that the client wants, needs and expectations have to be clarified and addressed. Therefore, the therapist needs awareness, understanding and agreement to work towards the client's expectations.

CLIENT/THERAPIST RELATIONSHIP

In cultural alcohol therapy, Ms. Gomez and Ms. Romero talked of the importance of establishing a client/therapist relationship. Ms. Gomez on the one hand sees mainly single Mexicano alcoholics who are referred by the

RESPONDENTS' TREATMENT APPROACH

Ms. Gomez described her treatment approach as a community family systems approach. This approach rebuilds the family and community support systems that were destroyed by alcohol.

Ms. Gomez said she uses a little bit of all theoretical approaches and interventions in treatment, including behavior modification and reality therapy.

Behavior modification is employed to direct the individual to use alternatives. For example, in the past the client may go to the local cantina to cash his checks. A behavior modification may be opening a bank account, thereby providing the means to reconstruct the problem behavior.

Ms. Gomez used reality therapy to engage the client in the here and now. Experts such as doctors, lawyers and community leaders (who are often recovering alcoholics) are used as teachers and role model in the beginning stages of treatment.

Ms. Gomez said that the crises intervention theory is also often used as part of therapy since the alcoholic's first seeking of help is usually the result of a crisis situation, for example, illness, arrest, loss of job.

Yet the family network system is the strongest foundation for alcohol therapy according to Ms. Gomez. Of primary concern is the family's need to be restructured so that it can be the main support for the alcoholic (rather than his drinking buddies). The alcoholic and his family are directed to become involved in their community supports such as church, Alcoholics Anonymous and Clinton House in order to support the restructuring process.

Ms. Romero's treatment approach was described as cross cultural therapy in which she uses an intervention method within the client's family, social

probation department. They are angry at the legal system while denying that their alcohol abuse is the underlying reason for their problems. In comparison, Ms. Romero's usual first contact with the Chicano alcoholic is through a family member who is the alcoholic family's symptom bearer.

In both practices the primary client is the identified Hispanic male alcoholic. Besides the denial of alcoholism, which is a very strong defense mechanism, the Chicana therapist has special concerns in establishing the client/therapist relationship because she is a Chicana female. As a Chicana she faces stereotyping, from both her culture and her clients. She is viewed as unequal or below the status of her male client. These stereotypes both Ms. Romero and Ms. Gomez stressed are difficult to overcome.

Yet both therapists see establishment of client/therapist relationship as one of the key factors in successful cultural therapy. They believe that a therapist must make the client feel secure, accepted and safe, while projecting an ambiente of good will. At the same time they must overcome the stereotype image and establish themselves as professional experts.

In cultural therapy there is an effort to equalize the roles between client and therapist. The therapist tries to gain respect and trust. The therapist reveals personal issues about herself to show she is nonjudgemental of the client. An example in the video-taping was Ms. Romero (as therapist) saying to the clients, "I have teenagers, too, and it's very difficult, I know."

In the cultural approach to alcohol therapy there is an effort to ensure a relationship of "confianza" or confidence. The goal is to create an aura of informality so the therapist may begin to seek information out on personal issues where the clients may believe she has no business in exploring.

Ms. Gomez describes her clients as angry at the system and blaming others for their problems. Ms. Gomez' clients are mandated to seek therapy, thus creating more hostility and denial. These elements of anger, hostility and denial combined with the values of traditional Hispanics (for example, that personal problems are not discussed outside of the home), Ms. Gomez feels make developing a relationship very difficult.

The clients Ms. Gomez sees also feels that people are predjudiced against them because of their culture and economic status. Therefore, Ms. Gomez begins her work with the clients by trying to break down the prejudice excuse and working with them towards developing a sense of responsibility about their lives and what happened to them.

Ms. Gomez feels that most of the alcoholics that enter treatment realize that something is wrong, but they are not sure what it is, and they do not believe that their troubles are the result of drinking alcohol. Instead they view alcohol as a social recreation, without seeing it as a coping crutch.

Ms. Gomez establishes relationship and trust by working with the family. She restructures the family system and works with the co-alcoholics as well as the alcoholic, teaching them new coping skills and support networks.

Ms. Gomez believes that the family is the most important asset and source of strength for the Hispanic and she tries to always get the family involved. If there is no family available, Ms. Gomez uses the group method as a substitute for the family.

In establishing relationships, Ms. Romero uses the technique of <u>conocimiento</u>, which means getting to know you. This process entails a learning experience where the client is the educator and the therapist is the learner. The client teaches the therapist all about himself, including

such areas as family background, for example, who were his parents and grandparents? Where did they come from? The categories vary and include personal data, for example, what are your hobbies, interests and goals in life?

If conocimiento is used with a couple, then Ms. Romero compares and contrasts their backgrounds to show how they developed their personal attitudes and values. In a family setting this often leads to increased family awareness, pride and sharing, resulting in a family bonding experience.

The therapist's role in this exercise is to create the ambiance of mutual respect, and non-judgemental attitude. The therapist shows the client that people have shared experiences as human beings, but also have unique experiences that make us different.

After the process of teacher/client to learner/therapist, Ms. Romero moves toward a relationship of "active partners," where the client's role is to begin to change and the therapist's role is teacher.

RESPONDENTS' USE OF SELF

The term use of self is a technique in which the therapist uses social work skills in a helping way to promote change from within the client. Both Ms. Gomez and Ms. Romero mentioned the term use of self as an important key in cultural therapy.

Use of self for Ms. Gomez meant acting as a support network for the client and his family. As therapist, her role would be to support the family system while also focusing on the sobriety of the alcoholic. The wives of alcoholics are of special interest to Ms. Gomez who uses herself as a role model for women, teaching responsibility and healthy ways of responding as the co-alcoholic.

Another expression of use of self which Ms. Gomez discussed was in the area of outreach, linking and networking in the community. In this capacity, Ms. Gomez becomes an advocate for the client and offers resources to the client that may help him to function in today's society.

Ms. Romero uses herself by sharing her life experiences with the client. She discloses her family and cultural values and talks about her role as a natural helper. Ms. Romero shares where she came from, who she is, and what she wants. Ms. Romero said that her grandmother was the best therapist she ever knew; her advice was to put yourself in front of others and take risks. Ms. Romero sees herself as taking risks with clients to help them get well.

Other uses of self that Ms. Romero uses are educator, advocate, friend and supporter. She describes herself as a listener, clarifier and resource person.

RESPONDENTS' PERCEPTION OF SUCCESS

Ms. Gomez measured and defined success through the use of the following indicators. First, the beginning stages of success are evident when the alcoholic begins to share his recovery process with his family. Secondly, there are positive changes occurring physically, occupationally and in the feelings and attitudes of the alcoholic and his family. There is also a constructive use of money, relationships and free time. Next, the individual and his family show increased self awareness of what is happening to them as compared to the previous attitudes of denial and ignorance. Finally, there is an obvious "stop" in the progression process of alcoholism, and a beginning of gradual recovery.

Success is defined by Ms. Gomez as when the family begins to take care of themselves psychologically and use coping skills to address stress in the present and the future.

Ms. Gomez also relates success in personal terms, reporting she gains satisfaction at seeing her clients grow, change and get a new chance at life.

As contrasting to Ms. Gomez' indicators of success, Ms. Romero says she gets a sense that the family has found the missing cause that led to their problems. The family begins to show progress but Ms. Romero doesn't discount that they may have further need of help later. Yet she feels that this experience has been a success if the client and his family have learned from the experience and are able to put what they have learned into practice.

When pressed to define success Ms. Romero answered that she doesn't define success, instead each family defines their own success.

In terms of future success in alcohol treatment, Ms. Romero feels it will be accomplished through education to provide the individual with validation, acknowledgement and help before the problem occurs or reaches crisis proportion.

RESPONDENTS' PERCEPTIONS OF BARRIERS

Ms. Gomez identified the major barriers to involvement and success in treatment as alienation, bebedo seco, language, machismo, definition of alcoholism and society's double bind. Perhaps the number one barrier Ms. Gomez discussed was alienation. Ms. Gomez expressed the opinion that for the majority of her Mexicano male and female clients, there is a strong feeling of alienation as a result of culture shock and lack of access to Anglo activities (such as swimming and golf) and low financial status. Ms. Gomez said the combined effect of these elements often lead to alcoholism since the alienated individual may turn to the cantina as a support system for friendship, acceptance and belonging. Ms. Gomez' response to this barrier is to educate the individual and family about alcoholism while

rebuilding a sobriety support system through family, A.A. fellowship, and community to avoid isolation.

Bebedo Seco (dry drunk) was defined as an abstinance game. The individual is not convinced that total abstinance is necessary. This leads to experimentation, increased drinking and back to the drinking support system. In order to address this barrier, Ms. Gomez works with the client on acceptance issues around his alcohol use and consequences.

Language also often acts as an alienator and barrier, not only barring the individuals from alternative support and treatment systems, but it also bars the individual from getting out of undesirable systems (for example the legal system).

With the Mexicano/Chicano male, the concept of machismo (having control) is often expressed in terms of how much liquor a man can hold without losing control. Therefore, machismo reinforces denial. Ms. Gomez considers the concept of machismo in therapy as a reinforcement to sobriety (as regaining control) through the process of self awareness, learning and taking responsibility.

Ms. Gomez sees the definition of alcohol use/abuse as a barrier. Historically, the Mayan/Aztec culture considered alcohol as sacred. Today, the Mexicano often defines his alcohol use as a social recreational activity without realizing it is progressively becoming a supportive, coping crutch.

Furthermore, society provides a double bind definition of alcohol use. On one hand it is an acceptable behavior. On the other, society has a negative attitude about the individual who abuses alcohol. He is seen as a bad person. Ms. Gomez' approach to this barrier is to acknoweldge both attitudes, but to focus on what is happening in the individual's life and experiences as a result of alcohol abuse.

The following is a brief summation of Ms. Romero's responses regarding barriers to treatment and success. Like Ms. Gomez, she acknowledges the barriers and often redefines them to be used as therapeutic tools.

Ms. Romero defines the number one reason for clients dropping out of treatment as the failure to clarify expectations of both client and therapist. This leads to feelings of failure and hopelessness for both the client and therapist. Therefore, Ms. Romero strongly emphasized the need to discuss, understand and clarify expectations in the beginning stage of treatment.

Acculturation has often been discussed as a barrier, but Ms. Romero broadens this concept by viewing the effects of acculturation on the individual as being compounded by the various levels of acculturation within the family. For example, the parents may be immigrants, monolingual Spanish, at a very low level of acculturation. The older children may be first generation and bilingual, and the youngest children, also first generation may be monolingual English. Therefore, there are three levels of acculturation, resulting in three levels of assimilation, to be intertwined in intervention to reach the whole family.

An important factor in creating alcoholism and as a barrier to treatment is the alcoholic's self image and identity. Ms. Romero explains that if the individual, as impacted from childhood, has a poor self image or loses that identity, it is difficult to impact the problem of alcoholism with therapy. Society provides validation to the individual, which often occurs in the form of stereotyping and labeling. This labeling may be seen as leading to expectations which result in reaction often manifested as alcoholism.

Therefore, Ms. Romero views her male alcoholic clients as men, whether Mexican, Hispanic or Chicano, depending on how he identifies himself. She acknowledges his self identity and interacts with him accordingly, thereby acknowledging that the person is part of a social environment with special emphasis on his values and self identity.

Language is seen as a two pronged barrier. First, when an individual cannot communicate effectively it is very difficult to locate and become involved with the helping system.

Also language barriers within the family, as a result of different levels of acculturation, promote family disintegration and can inhibit effective intervention.

Ms. Romero referred to the Social Action approach when she elaborated on the barriers created as a result of the service systems bureaucracy. She defined bureaucracy as being set up to serve itself (for example documentation and accountability) which often acts as a barrier to the therapeutic process. Ms. Romero further stresses the need for flexibility within the system, to encourage more La Raza therapists to serve La Raza clients. These La Raza therapists, Ms. Romero feels, should take an active role and process special knowledge and awareness of the role of La Raza within the system, especially when developing programs based on what has been successful with La Raza clients.

In the future, Ms. Romero did not see alcohol problems as decreasing. She explained the reasons for this. First, as a modern industrial society we are moving away from values, religion and family combined with the fast growth of technology. The result is that people will become more independent of each other, resulting in more alienation and alcohol problems.

ANALYSIS OF THE RESPONDENTS DEFINTTION OF ALCOHOLISM

It was interesting to note that Ms. Romero defined alcoholism as a disease of abusing a substance that is destructive in the majority of cases (not all cases). She defined the areas of the alcohol impact as being the individual, family and employment.

Ms. Gomez defined alcoholism in a more cultural and broader perspective. Ms. Gomez referred to alcoholism as psychological, social and physical progressive dependence on a drug/chemical that will lead to death with continued use.

Culturally, Ms. Gomez described the Mexicano alcoholic as beginning his alcohol use as part of traditional celebration. This tradition leads to dependence on alcohol, to cope with frustration, low economic status and adjustment problems. These adjustment problems are due to an alienation from his culture of origin while beginning assimilation into a new culture. The differences in the definitions of alcoholism by the two therapists show a difference in their treatment approach.

Ms. Romero takes a broader approach and views the alcohol as a symptom of the problem, while Ms. Gomez's therapy sees the alcohol abuse as the primary problem.

ANALYSIS OF CLIENT POPULATION

Both Ms. Gomez and Ms. Romero defined the majority of their alcoholic clients as Spanish speaking males. Ms. Gomez described the majority of her clients as Mexicano, first generation and documented. Ms. Romero apparently sees a broader range of alcoholic clients with varying cultural identities of Chicano, Mexicano and Hispanic. These clients also have varying levels of acculturation. Both therapists viewed the alcoholic's

family as being co-alcoholic clients, that have special needs and functions in the recovery process.

Neither therapist referred to their clients as voluntarily seeking alcohol counseling. Ms. Gomez defined the probation department as her main leverage and referral agents; whereas Ms. Romero's main referral agents are doctors, schools, as well as probation. The referrals are usually a family member of an alcoholic who is exhibiting stress and coping difficulties.

It was interesting to note that the majority of alcoholic clients coming for help to both therapists did not define their reason for beginning there as a result of their drinking. Ms. Gomez' clients felt that they were being discriminated against by the justice system because they were a minority with low social economic status. At the same time they denied their alcohol use as the reason for their arrest, which was usually drunk driving or drunk in public.

Ms. Gomez receives direct referrals of the alcoholic. Ms. Romero, on the other hand, has direct referrals of a member of the alcoholics of or complicated by the alcoholic's behavior within the family.

A last commonality with both therapists is that they use recovering alcoholics as role models, educators and support systems with new clients. This adds validity of role models and support networking in the therapy process.

ANALYSIS OF IMPACT ON CLIENTS

As expected, both Ms. Gomez and Ms. Romero were aware of, and sensitive to sexual identity issues between male client and female therapist from

a cultural perspective. Both therapists related that male clients expressed the feeling that they felt the therapist gender as females made them inferior to the status and abilities of a male. Therefore, the clients felt uncomfortable discussing their alcohol problems with female therapists, even if they were Chicanas. Ms. Romero included her age as a reason to cause further client discomfort.

What is interesting is not that Chicano/Mexicano clients have these feelings of discomfort, but how these two therapists addressed these feelings. The methods used to address these concerns seem to reflect each therapist's social worker style. Ms. Gomez appeared to be a more traditional therapist focusing on the client's feelings, relections, self awareness and change. Therefore, in the beginning stages of therapy, Ms. Gomez didn't directly confront the client about his feelings of discomfort; instead, she used male experts such as doctors, lawyers and recovering alcoholics, as guest presenters in the group setting, to introduce the material in a manner easily acceptable to clients.

Ms. Romero, on the other hand, reflected her assertive La Raza approach to therapy. She directly addressed the feeling of sex and age discomfort with her clients. First, Ms. Romero acknowledged their discomfort, expressed the desire to be a friend and showed respect while expressing her feeling that sex and age should not interfere in the treatment process.

Apparently, when working with the family, the female therapist was not as much of a threat or source of discomfort, as when directly interfacing with the lone male client.

Ms. Gomez related several advantages of being a Chicana therapist in the Mexicano family treatment process. For example, Ms. Gomez saw herself

as a role model, as part of a support system and facilitator to the Mexicano's wife in her new role and environment. Also, Ms. Gomez feels she acted as facilitator for the Mexicano's change in attitude and role in his new environment as well.

ANALYSIS OF RESPONDENTS TREATMENT APPROACH

It is interesting to note that both therapists used a directive, self involved approach with a strong cultural orientation. Both therapists said they incorporate a little bit of all theoretical approaches and pick and choose what fits best.

It seems Ms. Gomez comes from a stronger family base, while considering the community and cultural perspectives. Ms. Romero's orientation is cultural, considering the issues of family and community.

Both therapists consider the establishment of relationships as a crucial to successful outcome of treatment.

Ms. Romero and Ms. Gomez both use visual aids to assist in the impact on the client. Ms. Gomez uses a sculpture of a family to begin asking questions about family issues while Ms. Romero uses the exercise of "conocimiento" to introduce cultural aspects.

In both treatment approaches a variety of therapy modalities are used. For example, Ms. Gomez uses male groups, couple, family, as well as individual meetings. Ms. Romero on the other hand, appears to usually prefer couple and family meetings when possible. Yet each therapist seems to play the same role of educators, enabler, facilitator and friend in all settings.

ANALYSIS OF CLIENT/THERAPIST RELATIONSHIPS

In both of the respondents' cultural approaches there is an effort to equalize the roles between therapist and client, to create an aura of

informality, and to project "confianza," and "respeto."

Both approaches are non-judgmental and humanistic. Ms. Gomez attempts to establish relationship by breaking down barriers such as stereotypes about the role of the female, feelings of predjudice, anger and denial.

It is important to point out the major differences between the psychoanalytic treatment approach and the family cultural approach. The traditional forms of Freudion and ego psychology do not use these methods. There is no sharing of personal issues by the therapist. When a client asks personal questions, they are fielded in such a way as to prevent any revealing and discourage further questioning.

Traditional therapy also creates a power hierarchy where the therapist plays the role of expert, while the client is mostly left to do all the discovery work alone, seeking approval and encouragement from the therapist.

In traditional ego-psychology the therapist is not open about personal attitudes and beliefs, but creates a mirror image for the client to reflect upon. Traditional therapists are interested in such therapeutic issues as projection and transference. They do very little overt questioning and seldom give answers to problems such as "What can I do?" They often wait for the client to break his own denial and may not work on a specific treatment plan, but let the client engage in a running dialogue.

Traditional psychotherapists treat alcoholism as a symptom of an underlying problem. They have not been trained to understand the "disease concept" of alcoholism and they look for other reasons why the person is dysfunctional. When seeing an alcoholic they may work on issues of an oral dependency, a sociopathic personality, or a manic depressive disorder. They may not even recommend to the client that they stop drinking.

Both Ms. Romero and Ms. Gomez' approaches are therapeutically non-traditional but they are practical, functional and appear highly successful with Chicano and Mexicano alcoholics and their families.

ANALYSIS OF USE OF SELF

The respondents' considered the "use of self" as an important key in therapy technique. Since both respondents were educated in social work mode, it is understandable that "use of self" would become an important issue.

Ms. Romero takes a more assertive political view in her role of educator and helps the client to create change in the system. Ms. Romero uses her life experiences and cultural values to project a role model for clients in which taking risks and change is encouraged.

Ms. Gomez plays a more passive role and supports the client in learning ways to adapt to, cope, or make changes in their lives, family and society.

ANALYSIS OF BARRIERS

Again the respondents' different professional styles were evident in their approach to and perceptions of barriers.

Ms. Gomez described her more traditional social work appraoch as a Community Family System/Family Network System, focusing on the individual within his family, social and cultural environment. This was especially evident in her discussion of cantina culture, bebedo seco and concept of machismo, in which the individual was impacted by his support system, while being alienated within a society that traps him in a double bind situation. Ms. Gomez also included language and definition of alcoholism as other barriers.

In contrast, Ms. Romero's La Raza/Cross Cultural Therapy/Intervention approach, based on the Social Action Model with an educative emphasis, was on the individual with cultural values, expectations and perceptions interfacing independently with society through the development of concrete skills within a family environment.

It is of special significance that Ms. Romero stressed the need of La Raza therapists to provide services to La Raza clients in order to meet the client's special needs in a manner that compliments the cultural heritage, language, present lifestyle and expectations. Ms. Romero's approach views the individual as a member of a family, with different levels of acculturation, existing in a social environment. The two-pronged approach not only directs itself to modifying the social environment, but of acknowledging and developing the individual's values, and self image within his family environment through validation by society.

Special direction was given by Ms. Romero to view the individual as a man with his own special identity, not as a problem affecting a man. Ms. Gomez, on the other hand, uses the cultural concept of macho (to maintain/regain control) as an intervention tool.

Ms. Romero feels the number one barrier to the individual continuing therapy is the lack of clarifying expectations. This is an issue unfortunately that is often taken for granted and not addressed in many client/therapist relationships.

The administrative insights of Ms. Romero were highlighted by her definition of bureaucracy as serving itself and at times barring the therapeutic process with clients. The system was further exemplified as a barrier to La Raza clients when it lacked a La Raza orientation of services

provided. Awareness of a client's cultural orientation and perceptions unfortunately is lacking in many social service agencies, often creating a feeling for the Mexicano/Chicano client of being in a non-caring alien system that does not respect or understand him as an individual who has an identity, value and place in our society.

One last point that needs further analysis is Ms. Gomez's alienation and Ms. Romero's acculturation barriers as viewed in conjunction with their client population. Ms. Gomez' clients are first generation, undocumented, Mexicano males referred through the probation department for alcohol related offenses. Therefore, their feelings of alienation might be explained as feelings of separation from their homeland. Their choice of the term "Mexicano," defines them as aliens to the United States.

The majority of Ms. Romero's La Raza clients have different acculturating self identity labels: Chicano, Mexican American, Hispanics, denoting a blending of both Mexican and American cultures to create a hybrid La Raza identity. When viewed in this light, the different acculturation levels within the family exemplifies that children, in their developmental stages, identify and blend with their new environment much more readily than an immigrant adult.

ANALYSIS OF SUCCESS

In analysis of success, perhaps the most important and interesting point concerns how the therapists view success.

Success is very difficult to define quantitatively and qualitatively. It is important to remember that as individuals, we all have our own perceptions, definitions and expectations of success. On the other hand, the arbitrary dispensement of criteria of success cannot only negatively impact the therapeutic process, but also the individual's self identity.

One should not negate the effect of the self fulfilling prophecy in the individual's acquisition of success. For the therapist to contradict the individual's definition would only impede his success. This perhaps is the basic reason success in therapy is so difficult, vageuly and broadly defined by each therapist. Yet both therapists emphasized that family's ultimately define their own success.

Defining success in terms of abstinence from alcohol is a good start to recovery, but there is more change involved than just the abstinence from alcohol. It is also necessary for the recovering alcoholic to experience psychological, emotional, social, recreational, biological and environmental changes.

When analyzing both Ms. Gomez' and Ms. Romero's definition and measurement of success, Ms. Gomez' definition denotes a qualitative and quantitative measurement in very broad and flexible terms that can be applied to almost every individual's special circumstance with consideration of his family relationship, physical, occupational, financial, emotional, recreational, and self awareness changes. These changes also include the acquiring of coping skills and insight to be used in the future.

Ms. Romero defines success in terms of a sense that the family has found the missing link that led them into their present problems. She does not define that sense, link or problems. Yet, she does say that each family defines its own success. Therefore, Ms. Romero and Ms. Gomez define success in terms of manifest changes and increase in coping skills.

CHAPTER V: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY

In Chapter I, an introduction to the problem of alcoholism was presented. The main topics addressed included a description of alcoholism in the United States, with special focus on the effect in the family. The alcoholic Chicano/Mexicano was considered as being effected by a dual stigma of his cultural minority and alcoholic status.

In Chapter II, a review of the literature focused on alcoholics and alcoholism problems, with special focus on Hispanics and theories of alcoholism and treatment modalities. Alcoholism is viewed as a pervasive problem in our society which knows no social, economic or cultural boundaries. It appears from the studies that the Hispanic culture is documented as manifesting more alcohol related problems than the general population. This implies that the Hispanic alcoholic and his family are not receiving the special services needed for successful intervention.

In Chapter III, there was a discussion of the focus of the study. The study was exploratory, based on interviews with two Chicana therapists working with Chicano/Mexicano alcoholics and their famililies, with special consideration of treatment modality, success and barriers.

Chapter IV, contains the presentation and analysis of the study, covering the results of the interviews with the two respondents. The results cover the respondents answers to such areas as the definition of alcoholism, who their clients are, and what is the respondents therapeutic approach. Chapter IV also presents and analyzes the respondents client/

therapist relationship and how the respondents use themselves in the therapeutic relationship. The respondents also discussed what they considered treatment barriers and treatment successes.

CONCLUSIONS

A culturally oriented approach to alcohol therapy with Hispanic families appears to be a successful intervention method. The therapy provides the basic components to build a relationship of trust between client and therapist.

The techniques and skills of the culturally sensitive form of therapy break down the myths of the more traditional forms of psychotherapy. Cultural therapy involves a bilingual/bicultural orientation. Another component of the therapy is that the therapist/client relationship becomes more equalized as the therapist establishes herself as a natural helper.

Traditionally Hispanics under-utilize the mental health system, often preferring to use folk healers or home remedies. If Hispanics do use the mental health system, their length of treatment is extremely short than any other group of people.

One of the conclusions made in this study about the under-utilization of services by Hispanics is that the expectations of the client and therapist are seldom discussed or made clear.

Both respondents of this study pointed out that their Chicano/Mexicano clients first sought treatment for symptom relief while denying the underlining alcohol problem. If the problem of alcohol was not demonstrated to the clients' acceptance and satisfaction as being at the root of their symptoms, they dropped out of treatment. Therefore, through denial they ignored the disease and sought only a cure for the symptom.

Through the culturally orientated treatment process the therapist establishes herself as sharing common experiences and feelings. She becomes a friend and comadre in the client's therapeutic process, thus forming a special bond that creates a unique therapeutic tool and increases the possibility of treatment success.

In more traditional forms of psychotherapy, the client's expectations for outcome, is rarely discussed. However, in the cultural approach and especially in the conocimiento exercise, the expectations of client and therapist are discussed at lenght. The client is made to feel that he is an equal partner in the learning experience of therapy. He is asked to share his background, family members, upbringing, likes and dislikes. This exercise is all written down so that it may be visually seen as well as talked about. The therapist also shares about her life and background, thereby, greater rapport is established early on, expectations are expressed and agreed upon, and there is clearer communication.

The therapist explains the agency where she works, and what services it provides. She then goes on to explain her role at the agency, and what her limitations are as a therapist. With the expectations discussed early on in treatment, there is a chance for greater success.

Special consideration must be paid to the "gender gap" in treatment, and the sexism of a male client. Ms. Romero also felt that her age was a barrier to treatment.

A relationship of respect must be established. Ms. Gomez does not openly confront respect early on in treatment, while Ms. Romero directly confronts the issue in her La Raza approach.

Both therapists believe that a role of educator, enabler, facilitator and friend must take place in the therapeutic relationship. Their approaches are non-traditional, but are highly successful with Chicano and Mexicano alcoholics and their families.

Success in treatment is defined by the family, but both therapists believe that success means an abstinance from alcohol and an increase in coping skills.

RECOMMENDATIONS

It is recommended that a cultural orientation of alcohol therapy be available to fulfill the needs of Hispanic clients. It is hopeful that this cultural therapy approach would be used in training all workers in the helping professions.

It is recommended that the cultural approach to alcohol therapy be viewed as a valid model for alcohol education and prevention, and be used in the teaching curriculum of all training on alcohol therapy and related areas.

It is further recommended that alcohol therapy and alcohol education classes be reinstated at the School of Social Work, San Jose State University. Since alcoholism is a serious problem among Hispanics and the mission of the School of Social Work is to work toward the betterment of Hispanic people it is hopeful that a cultural perspective towards alcohol treatment could be made a permanent part of the curriculum.

It is recommended that the cultural approach to alcohol therapy be used as an educational and preventative tool for future high risk populations, such as children of alcoholics, special school programs and the juvenile probation department.

Lastly, it is recommended that future studies be conducted on the relationship between a cultural approach to alcohol therapy with Hispanic and the duration of treatment and the Hispanic client's success.

A broader knowledge base needs to be drawn and empirical data collected to develop new programs and expand present programs on Chicano alcohol therapy.

In conclusion, we would like to present a quote from the taping of Ms. Josie Romero in which she states:

"What I've shared up to now is not in books and it's not something you are going to learn by hearing other people like myself and others. A lot of it has to do with the use of self, your experiences, your skill and knowledge, and your wisdom. Everything counts, from the time you can remember, and putting it to use. In addition to that is that the role of the therapist working with Chicano families and with almost every oppressed minority is not that of a fifty minute hour therapist. We must take into consideration to begin impacting and educating systems. Being what I call a social change agent, in addition to being a therapist."[63]

Culture is perhaps one of the strongest influences on the individuals' identity development. The personality of an individual and how he expresses it should be viewed in a context of cause/effect of the culture's influence on the individual within his cultural environment.

In other words, no man is an island. Personality identity and the expression of the personality is a result of the individual's psycho-social development, experiences, environment and interaction based on the cognitive, biological and emotional aspects. Therefore, there are several important cultural considerations that are included in treatment. First, the agency and workers should have cultural awareness and the ability to

communicate in the client's preferred language. The client and his family's acculturational levels and interaction should be assessed and addressed. It is important to recognize the client's cultural identity, definition of and values as well as his individual self identity within his cultural environment.

The family views as the primary social unit within the culture. It provides interpretation, structure and transmission of culture from one generation to the next through the process of socialization. Family provides not only protection and the basic necessities (food and shelter) for survival, but also a sense of belonging and emotional support for development, growth and change of the individual within the family. The individual within the family, through roles, functions, rules, communication, boundries and interaction perpetuate the family.

An alcoholic within the family affects the whole family system. The family often reacts by accomodating to the alcoholic in order for the family to survive, thus creating a dysfunctional homeostatis.

The focus of the family members' roles quite often change from the normal psycho-social development of each individual to enabler, buffer, protector and victim of the alcoholic. Therefore, the disease of alcoholism affects not only the individual alcoholic but also his family, the co-alcoholics.

APPENDIX

STRUCTURAL INTERVIEW

*Questions asked During the Video Taping

1. Tell us about your job? What do you do here?
2. Who are your clients?
3. Define alcoholism for us please?
4. Do you work with people outside of the Hispanic culture?
5. What is your therapy technique?
6. How do you measure success?
7. How did you get interested in working with alcoholics?
8. What makes you different than other therapists?
9. What's in the future of alcohol therapy?
10. What is the difference between alcoholism in the Chicano community and the Anglo community?
11. What things get in the way of clients getting well?
12. As a female therapist, what are some of the barriers in working with Hispanic males?
13. Why don't alcoholics get well?

*Please note that these questions were not raised in the same order in both interviews as stated here.

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