In Freddie's case, the pastoral counselor begins with the knowledge that Freddie has had loving parents, a solid religious background, and a supportive extended family. The family must be encouraged to consider his sexual behavior far less important than how he feels about being gay in the context of his faith and every other area of his life. The counselor can help the family conversation by helping the parents realize that a narrow focus on sex, which reinforces widespread homophobia—especially in the church where any discussion of sexual activity outside of marriage, but especially homosexual sex—may trigger moral absolutes. By encouraging resistance to this way of thinking rather than fostering a stigma of deviance, the pastoral counselor can help the family build on their strong foundation.

These opportunities for an open dialogue may benefit Freddie and his family. The counselor observes that Freddie and his mother seem ready for the honesty and hard work that can lead to healing, but Freddie's father may be more reluctant to give up his silence. The church and its members may not be willing or able to fully embrace Freddie in spite of their views on homosexuality. Pastoral counseling promises no absolutes and offers no guarantees. It simply aims to bring mental and spiritual comfort to the troubled.

TWELVE

Addiction, Power, and the Question of Powerlessness

Joel Glenn Wixson

In an effort to move the question of addiction out of the moral realm, the originators of Alcoholics Anonymous (AA) worked to have addiction considered a disease. Consistent with what has come to be called the "disease model"[1] of addiction, it is an "equal opportunity disease" said to affect people from "all walks of life." An unintended byproduct of this shift has been the tendency to conceive of addiction as something that similarly affects everyone.

Sadly, this conceptualization ignores the implications of sociopolitical power,[2] culture, race, sexual orientation, religion, sociopolitical demographic, and other differences as they relate to an individual's experience of addiction. This essay critiques the disease model with regard to its marginalization of the experience of difference in struggling with the problems of addiction. AA and its use of the concept of powerlessness is thought of as an example of how a central tenet of AA, intended to support healing, can have the opposite effect. Reflexive and narrative practices are suggested as alternative approaches that allow people struggling with addiction to access some elements of self-help models (i.e., the social support component) while reflexively considering and perhaps rejecting others (i.e., the notion of powerlessness).

Alcoholics Anonymous: A Step in the Right Direction

It would be futile to attempt to present a comprehensive history of AA in this short discussion. AA has existed since 1935, and in the intervening years, many

stories of its origins have emerged. These accounts range from tracing its roots to the Oxford Group, through detailing the lives of its founders Bill Wilson and Dr. Bob. Rather than attempt to replicate these stories here, I will present a brief oral history of AA.

I am suggesting the idea of an oral history with the intention of conveying the somewhat amorphous nature of AA. In this context, the history is not one of citations and "facts," but one of a movement conveyed and perpetuated by involvement and participation. A formal history would tell a story of something static, rather than something constantly in motion. I believe the latter more accurately expresses the nature of AA.

AA is a singular entity, intentionally without organization or hierarchy. It took this form in its inception in an effort to uphold the commitment to being by, for, and about any individual who had a "sincere desire" not to drink. AA was designed to be an entity rooted in people, not institutions.

I probably first heard about AA on TV or on the radio. As a child, it meant little to me, except that I knew my father, an American Baptist Minister, would tell people they should go to meetings. He thought it would help.

I imagine there are lots of people who have a similar understanding of what AA is, based on the experiences of others—perhaps twice removed. Having worked in the field of substance abuse treatment now for some years, my experience and knowledge of what AA is has changed quite a bit. Along with attending meetings myself, I have worked with many people who have had long-term relationships with AA. These experiences draw me to consider AA as an entity that can be at the same time lifesaving and oppressing, supportive and problematic.

AA is also referred to as "the program," or "the fellowship." I have seen people's lives saved by what the program offers. I have also seen people turn from its doors and run, hopeless, back to the streets. I have experienced the vast differences that manifest as the "program," across meetings, through stories told about meetings, and articulated by colleagues in the field. In my experience, AA is as vast and complex as its membership, affecting each participant differently.

In this way, AA is not a discrete entity to critique, but a movement carried in the hearts and minds of its participants. AA was to be something available to anyone who wished to participate, not something that one had to join through initiation. However, a culture of "earning one's seat" has developed along the way. "Earning one's seat" refers to what a person has had to go through in order to "hit rock bottom" and "be ready to let go and let God," in the vernacular of AA.

An outgrowth of the idea of earning one's seat is the suggestion of insider-/outsider-ness. If you have not earned your seat you are considered an outsider.

You would not be excluded from attending meetings, but you would be expected only to attend "open meetings." In AA, open meetings are for anyone who might be interested in attending an AA meeting, problems with alcohol or not. Closed meetings are reserved only for those who have acknowledged a problem with alcohol. In an effort to protect the anonymous nature of the process, this dichotomy has been established.

As I am a person who does not consider myself a member or someone who has "earned my seat," I am cast as an outsider. As an outsider, I can support insiders in their desire to stop drinking, but I cannot "identify"[3] with them. I am not critiquing AA as someone who has used AA for personal reasons, though I believe I do have a personal relationship with AA, having worked in the field of addiction as long as I have. My outsider status makes me an observer, and rather than allow for any question around this issue, I would situate myself as such. I am a person who has known hundreds of people whose lives have been touched by AA in many ways. I have appreciated the basic tenets of AA and have applied them to situations in my own life, but I have not "earned my seat."

This point is relevant as it relates to the possibility of what persons can indeed understand of the fellowship from the "outsider" perspective. It has been my experience that challenging critiques of AA are often met with concerns about understanding. It is typically suggested that a lack of belief in the value of AA is rooted in a lack of understanding of its nature or "how it works."

This issue could be related to the insider/outsider dichotomy, or to the sublime power of the positive effect the program can have on individuals for whom it does work. From the perspective of someone who considers AA the thing that saved their life, it would seem odd indeed to hear that another might have concerns about it, especially someone who is an outsider. Additionally, it would be reasonable to consider the perspective of an outsider somewhat limited.

Although I acknowledge these concerns, I believe that AA cannot move forward without a careful consideration, not only of the lives of those who have benefited from what AA is, but also from attention to the effects it has had on those who have not benefited. I would point to my experience of having worked with people whose lives were adversely affected by their involvement in the program, and my desire to bear witness to these experiences in an effort to support this critique. I do not mean to suggest that this makes me an expert; I simply offer it as the basis for my knowledge.

It is for these reasons that my critique must be rooted not in response to documentation of a historical entity, but in response to something that is moving and changing; a critique based on AA as it is reflected in its participants, those

saved and those cast out. AA is not like a car that either starts or does not; AA is more analogous to the tides. Although they predictably sweep in and out, they are reflexive of the beaches they meet. High tide does not land on the same sand that low tide left in the previous cycle. Time has changed AA, but more than time, people reconfigure it from moment to moment. Insiders and outsiders, AA lovers and haters alike, carry the story of AA. It is this account of AA that I will reflect on, on this day, from this perspective, from this beach. I leave it to the reader to determine which grains of sand are useful and which should be left for someone else to ponder.

The "Disease" Approach to Understanding Addiction

Prior to AA's inception, problems with alcohol were popularly considered to be a reflection of the moral weakness of the person consuming the substance. In this way, the contribution of AA in the form of conceptualizing these problems as a disease was groundbreaking. In an effort to bolster this idea it has been suggested that AA's founders, Bill Wilson and Dr. Bob, worked with the American Medical Association to establish the formal diagnosis of "alcoholism."

Currently, though, the text most often referred to in the diagnosis of such disorders does not contain the term alcoholism. The current edition of the American Psychiatric Association's Diagnostic and Statistical Manual Text Revision refers only to the categories of alcohol abuse, dependence, and withdrawal. This not withstanding, AA literature contains many references to "the disease of alcoholism," and uses the term alcoholic to describe the people who would benefit from participation in the program.

Over the seventy years since AA's inception, many treatment continua have been established in the United States. Many adhere to the principal that problems with alcohol are most usefully described as being related to a "disease of alcoholism." In general these programs consider AA to be a vital, if not primary, component of their treatment.

Utilization of AA in these programs can range from the requirement of attending a certain number of meetings per week, to an almost total immersion in AA. Examples of these two extremes in the treatment system in the United States include outpatient counseling programs that suggest participants go to several meetings during the course of the counseling, to halfway houses that offer no other services and require that residents go to up to three meetings per day.

In order to understand how AA might be applied in the treatment context, it is necessary to understand the basic building blocks upon which it is based. They are the Twelve Steps and the Twelve Traditions (AA 1976). For practical purposes it is the Twelve Steps that are most relevant here.

Widely considered to have been a version of a program developed by the Oxford Group, an evangelical Christian movement of the 1920s, the Twelve Steps are intended to guide the alcoholic through a process of "recovery" from the disease of addiction. They are as follows:

- Step one: We admitted we were powerless over alcohol, that our lives had become unmanageable.
- Step two: Came to believe that a Power greater than ourselves could restore us to sanity.
- Step three: Made a decision to turn our will and our lives over to the care of God as we understood Him.
- Step four: Made a searching and fearless moral inventory of ourselves.
- Step five: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
- Step six: Were entirely ready to have God remove all these defects of character.
- Step seven: Humbly asked Him to remove our shortcomings.
- Step eight: Made a list of all persons we had harmed, and became willing to make amends to them all.
- Step nine: Made direct amends to such people wherever possible, except when to do so would injure them or others.
- Step ten: Continued to take personal inventory and when we were wrong promptly admitted it.
- Step eleven: Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
- Step twelve: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Ibid., 59)

The adherence to the notion that problems with alcohol constitute a disease, and that the disease could be treated with these Twelve Steps, led to the development of programs with a specific set of components. Traditionally, group meetings were thought to be useful as they provided participants with the

experience of becoming familiar with others who have the disease. Additionally, these contexts provided opportunities for participants to be confronted with various symptoms of the disease.

One of the symptoms traditionally associated with the disease of alcoholism is "denial."[4] Much has been written about the causes and effects of denial in the disease process (see Clancy 1961; DiCicco et al. 1978; Moore & Murphy 1961). It is widely accepted that denial is one of the main tools alcoholics use to attempt to maintain control over their alcoholism. Furthermore, it is widely accepted that the process of "breaking down" the denial of the alcoholic is essential if they are to succeed.

The notion that problems with alcohol could be understood as a "disease" and that problems with drinking could be described as "alcoholism," brought with it the suggestion that anyone could "catch" it. This way of thinking, in combination with the growing belief that AA was a treatment for the disease, led to the homogenization of the problem. This in turn led to a homogenization of the response. As with other entities characterized as diseases, the cure is the same regardless of who you are.

Groups are used to allow participants to confront their denial and other symptoms through hearing accounts of others' experiences, and as opportunities for other group participants to challenge directly conclusions individuals may be making about their lives and their experiences. Groups were constructed around themes thought to be generically associated with the disease of addiction, rather than driven by the specific needs of individual participants.

AA tradition has referred to the experience of individuals assumed to be under the influence of denial as having, among other things, "stinking thinking," or "doing the same thing and expecting different results." The group context of confrontation reflects the conclusion that the disease of alcoholism must be challenged for it to be overcome. It further reflects the conclusion that success can only be achieved if the alcoholic admits that he or she has the disease and, more importantly, accepts his or her powerlessness over its effects. This is reflected in the First Step of the process.

The notion of accepting powerlessness, its homogeneous application, and the effects of this stance constitute the basis of my critique. It has been my experience that powerlessness is not an idea similarly understood across diverse groups. This constitutes my bias in this discussion. The notion of powerlessness is inherently connected to sociopolitical power, and therefore the utility of accepting one's powerlessness is intertwined with the amount of power to which one has access in the first place.

I have known individuals for whom the experience of accepting powerlessness has been useful. Contrasted with this situation are accounts of persons I have known whose lives afforded them little power to begin with, and for whom a further diminution of power presented a life-threatening struggle. For the purposes of this discussion, I will present the example of an individual who, by virtue of her profession, has access to sociopolitical power, but by virtue of her gender has little power. I have done this in an effort to present the complexity of issues associated with power and addiction.

"Something for Me"—Betty's Story[5]

"I need to find something for me," she said, as the tears began to flow. Sitting in my office, Betty reached for the tissue box. This was our first meeting. Betty had been struggling for about six months with the role alcohol played in her life.

Betty had come in at the request of her family. They had grown concerned because she seemed to be spending more and more time drinking. From her own account, she would sometimes drink a whole bottle of wine in an afternoon. She would do this while she was home alone, waiting for her husband to get home from work, or her sons to return from school.

We were trying to understand how it was that alcohol had begun to exert such a powerful influence on her life. "Can you tell me what the tears are about?" I asked.

"The boys don't need me anymore, and Tom is always working. He doesn't need me," she replied.

"You said you wanted something for you," I responded. "I am curious about what you meant by that." From this query grew a recounting of a life in which Betty had been a leader. She had been the first in her family to move away from home. Alone, she had supported herself though college, and continued on to finish medical school. Prior to meeting her husband, she had been working at a family health clinic in Harlem, New York, part of a new program in which health-care providers went out into the city to care for those in need.

In our conversations, she recounted her experiences of going out into the housing projects attempting to care for those who lived there. Her experience of the conditions in which people lived had affected her profoundly. She saw, at first hand, the difficulties with which many people had to contend in living their lives. She felt a strong commitment to caring for these people, even though she knew the work entailed a relatively high amount of risk. These experiences

contributed to her strong sense that caring and connection were things she should stand for in her life.

After meeting her husband, Tom, they moved away from the city to follow the direction of his career. Soon after leaving the city, her first son was born. Betty adopted the role of caregiver and let go of her work in medicine. It was at this time that she started to feel pressured to change from the path she had taken as a leader, someone who stood outside of what was expected, and to adopt a more traditional role as a mother and wife. The pressure came from her family, who expressed their belief that this course of action was the most appropriate for her.

Eighteen months after their first son was born, she gave birth to her second son. Tom continued to develop his career, and began to spend more and more time at the office. Betty found herself taking care of the boys, the house, and the other associated chores. For the most part, she enjoyed watching them grow up, and, for a while, didn't miss her career.

When we started meeting, the boys were in their mid-teens and spending more time with friends, doing homework, and engaged in their own lives. Tom's career took up much of his time, leaving little time for him to spend with Betty. Betty was left with taking care of the house, doing the boys' laundry, playing golf with her friends, and talking on the phone. She wanted to do something more stimulating but found herself wondering how she could do anything without making herself unavailable to her sons if they needed her.

She found herself drinking while waiting for the boys to get home from school, or waiting for Tom to come home after work. It was during this time that Betty began to experience alcohol as her "only companion." She found it comforting and drinking helped her deal with her boredom.

It was in this context that we began to explore her desire to have "something for her." In talking about what this might be, she connected back to her experiences in the clinic and the work she had done in the city. She said she had given all that up for her husband's career and for the boys. She said that she felt like much of her life had been given over to her family's needs, and taking care of their home. She said that she needed something that she would find different, something she would find satisfying.

Betty and I had encountered many roadblocks in our attempts to describe something that would be for her. Betty felt a strong commitment to her sons' needs, and didn't see how she could commit to an activity that might make her unavailable to them. Her husband's work was somewhat unpredictable, making it difficult for her to know when his family responsibilities would be transferred to her.

Alcohol had helped her forget about her desire to find something in her life that would give her a sense of purpose. She found this assistance quite seductive. She struggled to conceive of a life without this support.

"I just have to admit that I'm powerless over alcohol," Betty eventually said, as the tears started to well up in her eyes. Over the course of several stays in Twelve Step-oriented detoxification facilities, she came to understand that powerlessness over alcohol was the essence of taking her life back. She was being invited to believe that the only way for her to change her relationship with alcohol was to admit that she could not control her drinking.

But how was she to experience this invitation in the context of a life already dominated by things she had given up? How was she to experience an invitation to powerlessness in the context of having so little control of the direction of her life? How was she to experience the suggestion that she give up alcohol in the context of a life where the only solace she believed she had from her memories of commitments she'd made and lost touch with, was in a drink?

Difference and Addiction

Betty's story represents an example illustrative of the experiences of many people with whom I have worked. Traditional modes of treatment based on the Twelve Steps don't adequately account for the differences in power experienced by many of the people who attempt to access recovery through these programs. The idea that someone might already be in a "one down" position because of culture, race, sexual orientation, religion, sociopolitical demographic, and other differences is not considered.

The First Step of AA assumes homogeneity of sociocultural power in relation to the abdication of power over one's relationship to alcohol. As it is written, it ignores the impact the requested admission might have in the life of a person whose existence is already characterized by the absence of power. It seems to minimize the implications of making such a request in such lives, and the difficulties and honest resistance that might occur in response to such a suggestion.

Betty had a great deal of trouble complying with this step. She experienced the idea of admitting powerlessness over her drinking as simply another instance of her having to give up something that was important to her. For her, alcohol was the last thing she had to hang on to. It was something that allowed her a brief respite from the pain that resulted from her having ended up in a life that seemed so far removed from the life she set out to lead while she was in medical school.

Although the context of the powerlessness invitation set out in the First Step is intended to free the person from the turmoil of repeated attempts to control one's drinking, for Betty, and many others, it is experienced as yet another loss of power. It is seen as another piece of one's identity being removed. Betty experienced the possibility of admitting powerlessness as another aspect of her character being taken away from her.

Although the substance abuse treatment system in the United States has had success in identifying the importance of groups and the utility of AA in its ability to fight against loneliness and isolation (both issues experienced by many as central in reclaiming their lives), it has fallen short in a critique of its ability to discern differences in the individual's relation to power in our culture. At best, AA assumes that power is equally distributed across the lives of program participants; at worst, it completely ignores the existence of sociocultural power and the role it plays in participants' experience of their lives.

This lack of critique might be traced back to a unique element of the substance abuse treatment system. This uniqueness sets substance abuse treatment apart from any other mental or physical health-care system in this country. This element is the prevalence of individuals whose personal experience is the primary credential they carry for doing their work.

The presence of what are known as paraprofessionals leads to an assumption that the power relations between participants and staff are equilateral. "We're all the same in the game" is an expression commonly used in an effort to assure participants that they are among equals, and that their lives are being understood in the context of people who have "been there" and share a common set of experiences. Being an insider among insiders is intended to have a positive effect on those seeking treatment.

The intention of this practice may be to diminish the possibility that participants will have a basis to believe they are being judged. Additionally, it is hoped that sharing a common experience may lend credibility to the position of the person attempting to counsel the participant. It is also suggested that the presence of paraprofessionals will aid those seeking help in hanging on to the hope that they, too, may yet be able to reclaim their life from their relationship with substances.[6]

Whatever the reason, the lack of awareness of differences in the experience of sociopolitical power in substance abuse treatment settings and philosophies is detrimental to the successful recovery of many people. I have worked with many individuals who are members of marginalized groups who experience the AA invitation to powerlessness as a final step they are unwilling to take. Like Betty, they understand the suggestion that admitting powerlessness over alcohol is the

only way to reclaim one's future as a replication of the very stressors that made the experiences offered by substance use so seductive in the first place. In their experience, admitting powerlessness amounts to a surrender of a different kind than the one envisioned by the founders of AA. It is tantamount to the acceptance of a life in slavery. It is not experienced as an invitation to move forward, but one to continue to slide into an abyss of domination and subjugation.

The suggestion that alcohol is "all I have left" will not sound unusual to many treatment providers. The ability of substances like alcohol to move into a place of cherished partnership is one of the great hazards of addiction. Once a person begins to hold this belief, others can begin to look like the enemy. Establishing trust with someone who may be predisposed to consider you an enemy is very difficult. For this reason many people who work in substance abuse treatment experience these types of statements as a tactic in service of the substance trying to keep people from taking their lives back.

In the context of levels of sociopolitical power, though, the issue becomes how to make the distinction between a tactic intended to keep people stuck, and a lifeline people have been hanging onto in the face of fighting against a paradigm of subjugation and marginalization. The former represents a position in which power is available but is being interrupted by excessive consumption. The latter represents the experience of oppression being mediated by consumption.

This is not to suggest that alcohol's intentions for Betty's life revolved around support. In fact Betty was herself growing more and more concerned about the way her relationship with alcohol was developing. She saw her reliance on alcohol's ability to soothe or buffer her growth in awareness of life problems, and she witnessed the effects that her drinking was having on her sons and on her relationship with her husband. None of this awareness made her happy.

What I am proposing is the necessity of a system of practice that acknowledges the differences in peoples' experience associated with differences in cultural background, race, sexual orientation, religion, sociopolitical demographic, and so on. What is needed is a treatment system that will allow those concerned to discern the distinction between invitations that are in support of new directions and those that are replications of past oppression. What is needed is a way to engage people struggling with addiction in conversations that consider their unique experience of living in relation to sociopolitical power and the role played by their relationships with substances. This represents a fundamental shift from an approach to treatment of problems with substances that advocates for a single path to recovery, to one that acknowledges the differences people experience in relation to this form of cultural power. Below I will outline such a system.

Changing the Discourse

Adopting a perspective on substance abuse treatment that includes a critique of sociopolitical power relations requires a fundamental shift in the way substance abuse is understood. Traditional models view substance abuse from the disease perspective, placing the disorder inside the person. The traditional view holds that substance use disorders must be treated in the context of this frame, and that abdication of one's ability to control them is essential.

This view is squarely rooted in modernist assumptions about humanity.[7] From this viewpoint diseases are entities that inhabit the bodies of individuals. Individuals suffer from these diseases until they are cured or the diseases are otherwise removed from the body.

Proponents of this perspective readily compare addiction to cancer, diabetes, and even allergies, and see their treatment as parallel to treatments for other similar disorders. From this perspective, the disease model is not a metaphor, but a description of the true nature of an individual's relationship to substances. The link, then, to forms of treatment informed by modernist thinking is a foregone conclusion.

An alternative perspective is to consider problems with substances as something that exists in our culture. The unique manifestation of cultural problems exists in the unique effects each has on the affected individual or community. From this perspective, a critique of the cultural implications of power on the affected individual can be included in the process of treatment. In fact this kind of exploration is an essential element of the process.

This alternative perspective to dealing with alcoholism has been discussed at length by various writers (see Epston and White 1990; Freedman and Combs 1996; Dickerson and Zimmerman 1996) in discussing the use of narrative therapy. The application of narrative therapy in the context of problems with substances, however, is less widely discussed (see Winslade and Smith 1997; Glenn Wixson 2000). A full description of the process of narrative therapy is beyond the scope of this chapter, but I will address some of the specifics as it relates to problems with substances generally and invitations to powerlessness specifically.

Addiction and Narrative Therapy

The practice of narrative therapy exists in a context of a specific stance in relation to problems. In this context, people are not the problem; problems are the

problem. Briefly, therapy progresses as the history of problem effects are traced through people's accounts of their lives. As the effects of problems are described, elements that stand outside of what one would expect, given the intentions of the problem, come to light. These unexpected elements often provide doorways to other unexpected elements that describe beliefs and practices that stand in resistance to the influence of the problem.

These beliefs and practices usually lead to more beliefs and practices. An accounting of these practices becomes an outline of preferences that people hold for their lives. As these preferred identities (White and Epston 1994) become more fully described, they provide resources to individuals seeking to reform their relationships to problems. Additionally, they provide a useful contrast between the preferred identity and the one associated with the problem and its effects.

In the context of Betty's invitation to express her powerlessness over alcohol, I attempted to consider the effects this decision might have in her life. In an effort to avoid assuming I could understand what effects this decision might have, I asked Betty if she would be interested in telling me what she meant by "admitting she was powerless over alcohol." Her response was, "It means I can never drink again." Again the tears began to flow.

"And what would it mean for you to never drink again?" I asked.

"It would mean that I couldn't be with friends," she began. "It would mean that I couldn't be comfortable when I go out to eat, that everyone will be looking at me and wondering what is going on. I mean—I've always had a drink. It's never been something that I didn't do. People will wonder what is going on with me."

Traditional treatment models would suggest that I identify these statements as part of her process of self-pity. They would suggest that she is rationalizing her use by connecting it to socializing. Traditional models of treatment would suggest that she is minimizing the danger of ongoing use by suggesting it is just part of what she does.

Narrative ideas, on the other hand, encourage me to consider her statements in the context of an implied preferred way of being. Her preferred identity is reflected in the choices she makes, in the beliefs she has, and in her hopes and desires for her life. Betty is expressing hers in her statements as she describes her concerns about losing her connection to practices that connect her to people that matter to her. Rather than dismiss her statements only as manifestations of the intentions of the problem, I can consider how they might connect to aspects of her experience that matter a great deal to her. I can consider with her

the possibility that they might, in fact, connect to still other elements of her experience she will find useful in renegotiating her relationship to substances. Additionally, I can further explore whether these elements of her experience reconnect her to relationships that matter to her.

I asked Betty if she would be interested in telling me why being with friends and not feeling like everyone else, and of other people wondering what was wrong with her, mattered so much to her. From this beginning point, over the course of several meetings, we began to explore her experience of relationship in her life. For Betty, caring and support were things she valued greatly. We discovered that these were things she, as a young woman, had been able to cultivate in a relationship with one special friend. She was able to do this in the absence of being able to find care and support in the context of her parents and brothers and sisters.

In this way, my curiosity about her response to my questions regarding her intentions relating to powerlessness, and my stance of considering these statements from the narrative perspective, allowed us to connect to meanings that were not consistent with those I would have been invited into through traditional treatment. Rather than being connected to some hidden desire Betty has to continue to drink, these statements were more usefully associated with her desire to stay connected to people. Moreover, tracing the origins of this desire led us to a commitment she had to caring and support.

I subsequently became interested in more fully describing this commitment. I did this by exploring with her the origins of this commitment, and wondered if there weren't people or traditions or experiences in her life that were supportive of it. This practice was intended to more richly describe elements of her life that were connected to her life preferences.

In engaging in this practice we resisted the invitation to ascribe assumptions that are based on naturalistic conclusions about people's motivations.[8] In so doing, we were more likely to discover valued elements of her life that could connect her to cherished memories and experiential resources that might be valuable in her migration away from substance use.

I hoped that by exploring the origins of her commitments to caring and attention, we would be able to identify resources she could use in her efforts to stay in connection to people she cared about without continuing down a road we both were concerned about. Furthermore, I hoped the process would offer us an alternative to the invitation to powerlessness that had started us on our journey. To further elaborate the origins of her commitment to care and support, I sent her the following letter:[9]

Betty,

At our last meeting you talked about spending time with your friend and that that was how you saw how other families lived. You also said that those experiences made you wonder why you weren't getting from your family what your friend got from his. You talked about wanting your parents to show up and support you at recitals and other events in your life and that you wanted, and still want, them to be involved. Was it being with your friend that got you thinking that your parents should be supportive of you in your life? If it was, how did this happen? If not, how did you find out about support and caring?

You said you wanted support from them and that that is part of what you are missing from Tom and your family now. I was wondering how it has been that you have not given up on wanting support up until this point? How is it that you have been able to stay with your desire to have your family care about you and your boys? What does it say about you that you have been able to hang on to the desire for support and caring until this point? How was it that you were able to reach out to others as a way to get that support and care? Was there something that happened in your life that got you to think it was worth hanging on to? Did reaching out to others let you know that there were ways to get support and caring?

I'm wondering what your family has missed out on by not showing interest in your life and your family. I'm also wondering about ways you have stood up for showing caring and interest with your sons. How is it that you have shown interest and support for your sons up to this point? What does it say about you that you have hung on to the position that caring and support matter, and made sure you show caring and support with them? What would they say about that? How do you think they would react to the fact that this is something you have been unwilling to give up in your relationships with them?

What do you think it says about your commitment to them that you have been unwilling to replicate your family's lifestyle with your sons? What do you think they would say about your ability to create your own lifestyle to stand up to how your family was?

In Partnership, Joel

This letter represents my attempt to connect Betty's commitment to caring and support throughout the events of her life. First, I address her commitments in the context of their origins in her young life. I am situating my questions in the context of her learning about what she now experiences as missing in her life. I am tracing the origins of the development of this sense of something missing. I am asking questions intended to trace the roots of her ability to discern the absence of caring and support in her current relationships.

In the second section I am attempting to encourage her to describe more fully what it is that has assisted her in staying connected to her commitments. These questions are intended to elaborate connection between her commitments and her efforts to live consistently with those commitments. They are also intended to find connections between her commitments and what it is that sustains those commitments.

In the third section I am exploring whether specific events in her life are examples of her living consistently with her commitments. I am wondering if things she shared with me about her actions are connected to experiences she had with people in her life. I am also inviting her to consider their voice in supporting her in her actions now. Questions that invite the evocation of voices of people in her life in this section and in others are examples of a practice intended to repopulate persons' lives with the presence of individuals who have supported or are supporting them in the living out of their preferred identity (White 2000).

By inviting people to consider who it is that would not be surprised by their attempts to hang on to their hopes and goals, or their intentions, and inviting them to consider how they would respond in witnessing their present actions or intentions that are consistent with those intentions, we create the possibility for people to add individuals to their resources from the past and present who support their ongoing efforts. In this way we were beginning the process of repopulating Betty's life and developing a community of concern shaped by her commitments to caring and support. Communities shaped around these specific commitments can be very powerful and useful to people as they face the intentions of the problem. This process can be extended in a variety of ways.

It is the recognition of the importance of developing a system of allies that correlates most closely to what traditional forms of treatment have to offer. AA offers a social context for the reclamation of lives from the problems of addiction. It is in the elaboration of the narrative and traditional modes of creating these networks of allies that a powerful collaborative melding of the two exists.

Narrative Therapy and AA: A Collaborative Approach

It is now commonly accepted that the most useful aspect of therapy is the relationship created by the therapist and the client. In my experience this is paralleled in AA. Many of the people I have worked with have pointed to the relationships they build in the AA community as being the most important aspect of the program. Their home groups, their sponsor, and those with whom they go on commitments become the communities of concern within which they develop a life of sobriety. The Twelve Steps, the lore, the sayings and propaganda, then, become the grist in which these relationships churn.

As I have stated, narrative practice recognizes the necessity and importance of communities of concern. These communities are centered on the telling and retelling of preferred identities as people and groups reclaim their identities from the grasp of problems. These communities may spring from the desire of a couple to redefine their relationship around the needs of their children rather than traditional constructs of marriage. They may arise from an individual's regaining his connection to his sense of core values. Or, as in Betty's case, a community of concern may be created around her establishment of closer ties to her commitment to caring and concern.

Additionally, communities of concern can be made up of a variety of individuals. Family members may be invited in to witness an interview with an individual, in which the individual expresses his or her commitments to strongly held values. A group of third graders might convene to proclaim their intentions to take their school back from bullying, or a group of "addicts" might invite close friends to a meeting to have their friends witness their conversations about their efforts to reclaim their lives from addiction, and the steps they have taken to do so.

Whatever their genesis and membership, these communities reflect what is commonly valued about the structure of AA. AA and other communities of concern share a commitment to the belief that a group's recognition of an individual's commitments and values is powerful. They share the understanding that reconnection with groups of people stands up against the insidious nature of addiction. They share a commitment to upholding the dignity of the people who participate in the resulting conversations. Additionally, and perhaps most importantly, they share the belief that the people who populate these gatherings hold the knowledge and resources necessary to reclaim their lives from the devastation wrought by addiction.

It is in this shared set of beliefs that the power for a melding of these seemingly disparate philosophies lies. The readily available community offered by local AA meetings can be lifesaving for individuals struggling with problems with addiction. Being able to, in most U.S. cities and on most nights of the week,[10] find open group meetings in which one can participate is an invaluable resource for millions. These meetings offer an alternative to the loneliness and isolation that confront many people attempting to take their lives back from addiction.

Combining this resource with narrative practices creates a union in which individuals may participate with others attempting to migrate toward a different kind of relationship with substances, while reclaiming preferred identities along the way. The support offered by the AA community, combined with the reclamation of values, goals, hopes, and dreams, may well provide a stable platform upon which to reclaim lives, families, communities, and entire cultures. This melding of approaches creates almost limitless possibilities for the future development of approaches to treatment that address the needs created by the growing cultural complexity of our society.

The primary contribution of narrative practices, in the context of problems with substances, is the ability to situate the reclaiming of preferred identities within the context of cultural forces and a critique of the influences these forces have had on the individual. While preferred identities are reclaimed from the margins of an individual's existence, the forces that supported that marginalization are exposed. These exposures are then explored to establish the tactics used in the process of marginalization.

In the telling and retelling process of the communities of concern, the marginalization and tactics used to do so are further exposed, creating the possibility for the critique to have even greater ripples into the community. This process allows for the effects of the critique to enter the community, situated within the context of its effects. In this way, it is less likely that any one group will be further stigmatized as the purveyor of the problem.

In Betty's situation the telling and retelling of her commitment to caring and concern had the effect of situating her experience as a child within the context of her commitment to creating a caring environment for her family and her community as an adult. Connected to this caring environment were many lessons she wanted to teach her sons about parenting and about responsibility and community. As the telling progressed, her sons were able to witness the ideas and invitations Betty received that tried to convince her that her commitments to specific ideas about parenting and community weren't legitimate or important. They discovered the connection she experienced between her desire to take care

of them, the sacrifices she had to make regarding her career, and the way those sacrifices led her to believe she had "given up on the community" and therefore had "no right to have a voice in what would be useful in the community."

This delegitimization of Betty's perspective led to the marginalization of the values she associated with that perspective. Continuing the process of marginalization, Betty struggled with her desire to become more active in the community, spending less time with her sons. With this came an invitation for her to consider herself a "less than perfect mom," a person who "selfishly focused on her own needs, rather than those of her children." These invitations served to further separate her from her commitments to caring and connection.

A critique of the origins of these invitations creates the opportunity to explore their tactics in engaging Betty's life. A telling and retelling process allows for the potential for these tactics to be known more broadly in the community. The knowing of these tactics, and the agendas they represent, create the possibility for others in the community to consider their existence in the lives of other families.

It is in this way that this process moves beyond the traditional constructs of therapy, those based on disorders in individuals, and into a process where critiques of sociopolitical power relations as articulated in the invitations members of oppressed groups receive from the society at large become the focus. It is in this context that the process of therapy becomes an active part of the process of social change, which constitutes the moral responsibility of the counselor (Hoshmand 2001).

By taking this step away from the "disorder vision" of addiction, narrative practices add an essential element to the process of addiction treatment. Additionally, these practices provide a revitalized platform for one of AA's original goals—that of moving the discourse of addiction away from that of a moral failing. In fact, as Betty's story exemplifies and my experience affirms, it is the strong commitment to a moral foundation and the invitations that delegitimize those moral passions that most often fuel the power of addiction. Narrative practice's ability to undercut this power by opening up possibilities to reconnect with those passions is what I have witnessed to be the most powerful aspect of this practice.

Conclusion

Alcoholics Anonymous is an entity with a seventy-year history of assisting people in taking their lives back from addiction. However, in the course of this history

AA has failed to provide a context in which the differences in sociopolitical power expressed in the lives of its participants can be critiqued with regard to their experience of the Twelve Steps. I have attempted to provide an invitation to that critique that recognizes the individual manifestations of the power relations it attempts to expose.

Additionally, I have offered narrative practice as a platform upon which an active, ongoing critique may be engaged in that might allow for the community aspects of AA to continue to be utilized, while the existence and effects of unequal sociopolitical power may be explored and acted against. It is my hope that by so doing, a melding of the two practices may provide those suffering with the effects of addiction a place where they can reconnect with their preferences for their lives, their moral commitments, and their passion for creating a better world. In so doing we can begin the process of working together in creating a better world for all of us.

THIRTEEN

Flowers and Songs: A Liturgical Approach to Pastoral Care

Eric H. F. Law

In 2002 the Roman Catholic Church canonized Juan Diego, the first Native American saint. It took almost five hundred years after the event in which he encountered the divine revelation through the Lady of Guadalupe at Tepeyac before the church recognized the significance of Juan Diego's role in the life of the church in the Americas. One of the reasons why it took so long was that there were disputes as to whether Juan Diego actually existed; perhaps he was just a legend. But one cannot ignore the impact of Our Lady of Guadalupe in the Americas. The story of Juan Diego is worth retelling here for the benefit of those readers who do not know the story. The summary below is based on Virgil Elizondo's extensive work on the Guadalupe event in his book *Guadalupe: Mother of the New Creation.*[1]

In 1531, ten years after the conquest of Mexico by Spain, "Everywhere the inhabitants of the lake and the mountain had surrendered" (ibid., 5). The church had worked diligently to convert the Indians to Christianity. But under this political backdrop, any transference of the faith was colored by the emancipation of the native way of life. Nevertheless, Juan Diego had been faithful in following the teaching of the church. On a Saturday night, he was on his way to Mexico City to receive his instructions from the priest. When he reached the foot of a small hill named Tepeyac, "He heard singing on the summit of the hill: as if different precious birds were singing and their songs would alternate as if the hill was answering them" (ibid., 6). When the song ceased, he heard someone calling him. He followed the voice and saw a lady whose clothing "appeared like the sun, and it gave forth rays." She asked him, "Where are you going?" (ibid.,