

## THESE CAMPS WERE DIFFERENT

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

**By Jayashree Venkataraman**

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### BACKGROUND

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

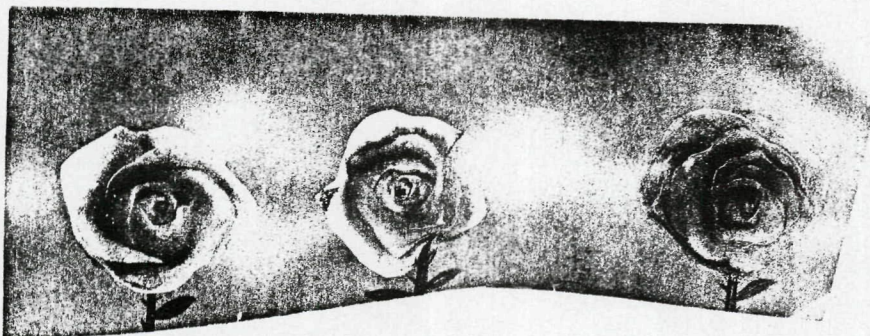
The Foundation, founded in 1980 by Mrs. Shanthi Ranganathan, a social worker, had been the wife of an alcohol-dependent husband. Mr. Ranganathan had traveled to the United States for treatment, but did not get adequate aftercare or recovery-group treatment. When he returned, he resumed drinking and subsequently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

lack of orthodoxy, some even placed the blame on his immediate family (Cherian, 1986; 1989).

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

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

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



## THE CAMP APPROACH

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

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

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

There appears to be no

precedent to this kind of treatment, i.e. take a full-fledged professional detoxification and therapy routine outside hospital boundaries. The clinic's director, and a team of professionals condensed and indigenized their treatment program to suit the context of the village, bundled themselves into an ambulance with the necessary equipment, and headed to the village. The director recounted the program's initiation:

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

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

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

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

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

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

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

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

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

Our objectives were:

- Identify and provide treatment to alcoholics living in rural areas.

- Use the existing community support to strengthen the recovery of patients.

- Create greater awareness about the problem of alcoholism and its ill effects among the rural population (Ranganathan, 1994).

## FEATURES OF THE TREATMENT PROGRAM

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

### PRAYER

The director recorded: *"The first camp was held in December, which is the marghazi month for us. So I used to do a lot*

*of pooja. So the patients joined me in these pooja. So having regular pooja, aarthi, chanting of bhajans became a regular feature every day, both in the mornings and evenings."*

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

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

### EDUCATIONAL LECTURES

Social workers gave daily lectures on issues related to alcoholism: on the disease concept, the need for total abstinence, required lifestyle changes, ways to stay away from

alcohol, or on the serious damages that alcohol can cause. The lectures were used to help the clients identify the issues present in his/her personal life. Among the clients, there was a high level of interaction and an exchange of personal information.

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

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

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

## STORYTELLING

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

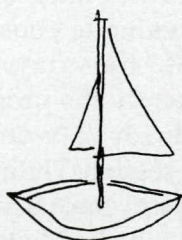
*"In the first camp, patients were just sitting around doing nothing. Their family would have left for home and they were just hanging out. So I started telling stories. The clients seemed to enjoy [this], and I found them to be attentive. So I continued that in every camp. In the rural areas, these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

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

*Ravi was 12 years old. Even at this age he was skillful in making toys out of wood. He used to make beautiful toys and that was his hobby. His father was of good help to him. He used to help his son to buy the materials required to make his toys. One day, Ravi made a beautiful boat. It was planned very well, the finishing was good, and it looked very beautiful. His father had all praises for his son's work. Ravi also was proud of his boat. One day after heavy rains, water was flowing in a little stream near Ravi's house. Seeing that, Ravi wanted to float his boat in the running water. He pushed his boat onto the gushing water and he was playing with it.*

*Suddenly there was a gush of water and his boat got swept away. Ravi ran behind it to retrieve it but in vain. He was dejected. He looked for it for days but he could not find it. He was preoccupied by this and was not eating or sleeping properly. The following week Ravi went to the market with his father. He saw a boat that was bright red in color in one of the shops. He ran to the shop and urged his father to buy that boat for him. When the shop keeper took the boat from the showcase, Ravi screamed 'Appa that is my boat, I made it. It has only been painted red.' Obviously, the shopkeeper did not look happy with what Ravi said. He asked Ravi to prove that this was his boat. 'Oh sure.' He just flipped the boat around and showed his name engraved on it. The shopkeeper was convinced and he gave the boat to Ravi. The little boy was happy: My boat-theme*

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



## GROUP THERAPY

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

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

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

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

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

## INDIVIDUAL SESSIONS

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

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

*"On the first sessions with my clients in the first camp at Manjakkudi, I was shocked and anxious. I told the other counselor who had come with me I really do not know what we have ventured into. In one of my patient's family there has been five suicides—you can imagine—and the patient has also attempted suicide. In another patient, his daughter committed suicide because she was engaged to be married and the bridegroom's family heard that the bride's father was an alcoholic and stopped the wedding. A third patient shared that he had started drinking because his wife [had] an affair with another man. Even though this had stopped he did not forgive her. When I heard all these stories on the first day of the first camp, you can imagine how scared I was. God where will I start,*

*what will I deal with and where will I go in these 12 days! But, at the end of the camp we had worked on these issues and everyone was sober, without any relapse within the past 5 years. With the client whose wife had an extramarital affair, after certain understanding he forgave her and let go. With the first client I described, we started him on antidepressants and he responded very well. With the other client whose daughter had committed suicide, he had a lot of associated guilt too, so we started him on antidepressants and moved him to a relative's house where he stayed for a while and improved.*

## FAMILY PROGRAM

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

There were several constraints in the program: women had to work for (per diem) wages so attending the program meant foregoing daily income and groceries for the evening meal. Families of field laborers in rural India (often paid minimum wages) bought groceries in small quantities every evening to cook the only meal of the day, dinner. Consequently the program was planned for 2 weeks, as a morning session. The ambulance picked up spouses in the morning who had to travel long

distances or rely on local buses, and dropped off them in the afternoon. They could have a meal in the afternoon in the camp site. This support encouraged spouses to attend the program regularly, and gave a boost to the client, who felt that "they are doing so much for me, I have to work on my sobriety." The program, a community meeting, lecture, and group therapy served all of the clients' family members.

## SOCIAL SUPPORT PROGRAM

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



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

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

## RECOVERING ALCOHOLICS SHARING

When the first camp was held, clients who had been to the main hospital at Madras and lived around the area of camp site were contacted to motivate potential clients for the camp. The clients from previous camp sessions could recommend a certain number of clients. The director believes this method helped increase the self-esteem of the old client, who gained the respect of the village because he

was on the "selection board." Moreover, they felt responsible for looking after the people he had recommended, which also reinforced his commitment to sobriety. The old patients from the previous camps were encouraged to share their experience and to give the message to the new clients that the program was successful, i.e., that someone from your very own community has done it, so why not you?

## CHILDREN'S PROGRAM

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

## FOLLOW-UP PROGRAM

Follow-up lasted 1 year. A social worker visited the village every month, met with all the clients, gave a re-educational lecture session on recovery, met with the client and family members, and distributed medicines. Relapses were also

handled during follow up. The support systems were mobilized, the local physician was contacted, and the client was motivated and detoxified by the local physician.

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

## REFLECTIONS

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

### Informal Atmosphere

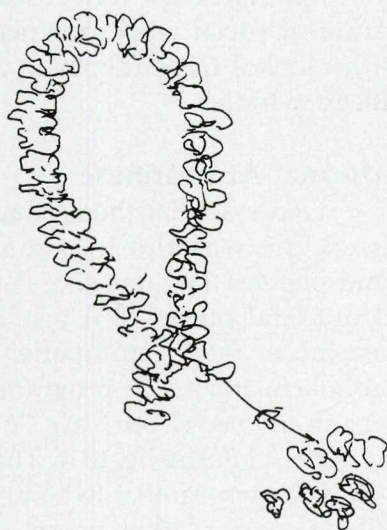
An essential theme that struck me was the informal atmosphere at the camp site. For all practical purposes it was a hospital, or rather an inpatient alcoholism treatment program, yet there was an air of casualness, informality to it. The style of life was similar to home. Clients wore clothes worn at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

The nature of the relationship with the clients

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

### Trust And Confidence

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



### Gratitude

Gratitude ran high among all patients, the families, and the village for the needed treatment, and also because the

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

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

### Social Stigma

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

the alcoholics." The community seemed willing to believe, have faith in the recovering alcoholics, have hope and think unanimously, that, "Even if this person was bad before, he has changed now."

### Disease Concept

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

### Shame And Guilt

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

### Willingness To Share And Be Honest

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

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

### Action-Oriented Approach

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

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

Several concepts were repeated and emphasized over others:

- *I should not drink for one day; that is today. Every day in the morning I have to pray to God and take this medicine they have given me. If I drink again, I will die.*

- *Every day I have to go for work.*

- *If I feel like drinking, I should buy some food, eat it and fill my stomach and go and sit in a place where there is no alcohol.*

- *Come regularly for follow-up.*

These repeated messages helped the individual understand what to do.

### Surrender To Bhagwan (God)

A strong theme that emerged was the emphasis and

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

### Role Of The Local People

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

### AFTER-WORDS

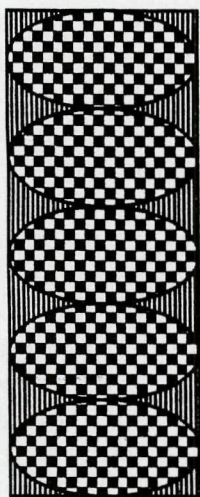
These camps have meant a lot to me and my family. My father was in the liquor business in the early 70s. He subsequently closed business because of prohibition in Madras. My education as a social worker and work with alcohol dependent individuals has been seen as my 'karma.' Since my father had sold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

many ruined families, here I was his daughter to do the evil away!

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

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

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



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

I felt uncomfortable about the instructive and directive role we took on. Also I wondered about how much the clients understood my role as a social worker as they have never been to one before. But the directive role that I had to take

helped in this process. I explained my role as a social worker to the client and bingo, clients talked about issues, understood instructions, families cooperated and goals were set! After the assessment the next step was to find ways to handle the problem rather than looking at the issue in-depth. This frightened me. I wondered if my approach would have negative consequences. Talking to the director and other colleagues with experience reassured me.

#### A Note on the Use of Stories

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

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

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