UNIVERSITY OF WISCONSIN-STOUT MARRIAGE & FAMILY THERAPY PROGRAM

Dealing with a Pandemic
Dale Hawley

A lot has happened since the last *MFT Courier*! The pandemic has brought changes in the program I never would have anticipated. When we left campus for spring break in March all was operating as normal. But that was the end of "normal" as we knew it. We did not return from spring break until September. Classes during the last half of spring semester were completed online using a video platform with which most of us had little familiarity. Within the course of a couple weeks, the Clinical Services Center moved from doing face-to-face in person therapy to 100% teletherapy. In addition to figuring out the logistics of doing teletherapy in a way that protected our clients, we discovered that our antiquated means of keeping records (paper and pencil) was no longer going to work. Within a few weeks we were able to transition to an electronic record keeping program, something we had been talking about doing for years. With the fall semester, we have shifted to somewhat of a hybrid model. Most classes are being offered in person, but with increased online components. We re-opened the on-campus clinic but continued offering clients the option of online therapy. We have shifted our staffing and processing times to include online and face-to-face meetings. While we have had to make a number of adaptations, the program is running more smoothly than I ever would have expected. That is not to say this has been an easy transition. We have had our share of missteps along the way and there are a number of things we are still trying to figure out. But, as they say, life is a journey and so is the transition we are making to adjust to "the 2019 novel coronavirus disease" or COVID-19. Like any journey, there are lots of lessons to learn along the way. Here are a few of mine:

- *People are adaptive.* The sheer number of adaptations we have had to make in a short amount of time is mind boggling. Students who had never done teletherapy were now doing *only* teletherapy. Instructors who had taught online only in a pinch were now doing it with all their classes. Clients who were used to meeting face-to-face now had to meet with their therapists through a screen. What I observed was that everyone involved made the needed changes without upheaval. Therapists figured out how to connect with clients via a web platform or phone. Supervisors learned how to support students using distance technology and discovered how to do live supervision when they could not be there in person. Clients kept coming to therapy and seemed to make the adjustment to online platforms without a hitch. We actually lost very few clients when we transitioned to teletherapy in the spring and a number of them have continued with this modality even when we re-opened the clinic. I want to give a special shout out to Karen Sinz. The shift to an electronic records program for a single therapist is challenging enough. To make this change in a matter of a few weeks for a whole clinic was a huge task and she has done it marvelously. All of this evidence has reinforced the idea that people are resilient, that when we are faced with difficulties, we can step up to those

challenges in ways that may surprise us. I am really proud of the way everyone in our program has pitched in as we have made some very difficult adjustments.

- *Teletherapy is here to stay*. If there was ever any question about this, it is now obliterated. We have been seeing the growth of teletherapy for the past several years, but the pandemic caused this shift to move into warp speed. Like other sectors in our society such as business and shopping, the vast majority of therapists have discovered that teletherapy is a viable option. Sure, many of us still prefer face-to-face interactions and we get frustrated with technological snafus that interfere with therapy. But now we know we can do teletherapy and that, in some cases, it may actually be a preferred modality. This presents some concerns, because there is a lot, we still have to learn about doing teletherapy effectively. Few, if any of us, received formal training in doing teletherapy. In fact, under current Commission on Accreditation for Marriage and Family Therapy (COAMFTE) standards, students are not allowed to do teletherapy (although those restrictions have been eased with the pandemic). But the next version of standards which take effect in a little over a year, not only allow students to do teletherapy, but require programs who use it to show how they train students in its use. The field is moving this direction. Although I do not know that teletherapy will replace in-person therapy as a preferred modality any time soon, we will certainly see more of it as we return to a "new normal" after the pandemic.
- *The importance of the cohort.* We have always felt that the strength of our program is the cohort model. It allows students to learn as a group, to support one another, to figure out interpersonal dynamics that parallel those they find in families. My belief in the importance of this model has only been strengthened by the experiences of the last six months. We have had to make a lot of adaptations in the way we do things and the cohorts have stuck together like glue. They watch out for each other, they have been a place of support in a time of isolation, and they have grieved together over lost experiences. We were not able to have commencement this spring, a time cohorts have often used for celebration and closure. The experience for students in the clinic has looked much different this fall with a mix of teletherapy and in-person therapy and it does not fit the expectations students had about what their graduate experience was going to be like. These adjustments have been really hard, but what I have noticed is the propensity of students to turn first to their peers for support. It speaks to the strength of the model.

We have all learned a lot in every aspect of our lives during the course of this pandemic. It has been a challenging time for us on multiple levels. And it has been a tremendous time to learn. Eventually we will come out on the other side of this and we will be changed. But is not that what therapy is all about? Dealing with the challenges we face and making changes to keep us in balance? This is as challenging an experience as I can imagine for a program like ours, but I think we have responded to it well and I have every confidence we will be stronger for the experience.

Pivotal Racial Moments and Therapy

Terri A. Karis

In the early days after George Floyd was murdered, I found myself frozen, unsure about how to engage with the turbulent, revolutionary, and heartbreaking racial moment our country (and the rest of the world) was experiencing. In my therapy practice, every single client and supervisee spent some or all of their session talking about race. Even white clients who did not generally talk much, or at all, about race. In talking with other therapists, I learned that this was true, not just for me, but for all of them, too.

A number of former students reached out to me via email, recalling class conversations about race or checking in to see how my family was doing, and I felt blessed to be in community with other therapists who care deeply about racial justice. One former student, Sharon Mitchell, shared stories of the meaningful racial conversations she was having with clients and of the mentoring she was doing with younger white therapists. She named her aspiration to "help white therapists who want to be a guide for white clients on their anti-racist journey." Conversation with Sharon sparked my idea of reaching out via email to University of Wisconsin-Stout (UW-Stout) marriage and family therapy (MFT) graduates to explore how I might be able to support them you during this pivotal racial moment. Two wonderful things came from that initial email.

First, I heard back from many of you and enjoyed updates on how you were doing and what was on your hearts and minds. I was reminded of our web of relational connections, of the bond we share across time and space, even if we have not been in touch for years. Second, with the support of UW-Stout graduate Corina Mattson, I started hosting a "Pivotal Racial Moments and Therapy" Zoom™ meeting, in which participants have talked about race in our lives, both in, and outside of therapy. Our meeting has evolved into a monthly event: a small core group of regulars and a place to explore race. While most people attend consistently, we also welcome people who come occasionally, as it fits for them. We start with checking in by sharing a racial moment from our lives and then deepen into whatever topics generate interest and curiosity.

One of the sweet surprises in the group is the connection participants feel to one another based on the common experience of having been an MFT student at UW-Stout. We have had graduates participate from almost every year over the past twenty years, up to the current MFT second year cohort. While some people have known each other, because they were in the same cohort, most have not. Nonetheless, the shared connection to our MFT program has supported us in readily feeling a sense of community with each other. I have had requests to include people who were not UW-Stout MFT graduates and made the decision to honor the bond our shared history creates and maintain a closed group.

The vulnerability and courage of participants as we have reflected has been inspiring. We have explored therapy session moments of shock or defensiveness, moments of courage and connection, as well as moments of second guessing and self-doubt. In individual conversations after meetings, I have learned about the shame that got stirred up after someone revealed the bias they had witnessed in themselves or the shame that got activated after they would shared something and then later felt exposed. Interestingly, these sharings were often ones that I had found especially powerful or insightful. Recognizing how risky it feels to share so openly, we were consciously practicing

supporting each other so we can grow our individual and collective capacity to face racialized conditioning.

My thinking about this aspect of the work has been strongly influenced by the work of UW-Stout MFT graduate, Rachel Martin, who has developed a somatically informed approach to help "white bodied" people have more resilience when it comes to racialized experiences, with other white people or in cross racial interactions. Rachel's Cultural Coherence organization (https://culturalcoherence.com/) provides training and a community of practice to support white people in developing capacity to stay present with each other during racialized discomfort. By supporting one another, those of us who are white can also explore how to hold ourselves and each other accountable—to act to address racial inequity and to repair when we cause harm.

One other resource I have found useful in recent months is Jennifer Harvey's book, *Raising white kids: Bringing up children in a racially unjust America*. For those of us who want to support white children in being racially literate and social justice oriented, it is a really useful resource. And for those of us who are white adults, it is also potentially helpful. Most likely we did not get the kind of racial development support that Jennifer describes. I found that reading this book felt somewhat like reparenting the young child part of myself who needed more guidance than I had received. I invite all of us to continue paying attention to racial moments. We can reflect on what we can do, in our therapy practices and in our lives, to heal racialized harm, and to align our life energy with the collective momentum for change that we are experiencing in this pivotal racial moment.

Resource

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…And Now Another Revision

Anne Ramage

In August 2020, I participated in an American Psychological Association (APA) virtual workshop on the new Minnesota Multiphasic Personality Inventory-3 (MMPI-3), scheduled to be released in late October of this year. The information contained in this article is based upon material from that workshop, as well as my broad experience in teaching, administering, and interpreting the MMPI.

From an historical perspective, the MMPI was developed by Hathaway and McKinley in 1943. The original test was comprised of 567 items and could be completed by both adolescents and adults. The psychiatric population used in the original study consisted of hospitalized patients at the University of Minnesota (U of M) hospitals. The control group represented "Minnesota normals" who were skilled or semi-skilled workers with an average 8th grade education; most came from a lower socio-economic background.

The primary goal of the instrument was to distinguish between sets of behaviors and attitudes that people with different psychological problems possessed and thus produce differential diagnoses. This objective was not completely met due to patients who often endorsed high scores on multiple scales. In the 1940s, the test consisted of basically four validity scales, 10 clinical scales, code-types,

and some supplementary measures. From the early 1940s until the 1980s, not much change was made in the MMPI.

In the mid-1980s, the U of M (which owns the instrument) appointed a committee to revise and renorm the MMPI. Butcher, Dahlstrom, Graham, Tellegen, and Kaemmer undertook this project and in 1989 introduced the MMPI-2. Changes in this edition of the test included the establishment of new norms, introducing new items via the Content Scales, adding additional validity scales (VRIN = Variable Response Inconsistency, TRIN = True Response Inconsistency, and backside F = Infrequency), as well as rewording some items and dropping others. The Clinical Scales and the code-types were left intact. Despite what seemed like major change, approximately 80% of the items remained the same from version 1 to version 2, attesting to the phenomenal job that Hathaway and McKinley did in the development of the original instrument. In 1992, an adolescent version (MMPI-A) was developed for 14-18-year olds. Creating a separate adolescent format ensured that items important to this population were included in the test (e.g., eating disorders, suicidality, use of alcohol and other drugs, and school problems, among others). In essence, the substitution of the MMPI-2 for the original version was fairly quickly accepted.

The next version of the MMPI came out in 2008, titled "The MMPI-2-RF" (RF stands for Restructured Form). Ben-Porath and Tellegen's goal in developing this version was to represent the "clinically significant substance of the MMPI-2 item pool" while having a test with better psychometric properties. By so doing, these authors hoped to improve the construct validity of the test. Changes included restructuring the clinical scales (resulting in the RC scales), adding additional validity scales, creating Higher-Order scales, and including specific problem scales related to somatic/cognitive, internalizing, externalizing, and interpersonal areas. Two interest scales and the revised PSY-5 scales were also added. In short, the MMPI-2-RF was a shorter version of the MMPI-2 (338 items) with 51 scales, but the elimination of the original clinical scales and code-types. The development of the MMPI-2-RF and its corresponding adolescent version did not invalidate the use of the MMPI-2 or the MMPI-A. Finally, in 2016, a revision of the MMPI-A (MMPI-A-RF) was released.

One of the weaknesses of the MMPI-2-RF was not updating the norms, along with failing to expand the MMPI-2 item pool. The goals of the MMPI-3 thus included establishing new norms and improving the content addressed through the test, since the United States (US) population had changed a great deal since the MMPI-2 was renormed. Issues that were examined included whether the response format should be changed from "true" or "false" to polytomous. Quickly the decision was made to retain the original way of responding. The wording of items was changed. For example, "I like to go to dances" became "I like dancing". Additional items were developed for areas that were insufficiently represented by the current item pool. Some of the Restructured Clinical Scales were shortened. Scales were developed related to Combined Response Inconsistency, Eating Concerns, Compulsivity, Impulsivity, and Self-Importance/Grandiosity. Other areas like Anxiety, Stress/Worry, and Interpersonal Passivity were substantially modified. Further, some scales from the previous version were dropped (e.g., Gastrointestinal Complaints and Headaches, Multiple Specific Fears, Aesthetic/Literary Interests, and Mechanical/Physical interests).

The third version of the MMPI-3 is now 335 items. Of this number, 220 represent original MMPI items, 47 of which have been revised for the MMPI-2 or MMPI-3. Another 43 MMPI-2 items were retained for version 3 with only 5 being revised. Finally, 72 new items were added. The reading level remains the same as the MMPI-2-RF, grade 4.5. The MMPI-3 represents a hierarchical set of scales with 10 validity scales, 3 Higher-Order Scales, 8 Restructured Clinical Scales, 26 Specific Problem Scales, as well as the Psy-5 Scales, updated for this version. The test is currently available in English,

Spanish, and French Canadian. As time permits, other language versions of the MMPI-3 will be made available by Pearson, Inc. who provides training on the test, as well as sells and distributes it. With the 3rd edition, comes another significant shift—in the past, test-takers had to identify as either "male" or "female," however, with this new version, the scores of examinees who identify as "transgender" will not be effected. Finally, as with other revisions of the test, the development of the MMPI-3 does not currently invalidate the use or rigor of the MMPI-2 or the MMPI-2-RF. In essence, only time and experience will help determine the sophistication of this new edition, as well as the continued usefulness of older versions of the MMPI.

Transitions and Opportunities: Teletherapy in the Era of COVID-19

Candice Maier

The COVID-19 epidemic and subsequent social distancing have changed the way MFTs provide clinical services to clients. While telehealth delivery for MFTs has been considered a specialized delivery service until recently, delivery in this modality is now a requisite of many MFTs who want to continue seeing their clients. I have had the honor and privilege of getting to witness some of the amazing work of our current student therapist interns at the Clinical Services Center via telehealth, as they work with clients remotely, in addition to balancing their caseload with in-person clients and off-site internships. In the meantime, I have also transitioned to telehealth, both as a therapist and as a supervisor. Our pandemic has forced our clinical trainees and supervisors—as well as trainees and therapists across the country and world—to transition to this new format in a relatively short amount of time. In addition, we are impacted by another pandemic: racial injustice (Twist, 2020). The reoccurring instances of racial injustice and violence in Minnesota, Wisconsin, and nationally, have led to a range of feelings including fear, anger, and despair among members of our MFT community. Terri Karis has taken the initiative to hold virtual meetings with current and former UW-Stout MFTs on learning how to navigate and deepen our racial conversations with our clients and one another. I am grateful and proud of the hard work of our faculty and students in having these crucial conversations. I am also appreciative of the tireless work of our staff that went into transitioning and implementing new safety measures in order to prepare our clinic and campus for the return of clients, employees, and students.

Back in April, I began working on two separate studies with colleagues on the experiences of both therapists and clients in receiving and conducting telehealth therapy since COVID-19. We used open-ended surveys to gather responses from 58 MFTs and 25 couples/families. We asked them what the process of transitioning to teletherapy has been like, any benefits they have found to engaging in teletherapy, the challenges they have experienced, and any advice they would give to other therapists and clients considering telehealth therapy in the future. We found that a majority of MFTs experienced a positive shift from in-person therapy to telehealth therapy (80% were at least slightly satisfied) and 74% reported they would be likely to continue providing teletherapy after the pandemic and social distancing regulations had ended. However, 72% of respondents still preferred traditional face-to-face therapy. MFTs talked about the challenges surrounding discomfort with family and children present, lack of privacy, increased distractions, and technology-related problems.

As for couples and families receiving teletherapy, thematic analyses revealed the following themes: (a) "making do" – an idiomatic expression used during World War II intended to provide people with tips on how to be frugal and creative with limited means (Magruder-Newman & Newman, 2018), (b)

emotional safety; as one participate stated, “I’m already in my safe place”, (c) practical benefits to participating in relational teletherapy from home, (d) logistical challenges for which telehealth therapists must attend to, and (e) that clients’ experiences hinged on therapists ability to accommodate to nuances in the new telehealth environment. Overall, participants’ experiences were reflected in a quote given by one participant: “It’s splendid once you grow into it”; teletherapy, while challenging at times, can provide surprising benefits. Both manuscripts are currently under review in the *Journal of Marital and Family Therapy*.

While we do not yet have an understanding of how the COVID-19 pandemic will impact our lives in long-standing ways, it is important to continue working on best practices and clear guidelines – such as research by colleague Markie Twist and others (Blumer et al., 2015) – to ensure clients’ needs are being met.

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Hungry? Angry? Lonely? Tired? Orgasmed?: H.A.L.T.O. Check

By: Markie L. C. Twist (she/they) and Guest Co-Author Coltan J. Schoenike (they/them)[1]

For years, one of the informal assessments I (MLCT) have done with clinical participants, and shared with students learning about clinical practice, is a H.A.L.T.O. check. The H.A.L.T.O check was an idea I developed while serving as a certified substance abuse counselor in my home state of Alaska. Indeed, I spent several years working with clients abusing opiates and polysubstances, as well as members of their relational systems. In addition, the growing awareness of H.A.L.T.O. means that newer therapists like myself (CJS) have been fortunate to have a H.A.L.T.O. check as part of my training, and I have been so grateful to have it in my metaphorical therapist tool box since my very first client.

H.A.L.T. is an acronym that stands for hungry-angry-lonely-tired. The first known reference to this acronym was in 1975 in the Alcoholics Anonymous (AA) World Services *Living Sober* publication

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by Barry Leach, who was himself an AA member. While H.A.L.T. is a self-care tool that has primarily been used in AA and other substance abuse treatment settings for decades (Melemis, 2015), it is also a tool that is easily portable and incredibly useful in everyday living, and thus with clinical participants across settings and presenting problems (Zomerland, 2014).

The application of this acronym in practice rests upon the Maslovian idea that most people can function pretty well as individuals and in their relationships, when their more fundamental needs are met. In other words, when they are not experiencing hunger, anger, loneliness, and/or tiredness. Through my experience working with clients and their relational systems in the context of substance abuse counseling and because of my sexological lens in practice, I added the O., which stands for orgasm, to the acronym--making it H.A.L.T.O. (Twist, 2013; 2019). Indeed, for many people, the need for physical intimacy and/or sexual release is just as much of a fundamental need as eating, sleeping, being free from anger, and experiencing social/human connection and secure attachment (Schoenike, 2020). A quick caveat to note regarding the addition of "O" to the acronym is that, unlike other needs in the acronym, orgasm as a need will be far more subjective from person to person. This is especially important to consider in the context of other factors like age, orientation, and/or trauma history. For instance, clinical participants who identify under the asexual umbrella and may experience sexual repulsion, individuals with a history of sexual trauma, and people who may be choosing to partake in complete celibacy for religious or other personal reasons may not see the O. as a part of their fundamental needs. Thus, with clinical participants when the O. specifically may not be applicable to them, the original H.A.L.T. acronym and related check may be a better fit for exploration of fundamental needs in real-time in-session.

When people start to become out of balance with these basic fundamental needs, it becomes very challenging for them to rationally handle their thoughts, feelings, and behaviors in real time. Indeed, most relatively healthy adult humans can manage one of these needs being out of balance for a short period of time, however, with two or more, most humans become less patient, less rational, more irritated--generally, just less healthy in that moment in time. For children/adolescents or adults who are recovering from out-of-control-substance-related behaviors, even being out of balance in one area can be enough to induce a melt-down in a kid or a relapse in a person's recovery.

When I (MLCT) work with clinical participants who are fighting with a partner, adolescent, friend, parent, loved one, significant other, and/or member of their relational system--whether they are disagreeing right in front of me in session in real time or are recounting a fight that happened outside of the clinical context, often a set of informal assessment questions I ask are from my H.A.L.T.O. check. I halt them and say something like, "I hear you disagreeing with each other and I just want to check in with you on your fundamental needs before we start delving into this disagreement further, because if two or more of your needs (when they are both adults not in recovery; or none if the clinical participant/s are in recovery or a younger human) are not met right in this moment, this might not be the best time to address this triggering conversation, as it is really hard to attend to our more significant issues and needs when our fundamental needs are not met." Then I ask the H.A.L.T.O. check:

H - Are you hungry?
A - Are you angry?
L - Are you lonely?
T - Are you tired?
O - Are you needing to orgasm?

If clinical participants respond with having all these needs met in the moment, then we continue discussing the disagreement. If they are non-recovering adults nor children/adolescents and have one or more need not being addressed in the immediacy, then we explore basic needs further before deciding whether or not this particular moment in time is going to be the most productive time to process disagreement. Here is the way such an exploration typically looks:

-If you are two or more, what can you do to address your H.A.L.T.O. check and related count right now:

- If the "H" is the issue, maybe it is time to eat a little snack or drink a little water?
- If the "A" is the problem, maybe take deep breaths, relax your body, or go for a quick walk?
- If the "L" is the concern, maybe we can do some quick warm-up exercises via clinical frameworks like emotionally-focused therapy (Johnson & Greenberg, 1985), the crucible model (Schnarch, 1991), or via techniques from the studied principles that make marriages work (Gottman & Silver, 1999)--all of which focus on attachment and turning towards each other?
- If the "T" or the "O" are an issue, maybe we need to save the dialogue around the disagreement, because it is difficult to do something about being tired in session in real time and it would be unethical to do something about needing a sexual release while in a therapy session?

Since more time of clinical participant/s is spent outside of the actual therapy room during the week--167 to 166 hours are spent in-between therapy sessions while a only a mere one to two hours are spent actually in therapy--it is helpful to give participants tools to take with them in-between sessions. Thus, once I (MLCT) go over the H.A.L.T.O. check with clinical participants, I encourage them to take it home as a tool to use when they notice they are going down a spiral into disagreeing, becoming frustrated, experiencing a loss of patience, etc. I suggest that as they start noticing these kinds of downward spirals, that they halt and do a H.A.L.T.O. check before continuing to engage with each other. I further suggest that if one or more of these needs are not being met at that moment, that they disengage in the downward spiraling exchange as soon as possible. I then invite them to re-engage after they have better met their fundamental needs. Even further, it can be beneficial for clinical participants to explore the use of this tool as a way that they can be more preventative and move beyond a "damage control" mentality through finding ways to maintain their H.A.L.T.O. levels more consistently rather than being aware of them after the fact and having to correct or curtail them once there is a problem.

For decades clinical, educational, and supervisory participants alike have found the H.A.L.T.O. check to be incredibly simple and helpful. I know for me (CJS) it has been a welcomed tool in working with my clinical participants during both my therapy internship and practicum, as well as in my work as a teaching assistant with educational participants. I have also found that, philosophically, it has been so powerful that I decided to reference it in my book about baking, self-love/care, relationships, and social justice, *Spread love (and buttercream!)*, that is slated to be released in December of 2020. We now invite you to halt and try the H.A.L.T.O. check out in your own work, as well.

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Tale of a Qualitative Study

Guest Author Manju Chawla[2]

Qualitative research can provide in-depth information on a specific research topic which focuses on gaining information from the perspective of the individuals participating in the study (Hall & Harvey, 2018). It also gives the researcher an opportunity to understand the nuances between the individuals and helps with identifying a diverse perspective on the topic of research. For this issue of *The MFT Courier*, I wanted to discuss my own experience of conducting a qualitative study for my dissertation manuscript, challenges that I faced while collecting the data, and how the process helped me appreciate the process of qualitative research, which is different from the viewpoint of quantitative numbers.

Let me give you some back story of why I chose a particular topic for my qualitative research. I spent most of my childhood in a small town in rural India in the state of Punjab, before my family moved to a bigger city. But my desire to stay in touch with my rural self always made me revisit the place during our summer holidays. That is partly the reason I joined a State Agricultural University in my hometown for my college education. Because it was an Agricultural University, I had ample opportunities to do volunteer work with the rural community. During my second year of undergraduate study, I was part of the National Service Program working in a village, where we held a drug awareness campaign for the schools and village community. That was my first encounter with the problem of drug use in the state of Punjab. For my next two years, I did not think much about the problem of drug use before I started working in the RAWE (Rural Awareness Work Experience) program as part of undergraduate community project. For this program, we selected a village and were given a couple of families to work with for three months. The goal was to help those families with skills that could be beneficial for them such as budgeting, creating awareness about women empowerment, weaving skills, entrepreneur skills, ideas of small businesses, and others. The people in the rural community were extremely warm and welcoming and they treated all the students as part of their family. During those three months, I met other families in that village who were dealing with

[2]Our guest author is one of our colleagues--Manju Chawla, Ph.D., who is an Assistant Professor in the Human Development and Family Studies Department at the University of Wisconsin-Stout, Menomonie, WI, USA. Email: chawlam@uwstout.edu.

the addiction of a family member. Few of the drug users were 18 or younger. I realized that the users and families had next to no resources to deal with the situation and whenever there is conversation about it, people tried to ignore it. Because I had started to know some of the family members personally, it was painful to see the helplessness and distress they were enduring due their family members' addiction. This motivated me to gain more knowledge about the issue of substance use in Punjab and to create more awareness to provide better resources to the rural population (since it can be an easily forgotten population). Fast forward to my doctoral program at Texas Tech University, I got a dissertation fellowship and I decided to go to India to conduct research on drug use in rural Punjab. I wanted to get a better perspective of the issue from the lens of the substance users, so I decided to use an exploratory approach using a qualitative method.

The prevalence and patterns of drug use in India vary among rural and urban populations. The majority of users in Punjab fall between the ages of 15-35 years and most of them are unemployed, and school dropouts. Every third male and every tenth female in Punjab has used drugs on some occasion in their lives (Phillip, 2007; Yardley, 2012), and despite the alarming increase in consumption of drugs in rural India, there is a scarcity of data related to the factors associated with substance use. Keeping that in mind, the goal of my study was to identify the factors associated with the drug use among youth in rural Punjab, and the resources that can be beneficial to the community to overcome addiction. In my knowledge, this is the first qualitative study that has been done to report the drug use in rural North India.

When I began the research, I had anticipated the challenges that I could encounter such as building rapport with the participants and/or creating a safe space to conduct the interviews. But, as I progressed in my research, I encountered additional challenges. For instance, it was difficult to build trust with the community, because for them, I was an NRI (Non-Resident of India) and they believed that they could get in trouble if they open up about their addiction. Substance use is highly stigmatized in India and families would rather keep it behind the doors to avoid community shaming. After talking to community leaders and a brief discussion with the village residents, I was able to recruit my first few participants for the study. But recruitment and conducting interviews were two entirely different tasks. Sometimes people would agree to participate and then would call me saying that their parents do not approve of their participation. I interviewed thirteen people for my study and 10 of them were from lower socioeconomic status (SES). It was interesting to see the refusal of people from middle or higher SES to participate in the study. Some of my participants mentioned that they knew that half of the youth of the village (from middle and higher SES families) was drug addicted, but would never come out, since it would bring disgrace to their families if they publicly accepted their addiction. It was also interesting to see that no woman participant came forward to participate in the study, which I was not surprised by, as drug use in women is the least talked about use in India. This does not mean that women do not use, but the use is frowned upon to another level when a woman is involved.

Another challenge that I faced was to get a hold of the participants because of their drug use. There were times when I would schedule the interviews and participants would not show up, often because they had used drugs that morning and would have no clue about their own whereabouts and it was hard for me to reach them. But in some of those participants, I saw a great desire to share their story. They would come back again to meet with me to schedule another appointment and would assure that they would come this time. What I saw in these participants was a mixture of helplessness and hope. They felt helpless because of their addiction, but they also wanted to overcome that addiction and participation in this study meant a lot to them.

All my participants showed a strong desire to overcome addiction but felt clueless about the process. More than 40% of them had tried taking help from de-addiction centers, but the outcomes were not promising. They either felt tortured at the center or they relapsed as soon as they were out, because of lack of support from the community afterwards. Some of the statements I received from my participants were:

> "There is no benefit of going to the centers because I have seen many of my friends going to the centers, but they gained nothing out of it."- [P1]
>
> "When people get out of control or show withdrawal effects, the officers in the center beat them, or ask them to divert their minds by doing some sort of work like mow the lawn or helping in the kitchen. If the person still doesn't listen, they embarrass you in front of others."- [P2]
>
> "It's just that when you come out of the center, you hang-out with the same people and people wouldn't let you quit the habit."- [P3]

When I first began the interview process, it was an overwhelming experience for me. When conducting the survey, the researcher does not meet with the participants, but in in-depth interviews, the researcher gets to meet with the participants, see them in their raw emotional states, especially when talking about something as personal and vulnerable as their addiction. Talking to people with addiction gave me an opportunity to understand the other side of the story of addiction (from the lens of the users), which would have been impossible for me to see as an outsider. What have I found? More than I had imagined gaining from a study. Other than data, I gained perspectives on lives of people living with addiction and their everyday struggle they face because of it. Participants mentioned various factors that were originators of their drug use such as 'trying for fun with a friend, trying to cope up from family conflicts, being part of a profession where drug use is normative, constant pressure from peers to fit in, unemployment,' and so on. Participants also mentioned how unprepared family and community is when it comes to support and help for an addict. Although participants in the current study reported some success rates of abstinence while in the centers, the perception of relapse after the center was consistent across participants. They believed that although patients would be sober in the centers, they are emotionally not ready to face the situation when they come back to the same village and routine. People do not trust them and addicts themselves do not trust themselves. Participants mentioned that addicts are going through a lot of pressure, because of the burden of their habits and putting more stress on them to quit drugs and humiliating or insulting them in front of others would not help them. Instead, creating an environment of trust and support might help them to quit the drug-related habits.

Conducting a qualitative research has helped me obtain a deeper understanding of "why" and "how" behind the problem of drug use. I am in the process of publishing the research to discuss the results of my study in detail. My goal is to shed some light on the issue of drug use in rural India from the users' perspective. I hope that more studies like this can help the professionals to incorporate required steps to create more awareness about the issue, and to provide more resources to the community and the families so that they can support and help people with addiction.

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The Office

Karen Sinz, Clinic Manager

I really do not know where to begin, but I will try. Due to COVID-19, in March the clinic was forced to move in a futurist direction, even though I had no idea what it would look like:

- Paper files to electronic records
- In-person therapy to telehealth
- Changing further to Telehealth schedules on Mondays and in-person sessions on Tuesdays
- Clients paying cash or check only, immediately after their session, to credit charge payments through Shoppes@Stout on any given day
- In-person staffing is now via a computer platform
- Therapist and I working from home and/or in the office
- A live calendar with updates happening any time of the day
- Superbills replaced with handwritten receipts
- "Love Notes" to email messages

As you read this, you can see our office practices have changed immensely. Most of this came to me quickly and along with hours of technology issues. To be honest, I cried many days, I screamed, I danced to loud hard rock music in my kitchen, and even started cocktail hour mid-afternoons on a few occasions. I had to change and do my job in a reactive way, instead of a proactive way. BUT with all this said, these profound changes have helped me personally realize that reactive is not that bad. All my years of worrying, trying to figure out every why, how, who, and when before it happened caused me much undue stress. I now realize that living reactively is okay. Change is not bad; it is just simply different. The new way of doing office practices are not less effective, they are just unfamiliar. I would go as far as to say although these changes have been challenging, I think they have been great for me personally and will be great for the future of our clinic. Stay safe.

HELP

Below are alumni that we are not able to contact by e-mail or US mail anymore. If you know of their current addresses, e-mail address or phone numbers, please let me know. They are not receiving this newsletter, and we sure would like them to!

Richards Alberts	Craig Amoth	Robert A Anderson	David R Bauer
Van Bredeson	Jeff Buikema	Linda Cherney	Judith Chido
Elsa Correalis-Rodriquez	Sven Daelemans	Jams Davis	Barbara Dopp
Karen East	Harry Ford	Sharon Gilles	John Geary
Margo House	Joseph Irvin	Cynthia Hirsch	Carol Johnson
Christine Johnson	Steven Johnson	Kenneth Jaslow	Joe Kirchner

Pamela McConnell	Paul McKenzie	Kathleen Moses	Donald Kube
Dane Paulson	Carolyn Pela	Mary Ann Reese	Mary Reynolds
Nancy Richson	Thomas Roberts	Marquita Ryan	Norma Schenck-Atchison
Blythe Ann Smith	Jay Stanish	Kathy Storandt	Toby Taubenheim
Charles Thesing	Patricia Walsh	Henry Wich	Denise Wildcat
Raymond Wreford			

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Please email Karen (sinzk@uwstout.edu) with your current email and mailing address & phone numbers. Even though we are sending out *The MFT Courier* electronically, we do keep a mailing address data base for all our alumni. We do not want to lose you. Also, if you receive the *MFT Courier* via email but would prefer a hard copy sent via U.S. mail, please let Karen know.

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