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ABSTRACT

This paper describes four elements of a leadership training program in alcoholism that distinguish it from other postgraduate programs. These four elements are: (1) clinical teams composed of and led by trainees with leadership rotating periodically among trainees; (2) weekly experience group meetings of each team to maximize understanding at affective and cognitive levels the processes affecting team functioning; (3) small group exercises which allow teams to examine the effect of structural and social definitions of the group on its function, independent of the individuals and personalities involved; and (4) the planning, development and executing of projects with an administrative or program development purpose. The author strongly urges that current short-term courses be modified, wherever possible, so as to include exposure to patients or clients, even if it means reduction in the didactic content of the seminar or institute. (Author/BW)

A Leadership Training Program in Alcoholism: Content

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A neglected aspect in the search for workable answers to providing and delivering adequate comprehensive services to alcoholics and their families resides in leadership: that is, comprehensive mastery of theories and knowledge about alcohol and alcoholism, integrated with delivery systems, research, and education. In a recent experimental program at Massachusetts General Hospital-Harvard Medical School to train leaders in the field of alcoholism the raw training materials were nurses, physicians, psychiatrists, psychologists, and social workers who had already received the basic training of their respective professions and disciplines. They were recruited from those people who exhibited interest in a career of service to alcoholics and other socially problematic groups, aspired to be leaders in their field, and who possessed qualities essential to leadership: grasp, intelligence, mastery of content, interpersonal and group skills, and a sense of mission. The raw teaching materials was composed of a group of dedicated and experienced social scientists and senior clinicians who were either thoroughly conversant with the alcoholism field or who possessed competencies appropriate to train people as leaders: administrative, human relations, small group, program development, and research skills. This training staff was complemented by the alcoholics and their families seen in health, social welfare, correctional, industrial, and other community agencies that run the gamut

of facilities where alcoholics may be served. The trainees, trainers, and alcoholics were brought together for a year to work within a flexibly-structured framework, some of the particulars of which form new departures from usual training efforts. The purpose of this paper is to describe four elements of the program that distinguish it from other postgraduate programs: (1) clinical teams composed of and led by trainees with leadership rotating periodically among trainees; (2) weekly experience group meetings of each team to understand at affective and cognitive levels processes affecting team functioning; (3) small group exercises which allowed teams to examine the effect of structural and social definitions of the group on its function, independent of the individuals and personalities involved; and (4) the planning, development and executing of projects with an administrative or program development purpose.

1. Rotating Team Leadership

Under the technique of rotating team leaders, training fellows were divided into two clinical teams. Each was composed of a nurse, physician or psychiatrist, psychologist, social worker, and three clinical assistants. Every ten weeks the team leader was changed so that, in the course of the year, each professional member had an opportunity to exercise his or her leadership capacities in a group with defined clinical responsibilities.

The decision to use this technique as a core element in the program grew out of several considerations. First, leadership roles in the alcoholism area have never devolved on members of a single profession or discipline. Indeed, work in alcoholism has for many decades assumed a distinctively multidisciplinary cast. Second, the mental health field

generally has begun to discard the notion that a specific professional background is necessary to leadership (although vested professional interests impede the progress of this reform). Further, and perhaps most important, is the fact that mental health personnel, out of choice or pressure, take on leadership functions without specific training as leaders. Assumption and delegation of authority and responsibility, making policy decisions, handling personnel problems, working with other organizational components and so on, often produce anxiety and consequent over-assertiveness, passivity, rigidity or disorganization in newly appointed leaders. If a leader fails to resolve initial anxiety about assuming leadership, these trends may become permanent work habits deleterious to effective leadership, so affecting the entire system negatively. The rotating team leader technique provides leadership in vivo under supervision and with the opportunity to understand the dynamics underlying assumption of leadership.

In the organization of the teams, there was no training staff member who supervised the team as a unit (although each member had an individual supervisor who aided in coordinating the trainee's program). We felt that a faculty team supervisor might well become, or be seen as, the de facto leader of the team, with the fellow-leader being no more than a nominal leader. Such a situation might subvert the aims of leadership training. As expected, each team developed its own philosophy and program of care guided by the leader of the team and tempered by his personal supervision and the didactic aspects of the program.

Individual supervision was Socratic rather than authoritative, idiosyncratic patterns of leadership and of team functioning were encouraged.

Obviously deleterious patterns of care were not accepted but trainees were given broad latitude in team development of unique approaches to patient care. During his tenure as leader the fellow could allocate responsibilities as he saw fit, with authority to make final decisions. In situations involving presumed or real medical-legal issues, the physician member of the team could veto the decision of a nonmedically trained leader, subject to review in the presence of all team members by the program director.

For one day each week the team was responsible for the evaluation of patients including alcoholics who came to the Evaluation Center of the Psychiatry Clinics. The center has 16,000 patient visits per year, approximately one-third of which involved alcohol-related problems. In addition to initial evaluations the team was responsible for continued evaluation of cases accepted by them and accepting referrals from medical and surgical wards of the hospital. Each team member followed a number of cases in casework, psychotherapy, or group therapy.

This approach to training is frankly experimental. It requires control sufficient to insure that patients are not endangered and freedom sufficient to permit professional growth, particularly in leadership areas. Techniques of control included individual supervision, meetings of the team with a faculty member whose skills resided in program planning and development, and ventilation and understanding of feelings in a group setting. Techniques of freedom included rotating fellow leadership and turning over of clinical responsibilities to the team. Despite considerable criticism by the fellows, they consistently rated the leadership experience high in their evaluation of the program.

2. Experience Groups

The rotating leadership approach, which cuts across professional identities and medical-non-medical differences, naturally provokes tension and anxiety, and may have several consequences, such as, the formation of informal cliques and clandestine power struggles that have little to do with rational issues but which can affect team functioning and care of alcoholics. In order to cope with these conflicts and to be able to take them into account in leadership and team actions, the membership of each team met weekly as a group with an expert in group dynamics. One purpose of the group was to identify and understand nonprofessional impediments to team function and effective patient care. Another was to help the fellows utilize themselves as tools in their work through increased self-awareness. In order to accomplish these goals, the group developed in an unstructured manner using the training model for group psychotherapy students. The experience group was an educational group with a mutual agreement between leader and fellows to focus and work on problems of group functioning with a goal of understanding the group process. The pursuit of understanding of group interaction was emphasized and revelation of personal material was incidental. In this sense, the group experience was not psychotherapy where the basic agreement between patient and doctor is to form a partnership to understand and work through personal pains and problems that the patient brings to the treatment situation. The leader's orientation to the training group was that explicit references to the content of the field of alcoholism were neither necessary nor desirable, but that increased understanding of one human being for another results in increased understanding and sensitivity in work

with patients.

One would expect that the group would move from a position of separateness and distance to one of closeness, intimacy and sharing; from a position of stereotype and prejudice to one of understanding and appreciation. These goals were attained in high degree. For most members there was a distinct change in their attitudes and work with alcoholics and with each other.

During the program's operation, it was clear to both trainees and staff that the group served an important function as a safety valve, providing an outlet for the inevitable disappointments and frustrations involved in a training program especially of the sort described here. The group served to make explicit and to facilitate dissolution of tensions that arose out of the operation of the rotating team leader concept.

3. Small Group Exercises

The use of interdisciplinary teams with rotating leaders brought into focus structural and organizational problems germane to leadership in general. Some of these problems revolve around issues of leadership and role conflict, decision making, planning work, intergroup conflict, and fitting team structure into a larger service structure. While the list is not exhaustive, it distils extensive discussions with members and leaders of the teams in the program.

In the second year of the program, a series of group exercises were constructed specifically to permit the fellows to come to grips with these issues from a perspective different from that provided either by team functioning in the Evaluation Center or in the experience group. Although the experience groups were excellent in providing a place to work on

interpersonal, affective issues, the small group exercises allowed the teams to focus on their own structure and process of functioning independent of the individuals and personalities involved.

As a result of meetings and discussions held with representatives of each team, a weekend workshop was planned with exercises focusing on issues of group decision-making, planning work for others to carry out, intergroup conflict, and role conflict in interdisciplinary teams. The workshop was led by a National Training Laboratories expert. The weekend was divided into four one-half day sessions, each session focusing on one of the above issues. Sufficient time was provided for follow-up and discussion after each exercise. Illustrative examples are the exercises on the dynamics of decision-making and planning work for others.

The exercise involving group decision-making is a simple task which convincingly illustrates many of the issues related to the problems of decision-making for a group. Each fellow was asked to rank 15 items of space equipment in order of their importance for survival on the moon. None of the fellows had any more knowledge than any of the others in the task area, nor were they personally or professionally involved with the content. The fellows were then asked to go as teams to separate rooms for a specified period to reach team decisions on the ranking task and to complete a questionnaire on their satisfaction with the process. At the end of this period, the teams were given results of their performance as individuals and as a team, compared to a standard based on a NASA ranking decision-making process. Finally, the two teams were brought together to discuss the relationship of their process to the accuracy of their ranking.

The teams saw that they had gone about things in different ways. One team had established a task-oriented procedure and had quelled any individual disagreements in order to reach decisions. This team did significantly better in ranking as a team than they did as individuals. They also had a significantly lower error score than the other team. In comparison with the other team, the members of this team reported lower satisfaction with their participation, team recognition of their contribution as individuals, and the opportunity for them to exert influence in decision-making. The second team spent a great deal of time getting dissident members to agree to particular rankings and refused to proceed until all members had agreed to the decision. This team was able to relate its concern for agreement of all members to its lower accuracy and to its higher level of member satisfaction.

Another exercise revolved around the task of planning work for others. The whole group was divided into ten planners and six operators. The operators were sent into another room and told that the planners would plan work for them, and that they might be called in at any time, but that if at the end of 55 minutes they had not been called, they were to go to the planning room. The planners were given a sample problem to solve with the instructions that they had an hour to solve the problem and teach the procedure to the operators so that the operators could solve a similar problem. The problem was a moderately complex logical exercise that involved the discovery that a matrix solution was the most reasonable way of proceeding. It is important to note that no skills in matrix algebra were required, but that the solution rested in the use of basic rules of logic.

This exercise demonstrated dramatically to the participants that people impose their own structure on such a situation and that the task does not determine the process. The most efficient way for the planners to teach the solution would have been to invite the operators in at the beginning. The operators could have gone, on their own, to the planners' room. It was the case that each group invented rules that would not allow them to do this. The planners saw themselves in positions of authority in which they had to demonstrate competence and not "confuse the operators." The operators saw themselves as underlings at the mercy of the planners, with no capacity to initiate action.

Feelings in the operators' room became increasingly angry, suspicious, and resentful, while in the planners' room, task-orientation was a dominant theme, accompanied by concerned, paternalistic attitudes. Never did the operators think of going to the planners' room; rather they began to express fantasies of being deceived and manipulated by the planners. The planners finally called the operators in after 50 minutes and were dismayed to find anger and resistance to their attempts to teach the procedure for solving problems. When the operators were given their problem, they worked quickly to the solution.

The subsequent discussion illuminated several aspects of group process. A cultural definition of manager-worker or teacher-student (or doctor-patient) relation had been adopted by both groups, such that the planners must necessarily maintain prestige. The lack of structure for the operators made it necessary for them to impose structure and generate a strong group feeling which led to their ability to work efficiently. The structure imposed by the groups did not, however, lead to the most

economical way of proceeding. Issues related to the importance of communication, the removal of ambiguity, and the necessity for participation of both parties were seen clearly and dramatically.

These descriptions illustrate the immediate impact and relevance of the workshop. In order to insure the use of knowledge gained in these sessions, two follow-up periods were held. The first dealt with discussion of ways of implementing new methods of team operation, and the second dealt with the actual trial of these methods in a role playing situation. The teams reported a high level of involvement with all of the sessions. Members further stated that positive changes in team function had occurred. Some of these were: greater participation of clinical assistants; more attempts to involve assistants in decisions; attempts to involve hospital staff who were not members of the training program in treatment of alcoholics; and increased cooperation from these staff members. There is no doubt that these exercises added considerably to the total training effort.

4. Administrative-Program Development Projects

As part of his activities, each fellow was required to complete a project in the area of administration or program planning and development. The topic of the project was selected by the fellow in conjunction with his discussions with the coordinator of the training program. The setting up of treatment or training programs in the field of alcoholism, the consulting process with existing agencies treating an alcoholic population, the problems of integrating treatment modalities and personnel from different professional backgrounds, and other issues of a similar nature were considered topics suitable for the project.

Among the projects submitted in the first year of the program was one in which a didactic group therapy program was designed and implemented; another which developed a routine radiologic and tuberculin testing service to screen alcoholic out-patients for tuberculosis and other pulmonary problems; a third which involved preparation of an orientation program for new employees of a community health service; and the writing of curricular materials for the alcohol unit of public school health courses from kindergarten through high school.

During the second year projects reflected an increased emphasis on relations with community agencies. They can be categorized into two groups: those that described problems and issues in consulting with community agencies and those dealing with setting up programs. One fellow presented an analytic study of his consulting relationship with a state agency treating young people with alcohol and drug problems. Another study dealt with consultation with a social service agency in the black community and a women's prison outside of Boston. Both of these institutions have many clients and inmates with severe drinking problems.

Projects dealing with the setting-up of programs included analytic studies of the process of designing and conducting an institute for training practitioners in the field of alcoholism; establishing and operating a drop-in center; and starting a detoxification unit.

Conclusions

In the foregoing, we have described several aspects of a program to train leaders in the alcoholism field. The aspects were chosen to convey a sense of the experimental and, we hope, innovative nature of

the program. In reviewing two years of operation of the program, other directions have suggested themselves to us which we would like to mention here as ideas to be implemented in the future. One set of ideas has to do with what might be called the technical side of the training process, while the second might appropriately be considered with the organization of training efforts.

Technical improvements considered have primarily to do with training leaders. We were not completely satisfied with the operation of the rotating team leader concept, primarily because it had an artificial quality, occurring as it did within the structure of an evaluation center where procedures and practices were established and where the scope for initiating changes in clinical procedures was in fact rather limited. The leaders in training thus had relatively little leverage to move in directions of their own choosing. Activities of teams should take place in settings where the possibility of change is in fact real; or in settings where individual trainees can indeed participate in administrative or leadership activities, such as, helping to draft and implement legislation; or working with a community to establish a treatment program; or with a school system in developing an alcohol education program.

With regard to the organization of training, leadership training should be broadened to include members of other professions and occupations; educational requirements should be more flexible so as to include the experienced but less educated worker in the alcoholic field.

Our experience with the training-within-training technique (described by Rivers) indicated the value of short-term programs that include clinical practice and consultation to the trainees' agency or institution. We

strongly urge that current short-term courses be modified, wherever possible, so as to include exposure to patients or clients, even if it means reduction in the didactic content of the seminar or institute.

13