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Where Reflection & Practice Meet

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PRAXIS

Where Reflection & Practice Meet

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Mission Statement

The School of Social Work at Loyola University Chicago created *Praxis: Where Reflection & Practice Meet* to give voice to the scholarly work of students and alumni. Our mission is to encourage and support the development of social work knowledge that will enhance the lives of the clients we serve, embody the humanistic values of our profession, and promote social justice and care for vulnerable populations. *Praxis* respects and welcomes all viewpoints.

Editorial Policy

Praxis is published by students in the School of Social Work at Loyola University Chicago. The editorial board is composed of masters and doctoral social work students. The board encourages students and alumni of the School of Social Work to submit papers that provide insight into clinical, policy, research, education and other areas relevant to social work practice. Submissions are accepted throughout the year and the priority deadline for the annual Fall publication is the last day of January editorial board and edits accepted papers with permission from the authors. Papers should be no longer than 20 double-spaced pages and submitted as a Microsoft Word document file (.doc). All identifying information, including contact information, should be on a separate page. Responsibility for accuracy of information contained in written submissions rests solely with the authors. Opinions expressed in the journal are those of the authors and do not necessarily reflect the views of the School of Social Work or the Editorial Board.

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EDITORIAL

The Uniqueness of Social Work Practice

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation.

~NASW Code of Ethics, 2008, preamble

I began teaching this year in both the BSW and MSW programs at Loyola. Teaching foundation level courses in these programs has encouraged me to further reflect on the uniqueness of the field of social work and what it means to be a social worker. A social work degree prepares an individual to intervene and effect change with individuals, families, communities, and at the policy level. Within these practice areas, social workers intervene with people of all ages, from all areas of the world, and with many different types of problems. How many other professions aim to make changes in so many different ways?

A historic and defining feature of social work is the profession's focus on individual wellbeing in a social context and the wellbeing of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living. (NASW Code of Ethics, 2008, preamble)

The person-in-environment focus allows social workers to practice in a wide variety of arenas, as interventions are specific to the client's social environment. As seen above in the preamble from the NASW Code of Ethics (2008), social workers look at wellbeing within the individual's environment. The articles in this volume of *Praxis* reflect this aspect of social work practice. The articles address many different problems various populations face and provide suggestions on how social workers can better assist these populations.

Allison Tan opens the volume with a discussion of integrating spirituality into social work practice, including ways for social workers to approach the subject with their clients. Spirituality is also an important part of a social work assessment (the bio-psycho-social-spiritual assessment) and so it is important that social workers are prepared to discuss this topic with their clients. Next, Kristen Brendel makes a compelling case for the incorporation of meditation into social work practice with clients since there is an evidence base for the effectiveness of meditation in treating certain problems. Aimee Hilado then presents a framework for working with refugees who have experienced trauma. Many refugees come to the United States suffering from trauma and it is vital that social workers are able to assist refugee populations.

Ashley Kappmeyer presents a very timely argument for a mandatory vaccination policy for healthcare workers. With the growing aging population, Robert Smith, Brittany Thomas, Emily Shubeck, Sarah Greenwald and Justin Baker recognized the need for services for this population and created a model support group for significant others that serve as caregivers for individuals with Alzheimer's disease. Next, Liza Brockway and Hilary Currin present culturally appropriate treatment methods for Latinas who have been trafficked into sex work.

Many students at Loyola are taking courses in substance abuse as part of the new CADAC program offered in the School of Social Work. Amanda Russell is one of these students and discusses Housing First and Harm Reduction

models as effective substance abuse treatments for individuals who are homeless, compared to abstinence-based treatments. Finally, this volume closes with Jeffrey Zacharias's policy piece addressing the bullying of Gay, Lesbian, Bisexual, Transgender, Questioning and Intersex (GLBTQI) adolescents in the school system.

As I am writing this editorial, I am reflecting on what a time of great transition this is for me. Not only am I preparing to finish up as editor of Praxis, but I am also preparing to complete the doctoral program. I have been a student at Loyola since 2000 and in the School of Social Work since 2004, and so it is bittersweet to think about my time as a student ending. I have begun the transition from student to teacher this year and am looking forward to a career in academia where I will always be learning and sharing knowledge with others.

I am excited to pass on the editorship to Allison Tan, who wrote the lead article and was instrumental in preparing this volume for publication. I am confident she will do an excellent job as editor. I would like to thank my doctoral cohort and dissertation committee for their immense support during the last few years. I am very grateful for all I have learned from them. I would also like to thank Dr. Rasheed for her guidance as faculty liaison and Dean Wall for his continued support of Praxis.

It is my hope that this volume will portray the uniqueness of social work practice through the variety of topics addressed by students in the School of Social Work. I believe the volume is a great representation of all that social workers can do.

Deanna D'Amico Guthrie, MSW, LCSW
Doctoral Candidate
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Our Clients' Spirituality...and Our Own: Implications for Best Practices in Social Work

By Allison Tan

Abstract

Many social workers avoid discussing religion and spirituality with their clients. This paper challenges social work practitioners to consider why and how to integrate both the clients' spirituality and our own into practice in appropriate and beneficial ways. Utilizing relevant literature, the author seeks to answer three questions important to social work practitioners: Why should I integrate spirituality into my practice? How do I talk about spirituality with my clients? And how does my own spirituality influence my practice? The author addresses the challenging scenario that arises when the social worker is faced with a client that maintains strongly discordant beliefs from his or her own. Implications for assessment, intervention, further research, and social work education are provided.

Introduction

The 2009 Harris Poll reported that 82% of Americans polled believe in God (Harris Interactive, 2009). Hodge (2001), reported similar numbers: 72% of those polled agreed with the statement, "My whole life is based on my religion." For 40% of respondents, spirituality was the most important aspect of their existence. This study found these rates to be even higher within communities of color. The pervasiveness of religion and spirituality in American life suggests that it is of critical importance for social work practitioners to integrate spirituality into their social work practice. Yet, social workers often struggle with how to competently address religion and spirituality with clients.

No matter what the reasons for our hesitancy to bring religion and spirituality into the practice setting, it is the aim of this paper to challenge social work practitioners to consider why and how to integrate both the clients' spirituality and our own into practice in appropriate and beneficial ways.

Before we can integrate spirituality into our practice, we must understand what religion and

spirituality are—particularly, how they differ from each other. Cascio (1998) describes religion and spirituality as 'twin issues'. While this label suggests strong similarities and overlap between religion and spirituality, which certainly do exist, there are a few basic distinctions between the two concepts. For the purposes of this paper "religion" and "spirituality" are considered according to the definitions stated by Sheridan (2004): *Religion* is "an organized structured set of beliefs and practices shared by a community, related to spirituality" (p. 6). *Spirituality* involves "the search for meaning, purpose, and connection with self, others, the universe, and ultimate reality, however one understands it, which may or may not be expressed through religious forms or institutions" (p. 7). The important distinction in these definitions centers around the organized, structural components of 'religion' as opposed to the highly personal nature of 'spirituality'.

Why Should I Integrate My Clients' Spirituality?

The guidance provided by social work resources is an excellent starting point for answering this first question: Why should I integrate my client's spirituality into my practice with him or her? Both religion and spirituality are addressed in the V-code, V62.89, in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), which reads:

This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning or spiritual values that may not necessarily be related to an organized church or religious institution. (p. 741)

Inclusion of this diagnostic V-code indicates the profession's validation of religion and spirituality as

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sources of presenting problems and solutions in practice. For some practitioners, the acceptance of "religious" and "spiritual" alike within diagnostic criteria may be enough to encourage integration.

For other practitioners, a broader answer to the "why" question may be needed. The saliency of religion and spirituality in American life indicates the importance of integrating spirituality into social work practice. Such integration is part of a strong, holistic bio-psycho-social-spiritual perspective in assessment and treatment (Cascio, 1998; Openshaw & Harr, 2005; Zapf, 2003). Virginia Satir argues in favor of spiritual assessment in her model of holistic assessment, stating that spirituality "is our connection to the universe and is basic to our existence, and therefore is essential to our therapeutic context" (as cited in Cascio, 1998, p. 527). Another related way of considering the integration of spirituality into practice may be to view one's spirituality as an aspect of client diversity (Openshaw & Harr, 2005; Rey, 1997). Social work practitioners are generally in consensus on the critical importance of valuing all aspects of client diversity.

The most convincing reason for the integration of spirituality into social work practice may be the potential one's spirituality holds as a key source of strength (Cascio, 1998; Gotterer, 2001; Hodge, 2001; Openshaw & Harr, 2005). For many clients, with estimates between 43 and 62% (Sheridan, 2004), religion and spirituality are identified as playing highly beneficial roles in their lives. Spirituality has a role in affecting vital areas of client functioning, including one's meaning in life, values, morality, organization of the universe, understanding of suffering, peace, and transcendence (Northcut, 2000). One atheistic social work practitioner makes a logical case for integrating spirituality into practice:

A sensible clinician, whether or not he or she is spiritual in any way, will realize that any purpose-giving, optimistic belief system that is relevant to a client, must, as a matter of sound practice, be acknowledged, explored, and reasonably integrated into the clinical process. (Hoyt, 2008, p. 225)

Spirituality's salience has been noted in many positive mental health outcomes, including improved coping ability; self-esteem; realization of personal strengths; and recovery from crisis situations including divorce, homelessness, sexual assault, and substance abuse (Hodge, 2001). These findings are based on the

literature showing participation in a faith-based community to be a strength for individuals in counseling (Calhoun-Brown, 1998; Cohen, Doyle, Skoner, Rabin, & Gwaltney, 1997; Ellison & George, 1994). Additionally, research has indicated that individuals who hold a spiritual belief system benefit from this cognitive schema in their handling of crisis and coping strategies (Ellison & Levin, 1998). Therefore, the call to integrate the client's spirituality into competent social work practice becomes nearly essential. However, more research into these findings is needed in order to develop empirically-supported evidence-based practices for incorporating spirituality into aspects of clinical social work practice.

How Do I Talk about Spirituality with my Clients?

One study (Sheridan, 2004) suggests practitioners are integrating spirituality into practice. Given a list of 22 "spiritually-derived techniques" (recommending spiritual books, praying publicly or privately for a client, recommending journaling, directly discussing religion and spirituality, collaborating with clergy, etc.), 67% of practitioners were able to identify at least 14 of these techniques that they currently implement in their practice. Sheridan's (2004) list of techniques is an appropriate resource for practitioners seeking ways to integrate religion and spirituality into one's practice. Additionally, the literature suggests how to engage a client in appropriate religious or spiritual dialogue. One common strategy is the use of spiritual genograms (Hodge, 2001; Northcut, 2000). Such an activity allows clients to talk about the spiritual and religious upbringing of their significant kin (such as parents and grandparents), fictive kin, influential people, and themselves. This can prompt discussion about how those spiritual roots have impacted the client positively or negatively, how his or her current beliefs and practices are similar or different, and whether the client's spirituality can be accessed to help with the presenting problem. Creating spiritual genograms with clients has been found to improve the atmosphere of open dialogue and also to increase the client's own sense of self-awareness.

This technique, while time-consuming and perhaps not appropriate for all practice settings, reflects a commitment to an open-ended narrative approach to

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counseling. Narrative therapy requires the practitioner's competence in asking the right questions. Recognizing
TABLE 1: Hodge (2001) Framework for Spiritual Assessment – Sample Questions

<i>Type of Question</i>	<i>Sample Question(s)</i>
Narrative (chronologically)	Describe the religious/spiritual tradition you grew up in. What sort of personal experiences and/or practices stand out to you during your years at home? How have you changed or matured from those experiences?
Affect	What aspects of your spiritual life give you pleasure? What role does your spirituality play in life's sorrows and joys?
Behavior	Are there spiritual rituals or practices that help you deal with life's obstacles?
Cognition	What are your current religious/spiritual beliefs? What are they based on?
Communion	Describe your relationship with the Ultimate? How does the Ultimate communicate with you?
Conscience	How do you determine right and wrong? What are your key values?
Intuition	Do you ever experience intuitive hunches, flashes of creativity, premonitions, spiritual insights?

that clients come into counseling assuming a separation between their spiritual lives and the issues discussed in session, we must ask questions in order to create an open environment for such dialogue (Griffith & Griffith, 2002) as a "standard part of the assessment phase of treatment" (Hoyt, 2008, p. 230). We *must* ask questions because otherwise "religious culture is invisible" (Rey, 1997, p. 161), in that one's religion cannot be outwardly observed in the way one's ethnicity or gender can be seen.

Suggested questions to begin a spiritual dialogue with clients can be found in many different sources (Griffith & Griffith, 2002; Hodge, 2001; The Joint Commission, 2002; Northcut, 2000). The Joint

Commission (JCAHO), the organization responsible for the accreditation and management of competent health care services nationwide, provides one such set of questions; these questions have been deemed appropriate for assessment dialogue in some of the most secular settings in the country. The aim of these question sets is to facilitate easy assessment and integration of a client's religious and spiritual life through a narrative approach.

Perhaps the most specific, directive, and frequently-cited framework for spiritual assessment is Hodge's (2001) model, which includes two levels of questioning. First, Hodge suggests an initial narrative framework, which is highly open-ended and includes chronological self-reflection. The second level of questioning takes a more anthropological approach, which addresses the client's affect, behavior, cognition, communion, conscience, and intuition. See Table 1 for examples.

Whether these particular questions resonate with the practitioner more or less than others, it remains important to actively consider how to assess the significance of spirituality in the client's life and to integrate the client's spirituality through questioning of some kind.

How Does My Own Spirituality Influence My Practice?

Once the practitioner has grappled with the issues related to whether spirituality should be integrated into their social work practice, and has concluded affirmatively that incorporating the client's spirituality into social work practice has value, the practitioner must explore his or her *own* religious and/or spiritual beliefs, as those beliefs can also have a tremendous impact on one's practice.

Discordant Beliefs

Given the individual nature of spiritual beliefs, it is likely that a social worker will possess a spiritual orientation different from that of the client. Instances in which the social worker experiences discordant beliefs (i.e., client beliefs notably different from the worker) are inevitable. In these situations, one should deal with these differences as any other, by acknowledging the differences, taking a one-down position, and inviting the client to explain his/her beliefs to you (Casco, 1998).

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Gotterer (2001) identified three different types of discordant belief scenarios. First, a practitioner may be highly religious and/or spiritual yet willing and able to acknowledge the value of others with different beliefs. Second, it often occurs that the practitioner is uncertain about his or her own religion and/or spirituality, and therefore he or she becomes wary of entering into that arena with clients. Third, a scenario can take place where a practitioner who is particularly non-religious and non-spiritual becomes either negative toward or dismissive of a client's religious or spiritual life. These three scenarios may comprise the majority of discordant belief situations. Yet there are a couple more dynamics to consider. Hoyt (2008) represents a fourth discordant belief scenario; he is a self-described non-religious and non-spiritual practitioner, yet he is consciously open to the possibility of religion and spirituality as a source of strength to his clients. Hoyt's conclusion is a powerful one: "the non-spiritual social worker can and must be as open as the spiritual social worker to integrating spirituality into practice" (p. 230).

In the experience of the author, a fifth discordant belief scenario must also be acknowledged and addressed. For some highly-religious practitioners, working with clients who do not share the same religious beliefs can be challenging. These practitioners are oftentimes not open to contradicting beliefs and tend to seek the religious conversion of their clients. The author's experience working within one faith-based organization attempting to serve the Lesbian, Gay, Bisexual, and Transgendered (LGBT) population holds several such instances; well-meaning religious social workers often allowed their own religious convictions about homosexuality to influence their ability to engage in therapeutic work with LGBT clients. When a social worker's own religious convictions manifest themselves in judgmental, close-minded ways (which in the case of LGBT practice, might even include detrimental attempts at conversion therapy), religion and spirituality can become destructive and detrimental to working with historically oppressed populations.

The most significant, and necessary, first step for any practitioner seeking to ensure his or her competency in practice with diverse clients is to develop self-awareness. A practitioner may *think* he knows what he believes, but he may be surprised by what a dedicated time of self-reflection might uncover. A practitioner might truly *believe* that her personal values do not influence her work, but she may be surprised

when she is faced with a particularly challenging value-laden issue in her practice. Yet, the profession of social work demands that practitioners achieve a level of cultural competence (which includes instances of discordant religious and/or spiritual beliefs). The National Association of Social Workers' (NASW) Standards of Cultural Competence set two interrelated standards expressing these challenges and the requirements of social workers (NASW, 2001). Standard one states: "Social workers shall function in accordance with the values, ethics, and standards of the profession, recognizing how personal and professional values may conflict with or accommodate the needs of diverse clients" (p. 4). Standard two focuses on the development of the social worker's self-awareness: "Social workers shall seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people" (p. 4).

How, then, can practitioners begin to prepare for discordant belief situations in their practice? How can social workers ensure a true understanding of self, related to their personal religious convictions and spiritual practices? Several techniques may be useful in these instances, such as: honest, vulnerable times of journaling; consultation with trusted friends and colleagues, completing one's own spiritual genogram; and many other acts of self-reflection. Whatever the method, the journey to self-reflection and self-awareness is a vital one for all social work practitioners. Self-aware social workers better understand when and how to address discordant beliefs when they manifest in practice.

What to Do

In instances of discordant beliefs, the practitioner's personal religious and/or spiritual beliefs can lead to the creation of barriers that become detrimental to the helping process. As already addressed, engaging in a time of self-reflection and the building of self-awareness can begin to address and prevent these barriers. While clear cut 'do's and don'ts' (i.e., guidelines for affirmative practice) are not widely-established, the concept remains significant to the competent integration of spirituality into social work practice – especially with populations that may experience oppression by practitioners who have discordant beliefs (e.g., the LGBT community, pregnant

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teens). Still, a conscious focus on establishing a truly affirmative environment can be an important next step.

For some highly religious and/or deeply spiritual practitioners, the task of creating such an affirmative environment may prove to be too difficult. There may be certain clients, populations, or presenting problems for which the practitioner may feel personally torn or uncomfortable to competently serve. Practitioners who, after a time of honest introspection and self-examination, cannot reach a place of sincere affirmation should take appropriate next steps. Hodge (2001), among others in the field, argues for clinicians to refer clients elsewhere for services if the practitioner "holds certain values so firmly that they risk imposing their positions on clients" (p. 210).

For example, in her work within the faith-based social services community, the author has frequently challenged Christian practitioners regarding their ability to work with LGBT clients. The question she asks such practitioners is: 'Where do you, as a practitioner, stand in your ability to help LGBT clients?' If the practitioner cannot genuinely ensure that his or her personal values and beliefs will not impose upon the LGBT client, it is often decided to refer the client to another service provider. Choosing to refer a client because of discordant beliefs should not be viewed by practitioners as weakness or incompetence in their practice. On the contrary, making such a referral may be the best service the client can receive.

Implications and Conclusion

The importance of integrating spirituality into social work practice cannot be underscored. Yet, the task of doing so in a systematic and competent way can be daunting. Especially in the face of discordant client/counselor beliefs, the integration of spirituality into practice can be a convoluted and controversial task. It is the inherent challenge of the social work profession to provide culturally (and spiritually) competent practice to all clients. Arriving at a set of 'best practices' for any set of clients and their presenting problems can be

complicated. Adding the component of spirituality to best practices can exacerbate this complexity.

The growing interest in the field of social work on evidence-based practice (EBP) holds significant, albeit problematic, implications for this current discussion; as social workers search for practices which can be empirically-supported and proven effective, the incorporation of aspects as subjective as one's own spirituality becomes a challenge. In their development of a model of EBP, Haynes, Devereaux and Guyatt (2002) suggest that EBP exists at the intersection of the clinical state and circumstances, the best available external evidence, the client's values and expectations, and the practitioner's clinical expertise. While this model is certainly informative, it does not specifically address the ways in which the practitioner's values and religious beliefs can impact 'best practices.'

Integrating spirituality into social work practice can have meaningful implications for both the client and the practitioner. Educators in the field of social work should consider encouraging social work students to examine their views on spirituality. Engaging students in self-reflective activities in the classroom may be beneficial to developing students' awareness of and comfort with their beliefs and the beliefs of future clients.

In summary, religious and spiritual beliefs impact both the client and the practitioner. One's spiritual life is an important and inseparable part of who we all are. Yet, religion and spirituality are often taboo subjects in social work practice. A spiritual assessment can be helpful to the practitioner's understanding of the client's bio-psycho-social-spiritual situation. Lastly, the practitioner must continue to implement self-awareness. As one begins to truly understand the strengths and limitations of one's own spirituality, an affirmative environment can be established. The amount of introspection required to achieve this end may be time-consuming, but the benefits to the client can be significant.

Our Clients' Spirituality...and Our Own: Implications for Best Practices in Social Work

Allison Tan holds a BSW from Taylor University and an MSSA from Case Western Reserve University. She has extensive social work experience in the field of HIV – in direct mental health practice, program supervision, and consultation. Most recently she served as the consultant to the AIDS Foundation of Chicago during the city-wide roll out of the medical case management system. She is currently working on a book chapter on best practices for working with the LGBT population from a Christian faith-based perspective. Ms. Tan is a doctoral candidate at Loyola University-Chicago, where she is completing a dissertation on models of peer-based HIV primary prevention programming. She enjoys teaching social work, currently as an adjunct instructor at both Loyola and Dominican Universities.

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Meditation as a Social Work Intervention

By Kristen Esposito Brendel

Abstract

Meditation can be used as an ethical, practical and effective social work intervention for treating most client populations. It has its origins in Eastern religious practices as a means to achieve overall states of peace and acceptance of self and others (Keefe, 1996; Kissman & Maurer, 2002). It has been progressively adopted by mainstream American society since the 1960's for stress-reduction, overall wellness and for spiritual growth (Keefe, 1996; Khalsa & Stauth, 2001; Taylor, 1999). Only recently has meditation been studied and practiced as an adjunct or primary social work or psychotherapeutic intervention. When employed in a mental health setting, meditation has demonstrated efficacy for the development of clients' self-awareness and self-acceptance (Andersen, 2005; Keefe, 1996). Clients with anxiety, depression, substance abuse, trauma, and an array of physical health problems have benefited from meditation (Keefe, 1996; Khalsa & Stauth, 2001; Kissman & Maurer, 2002). Thorough assessments should be conducted prior to treatment to establish a goodness of fit in regards to the type of meditation to be implemented and to rule out any contraindications such as psychosis or severe thought disorders (Andersen 2005; Keefe, 1996). Further research is indicated to ascertain best meditative interventions with specific client populations.

Introduction

"We can never obtain peace in the outer world until we make peace with ourselves."

-Dalai Lama

Social workers bear the ethical responsibility of putting forward best practices when working with clients or client systems (National Association of Social Workers, 2008). Social workers have a history of

utilizing diverse methods as a means to help clients improve their functioning and livelihood. They utilize theories that originate from the field of social work, such as empowerment and ecological framework and also borrow from other disciplines including psychology, sociology, and anthropology. Integrating meditation practices, originating from Eastern religions, are effective for enhancing client functioning in mental, physical and emotional domains (Keefe, 1996; Kissman & Maurer, 2002). Meditation used in religious traditions spans many Christian denominations (Birnbaum, 2005; Finley, 2004; McLemore, 2006) as well as Jewish (Weis, 2005) and Muslim practices (Shaffi, 2005). Clients do not have to consider themselves as religious or spiritual to benefit from meditation nor do they have to be familiar with Eastern religions. It is important to note that clients may be more familiar with the process of meditation than they initially believe. They may have experience and prior knowledge with meditation practices associated with common religious traditions such as prayers, chants, and quiet reflection (Kissman & Maurer, 2002).

Applications of meditation in social work can help in treating anxiety, depression, and substance abuse through the development of self-awareness (Epstein, 2007; Keefe, 1996; Khalsa & Stauth, 2001; Kissman & Maurer, 2002). Although meditation is becoming increasingly popular in modern society, social workers have just begun implementing meditation into their practices of social work with clients (Keefe, 1996). The focus of this paper is to discuss how meditation can be an effective social work intervention for most client populations.

Meditation Defined

Meditation usually refers to a state in which the body is consciously relaxed and the mind is allowed to become calm and focused (Keefe, 1996). Meditation often involves one-pointedness or the practice of focusing on a single stimulus (Rahula, 1974). Stimuli of

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focus are often breaths, heartbeats, or single words or sounds. It can also include a phrase, contemplatory idea or physical movement like walking, designing, and yoga. The goal for meditation will vary depending on the individual but traditionally involves working towards spiritual enlightenment and the elimination of suffering. Modern uses of meditation do continue to include enhancing spirituality but also focuses on the development of self-awareness, self-acceptance and mental and physical healing (Andersen, 2005; Keefe, 1996; Khalsa & Stauth, 2002; Kissman & Maurer, 2002).

Origins of Meditation

Siddhartha Gautama, who was born a Hindu prince and later became known as the Buddha, famously used meditation practices to achieve Enlightenment. To understand meditation, particularly as it originates in Eastern religions, it is important to be familiar with the story of Gautama and the progress of meditation into Western society (Keefe, 1996; Taylor, 1999).

Siddhartha Gautama was born a Hindu prince in 563 BC. Throughout his life, measures were taken so Gautama was sheltered from the tribulations of the world and was afforded all luxuries (Rahula, 1974). When Gautama was 29 and married with a child of his own, he was exposed to human suffering (Rahula, 1974). As a result of this experience, he relinquished all he knew and began a life as an ascetic to resolve universal human suffering. He submitted himself to learning from famous religious leaders and engaging in various religious practices, but none satisfied his desire to be rid of suffering (Rahula, 1974). Consequently, he abandoned all religious methods and went his own way. At the age of 35 and under the Tree of Wisdom, he attained Enlightenment. He then became known as the Buddha, meaning The Enlightened One (Rahula, 1974). The Buddha believed that understanding suffering was necessary before one could achieve and maintain nirvana or complete Enlightenment (Brenner & Homonoff, 2004; Rahula, 1974). Many followed the teachings of the Buddha and thus a new philosophy of life emerged in the East known as Buddhism.

The introduction of meditation to Western civilization began in the mid- to late 1800's when Ralph Waldo Emerson's essay, *Oversoul* (Emerson, 1841/2007; Taylor, 1999), reconstructed the Hindu idea of Brahman, the universal power, into the New England

vision of God. Henry David Thoreau also received inspiration regarding his ideas of civil disobedience from Hindu's notions of meditation, yoga, and peace (Taylor, 1999). In addition to Emerson and Thoreau incorporating Eastern religious practices into literature, the World Parliament of Religions was held in Chicago in 1893 (Taylor, 1999). At this event, representatives of the top ten world religions gathered to exchange information. This marked the first occasion that Americans and other attendees received teachings about meditation in their homeland (Taylor, 1999).

In the 1960's, meditation gained popularity in the United States with the movement of peace during the Vietnam War. For many, meditation seemed to be the alternative to war that they were looking for (Murphy & Donovan, 1999; Taylor, 1999). Transcendental Meditation, invented by Maharishi Mahesh Yogi, appealed to many celebrities and eventually became a well-established form of meditation in the United States (Mahesh Yogi, 1968; Transcendental Meditation, n.d.). Also, in the 1960's R.C. Suzuki (1964) and Alan Watts (1961) published several books and actively promoted Buddhism and meditation practices. According to Keefe (1996), Suzuki and Watts are to be credited for helping to popularize and bring meditation to mainstream Western society.

Twenty-first century American society experienced a revitalization of meditation practices partially due to the popularity of yoga and alternative medicine (Finger, & Arnold, 2002). Meditation has served to be an integral part of the mind, body, and spirit push in recent years (Finger & Arnold, 2002). It often accompanies alternative medicine, which is estimated to be 34 billion dollar industry in the United States alone (Marchione & Stobbe, 2007). The resurgence in popularity may also be attributed to the stressors in American society and the increased knowledge of the disease process associated with overstress (Keefe, 1996; Khalsa & Stauth, 2001). Numerous studies have suggested that meditation is effective in treating many health problems. This has led to medical doctors recommending meditation as an adjunct to traditional medicine (Keefe, 1996; Khalsa & Stauth, 2001).

Common Practices of Meditation

Meditation practice as used in hatha yoga, is most common in the United States (Khalsa & Stauth,

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2001). It composes mainly of the incorporation of postures, breath control, and concentrated meditation. It is considered a holistic yogic journey meant to achieve balance, calm the mind, and improve physical health on the path to spiritual enlightenment (Khaslsa & Stauth, 2001).

Transcendental Meditation, another common meditation practice, involves sitting quietly for 20 minutes twice per day while producing and focusing on a sound like 'om' (Mahesh Yogi, 1968). As simplistic as that may seem, formal training is recommended to help achieve the most successful outcome (Mahesh Yogi, 1968). Training is available in many larger demographic areas around the world. For a lifetime of training, costs range from \$375.00 to \$1,500.00 (Transcendental Meditation, n.d.).

Other types of meditation include sitting quietly, Tai Chi, various forms of yoga, taking walks, aromatherapies, mantras, mandalas (designs), listening to various sounds in nature, positive affirmations, contemplation, chanting, or any other activity that contributes to spiritual enlightenment or self-awareness (Khalsa & Stauth, 2001). There are also many aides that may be used to enhance meditation practice such as incense, herbal supplements, teas, clothing and mats as well as entire environments like prayer labyrinths, meditation rooms, and Zen gardens (Khalsa & Stauth, 2001).

Constructing Self-awareness and Self-acceptance through Meditation Practices

Both meditation and social work practice can assist clients in the development of self-awareness and thus the attainment of self-acceptance (Andersen, 2005; Birnbaum, 2005; Keefe, 1996). Self-awareness is the process of being conscious of motivators, feelings and responses to intrapersonal and interpersonal conditions (Keefe, 1996). It is constantly forming through mutual interactions between people and their environment (Fulton, 2003). Self-acceptance is the ability to accept every characteristic of ones' self without judgment (Phipps, 2000). According to Deepak Chopra, self-acceptance leads to compassion, forgiveness and being nonjudgmental of others; it is the first stage of liberation (as cited in Phipps, 2000). Self-awareness can pave the way for self-acceptance, which is akin to the Buddhist notion of Enlightenment (Phipps, 2000).

According to Epstein (2007), Buddhism is considered to be the most psychological of the world's religions. It is based on the *Four Noble Truths* outlined by the Buddha during his first sermon. These Truths are *suffering, thirst/dissatisfaction, cessation of suffering, and the path leading to the cessation of suffering / Middle Path* (Epstein, 2007; Rahula, 1974). The *Fourth Noble Truth* or the *Middle Path* is the path to cessation of suffering and involves a way of life of not over- or under-indulging. It is said to lead to peace, insight and Enlightenment (Rahula, 1974). According to Buddhist philosophy, this path is also known as the *Eightfold Path* and is the process of living life toward the goal of eliminating suffering. It consists of combining moral and principled practices with preparation in concentration and meditation and the development of wisdom (Brenner, 1997). Meditation is the essential ingredient to achieving the Middle Path (Brenner, 1997; Epstein, 2007; Rahula, 1974).

Mediation can assist the individual with further growth and development of self-awareness, potentially producing physical and psychological wholeness (Wolf & Abell, 2003). For instance, meditation helps with the growth or formation of self-awareness due to inward focusing, observing, and labeling. Since the process of Buddhist meditation requires that one remains focused on the observance of self, individuals can learn to become attuned to their physiological, emotional, and other internal dialogues and consequent responses (Wolf & Abell, 2003). The client can first distinguish what it is about the self that needs enhancing (often with the assistance of the social worker), and then the capacity to develop those areas. "These include the capacities to discriminate memory, fantasy, worry, the accompanying emotional content, and present-time perceptions, and to decide to some degree which cognitive or emotional responses will become stimuli to further responses and which will not" (Keefe, 1996, p. 441). Since self-awareness is constantly being formed, the use of meditation on a regular basis can help to accommodate changes in development (Epstein, 2007).

By using meditation as a means of developing self-awareness and discovering connections to the physical environment, self-acceptance can ensue. As discussed in the *Second Noble Truth* (Rahula, 1974; Epstein, 2007), the thirst for existence and non-existence is relative. The mind will benefit from relaxing resulting in subjective awareness and self-acceptance (Epstein, 2007). Clients can discuss their

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meditative discoveries with their social workers to help facilitate this process further and then, in turn, meditate on their discussions furthering the process of self-awareness and self-acceptance.

Other Therapeutic Benefits of Meditation

Aside from developing self-awareness and self-acceptance, meditation has been beneficial for people who have diagnosable disorders such as depression, anxiety and substance abuse. Khalsa and Stauth (2001) cited research from the Office of Alternative Medicine, which is a branch of the National Institute of Health. The report indicated that the relaxation response of meditation has shown to have the biological reaction of a reduction in oxygen use, lower secretion of stress hormones, an increase in immunity properties in the blood stream, and increased brain-wave activity. According to Khalsa and Stauth (2001) meditators reportedly showed a marked improvement in the following areas:

- Premenstrual syndrome symptoms decreased by 57 percent
- Migraine headaches decreased notably
- Anxiety and depression were reduced significantly
- Working people missed fewer days due to illness
- Patients with AIDS and cancer experienced decreased symptoms
- Seventy-five percent of patients with insomnia were cured, and almost 25 percent improved
- Patients with chronic pain required an average of 36 percent less treatment
- Patients with high blood pressure recovered completely, or improved (p. 42).

For clients with depression or anxiety, meditation can help with a sense of control over their situation where learned helplessness had become a factor (Keefe, 1996). In situations where traumatic events occurred, feelings of hopelessness and guilt are common as are repetitive and self-defeating thoughts. Meditative techniques may help victims separate themselves from the event thus leading to feeling more control over their reactions to the event (Keefe, 1996). Meditation may also help people with depression desensitize troublesome ruminations and develop

thought processes that evoke empowerment and self-regulation (Keefe, 1996).

Anxiety disorders are the most common psychiatric disorder in children and adults (Barlow, 2002). Meditation can help clients with anxiety alleviate their symptoms and produce positive biopsychosocial outcomes (Keefe, 1996). The mere act of meditation is a recommended form of anxiety reduction as meditation is by nature a physical form of relaxation. Meditation and other forms of relaxation strategies such as deep breathing and progressive muscle relaxation have been beneficial in helping to lower stress responses that occur acutely as well as chronically (Khalsa & Stauth, 2001). It helps clients self-regulate their behavior and lowering their autonomic responses to stress and anxiety in the short term as well in the long term (Keefe, 1996).

Meditation can help individuals with addictions and substance abuse problems learn how to better cope with their anxieties and stressors associated with the onset of their addiction and triggers for usage (Keefe, 1996; Kissman & Maurer, 2002). Meditation can become a crucial element in identifying the causes of and treating the substance abuse problems through focused attention on increasing mindfulness and coping abilities (Keefe, 1996; Khalsa & Stauth, 2001). Clients with addictions can learn to be more mindful through the process of meditation about their current states of being. Many people with addictions will often self-medicate their problems with drugs or alcohol so they do not have to deal with the reality or magnitude of their problems. Since meditation is based on and occurs in real time, it will help foster mindfulness of the issues at hand and then the coping skill of relaxation as the potential outcome (Epstein, 2007). As people with addictions continue to practice meditation, a desensitization of their issues is likely to occur simultaneously with the outcome of a more relaxed state of being and insight into their addictive cycle (Keefe, 1996; Khalsa & Stauth, 2001). Meditation can arguably help clients with substance abuse problems better cope with maladaptive problems as they develop, resulting in a lower relapse rate (Keefe, 1996).

Ethical Considerations

The primary mission of social work is to help enhance client functioning and meet the basic needs of clients (National Association of Social Workers, 2008). Meditation, when used as a social work intervention, is

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an ethical form of social work practice and falls under the National Association of Social Workers ethical principle of *Service*. Meditation helps to alleviate social problems by fostering empathy towards humankind (Andersen, 2005). Empathy is a natural derivative of self-exploration and Enlightenment. During meditation one learns to turn attention away from oneself while being attuned to the task at hand. When this method is utilized in conjunction with unconditional positive regard and respect for another person, empathy will likely transpire (Andersen, 2005).

Meditation helps to reinforce the *Importance of Human Relationships* (National Association of Social Workers, 2008) by bringing about mindfulness regarding clients' strengths, challenges, and influences. It encourages kindness and healing as the *Middle Path* of cessation of suffering (Rahula, 1974). The intended result is to strengthen the relationships with self and others through recognizing that improving relationships with others is also the same as improving the relationship with ones' self. The result can be an overall stronger system of being and the reduction of suffering among the client and clients' systems.

Contraindications

According to Epstein (2007), Keefe (1996), and Murphy and Donovan (1999), certain client populations could be put at risk if meditation is employed as a part of their therapy. At-risk populations include those who have been diagnosed with severe thought disorders, schizophrenia, auditory or visual hallucinations, delusions, psychosis or those who have a weak sense of self or poor conception of reality. Clients from the at-risk populations could risk possibly

aggravating or increasing psychosis, hallucinations and delusions. Proper screenings and assessments need to be conducted to rule out contraindications prior to introducing meditation.

Social workers employing meditation with their clients need to exercise caution particularly if they have not been adequately trained to apply meditative approaches as an intervention. Social workers need adequate training and continued supervision to assess for effectiveness and to provide appropriate feedback to clients (Keefe, 1996).

Conclusion

The approach of meditation and social work is credible, practical and generalizable to most client populations (Keefe, 1996). Meditation as a primary or adjunct intervention is congruent with social work ethics and guidelines. Meditation can facilitate the development of self-awareness, self-acceptance, as well as generate relief in a number of physical and mental ailments. Relaxations, guided imagery, physical movements such as walking, yoga and Tai Chi are among the many common meditative practices. Due to the simple and affordable nature of meditation, it is an intervention that is practical and safe for usage in most environments. A thorough assessment should be conducted prior to the introduction of meditation to determine what forms of meditation clients may be appropriate for and to rule out psychotic symptoms or other contraindications. Further research is warranted to study the effectiveness of meditative practices given specific client populations.

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Strengths and Challenges: Using Western Theoretical Approaches in Clinical Social Work Practice with Traumatized Refugees

By Aimee V. Hilado

Abstract

This article focuses on the impact of trauma on war-experienced refugees and explores the appropriateness of different Western theoretical approaches currently used in clinical social work practice. Several commonly used approaches to treating traumatized refugees will be discussed. A conceptual multi-theoretical approach to treatment is also provided as a modality that may be more useful than current Western approaches used to date. Recommendations for theory development in the area of clinical work with traumatized refugees and future directions for social work practice are included.

Introduction

According to the United Nations Convention Related to the Status of Refugees (1951), a *refugee* is defined as a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country" (Article 2). In a 2002 report from the United Nations High Commissioner for Refugees (UNHCR), 12 million people can be classified as refugees (Nicholl & Thompson, 2004). The U.S. receives thousands of refugees every year (Daniels, 2002), many of whom have experienced numerous traumatic circumstances. These circumstances can include the conflicts that precipitated their leaving, as well as their time in transit and resettlement in the U.S. (Kinzie & Fleck, 1987; Lie, Sveass, & Eilertsen, 2004; and Nicholson, 1997).

Refugees come to the U.S. to escape the persecution that enveloped their respective regions of origin and precipitated the need to flee. Upon arrival, refugees must cope with past experiences of loss, the hardships they have endured, the uncertainty of their circumstances pre- and post-migration, emotional

distress, and anxiety for their future (Alexander, Eyerman, Giesen, Smelser, & Sztompka, 2004; Bromley, 1987; Daniels, 2002; and Fong, 2004). At the same time, refugees are expected to acclimate immediately, learn a new language, find employment, and become self-sufficient with the goal of becoming a productive citizen (Alexander et al., 2004; Bromley, 1987; Daniels, 2002; Kinzie & Fleck, 1987; Lie et al., 2004; and Somasundaram & Jamunanantha, 2002).

Policies have been developed to support arriving refugees and enhance integration into the host society. Three-month monetary stipends are allocated during the initial arrival time to aid refugees in the resettlement process. Reunification policies grant entrance into the U.S. for some refugees who have family members already resettled in the country. These efforts, however, fall short of recognizing the impact of the previous experience that made these individuals become refugees, and how those experiences thereby impact transition to any host country (Bromley, 1987).

For many refugees, trauma is a part of those experiences. The impact of trauma is evident in the breadth of research available. Numerous studies explore the prevalence of posttraumatic stress disorder (PTSD), depression, and other mental health concerns highly correlated with trauma effects (Fong, 2004; Kinzie, 2001). Less prevalent is the availability of research on effective treatments for refugee populations exhibiting trauma-related symptoms.

To date, "Western"-oriented clinical approaches have been used to treat war-experienced refugees who come from diverse regions/cultures (Nicholl & Thompson, 2004). The term *Western* refers to the classical therapeutic interventions that were developed primarily for white, middle to upper-class gentry. Such interventions targeted those who had both the time and resources to focus on personal development through intensive individual treatment using approaches like psychoanalysis and its related psychodynamic approaches (Payne, 2005).

Refugees typically come from more challenging circumstances. Individual treatment is likely

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to be either inaccessible or inappropriate, especially because meeting human needs – such as food, shelter, and survival – are a greater priority. The appropriateness of therapeutic interventions also comes into question when cultures value interdependence over individuality or clients from certain cultural groups are skeptical of divulging personal feelings to non-family members. Because of these differences, Western approaches to trauma treatment are not easily adapted to non-Western cultures and little research has been produced to unanimously support the usefulness of any one treatment modality (Nicholl & Thompson, 2004). When working with traumatized refugees, the gaps in mental health treatment caused by using theoretical approaches based on Western ideals become even more apparent.

Trauma is highly prevalent in refugee populations and represents a substantial mental health need for this group (Alcock, 2003; Alexexander et al., 2004; Fawzi, Pham, Lin, Nguyen, Ngo, Murphy & Mollica, 1997; Gonsalves, 1992; Nicholl & Thompson, 2004; and Paulson, 2003). Refugee trauma is also indicative of a greater social problem because of the lack of effective treatments. When refugee trauma is not adequately addressed, it creates a social environment in which war-traumatized refugees are left with mental health needs that are untreated. The goals of resettlement and assimilation for refugees into their host country may not be fully realized or even inhibited if unaddressed mental health needs hinder the process of healing and adaptation into the new environment. Addressing refugee trauma, then, is an important consideration for countries that are welcoming refugees with the idea of granting citizenship to these displaced persons. As the number of refugees all over the world continues to increase, there is a greater demand for effective theoretical models for use in clinical settings to aid in the refugee resettlement process.

The purpose of this article is to understand the impact of trauma on war-experienced refugees and to explore the appropriateness of different theoretical approaches currently used in clinical social work practice. Trauma can negatively impact the functioning of the individual, and several commonly used approaches to treating traumatized refugees will be discussed along with commentary on the respective limitations in their uses. These approaches are based in Western traditions that do not readily translate to work with refugee populations from non-Western cultures.

One can argue that use of such approaches in the strictest sense is inappropriate and can be more disruptive than helpful in practice.

No one treatment modality is sufficient in treating the complex needs of refugee populations. Clinical social work practice with traumatized refugees requires a multi-theoretical approach that relies on various concepts, outside of theoretical foundations discussed in this article, as a means of providing more appropriate and effective treatment. It is further advocated that the client's history, her subjective experience¹, religious/spiritual affiliations, and the role of the therapist be given greater attention in the treatment modalities used with refugee clients. Furthermore, the article concludes with recommendations for theory development pertaining to clinical work with traumatized refugees and implications for social workers. As the profession of social work moves to redefine its purpose and direction, this article supports a more holistic approach in social work that is more aligned with post-modern, transformative approaches to clinical social work practice.

Defining Trauma

Trauma can be associated with negative experiences that may be linked to conflicts, natural disasters, violence, or feelings of fear, despair, and suffering (Paulson, 2003). A traumatic event is defined as an event that is "of considerable severity posing a threat to one's life or that of others, involve actual death or serious injury or threaten one's physical integrity or that of others" (Vees-Gulani, 2003, p.26). Moreover, the event can either be experienced or witnessed and can involve feelings of intense helplessness, horror, or fear (Vees-Gulani, 2003). The severity of exposure can vary in intensity and duration.

For most war-experienced refugees, trauma is an inextricable part of their experiences. There comes a point in the individual's experiences when conditions –

¹ The feminine pronoun will be used predominantly in this article in part because majority of refugees are documented as women and children and in part, for clarity purposes. The author recognizes that refugee populations do include men and the clinical interventions discussed are also applicable to male clients.

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both political and social – worsen and psychological defenses are no longer useful to her (Paulson, 2003). The individual may witness the kidnapping, rape, or killing of family members or friends. She may be a survivor of detainment and physical/psychological torture, which can humiliate and degrade her entire being (Paulson, 2003). The stories of refugees prior to arriving into their host country are fraught with similar stories of trauma, loss, and sadness.

These traumatic experiences, in turn, can have a deleterious impact on the daily functioning of those who experienced them. Studies have shown that refugee groups have a higher incidence of psychiatric illness than non-refugee groups (Lie et al., 2004). In addition, the severity of the traumatic stressor is highly correlated with the likelihood of developing Post-traumatic stress disorder (PTSD) (Sack, Clarke, & Seeley, 1996; Vees-Guilani, 2003). The impacts of trauma and PTSD manifest themselves in a number of ways, including: loss of appetite, inability to sleep, selective amnesia, recurrent nightmares, difficulty concentrating, avoiding activities that are reminders of traumatic events, and withdrawal (Fawzi et al., 1997; Sack et al., 1996). These symptoms can escalate to diagnosable mental illness, including anxiety disorders and depression (Kinzie, 2001). Consequently, refugees are typically vulnerable to trauma because of the nature of their departure from their country of origin, which identifies them with refugee status (Paulson, 2003).

Children are also victims of trauma caused by war exposure, as it impacts their social-emotional, physical, and cognitive development (Driver & Beltran, 1998). Although this article will not focus specifically on traumatized refugee children, consideration should be made for future study of this group. Current studies have documented the impact of trauma on school children manifested in the form of poor academic performance, difficulty working/interacting with peers and poor gross motor skills in the school setting (Driver & Beltran, 1998). As suggested, traumatic war events impact all war refugees, irrespective of age, status, education, gender, or country of origin.

Historical & Current Understanding of Trauma

Classical literature relating to trauma can be traced back to the Sigmund Freud era of the 1920s when Freud was treating World War I veterans (Paulson,

2003). Trauma was seen as an assault on the rational aspects of the ego in which both the id and superego overwhelm the ego with feelings of guilt and inadequacy. This, in turn, was seen as immobilizing the ego and disrupting the core of one's identity, with Freud positing that specific traumatic events cause a fragmentation of the ego and disrupts the continuity of being for the person (Alcock, 2003; Paulson, 2003). Primitive defenses (including disassociation) become organized to defend against the anxiety induced by traumatic events, which helps the person survive both extreme mental and physical anguish (Alcock, 2003). Subsequently, the clinical work aims to strengthen the ego by allowing the conscious to re-experience the trauma with the intention of gradually assimilating those experiences into the person's life in a manner that will not immobilize her (Paulson, 2003). Given this context, it appears that previous literature on trauma concentrated on the psychological resources of the individual and the ways in which treatment focusing on the individual is the primary avenue for addressing trauma-induced psychological problems. While the concepts introduced by Freud do consider the unique experiences of each individual, the work is focused on the individual's functioning and independent being; not necessarily the environment that has caused current functioning (Alcock, 2003).

More contemporary literature examines the ongoing psychosocial consequences of war and the chronic nature of traumatic experiences that cannot be isolated to single episodes or occurrences. Such occurrences have a salient impact despite the gap of time between the experience and current events (Alexander et al., 2004; Kinzie, 2001; Somasundaram & Jamunanantha, 2002). The concept of *collective trauma* or *cultural trauma* has also become prevalent in the contemporary literature, given the widespread impact of war and subsequently the instances of trauma that impact large communities at a given time (Somasundaram & Jamunanantha, 2002). According to this concept, when members of a given collectivity have been subjected to an event, it leaves a permanent mark on the entire group's consciousness, perception of identity, and the events remain vividly in the group's collective memory (Alexander, 2004).

When trauma becomes normalized within a given community, cultural coping strategies used by the group can be maladaptive and may infiltrate social institutions and structures at a macro-level (Alexander,

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2004). For instance, entire war-experienced communities such as the Tamil of Sri Lanka became silent against the opposition. In time, they developed deep-seated suspicion and mistrust of their fellow human beings, which was exemplified in their opposition to any power or leadership, even when the goals were for the reconstruction and betterment of that community (Somasundaram & Jamunanantha, 2002). Trauma, in such cases, impacts both the individual and the community structure as a whole.

War-Experienced Refugees: The Impact of Trauma in their Lives

There are a number of universal themes relevant to people who are considered to be war-experienced refugees. From the time conflicts arise in their respective regions of origin to the time they are resettled in a receiving host country, refugees experience a range of emotions. These include an ongoing sense of fear, uncertainty, and a need for safety. Refugees may also experience feelings of loss of homeland, loved ones, and their cultural underpinnings as they relocate. Moreover, there are feelings of worried expectation for what their futures will hold upon arrival in the host country (Bromley, 1987; Kinzie & Fleck, 1987; Sack et al., 1996). A lack of knowledge about the safety of the family members left behind can cause feelings of guilt or anxiety (Drachman, 1992; Gonsalves, 1992). Refugees may wonder why they have the privilege of being alive and safe, while others do not (Sack et al., 1996). In addition, feelings of loneliness, dejection, homesickness and isolation often result from leaving behind the family that might be a person's natural support system (Alcock, 2003; Lie et al., 2004). A lack of sufficient social support can exacerbate posttraumatic and depressive symptoms in refugees, creating issues with resettlement (Lie et al., 2004). Lastly, the impact of trauma, loss, and psychological torture cannot be minimized, as it can have a deleterious effect on war-experienced refugees irrespective of their country of origin (Kinzie, 2001). Cumulatively, these experiences can have a lasting effect on mental health and one's ability to resettle in the host country (Drachman, 1992; Nicholson, 1997).

The journey of a refugee is one wrought with traumatic experiences, which exacerbate an identification as the victim, as one may have been victimized numerous times. This self-identification as a victim and

the related impact on the person's sense of self-efficacy and esteem can be attributed to a more pervasive construct of victimization. This construct can encompass feelings of shame, guilt, and loss of self-worth that can be debilitating (Shapiro, 2003). Chronic identification as a victim can lead to neurobiological effects that can actually change the organization of the brain and its functions, so as to impact the physical, emotional, and psychological well-being of the individual and her capacity to function (Cozolino, 2002). Therefore, traumatized refugees present a diverse range of needs (both material & psychological) that are derived from their experiences, which will need to be addressed in the therapeutic encounter.

Current Clinical Social Work Practice with War-Experienced Refugees

Clinical social work practice incorporates a breadth of theoretical approaches and treatment modalities with the goal of helping a client achieve identified goals and supporting her general well-being (Cooper & Lesser, 2005). Clinical practice has been influenced by a variety of fields, including psychology and the social sciences, and is typically initiated by the client and terminated when improvements are seen (Padgett, 1998). This form of therapeutic intervention has become a typical strategy for addressing mental health needs in the general population and is becoming increasingly guided by evidence-based practices (Cooper & Lesser, 2005).

In order to address the diverse and potentially challenging needs of war-experienced refugee clients in clinical social work practice, the literature suggests a number of general practice goals. Goodman (2004) references work with refugee groups, stating, "social work practice with war-experienced immigrants requires knowledge of their traumas and fears" (p. 287) and the incorporation of cultural beliefs into the interventions used in practice. In addition, the therapeutic relationship must address the need to create a safe, holding environment for the client to explore her past experiences without re-traumatization (Herman, 1992; Varvin, 1998). This is developed through an empathic relationship that allows the client to come to terms with her experiences based on a timeline structured by the client (Herman, 1992).

Goals of clinical practice can also involve healing. Through the healing process, the therapist

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assists the client in grieving numerous losses, empowering the client to identify herself as a survivor (Goodman, 2004; Varvin, 1998). This can be achieved by encouraging her to tell her story (narrative therapy), involve herself in her community and even return to visit her homeland, if possible (Goodman, 2004). Furthermore, clinical work may be a venue to address any symptoms due to depression and PTSD that the client may experience as a result of her traumatic experiences as a refugee (Kinzie, 2001; Kinzie & Fleck, 1987; Nicholl & Thompson, 2004).

In order to meet these intended goals, basic knowledge of the client's experiences and beliefs are essential components in the therapeutic encounter (Goodman, 2004). The historical context – including personal perceptions of that history – and knowledge of cultural norms (e.g. the role of family and religion/spirituality) are necessary. Each element is part of a valuable foundation for building relationships with war-traumatized clients and must be considered before engaging the client (Goodman, 2004). Once this background and understanding is attained, the client can proceed to meet the various practice goals through strategic orientations used by the clinician. A discussion of common approaches will be examined in the following sections.

Theoretical Approaches to the Treatment of Trauma and its Related Symptoms

Psychoanalytic theory and psychotherapy

Psychoanalysis is a theory of personality, a form of psychotherapy, and a research tool that has undergone several modifications during the last few decades (Strean, 1996). Developed by Sigmund Freud in the last two decades of the 19th century in Vienna, psychoanalysis continues to remain a salient foundation for clinical social work. Psychoanalytic concepts underlie much of the modified orientations (i.e. relational approaches to psychodynamic psychotherapy) that surfaced in the 20th century and are used today (Curtis & Hirsch, 2003). Accordingly, its orientation provides social work practitioners with a means of helping individuals and groups enhance psychosocial functioning through understanding and using the unconscious of the client in the assessment and treatment plan.

Refugees often suffer from both the indirect effects (i.e. forced migration, financial instability) and direct effects (i.e. torture and rape of self or family members, time spent in a concentration or refugee camp) of wars and conflicts in their respective regions (Kinzie, 2001). These traumatic experiences have been positively correlated with high levels of PTSD symptoms, very highly correlated with depression (Kinzie, 2001). Psychoanalytic psychotherapy has proven useful in clinical work with refugees who exhibit these types of symptomatology (Kinzie, 2001; Varvin, 1998). As noted by Varvin (1998), "one of the inherent aims of psychoanalytic psychotherapy is integration, which implies placing the traumatic experiences in a symbolic order... that can be remembered or repressed, but will not be relived as an actual experience" (pp. 64-65). Through focusing on the client's unconscious needs, fears, and desires then subsequently integrating that into the client's reality, the therapist can develop strategies to collaboratively meet unmet/unconscious needs with his client (Strean, 1996). Studies have shown that a combination of supportive psychotherapeutic treatment and medications alleviate trauma-related PTSD symptoms (Kinzie & Fleck, 1987; Nicholl & Thompson, 2004).

The value of a psychoanalytic approach to treating war-experienced refugees lies in its understanding of the unconscious self. Trauma is seen as an assault on meaning, the impact of which occurs at various psychological levels (Alcock, 2003). Trauma causes a breakdown from what Freud terms the ego and initiates the use of defenses in maladaptive ways (i.e. repression, selective amnesia, etc.) that can involve disassociation (Alcock, 2003; Paulson, 2003). This keeps the individual from experiencing the present as reality and can be debilitating when performing daily basic tasks. Memories of traumatic experiences can be triggered by everyday events. Developing the capacity to distinguish between memories and the present by using this approach can be a liberating experience for the individual.

Although this is the standard application of this approach and results of several studies sound promising (Kinzie & Fleck, 1987; Nicholl & Thompson, 2004), there are a number of limitations in its application with traumatized refugee populations. In general and according to Kinzie (1987), the process of working with victims of severe trauma is difficult in and of itself for a number of reasons. This includes challenges from the

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interview stimulating a re-experience of the trauma, the numbing behavior that is typically associated with trauma victims, and the unpredictability of the therapeutic encounter because of external stresses and triggers (e.g., loss of public support, employment concerns, or conflicts in the media that mimic what was experienced pre-treatment which may reactivate posttraumatic symptoms) (Kinzie, 1987). Compounding these challenges are a range of cultural differences and belief systems that infiltrate the treatment process. Use of psychoanalytic psychotherapy, a Western model, may not be directly applicable to work with non-Western communities like refugees because of the cultural differences that will undoubtedly influence the treatment process (Nicholl & Thompson, 2004).

In addition, psychoanalytic approaches pay less attention to the role of cultural context, which is intimately intertwined with the client's identity. These approaches typically look at the individual to explain psychological problems without attention to the external circumstances that precipitated the problems or the greater environmental context (Nicholl & Thompson, 2004). The change is directed at the person and not necessarily at the environment. Although the social work profession uses a person-in-environment perspective, psychoanalytic approaches look primarily at the individual. For the vast majority of refugees who come from Eastern cultures, this orientation ignores the collective identity that is so crucial to the group's identity, which can further impact overall functioning (Alexander, 2004; Nicholl & Thompson, 2004).

Furthermore, the role of spirituality as a crucial factor in the client's perceptions, subjective reality, and beliefs is often ignored and is not greatly considered in psychoanalytic orientations (Curtis & Hirsch, 2003). This can impede positive outcomes. Moreover, desired outcomes should be defined by the cultural expectations of the client (Nicholl & Thompson, 2004). A refugee client may not seek enhanced individual functioning as seen in her ability to recount her traumatic experiences. The client may simply want to effectively be able to repress the experiences in a manner that is helpful to her and nothing more (Nicholl & Thompson, 2004). Although this is not the intended outcome in therapy proscribed by Western traditions, it may be culturally appropriate to the client and therefore should be upheld.

Psychoanalytic relational approaches: Self psychology

The techniques and approaches used in self psychology –one of the relational approaches of psychoanalysis – can be useful in clinical social work practice. Self psychology literature suggests that the goal of all psychological development is to achieve a well-regulated, empathic, cohesive, and vigorous self (Cooper & Lesser, 2005; Flanagan, 2002; Wolitzky, 2003). According to the theory, both in life and in clinical treatment, reactions to failures in empathy can be worked through if the disappointment and anger over unmet needs can be expressed and understood. This can, in turn, lead to a stronger and firmer sense of self, which can support healing for traumatized refugees (Flanagan, 2002).

The nature of change occurs within an empathic relationship that assists the client to experience failures, recognize needs, and have those needs met (Kohut, 1984). According to self psychology, the effects of trauma in refugees may be seen as repetitive empathic failures that occurred during their previous experiences. Due to the trauma endured, the individual is left with a fragmented sense of self. Self psychology provides a venue for correcting these chronic "empathic failures" that were experienced pre- and post- migration which precipitated psychological impediments. Through an empathetic and nurturing relationship, clients can re-build their fragmented identity and addresses issues of loss caused by previous trauma (Flanagan, 2002).

Before these outcomes can occur, however, the client must be willing to recognize and admit to empathic failures and be willing the repair those instances in order to effect change and guide interventions (Elson, 1986). This is the groundwork for growth and development of a stronger sense of self. It is expected that capacities to self-empathize, self-soothe, and self-comfort will be initially provided by the therapists but gradually be assumed by the client (Cooper & Lesser, 2005). Moreover, the goals of self psychology include a variety of outcomes: arousing curiosity, tolerance of uncertainty and emotions, increasing capacities for self-reflection, becoming aware of one's impact on others, separation from past experiences, mourning losses, and finding meaning in one's life (Curtis & Hirsch, 2003). At the termination of treatment, the client should be able to recognize needs, develop effective coping strategies and use techniques of self-regulation to address his mental health needs.

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When working with severely traumatized refugees there are limitations to using a self psychology approach. Severely traumatized refugees may not be cognizant of a need for repair or may not understand the meaning of "empathic failures." Therefore, the value of treatment may not be obvious to the client. Refugee clients may not seek treatment or see the therapists in the same lens communicated by Kohut. Furthermore, the ability to self-soothe and self-empathize is an ongoing process for this population, an ability that may not be achieved in therapy, but through engaging in other forms of social support such as the family, the community, and/or religious affiliates (Lie et al., 2004).

The timelines for treatment in clinical work may also be inappropriate for war-experienced refugees. The initial months after a refugee arrives are a time of suppression – suppression of pain, losses, and memory of experiences (Bromley, 1987). It may take a refugee anywhere from 6 to 12 months after arrival to gain awareness of their losses and their circumstance (Bromley, 1987). One can surmise that immediate treatment after arrival and scheduled weekly meetings may be inappropriate (if not, impossible). Firstly, the refugee client may be more concerned with adjusting to their new environment and gaining a sense of normalcy, and therefore delving into their unconscious thought as suggested in this approach may not be a priority or desire. Secondly, because the need for a safe holding environment is inextricably linked to building trust (Varvin, 1998), it may be unrealistic to quickly develop a trusting relationship that can support the treatment process in once weekly sessions. Although self psychology is centered on developing an empathic relationship as the basis for clinical work, the timeline for that achievement in work with refugees is less predictable.

The need for a new approach

While psychoanalytic psychotherapeutic approaches are the most commonly used when working with refugees suffering from PTSD or other trauma-related concerns, the empirical literature supports the position that a Western idea of an all-encompassing "cure" for a refugee's trauma symptoms is unlikely due to the complex nature of treating traumatized refugees (Kinzie & Fleck, 1987). No single trauma can be treated individually because of the integrated nature of the experiences (Kinzie, 2001). Because refugees experience multiple traumatic events in a given period,

this further compounds the complexity of treatment and diminishes the likelihood of curing all symptoms definitively.

Furthermore, without adequate research using control groups, it would be difficult to generalize results from one study to another. Studies that used a very small sample would also prove equally difficult in explaining outstanding results that exhibit the efficacy of benefits in this approach because the samples are so unique and targeted (Kinzie & Fleck, 1987). Overall, psychoanalysis and self psychology and their respective techniques do provide promising strategies; however, it cannot be considered the "magic bullet" for treating traumatized refugees in the United States.

Treatment of Traumatized Refugees: Other Considerations

Cognitive-behavioral therapy (CBT)

According to Paulson (2003), a number of studies have shown that CBT has been an effective modality for treatment of traumatized refugees. War-experienced refugees internalize a victimization construct that may be debilitating, as such refugees are fearful towards interactions with others and about their overall safety. These fears can be so extreme as to hinder the person from leaving her home (Bromley, 1987). Neurological changes can also occur as a result of long-standing exposure to traumatic experiences (Alcock, 2003; Lie et al., 2004; Sack et al., 1996). Cognitive theory and subsequently, CBT can address both cognitive processes and the neurobiological functioning impacted by trauma.

Cognitive therapy was developed as a method for correcting the faulty thinking that may be the basis for dysfunctional attitudes, feeling states, and behavior (Beck, 1976). According to Cooper and Lesser (2005), CBT is a skills-based theory in which the client is given various techniques that are meant to support the acquisition of healthier ways of thinking by helping the client to perceive a more accurate sense of reality. In a cognitive theory approach in social work practice, the social worker seeks to facilitate self-reflection in the client in order to identify, challenge and change "misconceptions, faulty beliefs, distorted cognitions, and irrational self-talk that have created dysfunctional emotions and behavior" (Lantz, 1996, p. 100). In doing so, this approach can support more positive self-

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identification for the refugee survivor and her experiences, thereby allowing her to function in her environment more readily without as much apprehension and fear caused by her previous traumatic experiences.

Despite the benefits of this technique, one must consider its limitations, as well. Beck (1976) states, "cognitive techniques are most appropriate for people who have the capacity for introspection and for reflecting about their own thoughts and fantasies" (p. 216). For refugee clients, this level of introspection may not be available. As noted previously, circumstances of trauma cause many refugees to experience PTSD marked with behaviors such as avoidance, suppression, high anxiety, and restlessness (Fawzi et al., 1997). These clients may not have the capacity to fully avail themselves of the benefits of CBT because of such inhibiting factors that would infiltrate the treatment process. Although CBT provides techniques to support the client's capacity for self-reflection, empowers the client to change and supports emotional well-being, such an approach may not be appropriate if the client is still at a level of psychological functioning in which feelings of fear, anger, sadness, or happiness cannot be fully understood, expressed or experienced due to previous trauma.

Narrative theory and therapy

Narrative theory is a postmodern theoretical approach that is strengths-based and focuses on the underlying meanings within a story to understand the client's sense of reality, within that client's given cultural context and circumstances (Cooper & Lesser, 2005; Kelly, 1996). Narrative therapy, derived from the theory, has also been recommended for work with war-experienced refugee populations because it is founded on a constructivist conceptual framework—a framework that emphasizes the importance of the client's subjective experience and perceptions of her problems (Cooper & Lesser, 2005) while maintaining a culturally sensitive approach which "does not presume a way of being but aims to understand the client's reality" (Kelly, 1996, p. 464). According to Kelly (1996), the goal of narrative treatment approaches in social work practice is for clients "first to understand, and then to broaden and change, the stories around which they have organized their lives... the discovery of more realities and more truths can free clients to see more alternatives and ways out of an impasse" (p.465). In turn, clients can

recognize and potentially mobilize inner strengths that were trumped by the traumatic experiences that cloud reality (Kelly, 1996).

While this approach is culturally sensitive and appropriate for work with refugee populations in general, there are some considerations that must be made in regard to its implementation. This approach would require the clinician to allow the client the time and space to feel trust and comfort in the therapeutic relationship before any work could be done. Again, this speaks to the timeline for treatment, in which refugee clients may not be ready to engage immediately. Time must be appropriated to build that trust and comfort that is essential in clinical work with traumatized refugees. Once these elements are established, the client may feel more at ease to share her story, allowing the treatment process to proceed.

Other diffused approaches for addressing trauma

Crisis Intervention methods have been cited as useful modalities when working with clients in crisis and can be translated to work with refugees. It follows the trend towards brief, focused treatment to deal with what is seen as immediate and practical problems (Payne, 2005). *Group work* has also been seen to assist with groups that are impacted by a shared experience, as groups can come together and address a need through collective action (Toseland & Rivas, 2005). These are other potential treatment approaches that can be applied to refugees because of the focus on specific experiences that evoke a need for targeted intervention.

Again, limitations are ever-present—particularly the time constraints and modalities involved in these methods. Trauma may not be easily healed in brief interventions like crisis intervention, and clients of diverse backgrounds may not be comfortable sharing personal affects within the settings outlined in group therapy. While elements from each approach may be useful, there are deficiencies in solely using one approach.

Multitheoretical Framework for Clinical Social Work Practice with Traumatized Refugees

The theoretical approaches discussed in this paper – psychoanalysis, self psychology, cognitive

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theory and cognitive-behavioral therapy (CBT), narrative therapy, and other diffused approaches to treating trauma and collective trauma – present both strengths and weaknesses when applied to clinical social work practice with traumatized refugees. There is little research that suggests any one theory or approach is more effective or salient in the treatment of war-experienced refugees (Kinzie & Fleck, 1987). Consequently, findings have shown that outcomes are similar irrespective of the different systems of therapy employed (Prochaska, 1999). Furthermore, research has suggested that the use of different models and their respective techniques have little influence on treatment outcomes as a whole (Ogles, Anderson, & Lunnen, 1999). Instead, the literature suggests other elements within clinical practice that should be attended to, elements that are of greater value than what any one theoretical approach can provide.

A transformative post-modern approach to clinical social work practice seems necessary when working with war-traumatized refugee populations. According to Payne (2005), “postmodernism suggests that there is an alternative way of thinking about knowledge and understanding” (p. 16) that it is socially constructed, and that knowledge is ever changing. Addressing refugee needs in practice requires a similar postmodern thoughtfulness that is adaptive when thinking about refugee populations and their circumstances given current global movements and basing therapeutic decisions on that information. Additionally, and under the guise of postmodernism, social work often seeks personal and social changes through interactions and knowledge that relies on both social and historical context (Payne, 2005). Clinical work with refugee clients does have the potential to change lives when there is greater understanding of social and historical circumstances. Thus, there appears to be value in developing a post-modern conceptual framework for addressing refugee trauma in clinical practice.

To a certain extent, Western social work theories can indeed be useful in understanding a refugee’s experiences (Bromley, 1987). What is necessary is a melding of widely used Western theories for treating trauma and then supplementing modalities with elements appropriate to the refugee clients. An ideal approach would be one that gives greater emphasis to the refugee client’s functioning, perception of her situation, personality traits, experiences and cultural

background, as well as the client’s context, when developing a treatment protocol. This approach reverts to the sound generalist practice principles and person-in-environment framework that grounds the social work profession but has received less attention in clinical social work practice (Bromley, 1987). In the attempt to simplify treatment by using standardized techniques from the various theoretical orientations available, the uniqueness inherent in immigrant populations has been pushed to the wayside. These populations do not conform to standardized techniques because the models for treatment were typically created for use with middle-class, Westernized cultures (Nicholl & Thompson, 2004). Sound methodology and skills needed to work with new populations being served, like refugees, require a framework that considers context as much as technique.

Concepts for Multitheoretical Framework

Several authors emphasize the importance of considerations that are sometimes outside the realm of various theoretical approaches used in clinical practice. These considerations are critical for work with refugee clients and are necessary elements for a new treatment framework. The concepts are as follows: 1) the role of historical and current context, 2) the role of the client’s subjective experiences and perceptions, 3) the role of culture, 4) the role of religion and spirituality, and 5) the role of the therapist.

Historical context

The historical context is relevant to the client as it frames her political and social belief system and can provide the context for her perceptions of the experience that led to her refugee status (Goodman, 2004). The client’s current circumstances must also be considered. Is she resettling in a new country by herself, with no ties to family or friends? Or is she transitioning with a large social support networks present at her arrival? Greater understanding of both historical and current context and circumstances can enable to clinician to understand the relevance of the client’s situation and story more thoroughly and to use that knowledge in the intervention.

Client’s subjective experiences and perceptions

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The client's subjective experiences and perceptions are at the heart of where the therapeutic process must begin. As narrative therapy emphasizes, understanding the client's subjective experiences and her perception of those experiences is crucial for understanding the client's view of her circumstances. The client's view of her experiences can direct the path to desired outcomes (Cooper & Lesser, 2005).

Perception is also crucial in terms of creating a safe environment in order for clinical work to proceed. As suggested by Nicholl and Thompson (2004), it is the perception of safety and not actual, physical safety that matters most. Furthermore, understanding the client's subjective experience and perceptions aids the clinician in protecting the client's self-determination, which is a hallmark of the social work profession. For some refugee clients, avoidance and acceptance may be the most desired, most adaptive approach to trauma-related symptomatology (Nicholl & Thompson, 2004).

Culture

One cannot underestimate the importance of culture when working with traumatized refugees, as culture is the lens through which all definitions are derived (Rogoff, 2003). According to Rogoff (2003), "people develop as participants in cultural communities. Their development can be understood only in light of the cultural practices and circumstances of their communities – which also change" (pp. 3-4). It is within a refugee's cultural background that her identity is developed, norms are understood, mental illness is defined, and seeking treatment is considered. Culture influences how and if treatment is sought for trauma-related symptoms and it influences the interactions in session, the content shared, and what the refugee takes home from the therapeutic encounter.

Cultural perspectives in clinical social work must also be considered. As McGoldrick, Giordano, and Pearce (1996) state,

Just because a culture espouses certain values or beliefs does not make them sacrosanct. All cultural practices are not ethical. Every intervention we make is value laden... [and]... we can never be too certain that our perspective is the 'correct' one. (p.25)

Although culture must be considered within the therapeutic encounter, it does not prescribe definite answers. Inasmuch as clinical efforts must take into consideration cultural influences, clinical practice must

remain based on evidence of effectiveness and ethical standards as outlined in the National Association of Social Workers' (2008) *Code of Ethics*. This delicate balance calls for more culturally competent practitioners who can weigh the impact of culture on clinical work while providing the most appropriate services to the client. All in all, the culture of the client, the impact of culture on clinical practice, and the need for culturally competent practitioners are essential elements of social work practice with refugee clients.

Religion and spirituality

Culture is very much tied to the role of religion and spirituality, which are also part of the cultural traditions shared by refugee populations. Religion and spirituality have been documented as providing valuable coping strategies for dealing with traumatic circumstances, loss, and uncertainty with a variety of different refugee groups (Ai, Peterson & Huang, 2003). Furthermore, Kinzie and Fleck (1987) suggest that giving credence to and reinforcing traditional values and beliefs can support therapeutic approaches with severely traumatized refugees. Unfortunately, and as some authors have noted, although the importance of religion and spiritual beliefs are relevant to work with refugee populations, many Western therapies neglect these areas in treatment (James & Wells, 2002).

The therapist

Lastly, the role of the therapist plays a crucial role in the therapeutic process. Kinzie (2001) argues that the skills and personality of the therapist is one of the most crucial elements when working with traumatized refugees. Because traumatized clients are seeking a way to meet very basic needs when they first begin treatment – i.e. physical and emotional safety, a trusting relationship, predictability, and the ability to re-establish social relationships with others – the ability to meet unmet needs depends on the therapist herself (Kinzie, 2001). A therapist working with this specific population must have the skills to contain the diverse range of emotions that may be felt, whether they are sadness, fear, or anger. With a warm, honest, and approachable demeanor, the therapist must build a safe and trusting relationship with the client and provide a safe environment for clinical work to occur. These personality qualities and skills will determine if needs and progress can be achieved. Therefore, *who* the therapist is holds as much importance as what the

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therapist can do (Kinzie, 2001). An empathic relationship with a therapist can aid the refugee in organizing and regulating her emotions that may have been fragmented due to previous traumatic experiences (Cozolino, 2002). An empathic relationship between therapist and client can support attunement. Through a dialogical approach, the client can reconstruct a productive narrative that is more enabling than previous narratives (Cozolino, 2002), which may have focused on the client as victim. Such outcomes cannot be achieved without a skilled and culturally competent therapist.

Benefits of a New Treatment Model for Traumatized Refugees

In consideration of these areas of interest, one can argue that these concepts should be the basis of a new theoretical model—a conceptual framework which can serve as a guide in clinical practice with traumatized refugees. The proposed model integrates areas critical to understanding a refugee client and treatment of trauma. A different approach to treatment is suggested—one that is not simply incorporating or adapting the noted concepts into pre-existing theoretical orientations. Instead, these five areas—historical and current context, subjective experiences and perceptions, culture, religion/spirituality, and role of the therapist—would be given greater consideration within a new treatment model. These specific areas could serve as a foundation for intervention and could have considerable influence on the treatment process when used with evidence-based treatment modalities for treating trauma victims.

The proposed framework places considerable attention on the client and the client's circumstances. This holistic approach provides even deeper insights into the needs and circumstance of the client. The breadth of information that can be potentially accessed with this approach would inform the treatment process but, equally important, it would inform on the basic needs of the refugee client. The therapist can gain insight to basic physical, emotional, and financial needs that need to be met through social services. The therapeutic encounter can also reveal a need to develop and re-establish social support networks that can further support concurrent individual clinical work. Substantial focus on the person-in-environment appears more fully attended with this approach, which is an added benefit of this conceptual framework for social workers.

Future Directions for Social Work Practice & Theory Development Concerning Refugees

The social work profession is on the cusp of re-defining itself in light of the changes in our client populations, the nature and scope of our work, and the impact of globalization. Clinical social work practice with war-experienced refugees is an excellent example of the ways in which a population cannot be effectively addressed using traditional/conventional social work approaches. Instead, a post-modern, transformative approach that considers the client's context more adequately can be more effective in meeting the complex needs presented by this group. Ramsey (2003) presents a number of suggestions that he believes should guide the social work profession as we move forward in the 21st century; ideas which are very much in line with developing theories and models for treating traumatized refugees.

According to Ramsey (2003), social work practice should move away from an ethnocentric view in practice towards a more relational view (ethnocentric referring to the ways in which practice can be narrow based on personal perspectives, training from a specific school of thought, and/or influences from the culture within which one operates). The goal is to move away from a narrow view of practice into a broader view that includes influences from interactions with diverse cultures and disciplines, as well as gaining experiences outside an immediate sphere of influence. In doing so, the profession would focus more on the individual as part of a collective group, consider the individual's worldview in clinical practice, and recognize the relevance of the person-in-environment network that is indicative of communal societies like those of non-Western communities (Ramsey, 2003). Bidgood, Holosko, and Taylor (2003) further support these ideals, as they recognize the growing impact of globalization and the need for more culturally-oriented definitions in the social work profession. These views have greater alignment with the collective nature of refugee populations served by the social work profession.

In turn, theory development focusing on clinical social work practice with traumatized refugee groups would be greatly enhanced if it considered: 1) the nature of being for refugee groups (i.e. cultural origins, social networks, and value/belief system), 2) the

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respective needs of the client in treatment (i.e. a safe space, trust, re-establishment of social relationships), and 3) the changing direction of the social work profession, which looks to a more holistic approach to social work practice. These elements can be incorporated with other aspects of treatment approaches that have shown to be useful with this specific population. Taken together, development of such a theoretical framework can provide deep-seated changes at a variety of levels and could support overall functioning for refugee clients.

At their core, current treatment models were developed in a Western tradition that emphasizes the importance of the individual and aims to enhance individual functioning. Refugee populations living in the United States do not come from this Western orientation; therefore, such approaches fail to recognize the importance of factors such as: a collective identity linked to family and community structures, the role of spirituality, and cultural perceptions of involving "outsiders" for support in mental health needs (Nicholl & Thompson, 2004). For many refugee groups, these elements far outweigh individualistic goals in terms of importance and priority (Goodman, 2004).

While it would be disadvantageous to render general psychoanalytic or cognitive-behavioral theoretical approaches useless when working with war-traumatized refugees, it would be equally erroneous to assume that these strategies are the most useful in and of

themselves. Given the material presented here and the complex needs of this population, one can surmise that the conceptual multi-theoretical approach described in this article can be a useful tool. This conceptual framework uses the client's beliefs, value base, and cultural context to support treatment of mental health problems that arise from their experiences as refugees. Although the conceptual framework in this article or any closely related model has not been thoroughly researched or tested, the combination of its strengths combined with general needs of refugee populations seem capable of producing positive outcomes based on what we know about the theories and refugee needs.

In sum, culturally competent work with refugees requires knowledge of history and context for each specific ethnic group, respect and empathy for diversity, and skills in relationship-building. The theoretical orientations, clinical approaches, and strategies discussed in this article are meant to serve as useful guides for social workers serving war-traumatized refugees. Although refugee experiences are unique to the individual circumstances and region of departure, the common elements of those experiences can be paired with the approaches and suggestions explored in this paper. In doing so, it enables social work practitioners to tailor clinical work to effectively meet the diverse and challenging needs of all refugee clients.

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Should Employers be Able to Mandate Vaccinations of Healthcare Workers?

By Ashley Kappmeyer

Abstract

With the recent threat of the H1N1 virus and increased focus on influenza, some hospitals are beginning to mandate influenza vaccinations for all employees, students, and volunteers. Studies have shown that vaccination of healthcare workers reduces the likelihood of infecting patients. Additionally, it is suggested that vaccinations are effective in reducing staff illness and absenteeism (Anikeeva, Braunack-Mayer, & Rogers, 2009). Despite the widespread benefits of staff vaccination, "fewer than half of U.S. health care workers receive the flu vaccine annually" (Tucker, Poland, & Jacobson, 2008, p. 32). Thus, some healthcare organizations are beginning to mandate staff vaccination as a condition of employment, often with exceptions for medical and religious reasons on a case-by-case basis. While this has increased vaccination rates significantly, there is controversy surrounding these requirements, including considerable debate regarding employee's autonomy about their own care. Despite these arguments, I believe that mandatory vaccination should be a policy in healthcare institutions. This brief is intended to aid healthcare administrators in examining the issues surrounding influenza vaccination of healthcare employees and the debates regarding compulsory vaccination.

Introduction

Approximately 36,000 influenza-related deaths occur in the United States each year. Research shows that between 14 and 37 percent of healthcare workers become infected with influenza annually and spread the virus around their workplace (Tucker et al., 2008). It has been suggested that when vaccination rates of healthcare employees are low, hospital-acquired influenza infections can account for as many as one-third of all influenza cases (Tosh & Poland, 2007). The Center for Disease Control and Prevention's Advisory Committee on Immunization Practices has recommended influenza vaccination of healthcare

employees annually since 1981 and has made healthcare providers in hospitals and outpatient settings a priority group since 1986 (Tucker et al., 2008; Salgado, Farr, Hall, & Hayden, 2002). Despite these recommendations, according to the 2003 National Health Interview Survey, only about 40 percent of healthcare workers received the influenza vaccine (Harper, Fukuda, Uyeki, Cox, & Bridges, 2005). In the American Journal of Nursing, Tucker et al. (2008) declared that "low rates of immunization among health care workers pose a public health threat" (p. 32). Suggested reasons for low rates of immunization in this population include inconvenience, concerns about effectiveness and side effects, impression that there is a low risk of acquiring influenza and transmitting it to patients, avoidance of medications, previous reaction to vaccine, and fear of needles (Goldstein, Kincaid, Gamble, & Bearman, 2004; Salgado et al., 2002). As a reaction to the low rates of immunization and increasing concern for patient safety, many healthcare institutions are developing some type of written policy regarding employee immunization.

The presence of an influenza infection in healthcare workers raises numerous concerns. The most evident issue is that of transmitting infection from worker to patient. Many patients in healthcare settings are those in groups categorized as high risk for contracting influenza, such as the elderly or people with chronic illnesses (Harper et al., 2005). Moreover, influenza has a typical incubation period of one to four days. In addition, adults can be contagious from the day prior to five days after the onset of illness (Harper, et al., 2005). Thus, because a healthcare worker can potentially be infectious prior to having any symptoms of illness, preventing an influenza infection from occurring in the first place is imperative to patient safety. Research studies have verified the correlation between increased vaccination rates in healthcare workers and decreased infection rates in their patients (Goldstein et al., 2004; National Foundation for Infectious Diseases [NFID], 2004; Poland, Tosh, & Jacobson, 2005).

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In addition to the increased risk of spreading infection, working while being ill poses other concerns in the healthcare environment. Research shows that numerous healthcare workers continue to work despite being infected (NFID, 2004). An employee's illness may impair their cognitive and physical functioning, thus affecting their ability to perform their job adequately and resulting in a lower level of patient care. There are also various other indirect consequences that can be improved with increased vaccination rates. For instance, the issue of employee absenteeism due to illness raises several concerns. Numerous studies have discussed that employee absenteeism is costly for institutions and can be reduced with increased vaccination rates (Anikeeva et al., 2009; Pearson, Bridges, and Harper, 2006; Tucker et al., 2008). In addition, as the healthcare industry strives for continuity of care, it is beneficial to reduce absenteeism. Increased vaccination rates have been associated with reduced absenteeism and correspondingly lower rates of medical error (Poland et al., 2005). Furthermore, high rates of absenteeism can lead to staffing shortages, resulting in bed shortages and the need to divert patients to other facilities (Poland et al., 2005).

A large medical center in the Chicagoland area has mandated influenza vaccinations for all employees, students, and volunteers. Exceptions are made for those with proof of valid medical or religious reasons. Discussion with employees raises concerns that this mandate has been very controversial, as many workers believe that an employer does not have the right to decide what is done to their bodies. A review of the literature shows that this has been controversial in other locations as well (Anikeeva et al., 2009).

Preexisting Policies

With the increasing concern about influenza, some healthcare institutions are beginning to develop policies regarding employee vaccination. These policies vary a significant amount, with some simply including emails sent to recommend staff get vaccinated while other institutions are mandating vaccination as a condition of employment (Anikeeva et al., 2009). There are also many institutions that have not developed any type of policy regarding employee vaccination (Goldstein et al., 2004).

The National Foundation for Infectious Diseases (2004) recommends many strategies for

increasing employee vaccination rates. It suggests having a leader responsible for administering the employee vaccination program. Additionally, it discusses that support from top management is essential, particularly having top management get vaccinated. NFID (2004) also recommends using multiple methods of communication to notify employees about vaccination, including email, staff newsletters, and message boards — emphasizing that these communications should be done in multiple languages. Furthermore, it is suggested to educate employees about the benefits of vaccination and to make the vaccine easily accessible. NFID (2004) recommends removing cost barriers to vaccination, stressing that institutions which are committed to employee vaccination should provide these free of charge if at all possible.

While many institutions are showing commitment to encourage voluntary employee vaccination, other organizations and some states have begun to require influenza vaccination of healthcare workers. On August 9, 2009, the New York State Department of Health issued an emergency mandate declaring that all personnel of certain healthcare settings must receive the influenza vaccination by November 30 of each year. There are exceptions for medical contraindications or if the State Commissioner of Health determines that there is a vaccine supply shortage that year (Kissinger & Cook, 2009). The basis for medical exemption from the vaccine comes from the most recent recommendations of the Advisory Committee on Immunization Practices. Current exemptions exist for those persons who have previously had a severe allergic reaction to the vaccine or a vaccine component, such as chicken eggs (New York State Department of Health, 2009). According to Tucker et al. (2008), fifteen states at the time of their research had enacted influenza vaccination mandates for healthcare workers in long-term care facilities, and five states require vaccination of every healthcare employee, all with appropriate exemptions. Although it appears many institutions are reacting to concerns with recommendations or policies, some have yet to respond.

Policy Discussions

The risk of healthcare employee influenza infection has already been discussed. It has also previously been verified that a high percentage of healthcare workers do not receive the influenza vaccine

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without some type of institutional action. Thus, for the health and safety of the vulnerable populations that healthcare workers serve, taking no action toward encouraging employee vaccination is not a viable option. Hence, it is necessary to determine whether institutional efforts to encourage voluntary vaccination or institutional mandates for compulsory vaccination are necessary.

Many institutions have put forth attempts to increase voluntary staff vaccination through educational, incentive, and other types of programs. Several studies show that these efforts have been effective in some institutions (NFID, 2004; Poland et al., 2005; Salgado et al., 2002). Voluntary efforts have the significant advantage of putting forth the information while still allowing employees to make decisions regarding their own care. However, studies have also found that voluntary vaccination is not typically effective in the long-term (Anikeeva et al., 2009; Tucker et al., 2008). These findings, combined with the overall low percentages of vaccinated employees in recent years contribute to the need for stricter action on an institutional or legislative level.

Mandatory employee vaccination as a condition of employment obviously achieves the highest rates of vaccination. However, there is controversy over whether employers should be able to order an employee to get vaccinated or if this is a medical decision over which employees should have autonomy. Critics suggest that vaccinating employees will not stop the influenza transmission in healthcare facilities, as many unvaccinated visitors will still be allowed to enter (Anikeeva et al., 2009). However, research has proven that increased vaccination of employees is correlated with a decrease in infection rates of patients (Salgado et al., 2002; Tucker et al., 2008). Significantly, according to the Center for Disease Control and Prevention, (1993) immunizing such high rates of healthcare workers may reduce hospital-acquired infection rates by achieving herd immunity. Furthermore, opponents put forth the debate that people generally have a right to accept or refuse medical care. Compulsory medical intervention typically only occurs when patients are incapable of making their own decisions or if there is present and serious danger to another person. These conditions are not met in the case of forcing healthcare employees to be vaccinated.

Moreover, arguments have been put forth that it is rare to compel one to undergo medical intervention

for the benefit of another person. Many of the supporting arguments for mandatory vaccination discuss the benefits to the patients, although it is the healthcare employee who is having medical treatment. It is further argued that there are possibilities of issues with workplace relationships and alienating employees who are forced to get the vaccine solely to keep their jobs. If employees disagree with the policies, they may fight against the policies or leave the organization. It may reduce employee morale if individuals disagree with the policy, but have to comply as a condition of employment. (Anikeeva et al., 2009).

Despite the arguments critics cite against mandatory vaccination, proponents suggest there are many reasons for policies to be enacted. As previously discussed, there are numerous benefits to the patients in healthcare facilities when employees obtain annual influenza vaccinations. Numerous scientific studies have shown the correlation between increased vaccination rates in healthcare workers and decreased infection rates in their patients (Goldstein et al., 2004; NFID, 2004; Poland et al., 2005). Thus, there is an obvious benefit of decreased threat of infection to patients who are often particularly vulnerable to infection. Furthermore, research shows that influenza vaccination of all employees is extremely cost effective in savings due to decreased employee healthcare visits, absenteeism, and medical errors caused by ill employees (Poland et al., 2005; NFID, 2004). An additional benefit to employees is the decreased risk of bringing the infection home to their families (NFID, 2004).

Moreover, there are already several other similar mandates on healthcare employees that have been met with little resistance. Healthcare employees are already required to be vaccinated against hepatitis B and rubella; prove immunity for measles, mumps, and varicella; and have an annual tuberculosis screening (Poland et al., 2005). It can be argued that these also threaten an employee's autonomy, pose risk of side effects, or are done solely for the benefit of another person. However, they are all requirements that must be met by healthcare employees in order to ensure patient safety.

Policy Recommendation

It is the author's recommendation that institutions adapt a mandatory immunization policy with exemptions for medical and religious purposes on a

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case-by-case basis. Medical exceptions would follow the recommendations of the Advisory Committee on Immunization Practices. As discussed above, these include exemptions for those persons who have previously had a severe allergic reaction to the vaccine or a vaccine component, such as chicken eggs (New York State Department of Health, 2009). Religious exemptions are for those such as Christian Scientists and Mennonite community members who do not believe in vaccinations as part of their faith (Ciolli, 2008). These exceptions will require a letter from the employee stating their specific objection and the basis of it in their religion. Even with allowing for exemptions, it is likely that the vaccination rate achieved by mandatory vaccination will be significantly higher than that achieved by any other means. The transmittal risk will also likely be lower as there will be fewer people to potentially spread the infection.

There are implications for medical social workers if mandatory influenza vaccination policies

become enacted. The most direct impact would be that medical social workers would be required to be vaccinated on an annual basis, unless an individual worker qualifies for an exemption. In addition, all members of the healthcare team would be affected if colleagues react negatively to mandatory vaccination policies. Negative reactions can reduce employee morale and cause discord between employees and the organization. There are also potential benefits to social workers, including working in a potentially safer, healthier environment with a decreased risk of infection.

Mandatory vaccination is necessary due to the threat that influenza causes our country each year. Healthcare employees do not achieve a high rate of vaccination voluntarily, thus mandating vaccination is essential to the health and safety of patients. Once mandatory influenza vaccination is enacted, I believe it will become part of the healthcare worker's annual occupational health routine along with tuberculosis screening.

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Designing a Psychoeducational Support Group for Significant Others of Individuals Recently Diagnosed with Alzheimer's Disease

By Robert Smith, Brittany L. Thomas, Emily Shubeck, Sarah Greenwald & Justin M. Baker

Abstract

Existing research cites support groups for caregivers of Alzheimer's patients are effective in mitigating burden and stress while increasing adaptive coping skills. Much of this research has used caregiver in a broad generalized definition, stating caregivers often join support groups after an individual has been living with Alzheimer's disease for a significant amount of time. This article focuses on designing a psychoeducational support group with the following two tenets: (1) the caregiver is the significant other of the Alzheimer's patient, and (2) the individual is recently diagnosed with Alzheimer's disease, inferring early-onset. The proposed group design will include group purpose and structure, preparation, screening and providing a blueprint of topics for a 12-week psychoeducational support group for group facilitators.

Introduction

The increasing incidence rates of Alzheimer's disease and other dementias have had considerable influence on the mental health community and health care professionals (Alzheimer's Association, 2009). As the prevalence of Alzheimer's disease continues to grow in tandem with the aging Baby Boomer population, caregiver burden and stress are slated to become salient public issues. For those family members and spouses who have taken on the responsibility as the primary caregiver for Alzheimer's patients, the implications of the disease can be overwhelming. According to Raybuck (1995), "caregivers must cope with feelings of anger, denial, frustration, grief, isolation and overwhelming burden" (p. 26). Research also suggests that, "family caregivers of Alzheimer's patients are at a

high risk for psychological distress, and exhibit greater rates of clinical depression and depressive symptoms than their matched peers" (Schulz, O'Brien, Bookwala & Fleissner, as cited in Mittleman, Roth, Coon, & Haley, 2004, p. 850). Intervention strategies attempt to provide comfort, support, and education to reduce the negative effects associated with caregiving and empower the individual engaged in this role (Raybuck, 1995).

Currently, 5.3 million people are living with Alzheimer's disease, the most common type of dementia (Alzheimer's Association, 2009). By the year 2030, the population of individuals 65+ with Alzheimer's disease is projected to reach 7.7 million; this represents over a 50% increase from the current percentage of individuals living with the disease (Hebert, Scherr, Bienias, Bennett, & Evans, as cited in Alzheimer's Association, 2009). Presently, close to 10 million Americans serve as informal, unpaid caregivers for Alzheimer's patients (Alzheimer's Association, 2009). This population consists of spouses, family members, adult children, friends and neighbors providing the bulk of assistance with daily activities (Alzheimer's Association, 2009). According to data provided by the Alzheimer's Association and National Alliance for Caregiving (2004), the percentage of caregivers attending to their spouse represents only 6% of the caregiver population. Spousal caregivers are also severely underrepresented in the literature for support groups catering to caregivers of Alzheimer's disease sufferers.

Caregivers may provide a range of tasks, depending on the level of cognitive impairment or physical limitations experienced by the individual with Alzheimer's disease (Alzheimer's Association, 2009). Due to the high degree of caregiver difficulty and progression of the disease, caregivers often experience a

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myriad of "psychological, social, emotional, physical, and financial strains" (Raybuck, 1995, p. 27). Psychological effects may include depression or stress as over 40% of unpaid caregivers report the "emotional stress of caregiving as high or very high" (Alzheimer's Association and National Alliance for Caregiving, as cited in Alzheimer's Association, 2009, p. 38). As indicated by Raybuck (1995), social consequences may include "perceived social isolation, lack of family support, or family conflict" (p.27). Physical health status may also be negatively affected by caregiver status. Self-reported declines in health, decreased immune functioning and reductions in sleep patterns have all been associated with the role of caregiver for Alzheimer's patients (Kiecolt-Glaser, Glaser, Shuttleworth, Dyer, Ogrocki, & Speicher, 1987). Caring for an individual with Alzheimer's disease is also associated with changes in employment (Alzheimer's Association, 2009). Family caregivers may be required to modify their work schedule or even terminate employment in order to provide in-home care or appropriate supervision to persons with Alzheimer's disease (Alzheimer's Association, 2009).

According to Smyth, Rose, McClendon, and Lambrix (2007), caregiver support groups are often endorsed as an appropriate endeavor for caregivers of Alzheimer's and dementia patients. The group structure facilitates a supportive environment that "decreases feelings of isolation and helplessness among members," while encouraging the employment of self-care techniques and positive coping skills (Raybuck, 1995, p. 27). Among support groups for caregivers of Alzheimer's and dementia patients, several common themes emerge: imparting of information, universality, and the installation of hope. Group members often identify and share negative coping strategies they use when caregiving, thus gaining some relief in their ability to relate to one another (Raybuck, 1995). Support groups also serve the essential function of allowing members to come to terms with the diagnosis of Alzheimer's and provide counseling (Mittleman et al., 2004).

Currently, limited research exists regarding the effects of support groups for caregivers with early stage Alzheimer's disease. However, some studies have speculated that this framework would provide therapeutic benefits to its members in terms of "grief work, decreases in feelings of isolation," and enhancing

education, information and resources around this topic (Yale, as cited in Yale, 1999). As the Baby Boomer population prepares to enter the 65+ demographic profile within the next two years, the issues facing Alzheimer's caregivers will become a major community health concern (Alzheimer's Association, 2009). More specifically, the development of support groups for caregivers with the status of "significant other" will need to be addressed as many individuals attempt to age within their own homes under the care of their spouse or significant other. A survey conducted by the AARP in 2003, found that the majority of seniors surveyed had the intention of remaining in their own homes for as long as possible, with the 65-85 age set being the least likely group to move relative to other age cohorts (Greenwald & Associates, 2003). The desire for independence and the maintenance of autonomy among this age group places a much greater burden on the significant other who may also function as the primary caregiver. Caregiver stress, social isolation, and decreased quality of life are major concerns for significant others who have taken on the responsibility of caring for a loved one with Alzheimer's disease. These issues become especially relevant as the disease progresses and the patient's ability to remain self-sufficient becomes compromised over time.

Literature Review

In response to the need for developing an evidence-based support group for significant others of individuals recently diagnosed with early-onset Alzheimer's disease, it was necessary to conduct a literature review of support group programs that utilize multimodal or unimodal interventions. It is important to note that although search terms such as *spousal support groups* and *significant other support groups* were used in database searches, there was little success in finding relevant articles. Therefore, most of the literature review will focus on the efficacy of caregiver support groups of patients with Alzheimer's disease.

There is little doubt that the need for caregiver support groups of Alzheimer's patients is relevant and growing in demand. With no cure and few mitigating measures for Alzheimer's patients, the stress and demands placed on spouses, significant others, children, and friends who provide care can be damaging to their mental and physical health.

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According to Barnes, Raskind, Scott, and Murphy (1981),

Given the absence of a specific medical treatment and formal rehabilitative programs for Alzheimer's disease, the family support group becomes a primary treatment modality for this disorder. Strengthening the morale, emotional well-being, and treatment skills of the care-providing family is perhaps the most important factor in attaining optimal health and function of the patient with early and middle-stage Alzheimer's disease. (p. 84)

According to Wasow (1986), the educational component of support groups is a therapeutic intervention. Having this knowledge can reduce panic in crisis situations, decrease negative emotions such as self-blame and guilt, and normalize stigmatizations that caregivers may be experiencing with the disease. Furthermore, understanding what the disease is, how it progresses, and how it affects behavior is paramount for caregivers who embark on a long journey of providing long and arduous hours of care. Educating the caregiver enhances coping skills and provides a framework for planning for the future.

Interestingly, a study conducted in 1991 by researchers Gonyea and Silverstein revealed that while support group membership was not associated with the families' knowledge of community resources, it was correlated with families' use of formal services. One formal resource caregivers and their families have turned to is support groups established by the Alzheimer's Disease and Related Disorder Association (ADRDA).

The two primary objectives of these groups are to: allow these families a place to meet others coping with a similar set of circumstances and share their concerns; and provide education to families regarding the etiology and symptoms of dementia as well as information regarding community resources (Gonyea & Silverstein, 1991, p. 44).

Gonyea and Silverstein's (1991) results suggest that support group participation is associated with the use of formal services; simply that "support group joiners" are "service users" (p. 51). In addition, exposure in the support group to other caregivers using com-

munity resources may be the impetus for other group members to view the use of formal services as a viable option. Gonyea and Silverstein (1991) suggest "support group [facilitators] might maximize this role of modeling effective service-user families to share with the group why they chose to use a particular service" (p. 52). The study is useful in understanding the benefits of caregiver support groups, but it is under the assumption that the group may have open membership and be ongoing, such as self-help groups. Thus, it may not be applicable to a closed-membership and time-limited support group for significant others of Alzheimer's disease patients.

Wasow (1986) cites that group composition is of particular relevance in achieving positive outcomes for support groups of caregivers of patients with Alzheimer's disease. Wasow (1986) discusses three major dilemmas with respect to group composition: (1) "Is it better to mix spouses, siblings, and children in one group or keep them in separate groups?" (2) Is it beneficial to have support groups that mix members whose relative has just begun to deteriorate with members whose relative is at the end stage? (3) "Should newcomers and experienced group members be mixed or separated?" (p. 95).

In response to these questions, Wasow (1986) is clear that the efficacy of the support group is based on homogenous membership. Caregiver is a broad term to encompass all who may play a role in caring for the patient with Alzheimer's disease. Because the bonds and attachments differ within a family system, the loss of a spouse versus the loss of parent is very different. In addition, mixing caregivers whose relatives are at different stages of deterioration from Alzheimer's disease raises other concerns.

Those who have relatives in the beginning stages of the disease may be frightened as they hear tales of what lies ahead for them. Those whose relatives are in the end stages may feel envy, boredom or even contempt as they listen to those who they believe have it much easier than they do (Wasow, 1986, p.95).

According to Martin-Carrasco et al. (2009), the psychoeducational intervention in support groups can effectively reduce the caregiver burden of those caring for Alzheimer's disease patients. The psychosocial interventions which have received the greatest support are: "information about the disease, organization of

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care, practical advice, skills training for the handling of behavioral problems of the patient, decision-making, and emotional repercussions on the caregiver" (Martin-Carrasco et al., 2009, p. 490). However, the authors stress that the most successful models of intervention are based on prolonged continuous support of the caregivers, which can ameliorate some of the depressive symptoms they feel from the task of caring for an Alzheimer's disease patient. The idea of group interventions with prolonged continuous support is contradictory to the majority of intervention models and techniques of fixed duration and limited to a certain number of sessions (Martin-Carrasco et al., 2009).

In a 1989 study conducted on Alzheimer's disease support groups for caregivers, Gonyea discovered that support groups were less successful in addressing the member's own intrapsychic conflicts including depressive symptoms. Research has found a strong correlation to higher caregiver depression when the patient's dementia is more severe. Furthermore, "little is known about the long-term impact of caregiver interventions in reducing depressive symptoms" (Mittelman et al., 2004).

Mittelman et al. (2004) "suggest that a short course of intensive counseling and readily available supportive maintenance can have long-lasting effects in reducing symptoms of depression among caregivers of [Alzheimer's disease] patients" (p. 855). The idea of reducing depression in the caregiver is often dependent on the amount of time the caregiver has cared for the Alzheimer's patient and the level of functioning of the patient. In a support group of caregivers, the group facilitator may be confronted with the dilemma of support versus therapy.

There are some conflicting views regarding providing therapy to a support group of caregivers of Alzheimer's patients.

Many members of support groups manifest a resistance to painful psychological insights, to the depth of their sad, negative feelings, or to anything that sounds like *therapy*...[and] have the following attitude: *We came here for support – give us that and no more.* (Wasow, 1986 p. 93)

Schmidt and Keyes (1985) reported that caregivers in support groups denied their personal needs, establishing a group defense against individual expressions of anger and grief: "To shatter that defense could promote flight

from the group and deprive the fleeing member of group support" (p. 349). In contradiction, Silver and Wortman suggested "groups have to examine the immediate and long-term effects of ventilating feelings," and "clinicians must identify any limiting conditions on the value of discussing feelings" (as cited in Wasow, 1986, p. 94).

To address this dilemma of therapy versus support, Wasow (1986) outlines the criteria for a successful support group of caregivers of Alzheimer's patients. Efficacy of the support group would be contingent on closed-membership and time-limited to four-week segments. In addition, the group purpose would be to provide educational support as well as address the caregivers' immediate needs and problems with little focus on the intrapsychic conflict. At the termination of the four week group session, members would then be offered another four week session derived from four different models of ongoing support groups: primary focus on therapy; primary focus on recreation; peer run self-help groups – a model similar to Alcoholics Anonymous; or an educational seminar model to continue to provide materials on the latest research on Alzheimer's disease. The third four-week series would allow members to switch groups or move back and forth between them. At the end of the 12 weeks, the facilitator would conduct a post-group questionnaire and have evaluation sessions with group members.

Based on the literature review, the researchers provide a conceptual framework regarding the importance and benefits of support groups to caregivers of individuals with Alzheimer's disease. Nevertheless, the information is generalized to provide a suggested structured outline in preparing and implementing a detailed plan for a 12-week psychoeducational support group for significant others of individuals recently diagnosed with Alzheimer's disease.

Group Purpose and Structure

The proposed group structure would constitute a psychoeducational support group, incorporating therapeutic techniques in addition to educational resources and support. The purpose of such a treatment group will be defined as a psychoeducational group for significant others of patients recently diagnosed Alzheimer's disease. The goals of the group will be to educate and provide emotional support to increase the coping skills and overall well-being of group members.

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To account for possible member attrition and absences, an estimated 14 individuals would be recruited to participate, with the stipulation that they identify themselves as the significant other of an individual recently diagnosed with Alzheimer's disease. The decision to limit group membership to caregivers experiencing the early stages of Alzheimer's disease is based on the assumption that the needs of members would be too varied across stages of the disease. For example, caregivers experiencing the end stages of Alzheimer's may benefit from more grief work, whereas caregivers experiencing the early stages of the disease would be more inclined to address educational components. In Zarit, Femia, Watson, Rice-Oeshger, and Kakos (2004), the authors cite specific needs for early stage Alzheimer's caregivers such as:

improving communication skills with the loved one, learning coping strategies for dealing with memory loss, finding ways for the individual with Alzheimer's to feel useful and integrated into family life, and addressing the experience of intimacy loss or dramatic role change for the caregiver. (p. 262)

Group members will not be discriminated against on the basis of age, race, gender or sexual orientation. "Significant other" in this group design implies a relationship based on marriage, civil union, companionship or status as a life partner.

The timing and duration of this support group would span 12 weeks, with each session conducted weekly for a total of 1.5 hours. During each session, both supportive and educational aspects of the treatment group will be emphasized. Techniques to foster mutual aid and coping, as well as learning opportunities through the use of presentations and lectures will be offered. Educational topics will build in intensity over the course of the group. In earlier sessions, when group members are grappling with building trust and ensuring safety within the group, topics will include denial and isolation. In later sessions, when group cohesion has been established, topics will consist of more difficult subject matters such as intimacy and end-stage planning.

The proposed group commencement time would take place at 11:30 am. An earlier meeting time is preferred for group members to account for possible sundown syndrome in their significant other diagnosed with Alzheimer's disease. Sundown syndrome is the

reoccurring onset of confusion and agitation in individuals with Alzheimer's disease beginning in late afternoon or early evening. According to Little, Stalin, Sunderland, and Volicer (1995), the "behavioral disturbances associated with [sundown] syndrome have been shown to cause significant caregiver stress" (p. 103).

To account for easy accessibility, a large, centrally-located community center, such as a hospital, would serve as the setting for the group. Ideally, group members would convene in a conference room or classroom in the gerontology ward of the hospital. It is important to consider the physical limitations that many older adult members may have; therefore, accessibility and convenience are essential. The hospital setting will also serve those individuals attending doctor's appointments for himself/herself or a loved one.

In the early stages Alzheimer's disease, individuals often can function independently, without the support of assisted living services. Therefore, the significant other can commit and participate in the psychoeducational support unhindered by the need to provide caregiving services. Due to the time-limited and short duration of group treatment, it is essential that members attend every meeting. While it is understandable that issues may arise prohibiting consistent attendance at group sessions, the need for caregiving services has the potential to interfere with group dynamics.

Referrals for group participation will be elicited from physicians, social workers, and the interdisciplinary team of hospital staff. The group facilitator should be an experienced social worker with knowledge of the psychosocial challenges of Alzheimer's disease and an understanding of group work practice. Essential qualities of the group facilitator should include: an empathic and non-judgmental attitude, knowledge of the course of Alzheimer's disease, and the ability to balance the exploration of personal issues with educational topics on the session agenda.

Weekly, the group facilitator may co-facilitate with an expert on the session topic. Expert educational speakers will be drawn from a variety of sources, ranging from nutrition and fitness experts to address issues of self-care, to hospice administrators and lawyers facilitating a discussion on end-stage planning. The combination of education and support components

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utilized by the group facilitator is intended to help members cope with the stressful life event of caring for a loved one with Alzheimer's.

Group Preparation

Once the member list has been compiled with all supporting documentation to include a pre-group questionnaire and informed consent, the group facilitator should place confirmation calls to each member reminding them of the time, meeting location, and any directions. It is essential the group meeting location is conducive to feeling of privacy, comfort and freedom from any type of interference while enhancing the feeling of confidentiality. The group facilitator should be cognizant at all times of maintaining a setting that is supportive, safe, and affirming to members.

Approved agency support and other organization sponsorship are essential and are to be accounted for in group preparation. The group facilitator should be prepared to track and document the efficacy of the support group to ensure continued support and further collaboration with collateral sources. Planned funding will assist in acquiring the necessary equipment, guest speakers, and other support material applicable for this type of group. Guest speakers, educational speakers, and interdisciplinary team members would benefit from extensive consultation with the group facilitator prior to the each session, ensuring continuity and organization in the group process.

In preparing for the psychoeducational support group, the group facilitator should conduct a self-assessment of possible biases and counter-transference issues that may arise while facilitating the group. The group facilitator is ethically and professionally responsible to discuss personal issues in consultation or supervision; therefore, the group facilitator should include either supervision or consultation in the preparatory plan. While the group facilitator does not have to share the same experience as the members, he/she should have extensive working knowledge regarding the challenges and crises that may occur within this type of group setting.

Group preparation involves preparing for attrition by some members due to a constellation of reasons such as rapid progression of the relative with Alzheimer's disease or perhaps the group member requires crisis management and counseling because of extreme intrapsychic conflict and impaired ego functioning. Whatever

the reason, the group facilitator should be prepared and have knowledge of appropriate sources for referrals.

Screening

Under the assumption that Alzheimer's disease afflicts the older population, predictions can be made that the majority of group members will be of senior status; this is an important factor in the screening process as research has shown that this population is often resistant to therapeutic intervention. Clearly, this resistance must be explored in screening interviews of potential group members by the group facilitator with an empathic and genuine approach. The screening interview may occur due to the potential member's own volition based on a doctor's referral, community informational literature, and online outreach. Recruitment for the screening process may also occur through mail mergers and cold calling by the group facilitator, following a similar model that bereavement services uses under the umbrella of hospice programs.

An important aspect in ensuring the group runs smoothly is making sure each member meets screening criteria. These criteria will verify that each member is a "significant other," and that their "other" is in the early stages of Alzheimer's. Based on Wasow's (1986) conceptualization, homogenous groups tend to operate and function more effectively with increased positive outcomes. Homogenous in this respect refers to "significant others" of "early-onset" Alzheimer's patients.

The screening process will consist of one initial interview with the potential group member. The initial interview provides the group facilitator the opportunity to assess the potential member for any complicated psychiatric issues that would cause group disruption thus making the individual inappropriate for a group setting. Ethically, several issues must be addressed in the screening interview for successful transition into the psycho-educational support group. The group facilitator must be as transparent as possible and deliver comprehensive information regarding the group's purpose, the material to be addressed, as well as the benefits and risks to the potential member. The concept of "significant other" may have different meanings to the potential members, especially with an older population. Potential members may have different views regarding their love

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or attachment as being greater than others' based on time spent together with the Alzheimer's patient or marriage. In the screening interview it is paramount the group leader define "significant other" and describe the potential group composition. Potential members must be investigated for prejudices that may surface as discriminatory verbal and non-verbal messages to other members causing discordance within the group setting. Qualifier questions such as: "Are you and the given individual in a relationship based on marriage, civil union, companionship, or status as life partner?" "How were you referred?" "Has a doctor diagnosed your loved one with early-stage Alzheimer's disease?" "Are you able to meet and devote one and a half hours per week during the scheduled group meetings?"

As a safeguard for the group facilitator and the sponsoring agency as well as for the group member, informed consent must be presented to the member in a thorough and comprehensible manner. The informed consent will address all issues of confidentiality, respect, diversity, and beneficence. The significant other who agrees to participate in the group will be given a pre-group questionnaire for several reasons: (1) to get a general sense of the member's expectations of the group, (2) to get a baseline of the member's knowledge regarding Alzheimer's as well as the member's emotional state, and (3) to compare with a post-group questionnaire for program efficacy, future program adjustment, and future funding and sponsorship.

Blueprint of Group Sessions

Twelve salient topics are chosen to focus on through the life of the 12-week group. The following topics will be presented chronologically:

Session One: Educational Overview

The first session will focus on delivering an understandable yet comprehensive overview about Alzheimer's disease. Before the educational overview, members will have a chance to introduce themselves and share their thoughts and feelings regarding their situation and becoming a group member. Handouts will be given to the members, which focus on the three stages of Alzheimer's and their respective symptoms. Potential issues that might arise over the course of living with a loved one with Alzheimer's disease will also be introduced. Lastly, the session will acquaint

members with the eleven topics to be covered in the coming sessions. In-depth sharing is not enforced nor encouraged at this stage of the group cycle.

Session Two: Denial

In the second session the group facilitator will explore and process the issue of denial in a sensitive and empathic manner. In addition, the facilitator will refrain from challenging the defense, instead educating group members of their possible use of denial.

Immediately following the diagnosis, there are many potential reactions for both the diagnosed individual and his/her significant other to experience, commonly manifesting in the form of denial. There may be difficulty accepting what seems to be just a minor memory problem as the manifestation of the beginning of a cognitive degenerative terminal disease. At this stage, the diagnosed individual is likely to be a functional and competent adult, thus debunking the gravity of an Alzheimer's diagnosis. In addition, the significant other has just been dealt a blow – mainly, that his/her loved one has been diagnosed with an incurable terminal disease with a prognosis of months to years. In the health care sectors, a medical diagnosis with severity often prompts the defensive function of denial to protect the individual with the diagnosis and the family from the anxiety and pain of accepting the reality of the potential loss of the loved one.

In the first half hour of the session, the educational component will focus on the minor symptoms of Alzheimer's and life expectancy rates after diagnosis. Following, the group facilitator will open the supportive hour with a sensitive but direct statement about the challenge of accepting and acknowledging an initial diagnosis of Alzheimer's disease. This will encourage further discussion and candidness from group members regarding issues revolving around their or their loved one's denial and how that denial may be manifest.

Session Three: Role Changing

The issue of role changing will be addressed with the group members in the third session. The members may identify as partners, lovers and equals with their significant other; however, the trajectory of the disease will ultimately shift the roles and the dynamics of the relationship. Members will gradually become aware of their ever-increasing shift into new

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and foreign roles such as overseer of finances, grocery shopper, caregiver, and even babysitter.

In the first half hour, the group facilitator will show a video on the topic of role changes in a couple where one is diagnosed with Alzheimer's. Following, the facilitator will invite the group to have an open discussion on their thoughts and feelings concerning the video. Suggestions for possible discussion will include the decision to bring into the home a paid caregiver or home health aide so that the significant other will not feel entirely responsible for physically taking care of his/her partner. Paid-for caregivers and home health aides serve two functions: 1) they provide additional caregiving assistance in what is often referred as the 36-hour day and, 2) they allow for some semblance of the entrenched roles in the relationship of the significant other and the individual with Alzheimer's to remain intact as the paid-for caregiver or home health aid may assist in the shopping, cleaning, and hygienic care of the patient.

Session Four: Intimacy

With the loss of certain roles and the taking on of new roles, there may be a decline or cessation of intimacy between the significant other and their diagnosed loved one. At this stage of the group, the facilitator should be able to assess group cohesiveness and level of trust among the group members, thus enabling the introduction of the sensitive topic of intimacy. The probability is high that most group members have spent a significant amount of their lives in an intimate relationship with the patient with Alzheimer's disease.

Information regarding the fluidity of the definition of intimacy will be presented to group members as well as potential changes in the dynamics of intimacy in the relationship as the Alzheimer's patient's disease progresses. Intimacy may include affectionate gestures, sexual behavior, and verbal statements. Potential early-stage intimacy challenges versus later-stage will be presented for open discussion among group members. Of particular importance is the significant other's transition from lover to caregiver.

Session Five: Loss of Self

The week's topic will address the diagnosed individual's experience with regards to feelings of loss of themselves – their own personality and life story. The salient message to group members is that with each loss

of cognitive ability, it is likely that the diagnosed individuals will suffer from feelings of isolation and detachment from themselves. The group facilitator should skillfully direct the group to view the disease from the perspective of the diagnosed individual and the constellation of challenges brought about by loss of self and the inability to further self-define. Excerpts from the book "Loss of Self" by Cohen and Eisdorfer (1986) will be read and then discussed in the second half of the session.

Session Six: Self-care

The week's topic will emphasize the importance of self-care for the significant other. As an activity, the group facilitator will pass out a questionnaire (not to be returned, but just to get members thinking) with questions such as, "When was the last time you did something for your own personal enjoyment?" and "When was the last time you left the house for recreation?"

The facilitator will also provide group members with a list of a 100 ways to engage in self-care, asking each group member if they can identify three items on the list that appeal to them and may be incorporated into their life routine to decrease stress and promote self-care. The goal of this topic is to invite the perspective that significant others engage in self-care behaviors while simultaneously caring for a loved one with Alzheimer's disease. In tandem with the goal, it is believed members will discuss what they do or do not do for their own self-care and then encourage and suggest options for their fellow group members.

Session Seven: Safety

The first half hour will be devoted to discussing safety issues with Alzheimer's patients. A guest speaker will present and educate on four subtypes of safety to include: safety at home, safety for the diagnosed individual, safety for caregivers, and safety when going out.

The second half of group will focus on specific and individual issues that members are struggling with, with regards to keeping themselves and their loved one safe. Topics might include night wandering, the question of keeping doors locked or unlocked and when or if to restrict the individual with Alzheimer's from certain activities such as cooking and driving.

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Session Eight: Family Conflict

Week eight in the support group itinerary will address the reality of potential family conflict. Every family has their own unique situation and circumstances that can lead to difficulties and potential conflicts within the family system. When a diagnosis like Alzheimer's disease occurs in a family, the dynamics in family functioning must be assessed before providing direction to avoid escalating family discordance. The group facilitator should refrain from advice-giving in dealing with family conflict, rather only bringing awareness to the potential for conflict to occur and then deferring the members to seek more of an individualized therapy with competence in the affects of terminal illness on family systems.

Possible topics for discussion may include whether group members have children. If there are children, are they mature and responsible with goals that are congruent with the caregiver? Will the children provide support and respite for the significant other? Are the children with financial security willing to be a monetary resource to provide additional and more comprehensive care as the Alzheimer's patient's plan of care becomes more costly? Additionally, discussion may include the assignment of particular roles in the multiple aspects of caregiving and whether assuming those roles have caused conflict.

All of the preceding topics have the potential to cause family disruption and conflict. Group members will be encouraged to share thoughts and emotions regarding any family conflicts they are currently experiencing as a result of the Alzheimer's diagnosis.

Session Nine: Will and Living Trust

Advance directives are often not addressed until a terminal diagnosis is given to an individual. The week's topic will include a guest speaker who will impart and stress the importance of sitting down with the diagnosed partner and composing a will and/or living trust while the diagnosed individual still has the capacity to have self-determination translated into a legal document. Handouts will be given to group members that provide guidelines and referrals to address this topic. Having advanced directives in place, such as a Do Not Resuscitate (DNR) order, can alleviate future crises. Deferring to wishes of the individual with Alzheimer's disease alleviates the burden on the part of the significant other of having to make difficult

decisions that may not be congruent with their loved one's goals. Once again, the group facilitator will address this topic using an empathic and sensitive approach as the topic reinforces the gravity of imminent death of the patient with Alzheimer's.

Session Ten: Services Available

At this stage of the group cycle, members should realize that they soon may be unable to handle the myriad of challenges in caring for the Alzheimer's patient. Once again, a guest speaker with an expertise in case management will provide an educational discussion regarding specific organizations and information about various public and private funding sources that can assist in providing care and comfort for the Alzheimer's patient as well as for the significant other. Following the guest speaker, the group facilitator will encourage members to disclose and network with other group members any information regarding services such as foundations, agencies, and day centers that they currently use or plan to use in the future.

The facilitator will be informing the group members of upcoming termination of the group so members can begin to process the gains of being in the 12-week group and the loss they may feel once the group has terminated.

Session Eleven: When and if to Transition out of Significant Other's Care

The week's topic is highly individual and unique to each group member and their partner diagnosed with Alzheimer's. The decision whether to place the patient in an institution is probably one of the most difficult decisions the members will have to make for their loved ones as their decline makes manageability at home no longer a feasible option. The group facilitator will show a video to members presenting the potential burdens and benefits of nursing homes, assisted living housing and other institutions. Possible alternative options will be presented, including having a full-time nurse living at the home, moving in with children if possible, or moving together to an assisted living complex. Of paramount importance is the group facilitator's emphasis on the significant other's consultation with medical and psychosocial staff currently providing care for the Alzheimer's patient.

During the supportive session, members are encouraged to share thoughts and feelings regarding the

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topic. Guilt, especially, will be addressed, as this is a major reaction to transitioning their loved one into an institution as it is an acceptance they no longer have the capacity to care for or save their loved one. Currently, members do not face this difficult decision situation, but advanced discussion may mitigate some stress and prepare members for common emotions.

Session Twelve: Grief

During the last session, the group facilitator will dedicate the full session to a supportive atmosphere regarding group members' current grief and how that grief will change as their partner with Alzheimer's declines to eventual death. The facilitator will normalize common grief reactions the members may feel currently and those that may happen after the death of their loved one. As part of termination the group facilitator will ask members about any grief they feel about leaving the group. Finally, the group facilitator will provide members with a packet of resources containing relevant information to the topics discussed, referral resources, concrete services, and bereavement resources.

From a strengths-based perspective, the group facilitator will end the session by asking each member to each identify a strength they have that will assist them in their journey as they care for their loved one. The facilitator will also ask members to each identify some component of the group that has been beneficial to their investment in the group process.

Group Purpose Assessment

In order to ensure that the purpose of the support group for the caregivers will be met, it is important to monitor the group's progress. This can be done using a variety of methods. One way to achieve this goal is through self-monitoring. The group facilitator would encourage members to journal between each session in order to monitor their progress in the group and at home with their significant other. Since this support group has an educational component, it is necessary to get feedback regarding the benefits of the knowledge imparted during each session. Another way to evaluate the group's progress is by having members complete a post-group questionnaire. As stated before, pre-testing each individual prior to the group will help to determine key topics and issues to address during each weekly ses-

sion. The post-group questionnaire will determine if the support group was effective. It is necessary to receive feedback on the guest speakers, the length of the sessions, the topics discussed and how each individual's emotional and mental state has improved since beginning the group.

Continuing Services

Successful models of intervention are centered on providing prolonged continuous support that caregivers may need, even after the psycho-educational support group has ended. Once the initial psychoeducational support group has ended, the group facilitator should conduct a follow-up session with each member 4 weeks after the last meeting and again 12 weeks later; this will help monitor the conditions of both the significant other caregiver and the Alzheimer's patient. If needed, the group facilitator would provide caregivers with recommendations on other services and programs that offer continual support, such as groups and/or individual therapy. Since the psychoeducational support group focuses on caregivers caring for their significant others that are in declining health, it would be detrimental and unethical not to provide them with referrals that could offer continual support dealing with individual issues that may have not been addressed in the support group. Of additional importance is providing members with information on programs and services that may address their medical and financial needs as well as the needs for their significant other as his/her health continues to decline.

Limitations

There are some limitations to consider when creating a psychoeducational support group for this population. Even though the group focuses on caregivers that have a significant other in the early stage of Alzheimer's, there is no control over how quickly each Alzheimer's patient's health may deteriorate; some may decline quicker than others causing a disruption in the group dynamics. There may be difficulty for a particular member to stay committed to the group and the weekly topics when the significant other is in a rapid disease progression. Circumstances of such may lead to other members in the group becoming disheartened and focusing on issues that they may have not encountered

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yet with their significant other. Additionally, an issue that might affect the group process would be the design of designated topics for each weekly session. Even though the topics created are focused on key issues that are seen in the caregiver/significant other relationship, the structure of the sessions may make the support group feel rigid. Members may want to continue discussing a topic from a previous session into the current session. By the group being structured this way, certain members may feel that they are not getting the necessary support they may need as well as that their expectations are not being met. When designing this type of a group, the group facilitator should have foresight and anticipate these limitations and effectively address them to ensure continuity and cohesion throughout the life of the group.

Further Discussion

In summary, this article reinforces that significant other caregivers should have the opportunity to receive psychoeducational support services in a group modality immediately following an Alzheimer's diagnosis of their loved one. Often, support groups are offered and available after the caregiving ends instead of when the caregiving begins. As with any individual diagnosed with a disease, the medical profession is ethically responsible to attend to the discomfort and stress of their patients and recognize that quality of life starts in the here and now. As social workers, counselors, group workers, and other ministering professions, it is our ethical responsibility to provide services to not just alleviate burden and stress but to prevent potential stress and burden with our clients. It is the authors' hope that individuals involved in groupwork practice with caregivers find this psychoeducational support group design and blueprint of sessions a useful working model in their provision of services.

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**Restoring Sense of Self:
Culturally Congruent Therapeutic Services with
Latinas Who Have Been Trafficked into Sex Work**

By Liza Brockway & Hilary Currin

Abstract

As attention to the trafficking of Latin American women into sex work has increased in recent years, international conventions have required that recovery service workers receive training in the particular needs of survivors. These requirements bring up several salient issues concerning the special needs of Latina survivors of sex trafficking, such as services that are culturally congruent. This paper will discuss sex trafficking in Latin America, explore the unique cultural implications of sex trafficking in the lives of Latin American female survivors (for whom the authors use the appellation Latinas), as well as provide a framework to culturally congruent therapeutic practice with Latinas who have been trafficked into sex work.

Introduction

Shockingly parallel to the global trade of exotic products and produce from countries that are often impoverished, the bodies of Latin American women and girls are commoditized within the realm of the global sex trade. While the buying and selling of women and girls for sex is a long-standing practice that has roots embedded deep within patriarchal attitudes and structures that have objectified and devalued women and exploited the impoverished and marginalized for hundreds if not thousands of years. However, only in recent years global attention to sex trafficking has increased (Phinney, 2001). With new global outcry against this horrific violation of human rights, multiple international conventions have been established, including the Inter-American Convention to Prevent, Sanction and Eradicate Violence against Women

(Convention of Belém do Pará) and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime (United Nations, 2001). Among other measures, these conventions require prevention, investigation and punishment of trafficking and violence against women, as well as provision of specialized care and recovery services to victims and training of those who provide services (Tsutsumi, Izutsu, Poudyal, Kato, & Marui, 2008). However, little work has been done to shine light on the particular implications that sex trafficking has on the lives of Latina victims.

Several scholars have asserted that in light of the multitude of needs of trafficking victims, the residual effects of trauma and cultural factors specific to Latinas, traditional therapy may not be a culturally competent nor an effective approach (Chung, 2009; Comas-Diaz, 2006; Shigekane, 2007). In order for practitioners to provide services based on best practices for Latina victims of sex trafficking, they must first understand the social and political contexts that create conditions of vulnerability for Latin American women and girls as well as have an understanding of the cultural constructs and beliefs that hold implications for the provision of therapeutic services to victims. With that knowledge as a foundation for culturally congruent practice, practitioners can seek to provide culturally relevant services that appeal to Latinas' sense of self in the context of family, community, and culture. Thus, based on literature on human trafficking in the Americas, sex work recovery, and Latino cultural perspectives on healing and sexual trauma, the purpose of this article is fourfold: i) to provide an overview of sex trafficking in Latin America; ii) to discuss the

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cultural implications of sex trafficking on Latina victims; iii) to provide a framework for culturally congruent therapeutic interventions for Latinas who have been trafficked into sex work; iv) and to provide recommendations for future research.

Trafficking for Sexual Exploitation

U.S. law defines sex trafficking as a severe form of trafficking persons...in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age...for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. (U.S. Department of the State, 2010a, p. 9)

In recent years, global attention has shifted its focus to what appears to be a growing and devastating trend. However, sex trafficking is a well-established business that only recently started attracting the interest of the world as the media began to highlight the victimization of blonde-haired, blue-eyed females (Hynes, 2002). While reliable data and exact figures are notably difficult to calculate due to poor record-keeping and the slippery nature of monitoring and uncovering trafficking, the State Department estimates that a minimum of 100,000 Latin Americans are trafficked internationally every year, yielding a profit that exceeds \$16 billion per annum, as estimated by The International Organization for Migration (Seelke, 2009). Each year, an estimated 17,500 Latin Americans are trafficked across borders into the United States (Seelke, 2009). According to the U.N. Office on Drugs and Crime, females comprise the majority of total human trafficking victims (65-75%), while the International Labor Organization concludes that females are "98% of victims in forced commercial sexual exploitation" (Seelke, 2009, p. 4). Exact numbers for Latina victims were not provided, though "a recent investigation estimates that some 10,000 women from southern and central Mexico are trafficked for sexual exploitation to the northern border region each year" (Seelke, 2009, pp. 6-7).

Since the installation of the Trafficking Victims Protection Act (TVPA) in 2000 and the introduction of the Trafficking in Persons (TIP) Tiered List in 2005, many Latin American countries have been identified as places of major source, transit, and/or destination of human trafficking for sexual exploitation. This report "lists countries on three tiers based on their

governments' efforts to comply with the 'minimum standards for the elimination of trafficking' found in Section 108 of the TVPA" with Tier 1 representing the highest level of compliance and Tier 3 the demonstrating poor compliance and minimal effort to comply (U.S. Department of the State, 2010b, para. 7). The first list in 2005 cited Latin America for not effectively addressing TIP and meeting the TVPA minimum standards, awarding Latin America the dubious honor as the region with the highest percentage of countries with a Tier 3 rank and Tier 2 Watch List status (Ribando, 2005). Latin American countries have made significant strides since 2005 to improve their compliance with TVPA guidelines with several countries shifting to Tier 2 status and only Cuba and the Dominican Republic remaining a Tier 3 nation (U.S. Department of the State, 2010c).

Factors Contributing to the Trafficking of Latinas into Sex Work

There are numerous contributing factors to this global human rights epidemic. Researchers view this booming industry as a direct result of globalization and the pure economic principles of the abundant supply of subjugated, disenfranchised, and exotic women and the demand for market-rate, non-committal sex (Phinney, 2001). Research indicates that this demand may be driven by a number reasons, including "the perception that [men] can ask a prostitute to 'do anything'...that sex is necessary to their well-being...and the feeling of power experienced in sexual encounters with prostitutes" (Phinney, 2001, p. 1). At its roots, demand "may be motivated by sexual desires, for others it is an expression of misogyny and/or racism" (Phinney, 2001, p.1). Poverty, debt bondage, migration, immigration status, and patriarchal cultural factors all play a precipitating role in the sex trafficking of women (Hynes, 2002; Phinney, 2001; Seelke, 2009).

Latin America is riddled with economic strife and deprivation. The World Bank's 2008(b) statistics show an unemployment rate of 7.3% and a vulnerable employment rate of 31.7% for Latin America and the Caribbean while the U.S. unemployment was at 5.8 % (Central Intelligence Agency, 2008b). This is further compounded by the uneven distribution of wealth. For example, data shows that 30.7% of El Salvador's and 59% of Honduras' population lives below the national poverty line as compared to 12% of the U.S. (Central Intelligence Agency, 2004; Central Intelligence Agency,

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2006; Central Intelligence Agency, 2008a). Extremely uneven distributions of wealth create a larger pool of economically vulnerable people. In El Salvador, the poorest 20% of the population holds only 4.3% of the nation's wealth (World Bank 2008a), which is only slightly better than conditions in Honduras, with the poorest 20% of the population holding only 2.5% of the nation's wealth (World Bank, 2006). Such extreme poverty leaves families and individuals vulnerable and desperate, willing to trust bondage debtors and sell family members into sexual labor (Hynes, 2002; Seelke, 2009). Traffickers tend to prey on people of low socioeconomic status who are susceptible to promises of higher wages and situations that force families to make desperate decisions. Poverty is viewed as a motivating factor in migration, tempting Latinas to seek better fortunes abroad (Hynes, 2002).

Migration is a key component in the sex trafficking industry. In many Latina migrants' attempts to escape poverty, natural disasters, and political terror, restrictive immigration policies in many destination countries lead multitudes of Latinas to travel under dangerous conditions to immigrate clandestinely (Seelke, 2009). The vulnerability of many migrant Latinas lends them to easily being funneled into treacherous relationships and deals with *coyotes* (people smugglers) and other opportunists. Traffickers may promise safe passage across borders to entrap Latinas into debt bondage, charging hefty fees due to the increased dangers they face in smuggling. Women are then ensnared in a struggle to repay this debt or face severe consequences, such as the threat of deportation or harm to their families (Hynes, 2002). As migrants, Latinas often face separation from family and support networks, anxiety regarding their precarious positions as undocumented and socially unacceptable sex industry workers, and an utter lack of knowledge regarding available resources and their own basic human rights (Hynes, 2002). Many victims of sex trafficking are young and therefore more susceptible to deception from traffickers during the recruitment stage. Additionally, women may submit to trafficking, viewing it as a means to obtain a better life (Gajic-Veljanoski & Stewart, 2007). This, however, does not legitimize trafficking, for "consent is a requirement of a continuous nature... most cases of trafficking are cases of vulnerable victims...it is impossible to consent to exploitation" (Gajic-Veljanoski & Stewart, 2007, p. 341).

Culture also plays a crucial role in the composition and maintenance of sex trafficking. The

very core of sex trafficking is the patriarchal view of women and the possession/ownership of their minds and bodies (Phinney, 2001). Lingering chauvinistic attitudes and practices of *machismo* lead to objectification of and discrimination against women and girls and are a propelling force that fuels the exploitation and degradation of vulnerable Latinas in the sex trade (Seelke, 2009; Phinney, 2001). According to Santos-Ortiz and Muñoz-Vásquez, "in traditional Latino cultures, sexual relations are viewed as a fundamental struggle, something females should try to avoid, and males should try to obtain from women and girls" (as cited in Fontes, 2007, p. 65). This cultural expectation of males to pursue and dominate women as well as the subsequent social rewarding of men who succeed in overcoming women's attempts to resist legitimate aggression toward women play a pivotal role in the sex trade.

Physical and Psychological Consequences of Sex Trafficking on Victims

Female victims of sex trafficking face a myriad of physical and mental health complications. According to Gajic-Veljanoski and Stewart (2007), "physical and sexual abuse, social restriction and marginalization overlap with psychological abuse, further jeopardizing women's mental health" (p. 345). Studies indicate high levels of depression, drug/alcohol abuse, somatic symptoms, suicidal ideation, and post-traumatic stress disorder resulting from exposure to forced sexual exploitation and enslavement (Barrows & Finger, 2008; Gajic-Veljanoski & Stewart, 2007). Women who are trafficked into sexual exploitation often develop chemical dependency during their traumatic experience, either as a coping mechanism to avoid pain or through forced substance consumption to increase compliance with abuse. Bepko and Krestan suggest that women's feelings of powerlessness also contribute to their abuse of substances (as cited in Mora, 1998). In addition to mental health complications, sex trafficking victims are prone to health risks such as injuries from physical torture, beatings, and rape; reproductive health problems; tuberculosis; and a variety of STDs, including HIV/AIDS. Poor access to health care merely compounds the mental and physical health complications associated with sex trafficking (Gajic-Veljanoski & Stewart, 2007).

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Cultural Implications for Sexual Trafficking in the Lives of Latinas

Latina Gender Roles

While Latino cultural norms differ according to nationality, region, history, socioeconomic level, and other important factors, we can look to broader Latino gender expectations of females to inform our understanding of how the tens of thousands of Latinas who are trafficked into sex work each year may experience the trauma of their exploitation. Latina femininity constructs are often described through the concept of Marianismo, which “originally stems from worship and emulation of the Virgin Mary, connoting women’s moral superiority alongside and admirable ability to endure suffering inflicted by men,” (Low & Organista, 2000, p. 141). While some Latinas advocate for the adoption of Hembrismo, a more progressive conception of Latina femininity (Low & Organista, 2000) which will be further addressed below, Marianismo continues to be an influential social construct that informs the development of female gender roles throughout Latin America. The perceived connection between femininity and the Virgin Mary has both positive and negative implications in the lives of Latinas. While Marianismo honors a woman’s capacity to be a mother, it also venerates chastity and virginity and thus requires a level of sexual purity that does not allow for sexuality to enter into the dimensions of acceptable womanhood. According to Low and Organista (2000), “Marianismo implies sexual purity and suppression; women are responsible for keeping themselves pure before marriage and once married they should not enjoy sex too much,” (p. 141). Fontes (2007) explains that in Latino culture, a girl or woman’s value as a female “may hinge on her chastity,” (p. 65).

Rape Myths and Assignment of Blame

Within traditional Latino gender roles, women are perceived to be responsible for men’s sexual arousal and behavior, which leads to the sociocultural perpetuation of victim-blaming and assailant-excusing rape myths (Low & Organista, 2000). In a study comparing beliefs about rape among Latina, African American, and non-Hispanic Caucasian women, Leafley et al. (as cited in Low & Organista, 2000) found that more than the other populations studied, Latinas internalized and accepted rape myths that assigned responsibility to the victim for her dress or behavior, as well as expressed the belief that women are responsible

for controlling both their own as well as the sexuality of men. Within Latino culture, members of the community may also be less likely to have sympathy toward victims of sexual assault or exploitation due to the traditional adherence to the belief that women are responsible for their own assault.

Shame

According to Clutter and Zubieta (2009), within the collectivist Latino value system, honor (both personal and familial) is a central value promoted by families, consisting of what Fontes (2007) describes as “a claim to worth along with the social acknowledgement of worth” (p. 63). Shame acts as the opposite of honor, existing when one is perceived by oneself, the family, or the community as unworthy. Victims of sexual abuse and exploitation often feel that they are soiled or spoiled, and therefore wholly and perhaps forever unworthy (Fontes, 2007). These cultural beliefs can compound the trauma of sex trafficking. Entrenched gender role expectations of chastity as well as victim-blaming rape myths often trap women in a paradoxical snare, causing intense shame and further isolation from the support of family who may disapprove of unfortunate victims. Rape myths and stringent gender roles create such rigid standards for women that reintegration may seem like an impossible and unlikely dream. The resulting despair may be so powerful that any possibilities of escape are obscured by the debilitating stigma and shame of sex trafficking (Fontes, 2007). When women do manage to escape from sexual exploitation, their sense of shame may be so strong that they cope with their trauma through avoidance, even fearing to admit their victimization to family members (Low & Organista, 2000).

Therapeutic Framework for Working with Adult Latina Survivors of Sex Trafficking

Among victims of violence, Latina survivors of sex trafficking present unique needs for services. Shigekane (2007) suggests that the needs of trafficking survivors exceed those of other marginalized groups because their experiences of severe physical, sexual, and psychological abuse, domination by others, acute trauma, and isolation from family require longer and more time-intensive service delivery. Many victims were trafficked at a young age and have experienced years of trauma and abuse. In comparison with other victims of crime, trafficked women experience higher levels of fear, more severe trauma, and less stability

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(Clawson, Small, Go, & Myles, as cited in Gajic-Veljanoski & Stewart, 2007). When compared with women who were trafficked into other forms of forced labor, women trafficked into sex work were found to have higher levels of anxiety, depression, and PTSD (Tsutsumi et al., 2008). Because of the complexity of the experiences of women who have been trafficked into sex work, Gajic-Veljanoski and Stewart (2007) recommend a multi-dimensional approach that integrates sexual assault, sex work, and addiction recovery services that are culturally informed and molded to meet survivors' needs.

Considering the application of Western therapeutic models to Latinas as well as victims of sex trafficking, scholars warn that many mainstream models' incongruence with the victim's culture of origin often alienates clients from treatment (Chung, 2009; Comas-Díaz, 2006; Shigekane, 2007). Additionally, a therapist's inability to speak Spanish can act as a barrier to the development of the therapeutic relationship by fostering miscommunication and a lack of understanding. If services are to be effective and align with the cultural experience of Latina victims of sex trafficking, service providers must rise above simple cultural sensitivity and toward an integration of Latino ethnic psychology and healing practices into treatment.

Healing Rooted in Raza Ethnic Identity

While there is much cultural and linguistic heterogeneity among and within Latina groups, programs that honor and validate cultural uniqueness and at the same time identify and utilize commonalities with Latina culture can foster empowerment and lead to healing (Mora, 1998). Among most Latinos, healing has its roots in Raza worldview (Comas-Díaz, 2006), which is paramount to the identity and wellbeing of the individual, family, and community (Falicov, 1998). Within Raza worldview, self-definition occurs within the collective contexts of family, ancestors, community, ethnicity, environment, and spirituality (Comas-Díaz, 2006). Contrary to Western notions of development such as separation, individuation, and differentiation, Latinos embrace a worldview that emphasizes connectedness, harmony, and holistic orientation (Comas-Díaz, 2006). Within Raza culture, *familismo* is elemental, denoting the natural extension of kinship beyond the nuclear family and yielding companionship, emotional proximity, interdependence, and emotional support (Comas-Díaz, 2006; Falicov, 1998).

In light of Latinos' common history of oppression and colonization, Latino ethnic psychology

seeks the restoration of connectedness, liberation, and ethnic identity validation (Comas-Díaz, 2006). Seamlessly integrated with a spirituality of emancipation, Latino ethnic psychology aims toward "calling back the spirit", which entails a "spiritual resilience and empowerment through affirmation of ethnic roots and practices" (Comas-Díaz, in press, as cited in Comas-Díaz, 2006, p. 440). *Sabiduría* is the ultimate goal of Latino ethnic psychology, referring to a spiritual and existential wisdom that entails perceiving obstacles in life as opportunities for growth and development (Comas-Díaz, 2006).

In the realm of traditional Latino culture, health is often conceived three-dimensionally as a harmonious integration of spirit (the religious/spiritual dimension), soul (the affective/emotional dimension) and body (somatic processes of health and illness) (Zacharias, 2006). Comas-Díaz (2006) suggests that illness arises when one becomes disconnected from oneself, one's community, and one's culture, and Ruiz notes that healing involves a reconnection with one's self (as cited in Comas-Díaz, 2006). Given the disconnection from their bodies that so many victims of sex trafficking experience in addition to their extreme isolation from family and sense of failing to uphold cultural values of femininity, Latina victims of sex trafficking, perhaps even more than other Latinos who receive services, are in great need of culturally congruent interventions that seek to restore their sense of connection to self, family, and culture.

Culturally Congruent Interventions Integrating feminist therapy and the ethnic psychology of Latinas

In helping Latinas heal from the violence and trauma of sex trafficking, clinicians can foster healing by integrating the ethnic psychology of Latinas with feminist therapy. In their work on sexual assault treatment for Latinas, Low and Organista (2000) recommended attending to Latina's ethnic and gender identity through culturally congruent feminist therapy in order to foster reestablishment of a positive self-concept. Latina victims of sex trafficking require an emancipatory empowerment approach, which Nelson (2006) describes as emphasizing "the recovery of self, which serves as a direct contradiction to the imprisonment of self under the umbrella of prostitution and trafficking" (p. 9).

Considering the sense of responsibility and shame that Latina victims of trafficking often

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experience, such an approach would entail challenging the disempowering sociocultural narratives that bind feminine worth to chastity and propagate traditional rape myths that place blame on women. Low and Organista (2000) recommend offering *Hembrismo* as an adaptive and progressive alternative to the traditional gender role of *Marianismo*, whose implications of shame and victim-blaming can inhibit the healing process for Latina survivors of sexual exploitation. *Hembrismo* is a sex positive Latina style of being that celebrates Latinas' agency, perseverance, strength, resilience, and ability to overcome adversity (Comas-Díaz, 1989; Low & Organista, 2000). Such an emancipatory process to healing should also include redefining rape as "sexual, genital contact without consent even if a woman dresses in an attractive manner or expresses romantic attraction and affection to a potential assailant" (Low & Organista, 2000, p. 151). Retelling the traumatic experience in order to reassign blame to the aggressor and develop new, adaptive means of coping can also aid in the healing process (Ho, Rasheed, & Rasheed, 2003).

Family therapy

By adopting a collectivist perspective, clinicians will be able to better serve their clients without asking the traumatized to adhere to an alien worldview (Low & Organista, 2000). Because many Latinas experience definition of self in relation to the context of family, practitioners must regard them not only as individuals, but also as members of a family and a community. While many victims of sex trafficking have traveled without family or a support system, some manage to reunite with family in the host country. The possibility of engaging in family therapy can be a powerful element in the process of reconnecting with one's sense of self.

For Latino families coping with the trauma of sex trafficking, techniques from narrative therapy are particularly pertinent, such as externalizing the traumatic experience "so it is not nested in the individual or within the family" (Ho et al., 2003, p. 168). In the process of reconstructing the family's narrative of the experience of sex trafficking, the counselor should emphasize that the trauma of sexual exploitation as well as the family's misconceptions of sexual exploitation hurt not only the victim, but the entire family through secondary victimization (Low & Organista, 2000). If family members blame the victim for being trafficked, counselors should provide

psychoeducational materials that redefine sexual abuse and trafficking (Low & Organista, 2000). While fostering an environment of support for the victim, the counselor may also need to help male family members process feelings of guilt surrounding their inability to provide protection, in addition to helping the entire family process their powerlessness to change the past (Low & Organista, 2000). If the survivor is able to reunite with her children, the counselor can play an important role in the redevelopment of the mother-child relationship and in processing the trauma caused by the relationship's disruption. Throughout the entire process of reconstructing the family's narrative of the trauma experience, the counselor should seek to foster more empowering means of coping and emancipatory perspectives of the trauma.

Holistic approaches

In sculpting interventions with Latina survivors of sex-trafficking to be congruent with Latinas' ethnic worldview, psychology, and perceptions of healing, clinicians should approach their work through holistic integration of mind and body. In their work on somatization, Canino, Rubio-Stipec, Canino, and Escobar (as cited in Comas-Díaz, 2006) found that, in comparison with other ethnic groups, Latinos demonstrate greater integration and expression of mind-body experiences. In Cane's work with traumatized Latinos (as cited in Comas-Díaz, 2006), she found that an integration of self-healing mind-body-spirit techniques such as acupressure, visualization, spiritual ritual, breathwork, body movement, and Tai-Chi yielded a reduction of symptoms of PTSD and traumatic stress. Practitioners can integrate those techniques, as well as dream interpretation, drama, storytelling, drumming, altar-making, and art with Latina victims of trafficking as well as their families in order to provide culturally congruent healing experiences (Bermúdez & Bermúdez, 2002; Chung, 2009).

Collaboration with indigenous healers and integration of folk healing practices

In light of the sense of brokenness, unworthiness, and disconnection Latina victims of sex trafficking often experience, collaborating with traditional healers such as *curanderas* and *santeras* (folkhealers) or *espiritistas* (mediums) can provide an inherently authentic and empowering participatory experience that is grounded in Latinas' homeland practices (Kaptchuk & Eisenberg as cited in Comas-

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Díaz, 2006). Informed by indigenous healing methods, practitioners can develop rituals of spiritual healing and psychosocial cleansing that address the experiences of victims of trafficking (Chung, 2009). Clinicians together with victims and their families (if present) can design a *limpieza*, (traditional spirit-body cleansing) or shame-releasing ritual, being sensitive to the timing in order to ensure that the client is ready for the intervention to avoid premature closure or forgiveness (Fontes, 2007).

Testimonio

Through work with Latina survivors of sexual, political, and other forms of trauma, Chilean clinicians developed a practice called Testimonio, in which the survivor's oral, visual, or verbal recounting of the trauma takes a primary role within the process of healing (see Aron, 1992). Within Testimonio, the clinician acts as a witness of the client's trauma, maintaining a supportive stance and making clear to the client that she or he "is not shocked or repulsed by the client's story, or by the client" (Fontes, 2007, p. 79). Throughout the process, the clinician allows the client to tell her story as many times as she needs (Fontes, 2007). Testimonio emphasizes the familial and communal effects of the trauma and provides an avenue for social action through the creation of artwork that exposes oppression and injustice (Comas-Díaz, 2006).

Therapeutic groups

In his work on women exposed to sex work, Nelson (2004) found that many women value therapeutic groups as a context for recovery because they provide an environment in which women can reveal their trauma to others who understand their experience. Fontes (2007) recommends that Latina clients have the opportunity to participate in group therapy in their native language. Nelson (2004) asserts that advocacy group models are much more successful than unstructured peer support groups with trafficked women, while Shigekane (2007) warns that peer support groups have yielded negative outcomes as early interventions due to the environment of competition, favoritism, and loyalty that traffickers often create among victims. Thus, before a counselor refers a survivor of sex trafficking to a therapeutic group, she or he should assess the client's readiness for group participation and the particular type of group that will best address the client's needs.

Cognitive behavioral therapy

Low and Organista (2000) recommend the use of culturally-tailored cognitive behavior therapy (CBT) with Latinas who have experienced sexual violence. Comas-Díaz (2006) explains that CBT can be modified to the intrinsic cultural resilience of Latinas as expressed in the adaptive value of *sobreponerse* (overcoming problems, adversity, or trauma), as well as the Latino value of regarding trials as opportunities for personal growth and the development of *sabiduría* (spiritual and existential wisdom). Muñoz and Mendelson (2006) identify other key elements of CBT adapted to Latino clients: the involvement of the client in developing interventions and the inclusion of Latino collectivist values and spirituality (as cited in Comas-Díaz, 2006). With the client and the family, culturally congruent CBT can be a powerful tool in the cognitive restructuring of the concepts of purity, rape, and shame, and can also help redefine the "stained victim role to an injured survivor in need of healing via helpful beliefs, activities, social supports, and sensitive services" (Low & Organista, 2000, p. 152).

Chemical dependency

In describing a successful program for women's recovery from sex work and trafficking, Nelson (2004) asserts that while the dimension of intervention that addresses chemical dependency can be informed by the 12 Steps of Alcoholics/Narcotics Anonymous, it must be grounded in a relational approach that addresses family relationships, history of abuse, self-esteem, sexuality, and spirituality. Programs for Latina victims of trafficking who are chemically dependent should also be non-judgmental, supportive, and empowering places for Latinas to find not only relief from the stigma of trafficking, but also that of substance abuse (Mora, 1998).

Empowerment and expansion of life choices

Nelson (2006) describes women who have been trafficked into sexual exploitation as having a distorted sense of life purpose or none at all. Because of the sense of hopelessness many victims of trafficking experience, Chung (2009) impresses the importance of building a concept of future and hope. Given the marginalization, vulnerability, and lack of education trafficked Latinas often experience in their home country, the young age at which many of them are trafficked, as well as the high levels of confinement that most victims of trafficking experience, many survivors

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lack skills necessary for independent living (Nelson, 2004; Shigekane, 2007). Thus, programs that seek to foster the healing and reintegration of Latina victims of sex trafficking should provide housing support, vocational choices, education on reproductive health, goal-setting, and training in language and positive communication skills (Nelson, 2006). Considering Nelson's (2006) recommendation that counselors draw upon the spirituality of trafficking survivors in the process of the expansion of life choices, counselors can appeal to the emancipatory spirituality to which many Latinas adhere, which can provide them with a sense of power with and through the divine to overcome the challenges they face in reenvisioning their future.

Future Directions

As the number of Latinas forced into the egregious and dehumanizing sex trade increases, there is much work to be done to determine best practices with Latina victims of sex trafficking. This article only seeks to provide a preliminary guide to therapeutic practice

based in prior research on human trafficking in Latin America, sex work recovery, Latina cultural perspectives of sexual trauma and recovery, as well as healing within Latino cultures. Although researchers have examined causes of sex trafficking in Latin America, the particular sociocultural implications and psychological outcomes of sex trafficking on Latina women remain conspicuously unexplored. Both qualitative and quantitative analysis must be performed on therapeutic interventions that incorporate the ethnic psychology and worldview of Latinas, culture factors such as gender roles, rape myths, and shame, as well as vital traditional and holistic healing practices that are emancipatory and seek to restore victims' sense of connection to self, family, community and culture. Practitioners will play a role of immense importance in delivering such culturally congruent interventions, acting as agents of change, witnesses of trauma, storykeepers, and advocates of justice for clients who have endured great pain and are in desperate need of services that are empowering and meet their needs.

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Housing First and Harm Reduction: Effective Models For Substance Abuse Treatment with Individuals who are Homeless

By Amanda Russell

Abstract

Substance-related disorders among individuals who are homeless not only greatly affect the individual but the family and society as well. This population struggles from barriers to obtaining and maintaining adequate treatment as a result of insufficient income, lack of health insurance and housing instability. Traditionally substance abuse treatments are aggressive and abstinence-based with high dropout rates. An effective solution requires accessible and integrated programs that not only meet the person's basic needs but also provide services that address his or her level of motivation. Social work research concludes that both harm reduction and Housing First models lessen the negative consequences of addiction but also work to alleviate homelessness. Evidence also suggests that there are several positive implications for practice on micro and macro levels.

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. (National Association of Social Workers, 1996, p.1)

Introduction

Individuals who are homeless and dealing with issues of substance abuse continually face problems locating affordable housing with additional barriers to seeking help and attaining resources. This population is especially vulnerable since these individuals often have

co-occurring mental illness (National Coalition for the Homeless, 2007). The interconnectedness between substance-related disorders and homelessness is a topic that is continually being researched and scrutinized in an effort to not only better understand its complex relationship but also to adequately address treatment options. The use of harm reduction strategies in conjunction with the Housing First model is a more effective form of treatment in comparison to traditional means of treatment in alleviating homelessness and decreasing the harmful effects of drug addiction.

The Relationship

Research provides evidence of the strong connection between substance abuse and mental illness. The National Coalition for the Homeless (2007) reports a 26% substance use prevalence rate among the homeless population, but studies assume a much higher percentage due to problems in defining members of this untraceable population and with the reluctance to self report their addictions. Moreover, a 50-70% comorbidity rate is attributed to dually diagnosed substance abuse and mental illnesses including disorders such as bipolar disorder, post-traumatic stress disorder, and schizophrenia (Padgett, Gulcar, & Tsemberis, 2006). As a source of relief from many of their symptoms, individuals suffering from these illnesses often self medicate through the use of drugs and alcohol. This act is potentially putting them at risk for eviction or loss of housing. Similarly, individuals who are currently homeless also seek drugs and alcohol as a means of coping with their current living situation. There is much debate whether homelessness is more commonly a contributing aspect to developing substance-related disorders or whether homelessness is purely a consequence of the abuse of drugs and alcohol (National Coalition for the Homeless, 2007).

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Regardless, this undeniable connection further complicates issues related to mental health.

Access to Treatment

Despite the causality of homelessness, this population has substantial difficulties in obtaining and maintaining treatment for their substance abuse, largely due in part to their additional mental health struggles. According to Principles of Drug Addiction Treatment (National Institute of Drug Abuse [NIDA], 2009), "treatment needs to be readily available" (p. 2). Insufficient income frequently results in a lack of transportation, lack of documentation, and lack of insurance or appropriate funds to afford treatment. Those not facing problems with insurance are often put on lengthy waiting lists. Interestingly, President Clinton authorized legislation denying any individuals with disability and addiction related problems from gaining mainstream benefits such as Social Security Income (SSI) and Social Security Disability Income (SSDI), which denied these individuals access to health insurance including Medicaid. Furthermore, these individuals are at greater risk for experiencing homelessness and have added barriers in locating subsidized housing due to income requirements and drug testing (National Coalition for the Homeless, 2007).

Two other vital factors have been identified concerning homeless individuals with mental health issues obtaining recovery options. First, regardless of accessibility, a person's reluctance towards treatment creates additional difficulties. Often without a positive support system, there is little or no encouragement from others to seek help. Second, they are typically untrusting of social service agencies due to past experiences with professionals (Zerger, 2002). This hesitation has best been described through the stages of change model (MacMaster, 2004). This transtheoretical framework was developed to explain the five-phase cycle (precontemplation, contemplation, preparation, action, maintenance) a person may inherently experience when an adjustment or behavior modification has to be met. MacMaster (2004), states, "Engagement of the individual can be accomplished by providing services that meet an individual's present level of change" (p. 358). In the model's application to substance abuse, these developmental periods are not only crucial to the

person's willingness towards cessation but also the likelihood of success at treatment (MacMaster, 2004).

The role that housing instability plays in an individual's prioritization of treatment deserves further attention. According to Maslow's Hierarchy of Needs, a set order of internal and external requirements exists that must be achieved before progressing to the next level and ultimately obtaining self-actualization. A person who has not met or is being deprived of his or her basic physiological needs such as food, sleep and shelter will have more difficulties and less desire in terms of personal growth or even treatment (Zastrow & Kirst-Ashman, 2004).

The Traditional Method

The current trend of treatment for substance related disorders stems from an ideology of abstinence-based programs and services. These types of services comprise nearly 99% of all substance abuse facilities in the United States (MacMaster, 2004). In a review of the literature, there is considerable support and evidence that abstinence-based treatments, meaning a requirement of sobriety, are effective (MacMaster 2004; Zerger, 2002). This treatment option typically does not take into account the issue of homelessness. Currently, most supportive and/or transitional housing options for homeless individuals are often also abstinence based (Zerger, 2002).

The most commonly known form of substance abuse treatment, the 12-step model, is consistent with this traditional abstinence-only approach. This model recognizes that recovery is a long term and ongoing process, although it also implies that a person will remain sober throughout participation. This peer support group is also the most utilized form of outpatient treatment with homeless individuals due to its typically low cost and availability; however, little research exists regarding its effectiveness with this specific population (Zerger, 2002).

Abstinence based programs often have rigid views of success translated into unattainable goals for those who are homeless and struggling with mental health problems. Treatment mandates comprise an additional problem for these individuals. Termination of services and other harsh consequences are troublesome and counterproductive when dealing with a population suffering from co-occurring mental illness, particularly in terms of alleviating the addiction and increasing

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functioning. An agency that requires sobriety in an abstinence-based program often responds ineffectively to individuals who relapse. These abstinence-only programs will often account the relapse as a failure rather than a natural part of the recovery process (Zerger, 2002).

According to Zerger (2002), recent literature on substance abuse practices acknowledges several downfalls in regards to treatment retention. After successful engagement into a program, efforts should be met to prevent drop out. This is ultimately a challenge with all treatments despite population. Reasons for drop out are broad and may be attributed to a general dislike of the program or program structure, the level of commitment or motivation from the participant, and problems in obtaining transportation (Zerger, 2002). However, one can address all these factors with proper implementation of preventive strategies and adequate staff training.

Housing First

The Housing First model is a more recently developed service delivery option that provides quick, permanent and independent housing to individuals who are homeless (National Alliance to End Homelessness, 2006). This model recognizes the importance of providing adequate housing prior to offering case management and other supportive wrap-around services such as addiction help and/or counseling. More importantly, while services are readily available, participation is not a requirement for maintaining housing. This model then refocuses its efforts infinitely on housing retention and increased functioning of the individual based on need. There are also several different types of models and features within the Housing First approach. (National Alliance to End Homelessness, 2006).

Sam Tsemberis and the Pathways to Housing program in New York is one of the initial Housing First models (Padgett et al., 2006). Similar to other models of this type, Pathways to Housing utilizes harm reduction in treating substance related issues and co-occurring mental health issues. Therefore, neither treatment nor sobriety is a requirement to obtaining and maintaining housing. Housing First models often employ evidence based Assertive Community Treatment (ACT) teams to provide low to high intensity supportive services. This aspect is especially important with individuals who have

co-occurring mental illness that may require less aggressive or low threshold services due to limited functioning as well as social support (Padgett et al, 2006).

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducted a four-year evidence based study in 1996 to compare the Pathways to Housing program to more common "treatment first" housing programs throughout the country. The Housing First program placed participants into permanent housing faster and recorded higher housing retention rates. Due to a lack of long-term outcome studies, there are no statistically significant differences among improvement of mental health issues, substance use and/or overall personal well-being (Padgett et al., 2006). In 2007, a similar review study by SAMSHA was conducted. In the Housing First model, 80% of participants remained housed compared to 30% of participants in the traditional abstinence based housing program. Additionally, research provided that the Housing First participants endured less service cost and had increased choice in treatment plans, housing, and basic daily living options. However, current research provides limited evidence that proves Housing First will eventually lead to the vast reduction or elimination of alcohol and drug abuse.

These proven cost-effective Housing First models span across the United States and into Canada in demonstrating their effectiveness in preventing further episodes of homelessness and subsequent housing retention. More importantly, these innovative programs provide seemingly unlimited support to the individual, emphasis on client-driven approaches, employ harm reduction strategies, and encourage consumer choice. Housing First programs are funded by Housing and Urban Development (HUD) and are relatively stable financially. Lastly, these programs are significant to the National "Ten Year Plan to End Homelessness" and are also certified through the Interagency Council on Homelessness as an evidence based best practice in working with individuals who are chronically homeless (Pearson, Locke, Montgomery, & Buron, 2007).

What is Harm Reduction?

The harm reduction model, an alternative method of treatment, is a relatively new framework and is a common feature to nearly all Housing First programs (National Alliance to End Homelessness,

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2006). Harm reduction was first developed and is still used in preventing the spread of HIV/AIDS through strategies such as sterile needle exchange programs. According to the Harm Reduction Coalition (2009),

Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself. (p.1)

In its application to substance-related disorders, the guiding philosophy of harm reduction believes that not only is substance abuse a natural occurring phenomenon in society but also that reducing the consequences from drug and alcohol use is a more practical approach to confronting this social problem. Most importantly, harm reduction strategies recognize the complexity of addiction and substance-related disorders especially with those facing social inequalities from racism and classism. Additional underlying principles state the importance of client-driven services, with emphasis on smaller success levels and individual empowerment (MacMaster, 2004).

By lessening the consequences of drug and alcohol abuse, harm reduction strategies benefit the individual, the community and society. However, strategies need to be implemented that allow for change to be possible with this difficult population. According to MacMaster (2004), "progression through the stages of change model can continue for individuals who use nonabstinence-based services. Rather than stopping or slowing this progression, involvement in harm reduction services could accelerate an individual's potential for continued change" (pp.359-360). Therefore, despite the individual's motivation towards change, harm reduction builds a relationship as a means of encouragement and support. Subsequently, harm reduction becomes a catalyst for recovery in which treatment can be sanctioned at any level of change. This is crucial for a population that often lacks adequate support, making the pressure of complete abstinence as the only option even more difficult. With the utilization of harm reduction, fear of scrutiny is now eliminated from the therapeutic process. Futterman, Lorente, and Silverman (2004) state, "A harm reduction philosophy creates a comfortable, respectful atmosphere in which patients

can connect to the program as a whole which goes a long way toward solving one of the most consistent problems of substance abuse treatment: patient retention" (p. 5). This is especially important in terms of contrast to abstinence only inpatient programs that exercise aggressive treatment and high drop out rates (Futterman et al., 2004).

In practice creative strategies are explored and assigned as action steps towards the completion of simpler goals based on individual capabilities and functioning. These measures differ strongly from definitions of success seen in traditional forms of abstinence-based treatment. These techniques confront drug addiction by addressing the use, reasoning, and setting of the substance use. Motivational interviewing and psychoeducation are often utilized with the harm reduction model. These methods are used to discuss the risks of combining drugs, the prevention of victimization and overdose, and physical harm. Switching the method of consumption to a safer approach can also be a beneficial harm reduction strategy. Bigg (n.d.) explains how harm reduction practices are put into practice: 1) Decreasing the concentration and frequency; 2) Substituting one drug for a safer choice; 3) Exploring alternatives for means of recreation and the problematic rituals that surround the drug use; 4) Creating a budget, such as an allowance for the drug abuse, can aid in permitting some financial stability; 5) Lastly, ensuring the safety of the individual and those in the surrounding area during the sell and use of drugs are also supported.

Challenges and Limitations

In addition to the effectiveness of harm reduction, the current research did indicate a few limitations in the findings. The most common limitation arose from the use of self-report measures of drug and alcohol consumption. The results of the individual studies cannot be valid if participants did not honestly report their use. For example, individuals might fear persecution from the professional if improvement or positive progress had not occurred. However, harm reduction creates an atmosphere along with a trusting relationship to help address this problem. To further evaluate the harm reduction approach, long-term outcome studies also need to be conducted to compare its effectiveness with other forms of treatment (Zerger, 2002).

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Viewed as an alternative method to treatment, research studies have also acknowledged the controversial nature of employing harm reduction techniques. With a larger focus placed on reducing the harmful effects of substance abuse, there is a general notion among the public and other professionals that these strategies are enabling for the individual, risking themselves and potentially harming others (MacMaster, 2004). Harm reduction, however, facilitates avenues for positive change rather than termination of services seen in more traditional forms of treatment. Similarly, harm reduction is not opposed to nor does it argue against effectiveness. This treatment practice also does not seek to replace abstinence-based practices. Unfortunately, there is little information available about the integration of these two frameworks (Futterman et al., 2004). Harm reduction methodology is also criticized as being contradictory to the current trend of drug policy in the United States. As discussed earlier, abstinence based programs and services have been the traditional method for substance abuse treatment since the passing of the Anti-Drug Abuse Act (100 Stat. 3207, 1986). However, it was in the earlier part of the twentieth century that the Harrison Act forbade the use and sale of non-medical substances (38 Stat. 785, 1914). The abstinence-only view is also observed within the educational system with the Drug-Free Schools and Communities Act Amendment of 1989, mandating drug free and zero tolerance policies for all students. Furthermore, the regulation of drug and alcohol policy typically lies within the criminal justice system through fines, arrests, convictions and most often imprisonment (MacMaster, 2004). Viewing substance abuse as a disorder through the social model, harm reduction works to treat the illness rather than prosecuting those with substance related mental health problems (Zerger, 2002).

Harm reduction is the primary model for drug policy for most of Western Europe in their consideration of addiction as a major health issue rather than as a legal issue as it is treated by the United States. The idea of harm reduction was first suggested in the United Kingdom in the 1920's. Nearly 30 years ago, it was utilized in the Netherlands in an effort to decrease the rising spread of Hepatitis C. The application of harm reduction was used with assertive outreach practices, providing bleaching kits and clean needles, as well as low threshold treatment options. Australia, Spain, Switzerland, and the United Kingdom adopted the harm reduction policy after finding a remarkable decline in

cases of HIV and Hepatitis C. In these countries, research continues to find that the harm reduction model "is associated with lower drug incidence and prevalence rates and lower rates of HIV and Hepatitis cases." (Mancini, Linhorst, Broderick & Bayliff, 2008, p. 384). Only recently has the United States begun implementing the practice of harm reduction among HIV/AIDS services with injection drug users (MacMaster, 2004).

Staff acceptance and understanding the harm reduction model have also been a challenge towards its recent implementation in programs and services due to its ambiguity in practice (Mancini et al., 2008). According to research, the integration of the harm reduction model "requires practitioners who can effectively engage clients, tolerate risky behaviors, and possess the flexibility and willingness to accept reduction of harmful behaviors as a legitimate and appropriate outcome" (Mancini et al, 2008, p. 388). A recent study was conducted to explore practitioners' and clinicians' attitudes about harm reduction and to identify what staff felt were the positive and negative features of this model. The research revealed that 92% of staff agreed that, "harm reduction is a useful and valid form of treatment" especially with those who have dually diagnosed mental illness and 90% disagreed that "complete abstinence is the only goal of substance abuse treatment" (Mancini et al., 2008, p. 393).

Implications for Social Work Practice

For social workers, theories of Housing First and harm reduction are both troublesome and beneficial to practice. The Code of Ethics (1996), states that "Social workers' primary responsibility is to promote the well-being of the client," (p. 7) as well as to "respect and promote the rights of clients to self-determination and assist clients in their efforts to identify and clarify their goals" (p. 7). With this in mind, these two strategies address the importance of first meeting the basic needs of individuals before they can be motivated for positive change. Both approaches also recognize the effects that limited or no social supports have on the individual's desire and willingness to seek treatment. Most importantly, both Housing First and harm reduction approaches acknowledge the additional struggles that co-occurring mental health issues present in the treatment process.

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Harm reduction strategies, based on the individual's level of change, aim to increase overall functioning while simultaneously reducing the harmful effects of drug and alcohol abuse for the individual and the greater society. However, the ethical consideration presented in the National Association of Social Workers (NASW) Code of Ethics (2008), "when the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others" (p. 7) needs to be considered. The use of illegal drugs and alcohol is not listed as prohibited in the Code of Ethics as a requirement for clients of these professionals (NASW, 2008). This means that clinicians need to abide by the policies and procedures of their agency and should always demonstrate good judgment and ethical reasoning in the treatment of addiction problems among their clients.

There are ethical dilemmas that arise with social workers' hesitance towards adopting the harm reduction philosophy. Mancini et al. (2008) believe that this model has the potential to challenge one's core beliefs. However, it is important for social workers to remind themselves of the person-in-environment perspective in regards to providing effective and client-centered approaches such as those of harm reduction. As stated in Principles of Effective Treatment, "No single treatment is effective" (NIDA, 2009, p. 2). Although there are several treatment options available, social workers should promote the integration of mental health and addiction services in order to provide effective practices.

Social workers and other professionals can advocate for more harm reduction programs in several ways on both micro and macro levels. Encouraging and supporting the utilization of harm reduction strategies and policies within one's own organization is one way to not only advocate but also provide effective treatment. Educating oneself as well as other fellow staff members, management and board members is also

important to influence the use of harm reduction. Other advocacy methods could include participation in harm reduction trainings and becoming a member of SAMSHA or other similar committees that work to identify evidence-based practices for substance abuse treatment. Lastly, social workers should also be aware of and refer to agencies that have adopted either harm reduction or Housing First models.

Conclusion

Harm reduction, in conjunction with Housing First models, can promote positive change in individuals by improving their quality of the life as well as working to eliminate homelessness and other negative consequences of their addiction. According to Principles of Drug Addiction Treatment (2000), "Effective treatment attends to multiple needs of the individual not just the drug abuse. The integration of these models makes not only treatment more accessible and continuous but is supportive of other individualized needs" (p. 2). Therefore, Housing First and the harm reduction model strongly understand the complex relationship between homelessness, mental health and addiction.

With regard to clinical practice, addiction issues along with the effects and consequences of substance use can be witnessed and dealt with in nearly all social work settings. Social workers should continually strive to explore more efficient ways for engaging and retaining clients in treatment regardless of population. Additionally, social workers raising awareness on the importance of utilizing harm reduction and Housing First models can also positively affect policy and funding sources for this population in the future. Lastly, continued research and development of effective substance abuse treatment can and will benefit everyone throughout society.

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The Bullying of Gay, Lesbian, Bisexual, Transgender, Questioning and Intersex (GLBTQI) Adolescents in the School System

By Jeffrey W. Zacharias

Abstract

The gay rights movement brought a new found visibility to the GLBTQI population. With this heightened visibility came setbacks including the bullying of those who identify as GLBTQI. No individuals are more susceptible to this than adolescents in the school system who need to view school as a place of safety in order to succeed academically. Adolescents are at risk for a variety of mental health issues if this is not so; therefore, schools need to be more aware of issues specific to GLBTQI adolescents. This paper will examine statistics and effects of homophobic bullying, specific frameworks schools can operate from in order to decrease risk factors such as suicide, and tools schools can implement in order to more fully support the GLBTQI adolescent.

Introduction

Carl Joseph Walker-Hoover would have turned 12 years old on April 17, 2009. Instead, the young boy committed suicide by hanging himself rather than endure another day of being bullied. The bullying stemmed from daily taunts for being gay. Although the boy had never admitted to this, it was the perception of his peers that he was gay. Lawrence King, an openly gay teenager, was only 15 years old when he was shot by a 14-year-old classmate in 2008. Lawrence was bullied on a daily basis by fellow classmates until one of them, a young man, walked into the school lunchroom and shot him in the head. For all the stories that we read about in the newspaper or view on television concerning GLBTQI bullying and violence, there are many more that go unreported. While these stories are tragic and shocking, the situations that Carl and Lawrence faced were not unique to them. GLBTQI adolescents are bullied on a daily basis in their schools, whether it is in elementary school, middle school or continuing through

high school. However, it is not just the individuals being bullied that are the victims of violence due to their actual or perceived sexuality. Sometimes, those being bullied strike back in a violent reaction to the abuse they have faced.

On February 2, 1996, 14-year-old Barry Loukaitis murdered a teacher and two students at his high school in Washington. He had been taunted by school jocks who called him a "faggot." On October 1, 1997, 16-year-old Luke Woodham murdered two students and wounded seven others at his high school in Mississippi, stating that he was constantly called "gay" by his peers. On December 1, 1997, 14-year-old Michael Carneal murdered three students and wounded five others at his high school in Kentucky after being called "gay" in the school newspaper. Bullying takes on many forms whether it is overt, such as in harassment, threats and violence, or whether it is more covert, as in isolation and exclusion from peers. School is a second home for adolescents, as they are there for eight or more hours per day and, as such, it should be a safe space for all those who attend. However, this is not the case for many adolescents, especially those who self-identify as GLBTQI. For these students, school is a hostile environment because the expression of their gender or sexuality falls outside of what others may perceive as the norm.

Background and Statistics

The bullying of students who have admitted to being GLBTQI, or are perceived as being GLBTQI, is epidemic in the school system, with estimates that as many as two million students are affected nationwide. According to the Gay, Lesbian, Bisexual and Transgender Youth Support Project (GLYS: 2007), "homophobic bullying is frequently aimed at youth who do not conform to traditional roles or gender presentation" (p. 1). However, this is not exclusive to

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schools in and of themselves, as many individuals are not sensitive to those who present as different. Teachers serve as role models for the adolescents in their schools and, as a result, students emulate their teachers' behavior and mimic what they say. If teachers are not tolerant of differences in gender and sexuality, then adolescents likely will not be tolerant as well, and bullying may develop as a result. According to Athanases and Comar (2008), some "well-meaning teachers remained unclear on how to address homophobia" (p. 11). Putting aside tolerance, if a school teacher is unclear about how to address homophobia in their school, how can it be expected that a bully, whose behavior is based on the intimidation of another student's real or perceived homosexuality, be able to do the same?

In a 2002 report by the National Mental Health Association (NMHA), "GLBT students hear anti-gay slurs about 26 times a day or every 14 minutes" (as cited in GLYS, 2007, p. 1). The anti-gay slurs include the words "faggot", "sissy", "homo" and "queer." According to Chase (2001), it was found that "31 percent of GLBT students had been threatened or injured at school sometime during the previous 12 months" (p. 17). In 2007, a National School Climate Survey (NSCS) was conducted by the Gay, Lesbian and Straight Education Network (GLSEN) and found that "significant percentages of Illinois students experience harassment at school, often because of their sexual orientation and how they expressed their gender" (p. 1). The NSCS is completed every two years and examines the experiences of GLBTQI youth in U.S. middle and high schools with the purpose of documenting anti-GLBTQI biases and behaviors in the schools. The national sample taken for the survey consisted of 6,209 GLBTQI students with 206 being from Illinois. It should come as no surprise that the survey found that "Illinois schools were not safe for many GLBTQI students in secondary schools. The statistics that led GLSEN to their conclusions are startling.

According to the survey conducted by GLSEN (2007), "91 percent of students regularly heard homophobic remarks, such as 'dyke' and 'faggot' from other students in their school" and "97 percent of GLBT students in Illinois regularly heard the word 'gay' used in a negative way in school" (p. 1). The NSCS further looked at the level of violence that GLBTQI students faced whether it be verbal harassment, physical harassment or physical assault. They found that "89

percent of GLBT students were verbally harassed, 43 percent were physically harassed and 21 percent were physically assaulted due to their sexual orientation" (pp. 1-2). The level of violence directed toward GLBTQI students, or those perceived to be GLBTQI, has a direct negative effect on the mental health of these students.

Effects of Bullying

GLBTQI students who are bullied are often insecure, withdrawn, experience an increase in behavioral problems, develop substance abuse issues as a coping mechanism, and may be more depressed than their peers. A report issued by the United States Department of Health and Human Services (DHHS: 2009) entitled "Healthy People 2010 – Reproductive Health," stated that "gay male adolescents are two to three times more likely than their peers to commit suicide" and that "GLBTQI adolescents account for 30 percent of all adolescent suicides" (p. 19). The strain on the mental health of these students can also have a direct effect on education.

National Education Association (2009) found that "160,000 children miss school every day out of fear of attack or intimidation by other students" (p. 43). In Illinois, the education of these students was adversely affected. According to the survey conducted by GLSEN (2007),

37 percent of GLBTQI students in Illinois that had missed school for safety reasons, were twice as likely as the general population of students to report they were not planning to pursue any post-secondary education and had an average GPA a half point lower than that of GLBTQI students who were not harassed (p. 2).

The NMHA (2009) found that "28 percent of GLBT students will drop out of school, which is three times the national average for heterosexual students" (para 3). These statistics show that GLBTQI students do not feel safe in the school environment, which results in higher rates of absences and the inability to succeed academically. According to Russell, McGuire, Larrive, and Laub (2008), "because safe environments and healthy peer relationships are critical to positive psychosocial adjustment for adolescents, school safety has become a concern for educators, parents and students" (p. 12). While there may be an increase in concern by the persons in charge, the GLBTQI students

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may not share the same perception that someone is concerned for their safety and well-being.

Students who are being bullied feel as if they have nowhere to turn and often do not feel supported by their teachers or school administrators. The school climate for them is one of hostility, insofar as the curriculum does not include discussion of GLBTQI matters and does not embrace diversity in terms of the sexual and gender expression of its students. Instead, most curriculum teaches from a heteronormative point of view. If the school curriculum does not take into consideration those matters that render the GLBTQI student invisible, one can posit that GLBTQI students would not be comfortable talking with the teachers themselves. According to Craig, Tucker and Wagner (2008), "many school officials either failed to intervene on behalf of GLBT students or were themselves hostile or abusive to these youth" (p. 239). The invisibility that the student feels at school is often similar to their experience at home. They feel ashamed and guilty about their sexuality, thus leading to feeling isolated from their family as well as from their peers. In turn, these students do not reach out for help but instead suffer in silence and allow the bullying to continue, which can result in an increased risk of suicidality. There are certain steps that can be put into place within the school system to stop the bullying of GLBTQI students, educate their peers and teachers, and lead to a decrease in risk factors such as suicide. A good starting point is to operate from a more socio-cultural perspective, particularly when examining risk factors prevalent amongst GLBTQI adolescents, such as suicide.

Socio-cultural Model

With an increased risk for suicidal behaviors in GLBTQI youth that have been bullied, it has been shown useful for clinicians working with these youth to operate from a socio-cultural model of suicide risk. A socio-cultural model examines risk factors associated with suicidality on an individual level as well as both a micro and macro level. According to Morrison and L'Heureux (2001),

to assess a particular young person's risk for killing themselves adequately, a clinician would need to know about the individual themselves (demographic and situational variables), the immediate environment that surrounds that individual (microsystem), and

the social conditions under which the immediate environment operates (macrosystem). (p. 41)

This model has been shown to be effective in that it takes into consideration not only the adolescent themselves, but other systems that have an effect on their lives and the work that must be done surrounding those systems. As the authors further state, "the proposed model is particularly useful in that it incorporates cultural norms and values, and provides clinicians with both primary (assessment and treatment of individuals) and secondary (assessment and treatment of environments) levels of intervention" (p. 41).

Risk Factors

Risk factors for GLBTQI adolescents are present on the individual level, the micro level and the macro level. Individual risk factors include coming out issues, gender issues and issues surrounding a "double minority" status. A major issue with an adolescent coming out concerning their sexuality is the intense feeling of isolation leading to a sense of hopelessness that can accompany this disclosure. According to Morrison and L'Heureux (2001), "a youth who is 'out' to others and self at an early age is at increased risk for assaults and harassment, and is thus more psychologically isolated" (p. 42). Furthermore, the process of coming out has different implications for gay male adolescents who statistically come out at an earlier age as compared to lesbian adolescents, thus increasing the males' sense of isolation. A final individual risk factor is that of "double minority" status and, according to the authors is when "GLBQ youth of color face both a lack of acceptance from their racial/ethnic community and racism within the GLBQ community, further isolating and placing them at increased risk for suicide" (p. 42). Youth that deal with a "double minority status" face not only issues surrounding their sexual orientation, but are at further risk due to the color of their skin or their ethnicity.

The second risk factor to examine when working with a GLBTQI adolescent who is potentially suicidal is the microsystem. According to Bronfenbrenner (1997),

the microsystem is a pattern of activities, social roles, and interpersonal relations experienced by the developing person in a given face-to-face setting with particular physical, social and

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symbolic features that invite, permit, or inhibit engagement in sustained, progressively more complex interaction with, and activity in, the immediate environment (p. 39).

In other words, the microsystem is that system which directly affects an individual and, in the case of an adolescent, would include systems such as schools, parents, teachers, friends and counselors. These individuals are more apt to take notice of suicidal behaviors present in an adolescent due to having more personal interactions with the adolescent. According to Morrison and L'Heureux (2001), "to adequately assess suicide risk for a GLBQ youth, it is proposed that an investigation of the microsystem's support of that youth needs to be taken into account when predicting suicide risk" (p. 42). This is where incorporating GLBTQI-specific curriculum into the school system becomes crucial. This curriculum could include discussions of GLBTQI persons in history, safer sex education and exploration of the effects of derogatory words upon others. Unless this curriculum is put into place in the schools, it can appear to the GLBTQI youth that their feelings are not valid and that the school system covertly, or even possibly overtly, supports homophobic bullying. The authors go on to state that "a ubiquitous tolerance of homophobic and heterosexist attitudes in teachers, peers, religious leaders, and family members may increase suicide risk for GLBQ youth" and that "this type of microsystem tolerance of homophobia may increase GLBQ youth suicide risk by increasing the isolation and depression a GLBQ youth feels" (p. 42).

The final risk factor for the suicidal adolescent is in the macrosystem, which includes laws, policies, guidelines and the mass media. According to Bronfenbrenner (1997), the macrosystem is comprised of "social and psychological features that ultimately affect the particular conditions and processes occurring in the microsystem" (p. 40). Some of the work that could be done on this level to promote healthy attitudes for GLBTQI adolescents would include developing non-discrimination policies in the schools, laws being enacted to protect GLBTQI individuals from harassment and violence, as well as the development of positive GLBTQI role models on television or in the movies. Actions that can be taken on the macro level can have a direct effect on both the micro level and at the individual level. At the heart of managing these risk factors is instilling a sense of safety for the adolescent and, in particular, helping the GLBTQI adolescent feel safe

while in school. When working with issues of safety and attachment with a GLBTQI adolescent who is being bullied, utilizing a psychoanalytic frame of reference can help to inform the ability of teachers or school administrators in maintaining a sense of safety in their school.

Psychoanalytic Framework

One of the early pioneers of psychoanalysis, as well as object relations theory, was Donald Winnicott. Winnicott proposed the concept of the "holding environment" and when looking at issues of safety in the school, one can see why it is imperative to provide an appropriate "holding environment." According to Twemlow, Fonagy, and Sacco (2002), "the holding environment is the setting in which aggression and love is fused, toleration of ambivalence is promoted and concern for others is tolerated" (p. 315). In other words, the "holding environment", which is the school in this case, is where the previously mentioned developmental milestones are achieved. Without the ability to achieve these milestones, an adolescent may be more likely to bully other adolescents because they lack skills for how to handle their feelings with respect to the differences of others. As the authors go on to state, the school "provides guidelines for creating an environment that can help children integrate aggression and love, while retaining the creative gestures of the ego" (p. 315). In order to develop a psychodynamically safe school, it is important for teachers and other school administrators to take a look at three separate stages of development: kindergarten through third grade, fourth through seventh grade and finally eighth through twelfth grade.

In the period between kindergarten and third grade, children begin to spend increasing amounts of time away from home and parents, while the teacher begins to take on a more parental role in their lives. At this point, it becomes important for the teacher to begin providing a sense of self-mastery in the children, which in turn provides a feeling of safety for them. According to Twemlow et al. (2002), "In K-3, a safe school environment allows children to move, play and grow in an illusory space where the teacher/mother finds ways of protecting them from fully realizing their helplessness" (p. 317). When the teacher is able to assist children in not feeling helpless, they begin to feel an increased sense of safety and thus develop the ability to

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handle aggression in constructive ways, such as not bullying.

As children start the developmental period between fourth and eighth grade, they begin to individuate more and separate from parental figures whether those figures are at home or in the school. At this stage of development, the authors state “the holding environment has to help children master the developmental task of giving up the image of the protective mother and instead becoming aware of the power of peers and group relationships in the real world” (Twemlow et al., 2002, p. 317). A good school will encourage children to develop appropriate relationships with their peers and recognize that there are differences between them, which need to be respected. It is this sense of respect that will aid in developing a safe environment for all students, particularly those that are marginalized such as GLBTQI adolescents, while allowing them to develop “a realistic grasp of their own strengths and weaknesses and be able to perceive them in others” (Twemlow et al., 2002, p. 317).

Finally, in eighth through twelfth grades, adolescents develop the ability to think more abstractly about the world and their place in it. As Twemlow et al. (2002) state, adolescents “tend to sublimate psychological tasks in more intellectual ways and appear more independent of the holding functions of school and parent” (p. 318). With this ability, the adolescent begins to realize the differences between themselves and others and it is with this realization that they may develop feelings of not being safe. This feeling can result in the development of pathological behaviors such as bullying; therefore schools need to work toward maintaining an appropriately strong “holding environment” that fosters safety for all students. No matter what the grade of the student, schools are a major part of the formative years of an adolescent. If they provide a strong environment in which the adolescent is encouraged to grow through appropriate peer relationships while moving toward individuation of self, an adolescent is more likely to feel safe. However, if the school is unable to provide this type of environment, an increased occurrence of pathological behaviors may develop, placing marginalized students, such as those who are GLBTQI, at greater risk.

Program Implementation

There are a number of steps that can be implemented in order to foster a sense of safety in the schools and decrease the occurrence of the bullying of GLBTQI students. A major step in making schools a safer place for GLBTQI students is educating teachers and other school administrators in raising their awareness of, and sensitivity to, bullying behaviors. According to Roberts (2008), homophobic bullying “is not always taken as seriously as other forms of bullying by teachers as it is often seen as a ‘natural’ reaction of young men” (p. 12). Teachers and other school administrators need further education on the many forms of homophobic bullying whether it is overt or covert. As the author goes on to state, “homophobic bullying is quite different from general bullying” and “unless there is a verbal element to it, it becomes very difficult to define the behavior as homophobic” (p. 12). Becoming more aware of physical violence and learning to recognize underlying homophobic intent on the part of a bully would be one step a teacher can take in order to keep GLBTQI students safe.

According to Daley, Solomon, Newman, and Mishna (2008), “an intersectional approach to understanding the experiences of bullying among GLBTQI youth focuses attention on the interactive relationship between systems of sexual orientation, gender, race/ethnicity, and newcomer/citizenship status, among other systems of social identity and social location” (p. 12). In other words, it would be beneficial for teachers and students to examine bullying not based solely on GLBTQI status, but to explore additional reasons bullying may be occurring. These can often include the color of their skin, socioeconomic status or their ethnic background. For instance, if an African American student was attending a predominantly Caucasian school and being bullied due to what they perceived was their sexuality, it would be appropriate for all parties involved to also explore bullying that may be happening due to racial differences. The authors refer to this as “double discrimination” or “double jeopardy.”

GLYS (2009) has developed a five-step approach to combat anti-gay bullying in schools. The first is to “create a school-wide policy that encourages respect for all and establishes consequences for those who bully or harass others” (p. 1). The second step is to “train students, faculty and administration to respond effectively to harassment and to stand up for one another” (p. 1). The third step is to “create a script or guideline for all staff to use so that they can respond

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consistently to youth who bully others” (p. 1). The fourth step is to “spend classroom time discussing the power of language” (p. 1) and the final step is to “be clear with bullies that their language is offensive to you and others at the school” (p. 1). In following these steps, teachers or school administrators can begin to make school a safer and more respectful place for all students.

The NMHA (2009) also developed a list of tools that may help to decrease homophobic bullying in schools. The first suggestion is for teachers to “be more alert to signs of distress in a student” (para. 1). The second is to “work with student councils to have programs on respect, school safety and anti-bullying” (para 1). The third is to “ask school administration to have an assembly addressing the issue of gay prejudice” (para 1). The fourth is to “develop a chapter of GLSEN or a Gay-Straight Alliance (GSA) in the school which allows GLBT students to feel as if they are not so alone” (para. 1). The fifth and final tool is to “encourage anyone who is being bullied to report it to a teacher, counselor, coach or parent” (para 1).

Conclusion and Recommendations

While the progress being made on the bullying of GLBTQI students may be too late to benefit Carl Joseph Walker-Hoover and Lawrence King, strides continue to be made to address the problem. While not implemented to address homophobic bullying directly, in 2001 Illinois became one of the first states to implement anti-bullying policies. Illinois passed two separate acts to address the situation -- the first being the 2001 Illinois Public Act 92-060, H.B. 646. The purpose of this act was to require school boards to work with PTA's and other community-based organizations to develop more stringent policies in dealing with students who showed aggressive behavior. It further went on to require that the parents and guardians of these students be notified of their behavior and potential interventions for the student. The second act passed was the 2001 Illinois Public Act 92-96, S.B. 1026. This act finds anyone guilty of a Class A misdemeanor who threatens or intimidates adolescents with the result being the student does not attend a public or nonpublic school or the bullying interferes with the attendance of an adolescent at that school.

There are also actions currently being taken on a national level to combat bullying. On May 5, 2009, a federal bill entitled the Safe School Improvement Act of

2009 was introduced by California Representative Linda Sanchez. With the support of 40 other representatives who came together across party lines, this act would make schools a safer place for all students. If passed, this bill would require schools that receive funding from the Safe and Drug-Free Schools Improvement Act to formulate a wide reaching anti-bullying policy that would include bullying based on race, religion, sexual orientation and gender identity/expression. It would also require those states to include bullying and harassment data in their state assessment reports.

In addition to the state legislation already in place and pending federal legislation, continued work is needed at a grass roots level with the individuals who, aside from parents, are spending the most time with the adolescents in our country – teachers, administrators, coaches and guidance counselors. There is a need for continuing education on issues affecting all students for, as Padva (2008) states, “anti-homophobic media can benefit social workers, therapists, teachers, guides, educational counselors, tutors and parents in their attempts to empower GLBT clients and to lessen homophobia among heterosexuals” (p. 117). The most important group of students to focus these efforts on are those who are feeling most oppressed by their teachers and peers and powerless over their situations such as GLBTQI students and those who identify their gender in different ways. An ongoing dialogue needs to occur not only between the adults in charge and the students, but between the students themselves. One of the strongest protective factors in the school would be those students who support and affirm each other and, in doing so make school a more affirming place for all students involved. This can be done through the formation of a Gay-Straight Alliance (GSA), which serves the purpose of providing a safe and supportive place for students to meet to discuss issues related to sexual orientation and work together to end homophobia. While progress is being made through the efforts of policymakers, researchers, teachers, parents and students, bullying of GLBTQI students continues in schools. In order for schools to be a welcoming and validating space for students across all walks of life, more work and education will need to be done in order to eradicate the phenomenon of bullying.

Social workers need to be at the forefront of the battle to eradicate bullying for all students, particularly for those who identify as GLBTQI. While they are called to make the world a better place for all

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people, greater attention needs to be paid to more vulnerable populations, such as GLBTQI adolescents. Social workers can be instruments for change by advocating, educating and being a voice for change

representing those who are unable to do so for themselves. It is through this change that schools can become a safer place for all students.

Jeff Zacharias, LSW, CADC received his MSW from Loyola in May 2010 with a concentration in mental health. In addition, he received his CADC Certification in April 2006. His first-year field placement was at the Center on Halsted working with GLBTQI clients and their mental health needs. His second-year field placement was at Northwestern Memorial Hospital in the Stone Institute of Psychiatry working with the mental health needs of adults in an outpatient setting. He currently works at New Hope Recovery Center as Program Coordinator for the Residential Day Treatment (RDT) and Intensive Outpatient Treatment (IOP) programs and as Primary Counselor. His interests include working with individuals facing addiction issues, persons with severe and persistent mental illness and issues within the GLBTQI population. He was awarded the Fuerst Policy Award for his paper entitled "The Bullying of Gay, Lesbian, Bisexual, Transgender, Questioning and Intersex (GLBTQI) Adolescents in the School System."

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Dissertation Abstracts

Congratulations and best wishes to Mauricio Cifuentes, Sonya Crabtree-Nelson, Aimee V. Hilado, Sara B. Johnson, Barbara Ann Mestling, Irma A. Sharp and Grace H. Tomas-Tolentino. The dissertation topics continue to represent the diversity of interests and the commitment to clinical practice of our Ph.D students. Dissertations are available on the 8th floor of Loyola's Lewis Library, 25 E. Pearson.

The Impact of Social Stigma on the Therapeutic Relationship for Latino Clinicians: The Elephant in the Room? By Mauricio Cifuentes

Social stigma is consistently mentioned in the literature as one of the barriers preventing Latinos from seeking, accessing and remaining in mental health care. This study focuses specifically on social stigma as a barrier to remain in psychotherapy. Social stigma is understood as the internalized fear of severe social disapproval for behaving against acceptable cultural meaning systems. With intersubjective theory as the analytical framework, this study primarily explores, through a series of focus groups with Latino mental health service providers of Latino clients, the perceptions those practitioners have regarding the influence of social stigma on the therapeutic relationship and the ways they address this issue in their practice. The constant comparison method from a grounded theory perspective and the software NVivo, as an auxiliary, were used for data analysis. It was found that social stigma is perceived by participants as inextricably linked to the engagement process. It is not seen as playing a significant role in the dropout of clients from therapy. Participants see themselves as responsible for engaging their clients and eventually addressing any barriers they may bring to the therapeutic encounter, including social stigma. The most common strategies reported by participants to fulfill these responsibilities are the use of flexible boundaries when interacting with clients, and the use of psychoeducation to inform them about the meaning and implications of the therapeutic process. Participants strongly recommend the use of groups as a therapy modality for effectively engaging clients and addressing the issue of social stigma.

How Counseling Helps: An In-Depth Look at Domestic Violence Counseling By Sonya Crabtree-Nelson

Intimate partner violence (IPV) is currently described by trauma researchers as a social epidemic (Briere & Jordan, 2004)¹. The array of domestic violence services we currently have in the United States were started 30 years ago by women victims assisting other women. Currently, the services we have for victims of IPV are largely unchanged and the literature lacks information on what is helpful to victims of IPV in a domestic violence counseling setting. The research points to the fact that women seeking domestic violence counseling experience an array of physical and mental health sequelae as a result of the violence. This study utilized a mixed-methods embedded design to explore the counseling services at domestic violence agencies from the points of view of both counselors and clients. The study looked at the interventions offered and their perceived helpfulness as well as the trauma symptomatology of survivors of IPV and the relationship factors between counselors and their clients. Three main categories emerged from the survivor and counselor data as important in domestic violence counseling: importance of the relationship, counselor's knowledge of domestic violence, and the specific interventions used.

¹ Briere, J. & Jordan, C. E. (2004). Violence against women: Outcome complexity and implications for assessment and treatment. *Journal of Interpersonal Violence, 19*, 1252-1276.

Understanding the Relationship Between Social Resources and Levels of Parent Involvement in Illinois Early Childhood Programs: A Program-Level Perspective

By Aimee V. Hilado

High-quality early childhood programs have been described as those that cater to the educational as well as non-educational needs of participants. This dual focus helps to keep families intact and supported, while promoting learning and development for the child. This dissertation discusses the findings from a mixed-method study that examined the relationship between social resources and levels of parent involvement in state-funded preschool programs in Illinois. Using survey data from the *Illinois Birth to Five Evaluation FY09 (n=843)* and interviews with ten preschool administrators who completed the survey ($n=10$) the study found the number of social resources provided by a program was positively associated with levels of parent involvement. The correlation analysis ($r = -0.22, p = .0001$) and analysis of variance (ANOVA) $F(2,708) = 23.19, p = .0001$ findings both demonstrated a positive relationships wherein high numbers of social resources were associated with higher levels of parent involvement in programs. Interviews with program administrators further suggest that providing social resources to the family was a critical focus in supporting the child in school. Discussions of implications for child welfare and policy recommendations for early childhood programs are provided.

Therapeutic Mentoring: Outcomes for Youth in Foster Care

By Sara B. Johnson

This study examined the impact of therapeutic mentoring on youth in foster care. Youth outcomes on the Child and Adolescent Needs and Strengths (CANS) measure for four groups of youth were compared. Three treatment groups were divided based on the amount of therapeutic mentoring received and compared on CANS outcome scores as measured from baseline to 6, 12, and 18 months. The fourth group did not receive any therapeutic mentoring. Outcome domains for emotional and behavioral functioning, peer relationships, academic functioning, and community involvement were analyzed. All youth in the study ($n = 262$) received counseling and support through the System of Care (SOC) program, designed to prevent placement disruption for foster youth. Analyses revealed a significant difference for youth who received therapeutic mentoring compared to youth without therapeutic mentoring. For youth mentored in the first 6 months of participation in the SOC program, improvement was demonstrated in the areas of family and social functioning, school behavior, and recreational activities. In the baseline to 18-month period, mentored youth showed significant improvement on measures for traumatic stress symptoms. Study results suggest that therapeutic mentoring shows promise for enhancing treatment interventions for youth in foster care and warrants further study to maximize the benefits for this specialized approach to mentoring.

The Complexities of Attachment, Peer Rejection and Gender Within a Middle School Dynamic: A Glimpse at Early Adolescents and Their Significant Relationships

By Barbara Ann Mestling

This was a mixed method two phase explanatory study of attachment, peer rejection and gender in a non-clinical middle school population. The purpose of the study was to illustrate the relationship between these variables with the assumption that there would be differences in attachment style between rejected and non-rejected students and further differences by gender. The Behavioral Systems Questionnaire (BSQ) and the Children's Self-Experience Questionnaire-Self-Report (CSEQ-SR) were utilized to determine interview subjects. A Parent Demographic Form provided background, life experience and social functioning information. There were challenges in the use of both instruments for this study's purposes. Although there were more secure non-rejected students than rejected, there were also insecure students who were non-rejected. Overall there were few students of either gender indicated as rejected by the CSEQ-SR, but parent report indicated more rejected students, especially female. There were insufficient students in each attachment category to make a rejected and gender comparison. However, the study was useful for its detailed description of middle school socialization-its risks and resilience, qualitative validation of gender differences in the incidence of relational aggression, and gender similarities in terms of caring family and community relationships as well as indications of parent-student anxiety within the middle school experience.

Immigration as a Theologizing Experience: Spiritual Well-Being as a Moderating Factor in Migratory Grief and Acculturation

By Irma A. Sharp

The purpose of this study was to investigate the relationship of spiritual well-being to migratory grief and acculturation. The study employed a cross-sectional design and a convenience sampling method. Data were collected from 75 Mexican immigrant adult education students in the city of Chicago. Instruments used to collect data were a demographic form, Spiritual Well-Being Scale, Migratory Grief and Loss Questionnaire, and the Stephenson Multigroup Acculturation Scale. All instruments were translated into Spanish, the native language of the participants. Multiple regression analysis was used to test the moderator effects of existential well-being and religious well-being, the two subscales of the Spiritual Well-Being Scale. Existential well-being and religious well-being failed to show a moderator effect. A moderate positive correlation was found between migratory grief and acculturation-degree of immersion in the ethnic society. This study also found a moderate negative correlation between self-perceived adaptation and acculturation-degree of immersion in the dominant society. This study extends current knowledge on the spiritual well-being of Mexican immigrants.

The Relationship Among Adult Attachment Styles, Shame, Dissociation, and Abuse Characteristics in Women Survivors of Intrafamilial Child Sexual Abuse Perpetrated by a Parental-figure

By Grace H. Tomas-Tolentino

The consequences of intrafamilial child sexual abuse (CSA) often evolve beyond the termination of abuse and pervade into adulthood, posing complex and enduring consequences for survivors (Courtois, 1999; Briere, 1992; Herman, 1981, 1991; van der Kolk & Kadish, 1987; Chu & Dill, 1990; Alexander & Anderson, 1994). The concepts of attachment, shame, and dissociation—in the context of childhood sexual abuse—are significant areas of study when working with adult survivors. The present study included 49 women with a history of childhood sexual abuse (CSA) perpetrated by a parental-figure. The purpose of the study was to identify the relationships among adult attachment styles, shame, dissociation, and specific CSA characteristics (age at onset, relationship to the perpetrator, duration of abuse, experience of other types of abuse). Participants voluntarily and anonymously participated in completing 4 self-administered measures on demographics, adult attachment styles, levels of shame, and levels of dissociation. Treatment variables were also investigated including type of treatment currently being received at the agency, frequency of this treatment, and overall duration of treatment to assess its possible relationships to adult attachment styles, levels of shame and dissociation, and CSA characteristics.

The major findings suggest that the experience of earlier age at onset, having a father as the perpetrator, longer duration of abuse, and experience of other types of abuse lends to a greater likelihood towards fearful attachment styles; adult survivors with fearful or dismissing attachment styles are more likely to have high level of shame; and adult survivors with high level of shame have high level of dissociation. Additional findings of importance are that the experience of earlier age at onset, having a father as the perpetrator, longer duration of abuse, and experience of other types of abuse lends to a greater likelihood towards both high levels of shame and high levels of dissociation which in turn were related to more frequent treatment. The finding also suggests that adult survivors with a high level of dissociation stay longer in treatment.