

PRAXIS

Where Reflection & Practice Meet

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PRAXIS

Where Reflection & Practice Meet

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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 Changing Nature of Social Work: Towards Global Practice

“We are living in a period of globalization that is currently affecting many countries of the world...This poses immense challenges for social workers who are expected not only to respond to the deleterious effects of globalization on local communities but also to make a critical analysis of the dialectics of local and global factors. This raises the issue of how we make social work education relevant to the changing context.”

~Mary Alphonse, Purnima George, and Ken Moffatt, 2008, p. 145

I remember five years ago sitting in orientation for the MSW program at Loyola. The faculty liaison at the time spoke about *Praxis* and how to become involved as a member of the editorial board. I thought *Praxis*, as a student run journal, was an innovative idea. I was very eager to become a part of this journal. I served as a board member under the previous two Editors, Christie Mason and Jeff Bulanda, who both did an excellent job continuing the legacy of Marian Sharkey, the first Editor-in-Chief of *Praxis*. After five years as a board member and a published author in *Praxis*, I am honored to introduce this volume as Editor-in-Chief.

This volume is representative of the shift in the field of social work, towards more international and global practice. In the lead article of this volume, Aimee Hilado presents this shift in the field:

There are a variety of global forces that are shaping social work practice and social service organizations in the United States. Immigration, globalization, and conflicts around the world are shifting communities across the globe and changing the demographics of countries to include more multiethnic populations. Globalization, specifically, has created pressures to develop social work professionals who are aware of international issues that have a domestic impact (p. 6).

As represented in the opening quotation, schools of social work need to prepare students to work with clients in this changing global context. All social workers, even those that do not work primarily with immigrant and refugee populations, must understand the impact global issues can have on those living in the United States and around the world. This understanding can help us to better advocate for our clients and for the human rights of marginalized groups.

Loyola University's School of Social Work is at the forefront of this movement. One of the School's Institutes of Learning is the Institute for Migration and Global Studies and Practice in Social Work, which is directed by Maria Vidal de Haymes, PhD (see http://www.luc.edu/socialwork/ssw_institutes.shtml for more information). Numerous research projects are contained within this institute, in addition to a sub-specialization in Immigration and Migration, and a summer field placement in Mexico, which is an intensive fieldwork experience in the rural village of Chiapas. The School also offers study abroad programs in Rome, Beijing, and India, which are open to both current students and alumni (see http://www.luc.edu/socialwork/academics_studyabroad.shtml for more information on international programs). The School of Social Work at Loyola strives to train social workers who can work in a global context, as can be seen by the many international programs open to current students and alumni.

This volume begins with an article by Aimee Hilado, who discusses the need for social service agencies to have a global focus. Next, Stephanie Loera, Lina Muñoz, Emily Nott, and Brenna Sandefur discuss ways social workers can improve access to mental health services for Mexican immigrants. Aimee Hilado, Erin Aydt, Nicole du Mont, and Claire Hanley then use a case study method to illuminate the experiences of Kosovar refugees. Celia-Luisa Arguello, Marisa Chumil, Jayna Punturiero, and Jacqueline Scott address the implications of the Violence Against Women Act of 2005 for immigrants who are battered. The last article on global social work, by Marisa Chumil, Diana Rodriguez, and Michelle Boyd, discusses advocacy efforts social workers can use to support Pakistani Muslim women in Pakistan.

The next three articles focus on other important issues in social work practice. Clinical social workers see clients with difficult diagnoses to treat, with one of those diagnoses being Borderline Personality Disorder. Lilly Danielson starts by discussing Borderline

Personality Disorder and two commonly used treatment modalities. Megan Seliga then reviews the literature to determine empirically supported treatments for clients diagnosed with Posttraumatic Stress Disorder and comorbid Borderline Personality Disorder. The volume closes with an article by Aaron George, Amanda Elliott, Jennifer Jennings, Kristin Cleland, and Matthew Brown on a model for a grief support group for spouses of deceased Iraq war veterans.

The diversity of articles on the topic of international social work shows how much room there is for social workers to intervene in international issues. The articles discuss the ways organizations can change to better function in an international context, working with immigrant and refugee populations from micro- and mezzo- level practice, and macro-level advocacy efforts to promote social justice. For those social workers who are not familiar with practice with immigrant and refugee populations or international social work, hopefully this volume will peak your interest to learn more and maybe even attend a study

abroad program. It is up to us as social workers to continually seek out areas of lacking knowledge and to be open to learning new information in order to better help our clients.

Deanna D'Amico Guthrie, MSW, LSW
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Reference

- Alphonse, M., George, P., & Moffatt, K. (2008). Redefining social work standards in the context of globalization: Lessons from India. *International Social Work, 51*(2), 145-158.

Creating a Global Organization in the Social Services

By Aimee V. Hilado

Abstract

This paper explores the variety of global forces that are shaping social work practice and social service organizations in the United States. Forces such as immigration, globalization and world-wide conflicts are shifting communities across the globe, changing the demographics of countries to include more multiethnic populations and creating pressures to develop culturally competent social work professionals aware of international issues that have a domestic impact in service organizations. This paper introduces a conceptual framework for creating a global organization to better address diverse populations encountered by the social work profession.

Introduction

There are a variety of global forces that are shaping social work practice and social service organizations in the United States. Immigration, globalization, and conflicts around the world are shifting communities across the globe and changing the demographics of countries to include more multiethnic populations. Globalization, specifically, has created pressures to develop social work professionals who are aware of international issues that have a domestic impact. As an increasing number of foreign-born populations continue to enter into the U.S., organizations adept with transnational issues (better known as global organizations) are in higher demand. This author argues that it is the globally oriented organizations that are essential in supporting the continued growth of a culturally competent social work workforce that is better equipped to meet the varied needs of a changing client community.

The purpose of this article is to: 1) understand how individuals and organizations adapt and address the growing demands created by global movements, 2) discuss what organizational qualities and structures are better suited to support workforce development, and 3) explore how this information can be used to enhance the services and the profession of social work. The article will also examine ways in which collaboration between the individual professional and the larger organi-

zation can produce change towards a more globally oriented organization. Current literature on developing a globally-oriented organization from other disciplines outside of the social sciences will be used as a reference. Michael Marquardt's (1999) model will be used to illustrate how to develop a global organization in the business sector. A framework, based on concepts from Marquardt's model, will then be provided as a guide for developing the global organization in the social services. As social work practice evolves with global political and economic developments, caregiving organizations must as well. Because of this, models for organizational change are needed.

Global Forces With a Domestic Impact

Immigration

"Migration is a fundamental human activity" (Daniels, 2002, p.3) and has been on the increase in recent decades. According to a report from The Urban Institute, the foreign-born population in the United States has tripled over the past 35 years due to immigration (Capps & Fortuny, 2006). In the 1990's, 14 to 16 million immigrants entered the country. This was an increase from the 1980's and 1970's, when 10 million and 7 million arrived, respectively. According to the U.S. Current Population Survey (CPS), the total foreign-born population surpassed 35 million in 2005 (Capps & Fortuny, 2006).

The reasons people migrate and the countries to which they migrate have major implications for the receiving locations. There is an increased likelihood that social workers will make some form of contact with arriving immigrants and refugees. Social workers will encounter these groups in a variety of locations, including schools, community centers, healthcare centers, and social service agencies (Healy, 2001). Migration is a universal process that occurs in all places in the world at all times (Daniels, 2002) and with this continuous movement, social work practice will need to continually modify its approaches, programs and services to meet the ever-changing and growing client population.

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Globalization

Globalization is another force that has been changing the landscape of societies worldwide. Global neighbors are no longer isolated from one another. As technology, communication, and commerce bring us closer to our neighbors, the shift in economics, employment, and labor strengthens some countries while weakening others (Daniels, 2002). An outcome of increased globalization is the immigration of individuals and families to areas that present more opportunities; these individuals and families leave countries that are becoming increasingly marginalized (Daniels, 2002).

Globalization has also created a global interdependence, which means that global events and processes have an impact at a variety of levels all across the world, including the individual and societal level (Lyons, Manion & Carlsen, 2006). In addition, this interdependence has impacted social work practice in our country, where international movements and events affect our clients who seek services in the United States (Healy, 2001). For this reason, social work professionals “need to have some appreciation of international perspective and feel better equipped for social work activities, which are increasingly likely to have cross-cultural and possibly cross-national dimensions” (Lyons et al., 2006, p. 2). Globalization is making this a reality, and cross-cultural exchanges are no longer uncommon.

Conflict

Conflicts around the world have increased the number of internally displaced persons and those seeking refugee and asylum status in the U.S. (Daniels, 2002). Again, we see movement of communities across national borders seeking safety, services, and better opportunities for themselves and/or their families. We see similar movements in labor and employment in business sectors that provide supplies, skills, or services for both groups trying to end conflict and groups that are contributing to the violence. Under such circumstances, the movement of individuals, families and communities is likely. Countries who receive these persons must be prepared to address the physical, emotional, and financial needs they present.

Taken together, these forces – immigration, globalization, and regional conflicts – provide excellent examples of international influences that have a domestic impact. These influences also highlight a need to develop a culturally competent workforce in service organizations that can meet the needs of multiethnic com-

munities. Regrettably, “many professionals are unprepared to provide informed and skilled assistance to individuals and families from other countries and cultures” (Healy, 2001, p. 193). While expectations for culturally competent social work professionals are common, well-understood standards in the profession, the process of becoming knowledgeable about multiple cultures is a difficult and complex task to undertake (Healy, 2001). Despite the complexity and challenges presented by the changing demographics in the U.S., the call for culturally responsive professionals and globally oriented organizations is becoming more apparent.

A transition to a global organization would best serve organizations assisting ethnically diverse populations, such as immigrant- and refugee-serving agencies, because these organizations are working with clients impacted by the aforementioned global forces. Implications for these types of organizations will be discussed in this paper, as well as a conceptual explanation and understanding of how such changes can be achieved. Developing a globally oriented organization requires both changes in the individual worker and the structural framework of a given organization. A theoretical understanding of how change and transition can occur will provide the basis for applying such strategies in real world case examples, which will be presented in the subsequent sections.

Changes Required in the Individual

Individual Learning

Change begins with the individual who evolves, is influenced by and acts, based on her experiences and circumstances. Novel concepts and skills are elements that can be learned to effect change. Individual learning is essential in professional practice settings and needs to be supported by the workforce management. According to Jacobs, Lukens, and Useem (1996), training (or learning) is an investment for both the employer and the employee, wherein employers encourage it and employees seek it in the workplace. Training has been seen as an opportunity for individual employees to enhance present performance and prepare for the future (Jacobs et al., 1996). Its presence is necessary in workforce development, as individuals are not born with an innate ability to do their job. Although understanding of tasks are recognized, knowledge of how to complete the task must be learned (Cohen et al., 1996). Accordingly,

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development of individual employees enhances the capacity of the organization as a whole.

The Role of Leadership

Leadership is an important aspect of any organization. The primary function is to produce change and establish a direction for change (Kotter, 1990). It is the authority in the leader that is valuable, whether the responsibility lies in the hands of one individual or several persons. Leadership is the glue that ties the organization together (Raso, 2006). Leaders serve a function of establishing direction, aligning people, and motivating and inspiring those around them (Kotter, 1990). While their roles are numerous, they must maintain the motivation, direction, and cohesiveness of the group in order to achieve intended goals. Leadership that starts with the individual leader who is motivated to create a global organization can, in turn, effect broader changes.

Cultivating the Culturally Competent Professional

Cultural competence in working with diverse populations is a major tenet of social work professionals and service organizations. Whether identified as cultural competence, cultural capital, a culturally competent system, or cultural responsiveness, the terms are similarly related and are based on the idea that there is a body of knowledge and skills that are needed when working with people of diverse backgrounds (Briggs et al., 2005). Green (1982) defines cultural competence as the professional's ability to think and act in a manner that is congruent with the expected behaviors and expectations of the culture with which a client identifies. For the individual and her skills, this could include:

1) an awareness of one's own cultural limitations; 2) openness, appreciation, and respect for cultural difference; 3) a view of intercultural interactions as learning opportunities; 4) the ability to use cultural resources in interventions; and 5) an acknowledgement of the integrity and values of all culture" (Green, 1998 as cited in Lynch et al., 1998, p. 493).

In order to cultivate cultural competence, the professional must begin with an awareness of her own culture. This lends itself to understanding her own context with relation to others, which, in turn, would increase compassion and awareness in professional practice (Evans, 2007).

Social service organizations already working with, or preparing to work with, culturally diverse populations must be cognizant of the professional's independent role in developing the skills necessary to work in this environment. Although the individual should strive to be competent, it is also understood that cultural competence encompasses an expansive scope of knowledge and it is unlikely that one person could ever fully achieve it (Lynch et al., 1998). Gaining cultural competence is an ongoing process in which learning must be constant. The individual's goals should be to endeavor to understand and respect the existence of diverse populations, be open to continued learning about diversity, and be able to adapt and approach different groups in a responsive and sensitive manner that is culturally appropriate to the client. This is the responsibility of the individual.

Changes Required in the Organization

Aside from these individual professional attributes, creating a global organization also involves changes in the organization itself. There are certain attributes of the organization that must be considered if change is to occur.

Organizational Training and Learning

Organizational training and organizational learning are two concepts that are often used when discussing how to develop an organization's workforce. *Organizational training* is "a device for improving the basic, technical, and managerial skills of their current or future workforce" (Jacobs et al., 1996, p. 159). Despite differences in training objectives, training is a mechanism for developing and adapting both the individual and the organization in addressing new information and advancing the workplace. *Organizational learning* describes the ability to understand and adapt to novel information and circumstances wherein employees are expected to acquire knowledge (Cohen & Sproull, 1996). It is an active process that requires action on the part of the individual and the organization.

It is this author's contention that organizational training and organizational learning are related when juxtaposed to issues surrounding cultural competence development in organizations, particularly those addressing the influences of globalization. In essence, both concepts illustrate an active means for employees to increase understanding of novel information and con-

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texts that impact their own work and performance. Ultimately, learning occurs within the context of the organization's structure. Depending on the appropriateness of that structure, it will determine whether or not workforce development, through active learning, can thrive.

The Relevance of Organizational Structure

Organizational structure is pertinent when addressing change. According to Senge (1994), the organization infrastructure can foster growth and development when work space is viewed as space for learning, with learning as a central objective. Furthermore, the structure can provide the foundation and design for acquiring and adapting to new global information, as well as improving the organization as a whole in light of those factors (Cohen, 1996).

A study by Carley (1996) described the relationships between structure and the capacity for learning and explored how some structures are more conducive than others to learning, adaptation and change. Findings suggested that team-oriented/horizontal organizational structures appear to facilitate learning more readily than hierarchical/vertical organizations. Albeit the lack of additional studies referencing the same correlation, the study's information may prove useful for consideration in organizations looking to develop structures supportive of learning. Team learning studies show that peers learned more from each other, developed better personal skills and interpersonal relationships with others, and experienced morale-building during the training sessions (DeMarco & Lister, 1987). It is a relationship worth noting, with implications for organizational planning and development.

Cultivating Cultural Competence at the Organization Level

What does an organization need to learn? One necessity at the core of this article is cultural competence. Davis, Johnson, Barraza, and Rodriguez (2002) described a number of characteristics related to *culturally competent systems of care*. Several of the concepts relate directly to what one should expect of an organization that espouses cultural competencies such as:

Professionals who are able to meet families' unique needs; an environment where families' stories and space are respected and held in confidence; a place in which families feel the freedom to share information about cultural difference; where professionals are more care

ful and accurate about things that involve individual families; and, a work ethic with families that raises the issues with families in which cultural competence is an important value to embrace. (p. 32).

Cross, Bazron, Dennis and Isaacs (1989) further describe a cultural system of care as a system that "acknowledges and incorporates – at all levels – the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs" (p. 13). Many of the characteristics identified by Davis et al. (2002) and Cross et al. (1989) suggest that it is not only the professional, but the entire organization's responsibility to approach its work with a culturally-aware consciousness. This is reflected at a systems-level through opportunities for training and infusing the importance of cultural competence within the organizational culture, mission, and vision.

Creating the Global Organization

We face a reality in the United States in which society is ethnically and racially diverse and access to resources is unevenly distributed between whites and nonwhites, with white Americans having greater status, power, and access over those who are nonwhite (Briggs et al., 2005). Globalization further exacerbates this reality as our foreign-born population continues to increase in this country. Change at the organizational level must occur to remedy this inequality.

The Global Organization: Bridging the Individual and the Organization

When cultural awareness, adapting to new, diverse populations, and learning is valued in both the individual and the organization, the intersection is where one can conceptualize the creation of a global organization. According to Carley (1996), organizational and/or group performance is highly dependent on the experience and capacity of the individual members. Therefore, organizations should learn in the same way personnel must learn, as the relationship between the two impacts the capacity and experiences of the two together. What is learned by one must be learned by the other.

Organizations are unique systems that align diverse individuals towards a common goal and/or mission. "A central feature of modern organizations is in-

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terdependence, where no one has complete autonomy, and most employees are tied to many others by their work, technology, managements systems, and hierarchy” (Kotter, 1990, p.49). One model aligning the individual and organization, thus creating a global organization, is discussed in the next section. This model requires systematic changes that become engrained in the mission, purpose, and culture of the organization.

The Makings of a Global Organization (Marquardt, 1999)

M. Marquardt’s (1999) global organization model is one of a few attempts to discuss globalization topics within an organizational structure. However, his model is with reference to national corporations who want to become active players in the global economy. Despite the disciplinary differences, the model can still be adapted for use in the social services. According to Marquardt (1999), in order to create a true global organization, it must be “one with a global corporate culture, global people, global strategies, global operations, global structure, and global learning” (p.46). Modifications and reframing need to occur at a variety of levels: from the individual to the organizational level, from the personal consciousness to the group consciousness. With each adjustment, individual employees and the organization can move towards a more global orientation. Developing a *global organizational culture* – one that reflects a global consciousness – is the first step in the process of becoming a global organization in Marquardt’s model. Although it is easier to change structures and operations, internal processes (such as values and perceptions) are more challenging but essential if the spirit of the organization is to change.

Adopting a *global vision* is next; a vision whose goals and direction are for a future that embraces multicultural ties to the global society. A *global mind-set* must also be developed, which embraces an expansive way of thinking that looks for ideas and concepts that are not limited to domestic borders. “The emphasis is placed on balancing global and local needs and on being able to operate cross-functionally, cross-divisionally, and cross-culturally around the world” (Marquardt, 1999, p. 49). These goals and objectives need to be embedded into the professional’s internal working perceptions and beliefs. This will influence her actions and performance in becoming more globally oriented.

Organizational values must reflect *global values*, which focus on global thinking, cultural sensitivity,

continuous learning, cultural customization of services, and developing an empowered global people (Marquardt, 1999). Again, these changes shape the actions and performance of the individual and the organization if they have been embraced and internalized. Lastly, *global learning*, which focuses on a number of valuable concepts, is essential. The most notable aspect is the importance placed on the learning process, in which a higher importance is placed on defining learning needs than finding answers. This makes learning a part of every person’s job responsibilities, and places more value on learning skills than any data collected (Marquardt, 1999). This process of learning how to learn is achieved by recognizing that no person has all the knowledge. The organizational culture must encourage constant reflection, examination of one’s knowledge and skills, and support truth-seeking in all endeavors when working with diverse client populations.

In practice, a global organization is created by the underlying structures that support training and learning, which are viewed through a global lens/framework. This construct of learning permeates all other qualities – global culture, vision, mind-set, values and learning. It is the learning, internalization, and acting in which the global organization will be formed. When an organization has a global perspective to learning within the structure, the workforce will be globally-oriented as well (Marquardt, 1999). It is worth noting that the concepts in Marquardt’s model make no mention of content relevant to globalization, but instead focus on understanding and recognizing novel situations and context that can impact the workplace in general. If the learning of content relevant to globalization is included in this model, the potential outcome could reflect a group of professionals who are cognizant of global issues, who think and act in ways that are mindful of multicultural and cross-cultural influences, and who are better prepared to work within a society that reflects the same context. In essence, the global organization can incorporate all the qualities of a culturally competent professional group that is needed in social service organizations.

Theory in Practice: Applying Conceptual Ideas into Current Social Work Practice

The conceptual framework for change provides a foundation for understanding the ways in which individuals and organizations can transition into being

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more globally-oriented and prepared to work with a diverse, international population. From the discussions presented in this paper, one can surmise that creating the global organization requires changes in the individual and the organization, and it must occur in the context of learning. Brown and Duguid (1996) describe the shift as a process in which personal identities change and new communities are formed or come together, with a revised mission in practice and in values. Both the individual and the organization as a whole must move towards a higher consciousness of global influences in the workplace.

Guidelines

How can systemic change occur then? This author suggests that the following steps, divided in to three stages, can serve as a guide in cultivating a global organization in the social services. As an exercise, consider these steps with reference to an agency that is serving new immigrants from Burma or newly arriving Sudanese refugees. Sample questions that should be considered with reference to the noted client population are listed below with each activity:

INITIAL ORIENTATION ACTIVITIES

1)Assess the current client population served, the environment/context of the clients, and consider any domestic or international circumstances, laws and/or policies that may impact the groups seeking services at the given organization.

(Sample questions: What are the needs of arriving Burmese and Sudanese clients? What were their experiences both pre- & post- migration? What policies have impacted them in their transition?)

2)Review the mission statement, vision, administration/staff, and the general culture of the organization to ascertain its level of cultural consciousness and competence. Also, evaluate these organizational elements and their congruency to the considerations noted in Step 1.

(Sample questions: Is my staff aware of the general history and cultural traditions of Burmese and Sudanese clients? Do they understand the circumstances that required the clients to migrate to this country? How prepared are staff members for working with this group?)

3)Revise mission statements, vision, and strategic plans to reflect global orientation.

(Sample questions: Does the current mission statement, vision, and plans reflect the needs of current populations being served? Do they take into consideration the cultural differences and perceptions of our clients?)

4)Update employee manuals and training materials based on findings from Steps 1 & 2 and which reflect revisions noted in Step 3. Both old and new staff must be re-oriented to the new revisions.

(Sample questions: Do our employee manuals reflect the changes in mission, vision, and strategic plans revised to reflect our currently served population? Are the staff well informed of these changes?)

5)Protocols must be developed to standardize the hiring of ethnically diverse employees who reflect the populations being served.

(Sample questions: Are we hiring staff that reflects the clients we serve? Are there adequate employees who can communicate with Burmese or Sudanese clients or have an understanding of their respective traditions?)

ON-GOING ACTIVITIES

6)Administration and individual staff members should familiarize themselves on global movement and anticipatory action through communications, news blasts and email updates reflecting news in the media and developments/initiatives at the local and federal level impacting the populations served by the organization.

(Sample questions: Are staff members aware of global movements that have a domestic impact? Is there a communications person who can provide this information agency-wide?)

7)Cultural competence training reflecting content on diverse ethnocultural groups and transnational issues should be provided to current and newly hired staff on a regular basis (weekly, bi-monthly, or monthly).

(Sample questions: Is there anyone available to provide training for working with Burmese or Sudanese clients? How often is training made available? How adaptable is the training to include new clients from other cultural backgrounds?)

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8) Clients should be engaged as active partners in the cultural competence training process and should be used as a valuable instrument in gaining first-hand knowledge of client experiences. Clients can be requested to speak at training seminars or staff meetings.

(Sample questions: Are Burmese and Sudanese clients being asked to partner with the agency around training and information sharing? Are their concerns and needs adequately voiced agency-wide?)

9) Policy and advocacy action must be standardized in the organization's goals of practice in order to support changes that meet the needs and interests of the client populations being served as well as the interest of the professionals who serve them (e.g., workforce development policies to support cultural training).

(Sample questions: Are policies reflecting the diverse needs of the clients being served? Are advocacy efforts being made to address the needs of Burmese and Sudanese clients at large?)

10) Provide supervision for staff and interpreters, especially those with direct contact with clients.

(Sample questions: Do staff and interpreters receive adequate supervision to process their work with Burmese and Sudanese clients? Are resources given to them that will help support them in their work with such groups?)

RE-EVALUATION ACTIVITIES (to be conducted 6 months to 1 year after implementation)

11) Re-visit the mission statement and vision, and adapt to changes in the client population and general organization climate.

(Sample question: When new clients are joining the agency, are their specific needs reflected in the organizations materials and climate?)

12) Conduct survey studies with organization employees to determine the level of cultural competence, areas of need, and staff satisfaction ratings. This information can then be used to shape future workforce development programs as well as further organizational change in the direction of the intended goals.

(Sample question: Are evaluative steps being taken to ensure that the staff feel competent in their work and areas of further training are detected?)

13) Encourage an organizational culture that values a more global orientation through recognizing individual efforts. This can be achieved through awards, office-wide celebrations, and financial incentives to outstanding employees who exemplify the outlined goals of a global organization.

(Sample questions: Are individual staff members encouraged to incorporate strategies for contributing to a globally-oriented organization in their own work? Are they recognized for such efforts?)

The goal of these activities is to normalize global consciousness in each individual employee and in the organizational culture as a whole. It is important to market the organization as a culturally competent/global organization with regular training, supervision and recognition internally and in the community. It is also important to support involvement of diverse staff and clients in the learning process as clients learn from the organization's staff and vice versa. Lastly, leadership/management must set the tone and sustain revised goals. By embracing the continuous learning process and making efforts to standardize learning in the organization, one can be optimistic that the creation of a globally-oriented social service organization is a possibility.

In consideration of the Burmese and Sudanese populations used in the example, immigrant- and refugee-serving agencies could benefit from transitioning to the conceptual framework presented in this paper. Changes in individual thinking and the organizational structure towards a more global orientation with ethnically diverse clients could produce a number of positive outcomes. It is plausible to posit that there will be a benefit to client relationships that will be enhanced with cultural understanding and willingness to learn. Clients may feel more open to share experiences when they feel they are interacting with practitioners and/or an organization that is receptive to cultural differences and open to working within a different cultural framework that is appropriate to the clients being served. There may also be greater ability for the organization, as a whole, to adapt to the changing needs of an ever-changing global context that brings a daily influx of diversity into practice settings. It is possible that such awareness can impact greater macro changes at the policy level, which would better serve clients received in social work settings across the country.

Creating a Global Organization in the Social Services

General Obstacles

Positive changes cannot be attained without work and challenges. The alignment of people, ideals, and objectives are what is needed to support organizational change in a standardized direction; however, this is not easily achieved. Due to the interdependent nature characteristic of modern organizations, unless large numbers of individuals can be organized and unified in one direction, the organizations and its people will stumble (Kotter, 1990). Organizational change reflects two types of gambles: one in which there is an uncertainty in the process of change itself, and the other in which there is the uncertainty of what the change will mean for the organization and the impact with its environment overall (Cohen & Sproull, 1996). In both cases, mobilization may be difficult if organizational change instills doubts or fear of risk to individual interests, or questions the potential impact on the organization. Resistance may occur if the organizational structure is not supportive of the change.

Furthermore, appropriate representation of the ethnic communities served is not reflected in the workforce, nor mentioned in Marquardt's global organization model (1999) or in Davies et al.'s (2002) culturally competent systems of care model. Although these models discussed the importance of cultural learning and embracing diversity, there was no specific reference to diversity in the employees as an additional method for enhancing cultural competence and a more culturally-aware organization. Without a representative workforce, the face validity of a global organization may be thwarted, with implications for both internal and external structure such as morale, buy-in, and participation in a unified mission.

Motivations for Development

The literature suggests a general need for organizations that embrace and encourage learning, team-building, and a vision, mindset and leadership oriented towards transnational views, thus creating the global organizations. Such an organization may be better equipped to deal with transnational issues and multicultural populations. Competent staff and organizations can then provide better outcomes for the clients served. One can surmise that there are also individual, societal, personal, and economic gains. Clients whose needs are adequately met in a culturally appropriate manner may engage in more positive activities (Nicholson, 1997),

seeking employment, enhancing individual functioning and family functioning, and becoming active citizens. While these projections are merely speculative, research on social support has shown positive individual results that can encompass this range if adequate support is provided (Lie, Sveaass, & Eilertsen, 2004). This is where the role of the global organization is relevant and can be crucial. As a social support network, the global organization may support changes overall.

Additionally, authors have embraced the importance of workforce diversity as a means of combating discrimination and fostering culturally sensitive approaches to working with multiethnic populations. These ideas are supported by Raso (2006) who states, "for your organization's culture to truly welcome and accept diversity, [it must] implement strategies for leadership, communication, workforce diversity, community relationships and multidisciplinary education" (p. 56). Some organizations recruit employees from diverse ethnic backgrounds in order to dissolve some of the differences between the staff and clients (Evans, 2007). Incorporating recruitment and policies that support diversity is crucial as it becomes a part of the agency's way of thinking, which can effect action (Lynch & Hanson, 1998). This move towards a representative workforce, as mentioned, can add to the efficacy of the organization.

Conclusion

This article provides entrée to discussing concepts that engender a global social work organizational model. This paper identified the systemic needs and changes for addressing globalization and workforce development in support and nurturance of culturally competent professionals. It is important to note that models and guidelines for creating a global organization are not made in a linear fashion within one body of research literature. Rather, the necessary elements discussed come from a variety of references from numerous disciplines. The conceptual framework presented in this article is just one model created for the social work profession, and the example populations and settings are meant to be conceptual examples of how such a model could be implemented in real-world settings. Further investigation is necessary to determine if other models that address globalization and cultural competence training can be found for similar helping professions. At the moment, such references are scarce.

Creating a Global Organization in the Social Services

While this paper can only be suggestive in both extent and scope to the needs of workforce and global organization development, the discussion highlights some points to be considered. This topic area and the limited research base have implications for social work practitioners, researchers and policy makers. Firstly, social service organizations need to recognize the growing demand for a globally-oriented organization as a means to provide culturally-sensitive, responsive care to diverse ethnic groups. Secondly, researchers need to study the impact and value of global organizations, versus organizations not oriented to addressing transnational issues in the workplace. Although there are remaining gaps in the literature that reference appropriate models and strategies for creating a globally-oriented organization, increasing literature in other disciplines may be the impetus for related research in the social work field.

Thirdly, policies are needed to ensure that workforce development is provided for those working with populations of different ethnocultural backgrounds. Public policy, in its design and implementation, must reflect the importance of diversity, grant access to all clients irrespective of cultural heritage, and create supportive environments that meet the needs of multicultural individuals and families (Briggs et al., 2005). In addition, related policies can serve as a catalyst to encourage workforce development and provide

encouragement for organizations to embrace diversity and cultural awareness, which are visible themes at national and international levels. Policy, coupled with additional social work research and program development, can support models and best practice approaches for service organizations working with transnational clients and communities. As noted in the examples presented, such changes can greatly impact the clients served by a globally-oriented agency.

Ultimately, “working effectively and ethically with those who are different, for fair and just outcomes, is a long-established imperative in social work” (Tesoriero, 2006, p.127). Social service organizations who are aware of global influences, who understand its impact on its work, and who have a culturally competent staff are better suited for meeting the needs of an ever-growing, diverse population who are in need of social services in the United States. In order for social work practice to be effective, appropriately responsive, and culturally-sensitive, social work organizations need to adapt to their changing clientele through systemic change within the organization and within individual professionals. In practice, this is achieved through learning, self-awareness, and increased respect for diversity. Although achieving such goals through organizational change and workforce development may prove challenging, it is an endeavor that is both worthy and imperative to social work practice.

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Call the *Curandero*: Improving Mental Health Services for Mexican Immigrants

By Stephanie Loera, Lina M. Muñoz, Emily Nott, and Brenna K. Sandefur

Abstract

As the number of Mexican immigrants in the United States has topped other immigrant populations, mental health practitioners in turn will be encountering this population with increasing frequency in the provision of services. This phenomenon brings up several issues regarding the potential special needs of Mexican immigrants, such as culturally appropriate services. This article will examine the mental health needs of Mexican immigrants, reasons this population may not receive necessary treatment, Mexican folk beliefs about mental health, specific folk healing practices, and ways to incorporate these needs and beliefs into a culturally sensitive social work practice.

Introduction

In 2007, it was estimated that 45.3 million Latinos were living in the U.S, constituting 15 percent of the nation's total population and making them the nation's largest ethnic/racial minority (Pew Hispanic Center, 2007; U. S. Census Bureau, 2007). A closer look at the Latino population in the U.S. shows that Mexicans make up two-thirds of the population, making them the largest Latino group in the United States (U.S. Department of Health and Human Services [DHHS], 2001; Potocky-Tripodi, 2002). Of the Mexican population, 42% listed themselves as foreign born and 71% spoke a language other than English at home (U. S. Census Bureau, 2000). The Pew Hispanic Center estimated there were 11.9 million undocumented immigrants in the United States in 2008 (Pew Hispanic Center, 2008), 7 million of whom are from Mexico, making it the country with the "most unauthorized immigrants in the U.S." (Pew Hispanic Center, 2008, p. iii).

From these statistics it is clear that this diverse and complex population of Mexicans is increasing in size. Because of the size of the population itself, as well

as added stressors on this population, such as migration or undocumented status, it is imperative to look at how Mexicans, native born and foreign born, are accessing mental health services and whether the services offered are appropriate to the population.

It was estimated in the Surgeon General's report that fewer than 1 in 11 Latinos with a mental health need contacted a mental health specialist, and among Latino immigrants, that number jumped to 1 in 20 (DHHS, 1999). Current research has found that Mexicans are less likely than any other Latino group in the U.S. "to receive mental health services, to experience satisfaction with mental health services, and to perceive mental health services to be helpful" (Shattell, Smith, Quinlan-Colwell & Villalba, 2008, p. 201). This perception is at odds with the population's mental health needs; among other mental health issues, researchers have found high rates of depression and anxiety, especially in Mexican women living in the U.S. (Shattell et al., 2008).

These numbers clearly exhibit the great need for ways to increase the number of Latinos accessing mental health care. Since Mexicans make up such a large number of the Latino population, this group will be addressed in this paper. To increase the numbers of Mexicans utilizing mental health services, it is important to make sure that these services are culturally appropriate. In order to create culturally appropriate services, an understanding must be gained of Mexican beliefs about mental health, as well as cultural methods of addressing those beliefs. These cultural beliefs can then be utilized and incorporated into services for this population, hopefully helping to increase the number of Mexicans utilizing mental health services.

Mexicans and Mental Health

Some of the stressors that have been found to impact Mexican Americans' mental health, specifically undocumented immigrants, are low educational attain-

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ment, low English proficiency, little or no health insurance coverage, poor housing, and low employment status, which usually results in low wages and often exploitation by employers (Sullivan & Rehm, 2005; Garcia & Saewyc, 2007). Other issues that put Mexican immigrants at risk of developing mental health problems are adjusting to cultural norms of the new country, establishing new relationships, discrimination, fear of being deported if in the country illegally, and separation from kinship networks and community in Mexico (Garcia & Saewyc, 2007; Grzywacz, Quandt, Arcury & Marin, 2005; Sullivan & Rehm, 2005).

It has been found that the migration from one socio-cultural system to another can bring an increased amount of stress to an individual and lead to serious mental health problems. However, this stress can be even greater for individuals who enter a country with irregular documentation because many do not qualify for services that are offered in the country. In the case of income and employment in the U.S. because unauthorized Mexican Immigrants (UMIs) “lack the legal benefits assured through immigration paperwork” (Sullivan & Rehm, 2005, p. 246), many are at times exploited by their employers and “more likely to receive less pay than their documented counterparts” (Sullivan & Rehm, 2005, p. 248).

As a result of UMIs having low paying jobs, many of them will experience great stress because of their inability to provide for themselves or their family who are either living in the U.S. or in Mexico (Sullivan & Rehm, 2005). Another stressor that UMIs experience is the inability to seek healthcare because of their status. Although UMIs are allowed to seek healthcare in certain parts of the country, many of them do not because they fear their undocumented status will be revealed to government authorities and consequently be deported. Therefore, if immigrants are not seeking healthcare, which is known as the route to accessing mental health services, they are left to deal with their mental health problems in other ways (Sullivan & Rehm, 2005).

Theories on Lack of Access

In a study done on recently immigrated Mexican adolescents, researchers found these adolescents to view mental illness as a result of their failure to adjust to life in the U.S. (Garcia & Saewyc, 2007). Adolescents described themselves as feeling socially isolated

and depressed about leaving their friends behind in Mexico (Garcia & Saewyc, 2007). Others also described losing their appetite, having low energy levels, and having physical aches when they felt depressed (Garcia & Saewyc, 2007). Adolescents who had jobs also explained that work-related stress had a serious impact on their health. For example, they described that due to their busy work schedule many of them had very little time to eat, seek health care, and get enough sleep. When participants were asked what they do when they are feeling sad, many responded that they would seek people they could trust such as “family, friends and some health care providers” (Garcia & Saewyc, 2007, p. 47). However, when participants were asked who they would go to “with a mental health concern...none of them mentioned a formal health care provider as an initial resource” (Garcia & Saewyc, 2007, p.48). Therefore, the study perfectly illustrates how adolescent Mexican immigrants perceive mental health and the possible reasons mental health services are not accessed by Mexicans living in the U.S.

Mexican values also play an important role in the utilization of mental health services. Some of the theories that have been used to understand the underutilization of mental health facilities and describe the impact of Mexican values are the alternative resource theory and barrier theory (Rogler, Malgady, & Rodriguez, 1989). The alternative resource theory explains the underutilization by looking at the traditional Latino social organization. Researchers explain the reason so many Latinos do not seek mental health services is because they are more likely to “turn to proximate and culturally familiar indigenous organizations” such as their “family, friends, religious and spiritualists groups” (Rogler et al., 1989, p. 46). Additionally this theory explains that if a person is still not healed or cured after visiting a close relative, then he or she will seek professional help. The theory of alternative resources delicately illustrates the value of family and loyalty to ones kin, also known as *familismo*.

The second theory that describes the underutilization of mental health services in the Latino community is Barrier theory. This theory explains that there are two obstacles that prevent Latinos from obtaining professional mental health services; the first is cultural values and beliefs, and the second obstacle is institutional barriers (Rogler et al., 1989). Barrier theory describes the cultural obstacles as: trusting family over others, re-

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specting the elderly and valuing their wisdom, having a sense of pride; and, for men, the idea of maintaining ones' masculinity, being manly and unaffected by stress (Rogler et al., 1989). With respect to institutional barriers, the most common reason Latinos underutilize mental health facilities is due to the lack of bilingual and bicultural mental health professionals (Rogler et al., 1989). It is also believed that the disparity in socioeconomic status can impact a client's decision to seek services. For a poor Mexican client, meeting with a therapist who is middle or of a higher social class can be extremely intimidating and cause him or her to not seek treatment (Rogler et al., 1989). A third barrier to receiving mental health services is the lack of mental health facilities in predominately Latino or Mexican communities (Rogler et al., 1989). Therefore, Barrier theory suggests that Latinos do want to obtain services, but do not do so because of the way mental health facilities are structured. Another reason, not mentioned in Barrier theory, that Latinos may not seek mental health services is the idea that navigating a new and large system like healthcare in the U.S. can be difficult and intimidating.

Folk Healing with Mexican Immigrants

If Mexican immigrants are not accessing U.S. mental health services, how do they deal with mental health issues? The traditional method of healing among Mexicans is commonly known as *curanderismo*, which utilizes the practice of folk medicine. The term *curanderismo* comes from the Spanish word *curar*, which means to heal. Healing, in this sense, requires treating an unbalance within the mind, body, or spirit. *Curanderismo* is an integrative practice with roots in Indian, European, and African traditions. It is not unique to Mexico, but can also be found throughout Central and South America (Zacharias, 2006).

During the early 16th century Spanish conquerors and priests brought with them medicinal concepts and herbs to Mexico. In turn, traditional and folk medicine in Spain has roots in ancient Greece, the Roman Empire, and the Arab world. Some Mexican folk illnesses may even be able to trace roots back to Arabic influence (Roeder, 1988). The Aztecs utilized herbal remedies as well as narcotics and hallucinogens and performed complex surgeries and procedures, such as bloodletting. Much of this medical system was destroyed by Spanish conquerors, but the practice of heal-

ing with herbs remained a part of the culture (Roeder, 1988). Modern *curanderos* continue to use the methods put into practice by indigenous Mexicans (Roeder, 1988). The use of *curanderismo* was historically persecuted by the Catholics during the inquisition, and so practices such as the use of oracles, dream interpretation, and hallucinogenic substances went underground (Zacharias, 2006).

Mexican law recognizes *curanderismo* as "culturally important but not medically valid" (Zacharias, 2006, p. 382). The small population that recognizes *curanderismo* as useful in the medical profession focuses on the use of herbal treatments and midwife practices and less on *curanderismo* practices as a form of psychotherapy. According to Zacharias (2006), the "growing influence of biomedicine in Mexico" has led to the rejection of *curanderismo* among the general public (p. 383).

In small towns that do not have access to medical care or other public health services, *curanderos* are often the only source of available treatment (Zacharias, 2006). *Curanderos* remain popular in Mexican communities because they often do not ask for money for services. Healers do not require medical insurance, and clients are not required to make appointments or fill out paperwork. Thus, there is no need for literacy, and no language barriers exist. Clients can go to the *curandero* that resides in their community, thereby reducing the need to travel great distances for services (Roeder, 1988).

In folk healing, health is understood by the interaction of three dimensions: the religious or spiritual dimension or *spirit*, the affective-emotional dimension or *soul*, and the somatic processing dimension or *body* (Zacharias, 2006). According to Zacharias (2006), the spirit plays a central role in the understanding of mental illness and psychiatric disorders and has a "religious, non-psychological significance" (p. 388). A balanced spirit includes both dream states and altered states of consciousness, which lends a sense of meaningfulness and identity. The soul is affected if the spirit is weak and cannot fulfill its function; dysfunction of the soul is exhibited by intense emotion, characterized by "pathological feelings of envy or rage, or an overwhelming sadness" (Zacharias, 2006, p. 388).

Finkler (1985) divides common illnesses into seven different categories: environmental, behavioral, nutritional, emotional, physiological, natural, and super-

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natural. Environmental illnesses are attributed to inclement weather and include rheumatism, cold and gripe. Behavioral illnesses can stem from too much thinking, for example, resulting in headache. Nutritional illnesses, also including headache, are a result of skipping meals or irregular eating habits. Nutritional deficiencies also can cause emotional reactions. Emotional illnesses resulting from such situations as bereavement, *susto* (fright), *coraje* (anger), and *nervios* (nerves) can manifest as unspecified illnesses, diabetes, diarrhea, and tonsillitis, respectively. Physiological illnesses such as high blood pressure can be suspect causes of headache or *nervios*. Illnesses attributed to natural causes, such as eating the wrong foods can cause *empacho* ["bolus attached to the stomach" (p.55)]. A supernatural illness such as *aire* (a word meaning air, wind, or aura/atmosphere in English) can cause intestinal problems or pains in the arms and feet as a direct cause of witchcraft (Finkler, 1985).

Interventions and Treatment

Folk healing is a spiritual practice that, according to a study by Zacharias (2006), can incorporate three types of diagnostic methods: "empathic and spiritual perception of the health status and problems of the patient; an oracle method; and verbal information gained through incidental conversation with the patient," (pp. 389-90). Zacharias's (2006) findings suggest that the less severe the illness, the more likely the patient is to be cured from the *curandero*'s healing practices. Findings also suggest that the psychotherapeutic interventions of *curanderos* might be as effective as Western methods of psychotherapy. Another important implication of this study suggests that the use of altered states of consciousness can satisfy the need for human bonding and may in fact compensate for deficient bonding.

A study conducted by Ortiz and Torres (2007) investigated herbal, spiritual, ceremonial, and psychological methods used by *curanderos* to treat alcoholics. The *curanderos* performed liver detoxification with the use of saline solutions and vitamins. The detoxification by hydration with water or herbal teas produces effects similar to intravenous hydration used in hospital settings. Herbal treatments were used to combat physical and emotional symptoms of alcohol use and withdrawal. Family issues were addressed, and family members were often involved in the administration of treatment.

The heat, darkness, and perspiration that occur with the use of a *temazcal*, or "sweat lodge" (p. 84), were used to facilitate an emotional release, as well as to release the toxins in the body that result from the consumption of alcohol. Plants may also have been used to brush the body during the sweat lodge treatment, thereby releasing therapeutic aromas. Treatment utilized massage and healing touch in order to release endorphins and reduce the production of stress hormones, to release toxins, to decrease the heart rate during withdrawal, and to improve sleep and the ability to tolerate stress. *Limpias*, or spiritual cleansings, were given to treat PTSD and other trauma in order to regain emotional balance. Prayer and meditation were used during treatment, as well as *platicas* (counseling) to help the client "better understand their current alcoholism and perhaps better engage the individual in the treatment method," (Ortiz & Torres, 2007, p. 86). The talks dealt with self-esteem issues, which can cause or perpetuate alcoholism. Societal issues such as violence in relation to alcohol use were also addressed (Ortiz & Torres, 2007).

Mexican Folk Illnesses and Culture-Bound Syndromes: Nervios

Folk beliefs and practices described above contain another aspect to be addressed in practice: folk illnesses, sometimes known as culture-bound or culturally interpreted syndromes. In working with ethnic populations a practitioner must know that there is a cultural understanding of mental illness, and that its interpretation might be influenced by the individual and social perception of the body-mind relationship. One prevalent example of such a condition is known as *nervios*. The condition recognized as *nervios* is one of the culturally-interpreted syndromes that have been reported in many Latin American countries as well as other regions around the world (Guarnaccia, Lewis-Fernandez, & Rivera, 2003). *Nervios* is consistently described by many Latino groups "as a culturally approved reaction to overwhelmingly stressful experiences, especially concerning grief, threat, and family conflict" (Guarnaccia, 1993, as cited in Baer et al., 2003, p. 317). However, it is possible to encounter particular definitions of *nervios* across different nations.

Researchers who have worked with Mexicans have found that *nervios* might be understood by this population either as an illness or as a symptom, but also

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may be used as an explanation of an illness (Baer et al., 2003). In a study done in Mexico City, Salgado de Snyder, Diaz-Perez, and Ojeda (2000) concluded that “*nervios* is an illness state associated with emotional, physical, and existential problems” (p. 454). Along with studies done with Guatemalans and Puerto Ricans, these authors found that in Mexico *nervios* has a higher prevalence in women from rural areas, especially those who have an underprivileged position in society. It has been suggested that women from a lower socioeconomic status are more likely to experience *nervios* throughout their lives (Salgado de Snyder et al., 2000). Therefore, researchers relate *nervios* with situations where stress, abuse, and neglect are constantly present. It should be noted that “the rural women with the highest prevalence of *nervios* and associated symptoms are those who are married, have a low level of education, are homemakers and have more than four children under their care” (Salgado de Snyder et al., 2000, p. 465). These authors also stated that for these groups of disadvantaged women, *nervios* may have the function of a defense mechanism through which they are able to withdraw from other people’s demands until they become emotionally stable and recuperated from their overwhelming and relentless responsibilities.

It is interesting that *nervios* has a low prevalence among men from rural communities. This may be explained by the traditional gender roles in Mexican culture that usually do not allow men the expression of feelings and weakness. Salgado (1998, as cited in Salgado de Snyder et al., 2000) stated that, “men [from rural communities] tend not to suffer from *nervios*; instead, they consume alcoholic beverages and/or become violent in response to their problems” (p. 466).

It is important to take into account that the definition of *nervios* may rely on personal and cultural interpretations; thus, the somatic and psychological expressions might have different significance for the sufferer (Koss, 1999). However, it is possible to identify a common description of *nervios* shared by Latino populations, referring to *nervios* as a generalized state of distress that is expressed with an array of somatic and psychological symptoms. According to Salgado de Snyder et al. (2000), some of the somatic symptoms include: headaches, backaches, trembling, lack of appetite and sleep, fatigue, physical agitation, menstrual irregularity, vomiting during the entire pregnancy, lump in the throat, difficulty breathing, chest pain, stomach ache,

nausea, diarrhea, flatulence, dizziness, blurred vision, fevers and sweating. In regard to psychological symptoms associated with *nervios*, the existence of behavioral, cognitive, and emotional manifestations such as irritability, anger, sadness, obsessive ideation, overwhelming concerns, lack of concentration, mental confusion, crying spells, fears, anxiety and erratic behavior have all been reported (Salgado de Snyder et al., 2000).

It is interesting to note that many of the symptoms associated with *nervios* may fit the criteria for depression or anxiety disorders as specified in the DSM-IV-TR. However, Koss (1990) states that *nervios* does not always imply the existence of psychopathology, but the manifestation of an internal conflict that cannot be managed by the individual’s internal and external resources. As a result, “*nervios* should be recognized as a ‘cry for help’ and might become the precursor to serious mental and physical dysfunction, particularly among those with fewer assets and overwhelming obligations and responsibilities” (Salgado de Snyder et al., 2000, p. 467).

Implications for Social Work Practice with Mexicans

In working with the Mexican population (as well as Latinos generally), the possibility must be considered that clients will present with folk illnesses or “culture bound syndromes” such as *nervios* that are not acknowledged in Western mental health or in the DSM. A client may exhibit symptoms such as a dissociative experience, screaming, or brief psychotic symptoms that appear similar to disorders such as schizophrenia, but that do not actually fit into this diagnostic category. Workers may interpret these symptoms through a lens that does not take into account cultural reasons for these symptoms, leading to a misdiagnosis of clients. This misinterpretation of symptoms (as well as lack of published diagnostic criteria) also leads to an under-diagnosis of folk illnesses. A contributing factor to these problems in diagnosis may be the assumption by the worker that only immigrants would suffer from a folk illness, whereas in reality, these illnesses may present in a client whose family has lived in the United States for generations (Gonzalez, Castillo-Canez, Tarke, Soriano, Garcia, & Velásquez, 1997). A vital step toward improving services for the Mexican population is to bring these culture-bound syndromes or folk illnesses to wider aware-

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ness and train mental health professionals to recognize symptoms and treat clients in a culturally competent manner.

One way to better address folk illnesses and to more fully meet the needs of Mexican clients is to find a means of incorporating cultural and folk beliefs into practice. Theoretical frameworks or diagnostic tools based on the importance of these beliefs may be helpful to accomplish this goal. It may also be necessary for the worker to collaborate with a more traditional healer in order to help clients. According to Zuniga (2001), an important part of cultural competency with Mexican clients (and Latino clients, generally) is an ability to be theoretically flexible and consider working with more traditional folk healers, such as *curanderos*, a need also hinted at by the low numbers of Latinos engaging in mental health treatment (DHHS, 1999), instead preferring to consult family or folk healers. It is estimated that somewhere between 7 and 44% of Latinos consult folk healers (McNeill, Prieto, Ortiz, & Yamokoski, 1989).

Despite this obvious need, there is a paucity of literature concerning examples of or methods for the integration of traditional folk healers into contemporary social work. This seems to overlook a valuable tool in engaging the Mexican population in mental health treatment. These folk healers and religious leaders can be vital for outreach to those who may desperately need services, and encourages respect of the client's cultural and spiritual values. Kelly (2007) stated that in his work with Mexican adolescents, this has been a vital part of involving clients and families in treatment. He refers to religion as a mediator, and cites the families' faith as an ally that bolstered his own interventions. In one of Kelly's examples, a *curandero* became a vital part of working with a client displaying schizophrenic symptoms. The involvement of a *curandero* allowed religious and cultural beliefs to be integrated into a psychiatric treatment plan, creating a holistic and culturally appropriate intervention for the client. Instead of being a barrier, this case showed that "immigrant religious traditions can act as protective factors when they are engaged by culturally competent educators and social workers" (p. 268). For Aros, Buckingham, and Rodriguez (1999), incorporating a *curandero* into the treatment team allowed the client to express grief over a loss. This was an outcome that was not accomplished in counseling until a modification of the treatment plan was made to include a *curandero* in this client's intervention: "it is evident

that a *curandero* may well use psychological interventions...that can impact certain clients in ways that we now cannot" (p. 91).

The important role that these traditional beliefs and practices play in social work practice means that assessing a client's folk beliefs is an essential part of assessment with Mexicans. The Folk Belief Subscale, created by Cuellar, Arnold, and Gonzalez (1995), can be a helpful tool in bridging this gap. There are three factors in the Folk Belief Subscale: Experience, Belief in the Supernatural, and Folk Practice Ideologies. These factors can assist the therapist in assessing whether the client has previously worked with a folk healer, whether the client believes that folk beliefs have the capacity to heal, and whether the client subscribes to an ideology that would involve working with a folk healer. This can aid the therapist in ascertaining the extent to which it may be helpful to utilize traditional healing practices in forming an intervention with the client.

Due to the vital importance of cultural factors to mental health treatment (McNeill et al., 1989), and the importance of folk beliefs and spirituality to the Mexican culture, utilizing a theoretical framework that acknowledges the importance of faith and spirituality as indigenous coping strategies may be helpful to the therapist. One such way of working with clients uses *La Fe de la Gente* theoretical framework (Villa, 2001). This framework evaluates clients along two planes, *la fe* (faith) and *la vida* (life). On the *la fe* plane, the client is assessed for the level of their interaction with spirituality, as well as spiritual beliefs; the *la vida* plane involves the client's interactions with family and community, as well as how the client's spirituality affects his or her life.

Additionally, *La Fe de la Gente* is a useful framework because it stresses the essential nature of cultural competence and integrates other cultural values into a framework for working with clients. The framework also utilizes *la platica* as the style of interview. This is described as a "polite, informal, mutually rewarding conversation" (Villa, 2001, p. 376), which is a more natural style of interaction in the Mexican culture. Aspects of this type of interview include conducting the interview in the home and letting the client have more control in guiding the conversation, incorporating the cultural value of *personalismo* into practice (Villa, 2001).

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Future Directions

In order to achieve best practices with this population, more research must be done on the effectiveness of frameworks such as *La Fe de la Gente*. Qualitative and quantitative analysis must also be completed on interventions in which traditional healers such as *curanderos* are consulted and incorporated into social work practice. Guiding frameworks for utilizing such interventions need to be made widely available, as well as a more detailed and researched guide on how to diagnose

and treat folk illnesses such as *nervios*. This work is necessary in order to find a way to reach the large, ever-growing population of Mexicans whose needs are not currently being met by the Western method of mental health treatment. Without a system that incorporates clients' needs and beliefs into interventions, gains cannot be made in increasing Mexican utilization of mental health services. This points to the vital nature of understanding this population's beliefs and traditional methods of coping, using this knowledge to assist clients by the most effective means available.

Stephanie Loera completed the MSW program at Loyola University in May 2009. She was born and raised in the city of Chicago and for the last five years has been working with children and families at El Valor, located in the predominately Mexican community of Pilsen. While in the MSW program, Ms. Loera's first year placement was in the pediatric unit at Cook County's John Stroger Hospital. Her second level field placement was at a community mental health agency in the Humboldt Park area where she did child, adolescent and adult therapy. Currently, Ms. Loera is working at the Erickson Institute in their Early Childhood Project with DCFS as a regional screener.

Lina Muñoz completed an M.S.W. at Loyola University Chicago in May 2009. In the summer of 2007, she completed her first internship abroad in Mexico where she provided mental health services to children and adults in a rural community in the state of Puebla. In her second internship she worked at DCFS as a child abuse investigator. Ms. Muñoz is currently enrolled in the PhD program at Loyola University Chicago where she was awarded entry and a competitive merit scholarship with research responsibilities at the Institute for Migration and Global Studies in the School of Social Work. As a Graduate Research Fellow, Ms. Muñoz is now assisting Dr. Maria Vidal with a project that requires her to work with the Mexican Consulate of Chicago, a consortium of Latino community based human service agencies, numerous Latin American universities, and Jesuit Migrant Services in Mexico. In this role she is visible to the larger transnational Latino community as a university representative and social worker. Ms. Muñoz had the opportunity to develop her own research projects and present them at two international conferences about migration. She has traveled abroad and in the United States and has learned tremendously from those experiences becoming very aware and sensitive to cultural issues.

Emily Nott is a graduate student of social work at Loyola University Chicago with a focus in migration studies. During the summer of 2009 she completed an internship in the Mexican state of Chiapas, during which time she worked with various indigenous communities. This opportunity gave her a hands-on learning experience about internal migration in Chiapas as well as the organization of cooperatives of indigenous peoples, self-sustainability, and indigenous culture. Ms. Nott attended the Fifth International Conference on Migration in Guatemala City in 2008 and had the opportunity to visit Bogota, Colombia in March of 2009 to learn about the protection of children's rights under the United Nations' Convention on the Rights of the Child. She is currently part of a student panel for the planning of a conference on migration to be held this fall in Chicago. Ms. Nott recently began an internship with the Immigrant Child Advocacy Project, advocating for the rights of detained unaccompanied immigrant minors in the Chicago area. Ms. Nott has previously spent two years living and working in Mexico, which fueled her desire to become involved in migration and human rights issues.

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Brenna Sandefur is completing her MSW at Loyola University Chicago, where she is concentrating in school social work and migration studies. She has just completed a field placement at Jewish Vocational Service in Kansas City, MO, where she served refugees through counseling and case management. Cultural competency in social work practice is one of her major areas of interest.

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Kosovar Refugees: An Account of Departure, Resettlement in the United States, and Methods of Engagement in Clinical Social Work Practice

By Aimee V. Hilado, Erin Aydt, Nicole du Mont, and Claire Hanley

Abstract

This article focuses on the experience of Kosovar refugees, beginning with a historical overview of the conflicts in Kosovo and a case study interview with one former refugee from the region. Several themes including trauma and loss, the resettlement process, the role of family and spirituality, and adjustment to life in a host country surfaced in the interview and are discussed in relation to the general circumstances and context of war-experienced refugees. Clinical social work practice is discussed, applying psychotherapy, narrative therapy, and the empowerment approach. An integrative model based on the client's strengths and experience and a trusting therapeutic relationship is suggested as a means of providing effective clinical services for war-experienced refugees.

Introduction

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” (United Nations Convention Related to the Status of Refugees, 1951). Hundreds of thousands of new applications from persons seeking refugee and/or asylum status are received yearly by the UNHRC. As conflicts around the world continue to grow and more and more individuals and families are being displaced, this article attempts to shed light on the experiences of refugees through a case study interview conducted with one former refugee from Kosovo. To begin, this paper will provide a historical overview of the conflicts that led to the Kosovo refugee crisis. Several themes will be explored that surfaced throughout the interview and in the literature, including experiences of departure from the region and resettlement in the host country as well as the role of family structures and religion/spirituality

in negotiating these transitions—themes that can be translated to many refugee populations all over the world. Moreover, the impact of trauma and loss for war-experienced refugees will be highlighted.

This historical context and the highlighted themes provide a foundation for the concluding sections of this article. These sections focus on universal themes in refugee resettlement and general practice goals for working with Kosovar and other Balkan populations. Additionally, several clinical methods for engaging refugee clients will be discussed with a goal to explore the appropriateness of various theoretical approaches when used in clinical social work practice. The authors of this article argue that no one treatment modality is sufficient in treating the complex needs of refugee populations and there is a need for a new, multi-theoretical approach for providing effective clinical services to war-experienced refugees.

The Case Study

(For confidentiality purposes, the name of the interviewee has been changed.)

Edisa, 39 years old, Albanian female, is a former refugee from Kosovo who was resettled in Chicago, Illinois nine years ago. After the researchers received informed consent from Edisa, she answered a number of their open-ended questions related to her experiences of fleeing Kosovo amidst conflict, of receiving refugee status, of resettling in Chicago, and of transitioning to life in the United States. Edisa was initially hesitant to share her story despite the length of time she had been away from the conflicts, however, she was very cooperative and open once the interview process began. Her account of personal experiences provides valuable insight into general feelings shared by other Kosovo refugees and displaced persons in the region. At the same time, Edisa's story can be translated to that of persons who find themselves in similar circumstances all over the world. This interview presented a number of themes that are congruent with

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much of the literature on refugee experiences and has implications for social workers who provide clinical services to this population.

Historical Overview

The Balkan Peninsula is the easternmost of Europe's three great southern peninsulas. More commonly known as the former Yugoslavia, the peninsula is comprised of Slovenia, Croatia, Bosnia and Herzegovina, Serbia, Kosovo, Montenegro, Macedonia, Albania, Bulgaria, Romania, and Moldova. Kosovo is one of the smallest nations in the former Yugoslavia but has received a great deal of attention over the past few decades. Political, economic and cultural changes have resulted in merciless conflicts that targeted Kosovar civilians and decimated the country. Great nationalistic sentiment felt by Serbians and Albanians over this region is thought to have been the root of conflict (Edisa, personal communication, April 14, 2008; *The Balkan crisis*, 1997).

From the early days of the Ottoman Empire until well into the early 20th century—except for the period between 1945 and 1980—Kosovo has experienced conflict between the factions that consider the region their homeland, particularly the Serbs, Croates, and Kosovarians. The First Balkan War took place from 1912–1913, after which Serbia reclaimed Kosovo as part of its territory. After World War I, the new state of Yugoslavia was proclaimed. Kosovo became part of the kingdom of Serbs, Croats, and Slovenes (Fong, 2004). During this time, Kosovo was under German military occupation but remained governed by Serbian officials. After World War II, the Germans left the Yugoslav regions. Kosovo, along with the rest of Yugoslavia, was taken over by communist leader Josip Broz, more commonly known as Tito. He came into power in 1945 and remained in power until his death in 1980, a period considered peaceful and positive because of his efforts to bring the Yugoslav region together after World War II divided it into separate nationalist factions (*The Kosovo Report*, 2000).

During Tito's leadership, Kosovo became an autonomous constituent part of Serbia with standing similar to a republic (*The Kosovo Report*, 2000). Kosovo had its own administration, assembly, and judiciary and was a member of both Serbian institutions and federal institutions with rights to veto the collective presidency and the federal parliament (*The Kosovo*

Report, 2000). Kosovo-Albanians, however, made up 78% of the Kosovo population in 1981, which far exceeded the region's Serbian and Montenegrin populations. Still, Serbian rule prohibited Kosovo's complete independence (*The Kosovo Report*, 2000).

Tito's death in 1980 marked the beginning of a period riddled with political uncertainty and general instability throughout the former Yugoslavia. In Kosovo, demonstrations protesting Albanian nationality status were prohibited with great violence, academicians were fired from their positions, and the provision of Albanian textbooks to schools was halted. As Serbia continued to exert its authority and control over Kosovo, the polarization between the Serbians and Kosovar-Albanians continued to grow. These tensions were further compounded with Kosovo's failing economy and an alarming increase in the unemployment rate. The rate rose from 27% in 1980 to an estimated 40% by 1990 (*The Kosovo Report*, 2000). Violence increased against Serbians, and it was during this time that Slobodan Milosevic, a Serbian, began to intervene in Kosovo and Serbian political affairs (Kosovo and Serbia, 2008).

In 1987, Milosevic spoke out against the violence being perpetrated against Serbians and became a national hero to the Serbian population of Yugoslavia. The Serbian government soon took more control over Kosovo, revoking its autonomy in 1990. This act was followed by various forms of strategic cultural and ethnic cleansing tactics that initially began as restrictions on family planning, sale of property, and employment that forced Kosovar residents to seek work in other Yugoslav regions. In time, the tactics escalated to reports of human right violations including arbitrary arrest, torture, and detention without trial (*The Kosovo Report*, 2000). These violations, along with reports of increasing Kosovar Albanian refugee numbers in Germany and Switzerland, attracted more attention to the growing crisis in Kosovo (Bellamy, 2002). These movements also gained the attention of the United Nations, which began to keep a closer watch on the human rights situation in Kosovo (*The Kosovo Report*, 2000).

Several groups formed to help address the growing human rights violations and conflicts in Kosovo. The League for a Democratic Kosovo (LDK) was formed to lead a peaceful resistance movement against Serbian forces (International Debates, 2008). Kosovar-Albanians were to pay "voluntary" taxes that

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would fund education programs, cultural activities, and sports and health care services while advocating for an independent Kosovo. The Kosovo Liberation Army (KLA) was formed in 1997, with a goal to establish independence for Kosovo. Unlike the LDK, the KLA utilized more confrontational tactics that consisted of small, unorganized attacks against Serbian police forces (International Debates, 2008). Edisa (personal communication, April 14, 2008), the interviewee in this article, likened the battle between the KLA armies and the Serbian army to that between David and Goliath. The Serbian army had more advanced weaponry and ground forces, which made it virtually impossible for KLA forces to stop their intrusion. The conflicts transitioned into a full civil war, which began in 1998 and led to the humanitarian crisis that lasted two years. In that time, 200,000 to 300,000 Kosovar-Albanians were displaced from their homes and many Kosovar civilians, including many children, were killed at random. Despite a call for an immediate ceasefire from the UN Security Council, the war continued as Serbian forces began establishing permanent positions throughout Kosovo (Bellamy, 2002, *The Kosovo Report*, 2000).

A turning point in the conflicts came in January 1999. An attack on a village called Racak in the central region of Kosovo led to an investigation by the Organization for Security and Co-Operation in Europe-Kosovo Verification Mission (OSCE-KVM), in which evidence was found of arbitrary detentions, extrajudicial killings, and mutilation of unarmed citizens. The chief prosecutor for the International Criminal Tribunal for the Former Yugoslavia (ICTY) was not granted access into Kosovo for further investigation and negotiation, which further exacerbated tensions (*The Kosovo Report*, 2000).

In February and March of the same year, several peace talks were attempted between Serb and Kosovar-Albanian leaders, but they were unsuccessful. In that same time frame, more than 200,000 new refugees were driven from their homes in Kosovo. Millions remained on the Kosovo-Macedonia border, hoping to seek refuge in Macedonia (Edisa, personal communication, April 14, 2008). Others were granted access to Western countries as well as to Kukes, Albania, and Skopje (Hilary Clinton hears Kosovars' tales of tears, 1999).

Yugoslav resistance precipitated a NATO air strike between March and June of 1999 aimed at ending

the crisis. Milosevic surrendered and NATO took control over Kosovo (*The Kosovo Report*, 2000). It was not until February 17, 2008 that Kosovar-Albanians were able to celebrate their independence as a completely autonomous nation (Kosovo declares independence from Serbia, 2008).

The Refugee Experience: Similar Themes and Shared Concepts

The literature and the interview with Edisa suggest a number of universal themes relevant to those considered war-experienced refugees. From the time conflicts arise in their respective regions, refugees experience feelings of fear, uncertainty, a need for safety, loss, and expectations for the future (Kinzie & Fleck, 1987). They bring this history with them to the host country.

Departure from Kosovo: The Pre-Arrival Circumstances and Resettlement Experience.

A refugee's story begins long before migration into the host country. For Edisa and other people from the former Yugoslavia, this story involves living during a civil war. As noted in the historical overview, the conflict between the Albanians and Serbians created an unstable and violent environment. Albanians experienced ethnic persecution, which included loss of jobs and land, torture, and death. Edisa's home, which was once a safe and familiar place, became a dangerous and foreign environment as seen in Edisa's comments: "Serbia had tanks and planes and helicopters and military. You cannot imagine us with one gun and them with that" (Edisa, personal communication, April 14, 2008). Like other refugees, Edisa's sense of safety, normalcy, and community was lost due to political instability and ethnic conflict (Keyes & Kane, 2004). Amidst these conditions, Edisa fled her home.

The decision to leave one's home can be a difficult one. It is often the first step in what can be a long and arduous journey. Prior to resettlement in a host country, a refugee may need to travel for a lengthy period of time in unsafe environments, without basic human needs, such as food, water, or shelter being met (Drachman, 1992). Like Edisa, some may reach a refugee camp, but conditions do not always improve once they arrive at the camp. Moreover, the period of flight often further traumatizes the individual (Gonsalves, 1992).

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Edisa spent two years moving from place to place, staying with various family members before entering a refugee camp. Although she did not report a lack of food or shelter, she experienced multiple losses during this time. Her father passed away and her house and all her belongings were burned. She reflected her sense of this loss to the interviewers: "I went over there and there was nothing. There was nothing. The house was burned two times, three times and then grenades all over the place and not safe. No money, no food, no nothing" (Edisa, personal communication, April 14, 2008).

Despite all that the family lost, they questioned their decision to leave behind all that was familiar, "Are we going? Should we stay? You have to leave everything..." (Edisa, personal communication, April 14, 2008). The reality of the loss of one's family, friends, familiar environment, and roles and status is realized once in the host country. Individuals who have been forced from their home country may experience "prolonged grieving, disorientation, and alienation" as a result of these losses and the culture shock of moving to a new country (Fullilove, 1996).

It is often a struggle to maintain a link to the home environment while attempting to adjust to a new environment. Edisa preserves this link by going home to Kosovo every year. "I go every year not to lose the contact, because losing the contact would be too much. I've lost so much already" (Edisa, personal communication, April 14, 2008). Perhaps her ability to return to her home country and her contact with family members has helped Edisa settle into life in the U.S. Edisa's circumstances, however, are unique. Many refugees are not able to go home and do not have contact with their family members (Chung, 2001).

Transitioning to Life in the United States

Saying goodbye to family members is a sacrifice some refugees are willing to make for the promise of safety and success in the United States. Despite her apprehensions to leave her homeland in the face of war, Edisa had made the decision to come to America in the hope of better outcomes in a new country. She said, "We have this opportunity to go somewhere else to see what is going on and see what we can do next" (Edisa, personal communication, April 14, 2008). Upon their arrival, Edisa and her family were met with representatives from a local Chicago refugee-resettlement agency. The agency provided moral

support and "everything you need to start a new life" (Edisa, personal communication, April 14, 2008). This included a fully-furnished apartment paid for three months, clothing, and food. This resettlement model is a common experience for many refugees who relocate in the Chicago area (Edisa, personal communication, April 14, 2008). Edisa and her brother immediately availed of the agency's services and began to take English-language classes that enabled them to obtain employment in their first month in the United States. For Edisa and her family, coming to the United States was a new start with generally good health, education, skills, and a positive attitude as they began to piece their lives together again in a new country.

Other refugees from Kosovo do not meet with such success so quickly after arrival in the United States. Edisa's uncle, aunt, and cousins were resettled two weeks before Edisa and her family arrived and immediately decided to return to Kosovo despite the dangers (Edisa, personal communication, April 14, 2008). The financial strain of raising three children and the lack of desire to find employment resulted in their decision to return to Kosovo. This is a struggle felt by many refugees. Skills or degrees obtained in the home country may not transfer to the United States and one may lose occupational status (Yost & Lucas, 2002). This loss can lead to feelings of uselessness, frustration, and anger.

Home versus host culture distinctions create adjustment issues for newly arriving refugees. Often the morals and values of the host country are "dystonic with ethnic traditions" (Perez Foster, 2001, p.154). The importance of family and community emphasized in the Balkan culture (Fong, 2004) is in stark contrast with the culture of the United States, which espouses the importance of personal responsibility and self-sufficiency. Individuals are expected to make choices about health care, housing, school, and other matters. This can be overwhelming to people coming from countries where these freedoms did not exist (Yost & Lucas, 2002; Drachman, 1992). These cultural and societal differences may add to feelings of confusion or hopelessness and further impact resettlement (Segal & Mayadas, 2005).

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Coping Mechanisms and Strategies for Kosovar Populations

Each ethnic group copes with these complex circumstances in their own culturally appropriate manner. For Kosovar populations, reliance on the family structure and the role of religion and spirituality are primary coping mechanisms that have implications in practice.

The Role of the Family

The family is a highly important social structure for Kosovar people and those from the Balkan region in general. Such families usually have a hierarchical structure and clear power-based roles, with men in dominant positions and women fulfilling more nurturing, passive roles (Snyder, May, Zulcic, & Gabbard, 2005; Fong, 2004). These patriarchal family lines are deeply rooted in the history of the region, with some tracing back centuries (Snyder et al., 2005). Both the value placed upon the family and the tendency toward clear, patriarchal structure within the family are highly characteristic of the Kosovar culture.

Edisa's experience of immigrating to the United States reflects this patriarchal nature of Kosovar families, the relevance of the family in all decision-making, and the family as a primary social support. When Edisa, her mother, sister, and brother decided to leave for America, the entire family agreed that two siblings were designated to remain in Kosovo. As Edisa stated, "Not everyone to leave. That is how important everything is. Your background. Your family. Your house. Your land. Your born place. You can't replace that" (Edisa, personal communication, April 14, 2008). This suggests that both family life and family history are highly important to Kosovar people. Because Edisa's father was killed in the conflicts, her departure from Kosovo required the accompaniment of at least one male family member. Edisa described the importance of living and moving with her brother, saying, "We women were educated and open-minded but still...me, my sister, and my mom to come with no man in United States would be more difficult" (Edisa, personal communication, April 14, 2008). Upon arrival in the United States, Edisa commented that her family stressed the importance of staying together. It was a source of comfort, strength, and security in the resettlement process (Edisa, personal communication, April 14, 2008).

Role of Religion and Spirituality

Religion and spirituality are also important factors in Kosovar life and relevant when working with this population. Three main religions are practiced in Kosovo: Roman Catholicism, Islam, and Orthodoxy (Religion in Kosovo, 2001). Most of the Kosovar-Albanian population is Muslim, while a minority of Albanians practice Catholicism and most Serbians practice Orthodoxy (Religion in Kosovo, 2001). For Kosovar-Albanians, religious and spiritual beliefs have proven to be an important way to understand and cope with the experiences of immigrating to the United States (Ai, Peterson, & Huang, 2003; Ai, Tice, Huang, & Ishisaka, 2005). Studies have shown that Kosovar and Bosnian refugees use both positive and negative religious coping in response to their wartime experiences. In one study, refugees with a higher level of spirituality used more positive coping methods, such as seeking God's strength. Those who experienced higher levels of trauma used more negative coping, such as asking God to strike their enemies (Ai et al., 2003; Ai et al., 2005).

In the interview, Edisa's responses suggest that a sense of spirituality helped her move through the conflicts and traumas she faced. In her answer to a question about coping with loss, Edisa stated, "You find the family and God" (Edisa, personal communication, April 14, 2008). Her comments imply the use of positive religious coping strategies in response to her traumatic past. Such methods may also be employed by other Kosovar displaced persons and refugees (Ai et al., 2003; Ai et al., 2005).

Presenting problems: Mental Health Concerns for Kosovar Populations

Trauma and Loss

Many refugees from Kosovo have faced traumatic experiences of death, violence, or torture during the region's conflicts. In particular, Kosovar-Albanian Muslims faced the most severe persecution, including mass rape and torture (Fong, 2004). Experiences of trauma, loss, and identity issues influence a refugee's capacity and motivation to adjust to life in a new country (Kunz, 1972; Lin, Tazuma, & Masuda, 1979; Drachman, 1992; Nicholson, 1997). It is difficult to learn a new language, look for a job, or seek out social connections when one's coping skills and

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adaptability have been impacted by these types of experiences (Fong, 2004).

Edisa related several experiences in the interview that can be considered traumatic (Edisa, personal communication, April 14, 2008). She was forced to move back and forth from her home for two years, staying with extended family members while her parents remained at the house in order to protect herself from the Serbian military. During one of these departures, Edisa's father was killed by Serbians who invaded her town and killed all of the men running the households. Her house was later burned down by Serbians. Edisa also experienced separation from her family for several months while she was at the Macedonian border with her aunt and uncle, waiting to take refuge in Macedonia. Many of Edisa's concerns centered on losses felt from being separated from her family and losing her father (Edisa, personal communication, April 14, 2008). These feelings of loss are likely felt by others who were in similar circumstances.

Psychological torture was also pertinent to ethnic Albanians in Kosovo at the time of the conflicts (Edisa, personal communication, April 14, 2008). The movement of populations from their homes to places considered safe was initiated by rumors that the Serbian military was entering towns and killing young women and men (Edisa, personal communication, April 14, 2008). Edisa's story revealed a constant sense of fear and terror. In reflection on her departure for Macedonian refugee camps, Edisa stated, "It was like they were playing these games. They said that we will burn this town tonight and everyone must go to Macedonia or else you will be burned. All these rumors. Of course everyone is scared and doesn't know where to go. So we just go where everyone else is going" (Edisa, personal communication, April 14, 2008). It can be deduced from this description that many Kosovar-Albanians experienced similar psychological torture.

Compounding traumatic experiences with instances of loss and psychological trauma has left many Kosovars with symptoms of Post-Traumatic Stress Disorder (PTSD) and depression. One study of 120 Kosovar-Albanian refugees in Great Britain found that 38% had PTSD (Turner, Bowie, Dunn, Shapo, & Yule, 2003). Kosovars who experienced primitive and horrific torture—such as confinement, bamboo shoots under the nails, submersion in water, cutting, whipping, labor camps, starvation, rape, and psychological torture

such as hurting family members in sight of everyone—were considered likely candidates for PTSD diagnosis (Fong, 2004). Moreover, a data analysis of four studies of refugees found a high correlation between trauma-related PTSD and depression (Fazel, Wheeler, & Danesh, 2005). In this analysis it was reported that 71% of refugees diagnosed with major depression also had a diagnosis of PTSD (Fazel et al., 2005). Trauma related to episodes of loss and torture can be a chronic condition that takes a great deal of time to heal (Kinzie, 2001). Edisa had difficulty telling her story despite leaving the conflicts more than nine years ago. The effects of trauma are palpable and may heavily influence general well-being.

Clinical Social Work Practice with War-Experienced Refugees

General Goals in Practice

There are a number of practice goals for working with war-experienced populations similar to those from Kosovo and other Balkan regions. Goodman (2004) references work with Balkan populations, 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. Creating a safe, holding environment and developing an empathic relationship between the client and therapists is also paramount to beginning clinical work, as trust is necessary before clients are able to share their experiences (Varvin, 1998). General knowledge of clients' experiences and beliefs is also an essential component in the therapeutic encounter wherein clients' personal understanding of their experiences and Kosovar cultural norms (e.g., the role of family and religion/spirituality) need to be equally considered (Goodman, 2004). Each element is part of a valuable foundation for building relationships with Kosovar and other Balkan clients and must be considered before engaging the client. Once this background and understanding is attained, the clinician can proceed with various methods of engagement, which will be discussed below.

Methods of Engagement

Psychoanalytic theory and psycho-therapy. Sigmund Freud's 19th-century psychoanalysis and its related psychotherapeutic orientations remain a relevant

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force in clinical social work practice (Curtis & Hirsch, 2003). Refugees often suffer from both the indirect and direct effects of wars and conflicts in their respective regions (Kinzie, 2001). This can range from forced migration to national financial instability to instances of torture or time spent in camps. Psychoanalytic psychotherapy provides social work practitioners with a means of helping clients enhance psychosocial functioning by working with their unconscious thoughts that are revealed through the therapeutic encounter. This helps clients process trauma and avoid re-experiencing previous repressed experiences as actual events (Varvin, 1998). Studies have shown that this orientation also helps alleviate symptoms associated with PTSD and depression symptoms when used in conjunction with medication (Kinzie, 2001; Nicholl & Thompson, 2004).

While these results sound promising, there are a number of limitations in this approach that were cited in the studies and which should be considered when working with traumatized refugees. Psychoanalytic psychotherapy is a Western model that may not be directly applicable to work with non-Western populations such as Kosovar refugees (Nicholl & Thompson, 2004). According to Kinzie and Fleck (1987), the process of working with victims of severe trauma is difficult in and of itself for a number of reasons. Challenges include the interview possibly 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 such as the loss of public support, employment concerns, or media outlets covering the conflicts in the refugee's country (Kinzie et al., 1987). Compounding these challenges is a range of cultural differences and belief systems that infiltrate the treatment process (Nicholl & Thompson, 2004). The timeline for treatment may also be inappropriate because refugees typically take anywhere from 6–12 weeks post-arrival to begin understanding their experiences and losses (Bromley, 1987). Although psychoanalytic psychotherapy does provide promising strategies, it cannot be considered the "magic bullet" for treating traumatized refugees in the United States.

Narrative therapy. Narrative therapy has been recommended for work with war-experienced Balkan populations partly because it is a postmodern approach that is strengths-based, focusing on what the client can do versus what he or she cannot do (Cooper & Lesser,

2005). This approach also is culturally appropriate and sensitive to the client's background because it does not assume one right way of understanding a client (Kelly, 1996). Instead, clients, their story, and their understanding of their circumstances are at the center of the treatment modality (Kelly, 1996). Narrative therapy enables clients to understand their story. Then, through work with a skilled clinician, clients will work to broaden and change the story so that they can see alternatives, identify ways to overcome challenges, and redefine themselves with a more confident and capable persona through their revised personal narrative (Kelly, 1996). With a new story, clients may be better able to recognize their own strengths and move past the stories of previous trauma that inhibited their mobility.

Edisa's case presents an example of a personal narrative that depicts cultural beliefs, which are a part of her sense of reality. Edisa had to work through this sense of reality when she resettled in Chicago. As noted earlier, Edisa and her family decided that some members would stay in Kosovo while others would go to America despite the dangers facing those who remained in the Balkans. This separation was a loss Edisa had to grieve as she shared her story. The clinician's role was to make no comment on the appropriateness of that decision and to remain an active listener to Edisa's story. Edisa concluded her story by saying that difficult decisions needed to be made, and in the end everyone was better because of those decisions. It appeared that Edisa was at peace with past events and seemed poised to make future decisions.

Edisa's example demonstrates that this approach is culturally sensitive and appropriate for work with Kosovar refugee populations. However, some considerations must be made with its implementation. The clinician must allow the client time and space to feel trust and comfort in the therapeutic relationship before any work can be done. Once trust is established, clients may feel more at ease to share their story, allowing the treatment process to proceed.

The empowerment approach. The 1930's, 1960's, and 1970's were periods marked by political commitments to social reform in the United States (Payne, 2005). Empowerment theories emerged during these times. According to Lee (1996), "utilizing empowerment theory as a unifying framework presents an integrative holistic approach to meeting the needs of members of oppressed groups" (p. 219). Based on an ecological perspective that recognizes the

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interdependent and transactional nature of all relationships, the empowerment approach focuses on three dimensions that reside within the client: 1) developing a positive self identification; 2) building knowledge and capacity for understanding the realities of one's environment; and 3) cultivating strategies and resources for functioning within one's environment (Lee, 1996).

This approach is meant to serve all people by providing a critical consciousness that can enable and strengthen a person to overcome obstacles. For war-experienced refugees, the empowerment approach provides a supportive and enabling pathway to move forward from their past which is often marked with deleterious and traumatic experiences that have impacted their lives. For Kosovar refugees like Edisa, this approach can help cultivate inner strengths that enable the individual to have a positive perspective on life, look for opportunities, and strive towards self-sufficiency and independence once they arrive in their host country (Edisa, personal communication, April 14, 2008).

Implications for Social Work Practice and Research

The impact of trauma in refugee populations is evident in the breadth of research available. Less available is research on effective treatments for refugee populations exhibiting trauma-related symptoms. Western-based clinical approaches typically have been used to treat war-experienced refugees who come from diverse regions and cultures. But because such approaches are not easily adapted to non-Western cultures, little research has been produced to unanimously support the usefulness of any one

treatment modality (Nicholl & Thompson, 2004). When working with traumatized refugees, specifically from Kosovo, the gaps in using theoretical approaches based on Western traditions becomes even more apparent.

The three theoretical approaches discussed in this article represent commonly used practices in clinical social work when working with Kosovar refugees or refugee populations in general. Other treatment approaches such as cognitive-behavioral therapy, crisis intervention, and systems theory can inform work with this population and may be equally useful. With all treatment modalities, however, there are limitations—mainly because these approaches were founded in Western traditions that focus on the individual and the individual's functioning. Kosovar refugees who do not come from this same orientation may not initially relate because approaches such as psychoanalysis do not tend to focus on the ideas of collective identity linked to family and community structures, the role of spirituality, or cultural perceptions of involving others in one's mental health needs (Nicholl et al., 2004). For Kosovar refugees, these aspects of their identity are essential, and the absence of them in the therapeutic encounter can be a barrier to progress.

In sum, providing culturally sensitive and responsive services to war-experienced refugees requires a postmodern approach that takes the strengths of various theoretical perspectives and applies them in practice. This includes consideration of the client's beliefs, values, and cultural context to support treatment of mental health problems that arise from their experiences as refugees. To date, an integrative model that combines approaches like those described in this article has yet to be developed, researched or tested, but the need is great if social work practitioners aim to provide effective services to war-traumatized refugees.

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Protections and Limitations for Immigrants who are Battered in the Violence Against Women Act of 2005

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Abstract

Domestic violence is one of the most widespread victimizations experienced by immigrants. Policy has evolved to include protections for immigrant women who are battered, and yet limitations still exist. Protections and limitations in policy leading up to the 2005 Violence Against Women Act are reviewed and recommendations for social work practice are offered.

Introduction

Domestic violence indiscriminately affects all people of different races, ages, sexual orientations, religions, genders, socioeconomic statuses, and educational levels. Ludsin and Vetten (2005) define domestic violence as “a form of control where methods can include physical, sexual and psychological abuse or economic abuse or any combination of these” (p. 17). These types of power and control issues become even more complex for immigrants.

Specifically, violence against women is one of the most widespread victimizations experienced by immigrants (Davis & Erez, 1998; Raj & Silverman, 2002). Erez, Adelman, and Gregory (2009) argue that men who batter immigrant women utilize unique forms of domination and control by taking advantage of the lack of family support in a new country, threatening deportation, and relying on language barriers to further keep the woman from seeking assistance, to name a few. Although the Violence Against Women Act (VAWA) of 2005 has created specific provisions to help alleviate the control that batterers have over their partners, many immigrants are unaware of these protections (Erez et al., 2009). Therefore, batterers continue to use the threat of deportation, even though legal protections are in place to prevent automatic deportation.

When thinking about domestic violence within immigrant communities, it is important to acknowledge immigration as part of an identity (Erez et al., 2009). Immigration is “part of the interactive dynamic process that, along with race, gender, sexual orientation, and

class, inform[s] women’s experiences of and responses to domestic violence” (Erez et al., 2009, p. 34). For example, it is impossible to understand domestic violence within a Korean American community and subsequently understand domestic violence within a community of Korean immigrants living in the United States. Perhaps a woman who has grown up and lived in Korea all her life would decide to leave an abusive partner because she has the support of her family and friends and because she is aware that there are laws protecting her. However, if that same woman was a Korean immigrant in the United States, she may stay with her partner because she does not know the protections afforded to her and she may believe that her partner can get her deported. Immigration, like other aspects of one’s identity, informs one’s experiences of domestic violence.

In addition to immigration status, an individual’s culture, race, age, sexual orientation, religion, gender, socioeconomic status, ability status, education level, and so on create unique experiences and challenges. Immigrants also have factors such as language, cultural beliefs, stigma, and fear, which continue to be barriers to services for battered immigrants. Social workers must understand these identities and connections to effectively seek ways to help battered individuals. In addition, Erez et al. (2009) observe that “when referenced, intimate partner violence among immigrants is either naturalized (i.e., that’s just the way they are) or culturalized (i.e., that’s how they treat their women)” (p. 52). These statements suggest that domestic violence is a problem in other cultures but not in our own. This way of thinking is a barrier to services for immigrant survivors of domestic violence.

Despite the obstacles immigrants who are battered face, VAWA of 2005 offers some protections through various provisions designed specifically for immigrants, including the elimination of some obstacles in the cancellation of removal process, enhancing confidentiality, improving the processing of VAWA cases, and creating Inter-national Marriage Broker regulations (Lin & Orloff, 2005; Conyers, 2007). These

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are further discussed later in this paper. Immigration policy in relation to domestic violence and the protections afforded as well as the limitations will also be reviewed. The evolution of VAWA and its provisions related to immigrant women is examined. Finally, macro and micro-level recommendations for social work practice are offered.

Review of Immigration Policy Related to Partner Violence

The history of immigration policy sways between favorable protections and restrictive limitations towards victims of domestic violence. Though humanitarian priorities of policy have influenced provisions for immigrants living in violent family situations, immigrant victims still must conquer overwhelming barriers.

In 1986, Congress passed the Immigration Marriage Fraud Amendments (IMFA), which specifically focused on mixed status marriages. Though the purpose of IMFA was for the Immigration and Naturalization Services to analyze immigrants' marital relationships in order to discover and deport anyone who obtained status fraudulently, these attempts to regulate possible fraud actually had increased perpetrators' power and coercion over their immigrant spouses (Anderson, 1993). IMFA stipulated that immigrants deriving legal status based on a marriage of less than two years were conditional immigrants (Kurzban, 2006). In order to remove that conditional status and adjust it to legal permanent resident (LPR) status, the couple had to apply jointly within ninety days of the second anniversary of having received the conditional status. If during those two years, the marriage was not maintained, the immigrant spouse lost legal status and faced deportation by immigration officials. Under IMFA, battered victims could not petition for their own status. Consequently, immigrant spouses were trapped in abusive relationships for prolonged periods of time, if their perpetrators used delay tactics or coercion. The victims' path to legalization and ability to remain in the United States was exclusively dependent on their spouses and the continued viability of their marriages (Anderson, 1993).

In order to remedy some of the IMFA barriers immigrant victims faced, the Immigration Act of 1990 was passed. This Act included a waiver for battered spouses to obtain their permanent resident status

without the assistance of their spouses when their spouses had not taken any steps to remove the conditions from the victims' status. In addition, the Immigration Act of 1990 also eliminated the absolute prohibition on adjustment for marriages during deportation proceedings that had been established from IMFA (Kurzban, 2006). However, the Act did not provide any remedy for those victims whose spouses initially refused to file for conditional residency (Family Violence Prevention Fund, 2009).

VAWA of 1994 helped to address these aforementioned limitations. Mainly, immigrant women who have been abused now were allowed to self-petition for legal permanent residency without approval or sponsorship from their spouses. This ability to self-petition permitted immigrant victims a path to legalization, even if their spouses had withdrawn petitions or failed to file them on the spouses' behalf. Consequently, this provision sought "to regulate power dynamics in a marriage" and prevented perpetrators from using immigration status as another form of control over their immigrant spouses (Abrams, 2007, p. 1696). However, VAWA of 1994 did require immigrant victims filing self-petitions to have lived in the United States for at least three years (Bhandari, 2008).

VAWA of 1994 also implemented legal avenues for children. Protections were extended to cover undocumented children in victims' self-petitions, and children abused by citizen or LPR parents could apply for this remedy. Also, a "woman who has not been abused herself can self-petition to become a permanent resident if she is a parent of a battered child abused by the woman's citizen or permanent resident husband" (Family Violence Protection Fund, 2009, para. 3). In addition, VAWA of 1994 legislation provided funding for domestic violence counseling centers in order to offer more adequate services to victims and also advocated for a multidisciplinary approach that required "the criminal justice system, the social services system and nonprofit organizations to collaborate to effectively respond to domestic violence" (Conyers, 2007, p. 457).

Despite such advances for immigrant victims of domestic violence, two acts were passed in 1996 that created limitations in access to government resources. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) placed restrictions on public benefits, such as food stamps and Supplemental Security Income, for legal immigrants and created bars

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for irregular migrants from most federal, state, and local public benefits. Also, PRWORA required the verification of immigration status in order for migrants to receive most federal public benefits. According to the National Association of Social Workers' Summary of Provisions (1996) for PRWORA, there was a reduction in benefits for legal immigrants of more than 22 billion dollars, while irregular migrants were already ineligible for most major entitlement programs. Douglas-Hall and Koball (2004) noted a sharp decline in immigrants' participation in public benefit programs, particularly due to confusion over eligibility and fear of repercussions for future immigration status.

The second restrictive welfare law of 1996 was the Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA), which implemented additional limitations by declaring irregular migrants ineligible for Social Security benefits and providing the State with authority to limit cash public assistance. Though both PRWORA and IIRAIRA established barriers to financial benefits that immigrants who are victims of domestic violence might have needed if fleeing from their perpetrators, IIRAIRA included a provision to help reinforce the necessary protection for immigrants living under a violent family situation (Family Violence Prevention Fund, 2009). IIRAIRA incorporated new grounds for deportation, which included convictions for domestic violence or for voiding a court protective order entered to prevent domestic violence. It also preserved access to VAWA immigration relief and extended limited public benefits access to immigrant victims applying for VAWA protection (Conyers, 2007). Despite these provisions to offer immigrants who are battered some protections, "other provisions of [PRWORA and IIRAIRA] eroded the progress gained in protecting the rights of battered immigrant women just two years earlier with the passage of the Violence Against Women Act of 1994" (Family Violence Prevention Fund, 2009, para. 7).

Domestic violence and immigrants' rights activists continued to advocate for additional protections under the law. Consequently, there was a reauthorization of VAWA in 2000. For immigrants who are victims of domestic violence this act improved access to cancellation of removal, a form of legal relief available to those in deportation proceedings. In addition, it allowed funding for grant programs to be used for immigration assistance. Immigrants who are

victims also became eligible for two new non-immigrant visas: U visas were available to either victims of or those who possess information regarding many forms of criminal activity like rape, domestic violence, and sexual assault; and V visas provided legal status for victims of sex trafficking and forced labor (Bhandari, 2008). In addition, the residency requirement was removed, allowing battered women to obtain legal permanent resident status without leaving the country (Family Violence Protection Fund, 2009). Furthermore, access to the VAWA protections for battered victims was restored to irregular migrants, regardless of whether or not they had proper legal documentation.

VAWA of 2005

Although the Violence Against Women Acts of 1994 and 2000 were successful in taking steps to reduce the amount of violence against immigrant women, the provisions in each of these acts left many gaps in services for immigrant women experiencing violence. There were still large numbers of women being deported or remaining in abusive relationships for economic reasons, while others were not eligible for VAWA protections at all (Lin & Orloff, 2005). Consequently, VAWA of 2005 seeks to address some of the issues that the previous bills failed to remedy by expanding services to a larger group of people who experience violence, eliminating some of the obstacles women face in the cancellation of removal process, enhancing confidentiality procedures, providing economic security for immigrant victims and their children, creating improvements in processing VAWA cases, and creating International Marriage Broker (IMB) regulations (Lin & Orloff; Conyers, 2007).

In the 2005 reauthorization of VAWA, Congress added four crimes of violence against women (domestic violence, dating violence, sexual assault, and stalking) as a way to provide services and protections to groups that had previously been excluded (National Coalition Against Domestic Violence [NCADV], 2006). In addition, VAWA 2005 seeks to provide protections to other types of family violence victims, which the 2000 version did not address. In VAWA of 2005, immigrant child abuse and incest victims are eligible to self-petition for relief up to age 25, and immigrant elder abuse victims who have been abused by a son or daughter who is a U.S. citizen are also eligible to apply for VAWA relief (Lin & Orloff, 2005). Title VIII,

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Section 805 of the act also allows access to VAWA immigration protection through VAWA's aging out protections and Child Status Protection Act relief after they are 21 years old, to immigrant children who are abused or children of immigrants who are abused (Lin & Orloff, 2005). Therefore, access to relief will be based on when the petition was actually filed and not when immigration status is granted. Finally, when immigrants self-petition under VAWA, their application for adjustment status is inclusive of their children, allowing children permanent residency along with their self-petitioning parent (Conyers, 2007). The expansions in the protections for children are a particularly important aspect of VAWA, as they help to eliminate one more barrier battered immigrant women face in seeking services, the fear of losing their children.

The threat of deportation looms greatly over an undocumented woman and presents yet another obstacle in her decision to report her abuse or access services. VAWA of 2005 seeks to address this obstacle by allowing women more opportunities to file for relief from deportation and attempts to remove some of the barriers in the cancellation of removal process. VAWA of 2000 provided for motions to reopen deportation/removal status cases, allowing petitioners to apply for cancellation of removal within one year of the entry of a final order (National Immigration Law Center, 2000). VAWA of 2005 clarifies the 2000 motions to reopen by giving eligible applicants the opportunity to file one motion in order to access VAWA relief, not holding them accountable to reopen filing deadlines and numerical limits, providing that they are in the U.S. at the time of the filing (Lin & Orloff, 2005; Conyers, 2007). In addition, victims of domestic abuse become exempt from penalties for failing to voluntarily leave the country if they can prove that extreme cruelty or battery was the cause of their failure to leave (Lin & Orloff, 2005). Further, it encourages the use of the I-212 process, which allows the Department of Homeland Security the discretion to waive prior entry and removal problems for immigrant victims of domestic violence so that immigrants who are victims who qualify for relief can get around reinstatement of removal obstructions (Lin & Orloff, 2005; Conyers, 2007). It also improves the cancellation of removal process by allowing judges to provide the VAWA 2000 domestic violence victim waivers (Lin & Orloff, 2005). VAWA of 2005 also increases the protection of victims by providing U visas to family members accompanying or following them

without having to prove extreme hardship in their country of origin (Lin & Orloff, 2005). Finally, VAWA of 2005 adjusts the good moral character definition to make clear that a prior removal order does not effect whether an applicant can show "good moral character" (Lin & Orloff, 2005).

Another major difference in VAWA of 2005 is the improvement of measures taken to protect the confidentiality of all victims of domestic abuse, stalking, sexual assault, and trafficking (Lin & Orloff, 2005). The 2005 act extends confidentiality protections to trafficking victims and other victims eligible for VAWA immigration relief. Lin and Orloff (2005) state that

these provisions are designed to ensure that abusers and criminals cannot use the immigration system against their victims. Examples include abuses using DHS to obtain information about their victims' immigration cases, and encouraging immigration enforcement officers to pursue removal actions against their victims (p. 4).

Section 817 is not only designed to protect the confidentiality of the battered spouse, but also prevents Immigration and Customs Enforcement (ICE) from relying on information from the abusive spouse or family members to arrest or deport the battered immigrant spouse (Conyers, 2007; Lin & Orloff, 2005). In addition, Section 817 ensures that the specially trained VAWA unit will provide immigrant victims with referrals to confidential legal and domestic violence services with trained professionals (Lin & Orloff, 2005).

Economic stability is another area of concern for immigrant women when considering leaving their abusive spouse, as many women are financially dependent on their spouses. Further, because of this financial dependence women are often reluctant to report the abuse or cooperate in the batterer's prosecution (Conyers, 2007). VAWA 2005 seeks to address this concern by expanding the work authorization to VAWA self-petitioners (Lin & Orloff, 2005). The 2005 act not only grants work authorization to an immigrant with an approved VAWA petition, but also to U visa and T visa applicants (Lin & Orloff, 2005). In addition, immigrants, who are either accompanying or joining their immigrant spouse to the United States, can qualify for work authorization if they

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can demonstrate that they (or their child) were battered or subjected to extreme cruelty while married to their spouse (Conyers, 2007). Immigrants who are admitted through the A (foreign diplomats), E-3 (Australian investor), G (international organizations), or H (temporary worker) visa nonimmigrant programs are eligible (Conyers, 2007). These provisions are designed to give immigrant women an opportunity to achieve some form of financial independence.

One of the most important additions to VAWA of 2005 is the intention to expedite VAWA cases through the creation of the VAWA unit. The VAWA unit, with a consistent and stable staff that is trained to recognize cases of domestic violence, trafficking, and sexual assault is designed to expedite VAWA cases for self-petitioners, which can often be a very lengthy process (Conyers, 2007). As VAWA cases are the unit's sole responsibility, they will be able to improve communication and response times to applicants, their representatives, and other service providers (Conyers, 2007). The VAWA unit is also designed to ensure the consistency of VAWA adjudications and is specially trained to recognize appropriate cases as well as identify fraudulent cases (Conyers, 2007). In addition to the VAWA unit, other technical amendments, including the creation of a uniform definition of a VAWA self-petitioner, were made in order to eliminate some of the obstacles immigrant women face throughout the cancellation of removal process, making it easier to stop deportation orders (Lin & Orloff, 2005).

Another important measure that came out of VAWA of 2005 was the creation of the International Marriage Broker regulations. According to Conyers (2007):

The provisions of the International Marriage Broker Regulation Act of 2005 (IMBRA)...are designed to minimize the incidents of domestic violence in international marriages, to ensure that victims receive what can be lifesaving information, and to provide the first meaningful federal regulations on IMB agencies (p. 467).

This requires that anyone who applies for a K visa (a visa for a foreign spouse or fiancé) must provide criminal background information, and it also limits the ability of abusive U.S. citizen petitioners from obtaining K visas for non-citizens (NCADV, 2006; Conyers, 2007). In addition, information on domestic violence is distributed to all foreign fiancés and spouses in the

appropriate language (NCADV, 2006). These regulations are extremely important as foreign fiancés and spouses obtained through IMB are often isolated from their friends and family once in the U.S. and may not speak any English, making them extremely vulnerable to abuse.

In addition to the specific sections addressing battered immigrant women, VAWA of 2005 also makes other significant changes in its reauthorization that impact immigrant services. For the first time, immigrant women become eligible for services and protection from deportation if they were sexually assaulted, as funding for sexual assault is added to VAWA of 2005 (NCADV, 2006). In addition, funding is provided for violence against women education and prevention targeted towards youth, particularly in schools (NCADV, 2006). Further, through the education and prevention targeted towards youth in schools, immigrant children will be better able to recognize and report the abuse they may be witnessing in their homes. In addition, Grants to Encourage Arrest Policies, Rural Domestic Violence and Child Abuse Enforcement grants, and STOP (Services for Training Officers and Prosecutors) grants all provide provisions for funding that includes assistance in immigration matters (NCADV, 2006). Finally, the Civil Legal Assistance for Victims of Violence grant provides that any legal service organization that receives money from this grant can work with any victim of domestic violence, sexual assault, or trafficking regardless of immigration status (NCADV, 2006).

Limitations of VAWA 2005

Despite all of the provisions VAWA 2005 puts in place to reduce violence against immigrant women and provide them with a safe and less complicated means to obtaining legal permanent residency in the United States, there are still gaps in the policy that fail to address the needs of all immigrant women. One of the major criticisms of VAWA is that its provisions are all centered on a woman leaving her abusive spouse or partner (Goodman & Epstein, 2005). Schuett (2005) writes, "at the heart of VAWA is the mistaken presumption that by removing women from their homes, jailing their husbands and indoctrinating their children, this will have a positive impact on intimate partner abuse" (2005, para. 3). All women do not want to leave their abusive partners, and sometimes abuse is

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perpetrated by both partners. In addition, VAWA offers no protections for domestic partners or same-sex couples who may be experiencing abuse, as the current immigration law does not recognize these relationships.

In addition, Bhuyan (2008) argues that the requirement of proving good moral character to receive services and protections through VAWA implies that one has to be a “good enough victim” (p. 164). Bhuyan further states that the “process of regulating immigrants inevitably invokes an evaluation of what is desirable in an immigrant. The assessment of worthiness in immigrants is based on dominant ideological values for gender, race, and class toward ensuring citizen subjects who will be productive in the market economy and loyal to the state” (p. 154). Also, many immigrants may still be unaware of the services provided to them (Erez et al., 2009). Lastly, the growing anti-immigrant sentiment within the United States has in some cases resulted in the exclusion of some immigrants from access to necessary education and medical services, which can hinder access to domestic violence support (Erez et al., 2009).

Macro and Micro-Level Recommendations for Social Work Practice

As stated above, the overall goal of VAWA-based immigrant provisions is, “to cut off the ability of abusers, traffickers, and perpetrators of sexual assault to blackmail their victims with threats of deportation, and thereby avoid prosecution” (Lin & Orloff, 2006, p. 1). Based on the information presented in this paper, it is important to consider what needs to be done on the macro and micro-levels of social work practice to ensure that this important goal is realized. VAWA 2005 provisions discussed in the previous section clearly provide enhanced protections for immigrants, such as increased opportunities for immigrants who are battered to self-petition and for their children to be afforded protections and access to VAWA services. However, past research demonstrates that many immigrant women who are battered face barriers to receiving the benefits of VAWA, and thus are unable to escape their abusers or access resources to improve their situation.

As was mentioned earlier, it is important to consider whether immigrants who are battered are even aware of the protections afforded to them in VAWA. Dutton, Orloff, and Hass (2002) proposed that outreach to immigrant women who are battered be increased due

to the lack of awareness about services and resources that can aid these women. They note that this population is generally isolated from legal and social services due to their immigrant status. As such, it is necessary that educational campaigns focus on providing awareness about this issue and of community resources for immigrant women who are battered. Given the language needs of immigrants, it is important that educational campaigns be available in the language of those they are attempting to reach and also use several media forms in order to reach the non-literate part of a community (Dutton et al., 2002). Part of this education would mean dispelling the myths batterers tell the victims and decreasing the fear of deportation, which countless reports have demonstrated is a main barrier to seeking help (Anderson, 1993; Dutton et al. 2002; Shetty & Kaguyutan, 2002). Also, it is important that such campaigns educate immigrants about the VAWA self-petitioning process and present this process in an accessible way. Educational campaigns should also target those who have contact with immigrant women who are battered, including religious figures and immigration attorneys. Social workers have a large role to play in creating these partnerships and training programs that promote education and detection of domestic violence. This recommendation is something that affects both macro and micro-level practice because it can result in a national public awareness campaign. If social workers become more informed about the issue of domestic violence and the protections and limitations of VAWA, then as a profession they can meet their clients’ needs and direct them to resources for assistance.

In order to ensure that these recommendations can come to fruition, it is essential to have sufficient funding. If the policy does not have adequate funds, especially for provisions that address those in the immigrant population who are battered, implementation of VAWA 2005 will be a difficult task and subsequently will not be able to effectively help those it seeks to protect. It is important to note that even though provisions of VAWA may authorize a certain amount in funding, it does not mean that funding is received. Given the current economic situation in the United States, it is especially important to be alert to changes in funding for policies such as VAWA to ensure that funds are not cut. For the most part, however, given that Congress was able to pass VAWA 2005, it appears that this piece of legislation is a priority.

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Unfortunately, in Fiscal Year 2008, there was no funding appropriated for VAWA's Outreach to Underserved Populations Grant Program, a program that targets people of underserved racial/ethnic populations which includes immigrants (National Network to End Domestic Violence [NNEDV], 2009a). Without funds to address the needs of immigrant women, practitioners face difficulties in providing educational campaigns and resources that will help immigrant women who are battered. NNEDV (2009a) reports found that there is a two million dollar funding need to address the needs of communities of color, including immigrant communities. In addition, Outreach to Underserved Populations has a two million dollar funding need, which would provide for initiatives to better reach the immigrant and minority population of the United States. Agencies and social workers must become knowledgeable about the unique needs of immigrant women who are battered and support legislation that fully funds programs that will reach this community.

NNEDV (2009b) reports that Congress passed a budget that increases funding for VAWA, and NNEDV is now urging citizens to advocate and begin letter writing campaigns to ensure that the Fiscal Year 2010 budget includes amendments to set the groundwork for full-funding of VAWA and VAWA-related grants. Social workers must be alert to changes in the federal budget that will affect VAWA implementation and lobby or write their representatives in Congress to ensure that the budget does not decrease

or cut funding to VAWA policy. Additionally, special attention must be given to ensure that this increased funding is directed towards initiatives that will reach underserved populations like the immigrant group.

Given the limitations of VAWA 2005 discussed in the previous section, advocacy is recommended on the macro level for changes in VAWA that allow for more support to women who are battered and remain in the relationship. Women who stay with their batterer are often criticized and essentially blamed for the violence they experience (Dutton et al., 2002). It is important to recognize that women stay with the batterer for many reasons, and VAWA policy must seek to protect these women, even if the predominant climate in domestic policy tends toward encouraging women to leave their abuser.

One of the dynamic parts of being a social worker is the ability to be both a clinical practitioner and a policy advocate for social justice issues such as those experienced by immigrant women who are battered. When policy level legislation is promoted that increases funding and the amount of resources for the population at hand, this becomes something that can help practitioners at the micro-level ameliorate the difficulties and barriers faced by immigrant women who are battered. Therefore, it is the job of policy advocates and social workers to ensure that VAWA legislation remains funded in order to protect women who are battered, immigrant and non-immigrant alike, to receive the resources and legal help that they need.

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The Struggle for Rights: Pakistani Muslim Women in Pakistan And How to Support Advocacy Efforts

By Marisa Lazio Chumil, Diana Granillo Rodriguez, and Michelle L. Boyd

Abstract

Pakistani women suffer various forms of human rights abuses, such as domestic violence, honor killings, acid and stove burns, and female genital cutting. The key issues that are presented in this paper consist of the psychological affects that these abuses have on Pakistani women such as depression and posttraumatic stress disorder, the mental health approaches and traditional healing practices that are used to treat these illnesses, and the current multi-disciplinary methods to advocate for the human rights of Pakistani women. The implications of this paper demonstrate a need for advocacy from a multi-level social work approach in order to seek equality for Pakistani Muslim women.

Introduction

Women in Pakistan are faced with numerous challenges that no woman should ever have to face. Due to Islamic religious beliefs and family customs, women suffer various forms of human rights abuses, such as domestic violence, honor killings, acid and stove burns, and female genital cutting. The key issues that are presented in this paper consist of the psychological affects that these abuses have on Pakistani women such as depression and posttraumatic stress disorder, the mental health approaches and traditional healing practices that are used to treat these illnesses, and the current multi-disciplinary methods to advocate for the human rights of Pakistani women at micro, meso, and macro social work levels. Although the history of the region and the complexity of the issues are ancient and vast, for the purposes of this paper and to provide a foundational context for social work practice, a brief cultural overview will be presented.

Role of Religion

Though domestic violence and human rights abuses against women are significantly prevalent in

Pakistan now, the country was built on principles of liberation for religious freedom. Initially, Pakistan had been founded as a homeland for Muslims from Hindu India, which had been a British colony for almost one hundred years. In 1947, India gained independence and was divided into two countries. This creation of Pakistan was intended to be a nation of refuge for Muslims (Belt, 2007) and provides a basis of cultural strength for the country.

Of the 172 million inhabitants currently in Pakistan (Population Reference Bureau, 2008), 97% are Muslims who adhere to the Islamic faith (Belt, 2007). The word *Islam* comes from the Arabic root word for peace, *salaam*, which literally translates as “surrender-devotion to submit oneself to Allah’s will... accepting everything that happens in life, as it is and as it comes, with trust and serenity, listening with hope to the teachings of life” (Farooqi, 2006, p. 402). These tenets of the faith also contribute to a foundation of cultural strengths. In addition, essential to Islamic faith are the *Five Pillars of Islam*. These basic principles include sole confession of faith to Allah; structured ritual of five daily prayers; fasting during the month of *Ramadan*; alms giving as a personal responsibility to ease the hardships of others; and, the pilgrimage to Mecca, in which the community honors those who complete the journey (Hooker, 1996).

These and other values of the Islam faith are the means by which the Pakistani community conceptualizes and interprets mental health. The explanation of mental illness is that it is caused by doubt and dissociation due to individual compelling needs or to external social pressures that are counter to the teachings of the prophet Muhammad and the Koran (Farooqi, 2006).

In addition to Islamic views of mental health, another theme of Islam is the role of *jihad*, which literally means *struggle* and refers to either an inner spiritual struggle or an external physical struggle. Examples include struggles for personal consistency in prayer, struggles to give alms, and struggles in physical combat against nonbelievers (Davis, 2009). The call for *jihad* is increasing in Pakistan, mostly in the North-West Frontier Province due to the high concentration of seven di-

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verse tribal groups. Tribal feuds among the groups instigate violence related to different tribal codes that, for example, include interpretations of how honor is linked to families' authority and survival. In order to settle the claims of these tribal feuds, tribal elders and chief mediators hold councils.

Found within these tribal councils are discriminatory practices and abuses against women, who within Pakistani society are the symbol of family honor. An example of the gender violence based on tribal culture is honor killings, which occur against women, suspected of disobeying or dishonoring the family. "Though many honor killings are believed to go unreported, the Human Rights Commission of Pakistan said at least 174 women were victims of such crimes nationwide in 2005, 270 in 2006, and 280 in 2007" (Shahzad, 2008, para.10). Human rights groups complain that very few perpetrators are convicted and punished. LaShawn Jefferson, Executive Director of the Women's Rights Division of Human Rights Watch, urges Pakistani officials to monitor how tribal councils operate in order to respect gender equality. According to Jefferson, "These tribal councils must not be used as vehicles to deny women their rights and physically assault them" (Human Rights Watch, 2002a, para.3).

Such abuses against women also occur under Islamic law. Strict Islamic laws, like the *Hudood Ordinance*, were first introduced in 1979 by the former military dictator Muhammed Zia-ul-Haq (Human Rights Watch, 2002b). This specific Ordinance stemmed from interpretations of the Koran's divine teachings that judge vice-related offenses like rape and premarital sex. Consequently, the *Hudood Ordinance* institutionalized discrimination against women in both law and practice. For example, since rape victims were blamed and rape was therefore related to adultery, women who had been raped were prosecuted and punished, rather than their perpetrators. Fortunately, women's advocacy groups have been engaging in protest and activism against the *Hudood Ordinance* and other laws that are based on the gender bias found in Pakistani's judicial and enforcement systems.

Social and Familial Structure

The systematic gender discrimination in Islamic law also has informed social structures, familial functions, and interpersonal relationships. Zohra Yusuf, co-founder of the Human Rights Commission of Pakistan, "points out that the customary traditions and practices in

remote parts of Pakistan are far more repressive than Islamic codes" (Santoli, 1994, p. 37). One of these traditional customs establishes that a woman can be sold to a man in marriage. This often occurs as young as puberty and includes a fixed price for the bride. According to human rights activist and Chairperson of the Human Rights Commission of Pakistan, Asma Jahangir, the basic family unit is where the discrimination [against women] begins (Association for Women's Rights in Development, 2008).

There are several examples of discriminatory practices within society and family. Freedom of movement is unequally applied to women since a male relative must accompany women when they leave the house. Also, women can have only one spouse while men are permitted four. Daughters are allotted half the inheritance of sons. In addition, women are pressured to cover themselves and to guard their modesty. Furthermore, a woman's testimony in court is worth half that of a man's.

Human Rights Abuses Against Pakistani Women

In Pakistan, cultural practices such as *Watta Satta* play a very important role in women's mental health. These practices include arranged marriages and dowry, which is the money or goods that a woman brings to her husband in marriage. Additionally, religious and ethnic conflicts, inhumane treatment of women, the role of in-laws in daily lives of women, and the extended family system signify major psychological issues and stressors (Gill, 2004). Author Unaiza Niaz, who works at a psychiatric clinic and stress research center in Karachi, Pakistan, states, "Both before and after marriage, the increasing demand for dowry can spiral into harassment, emotional abuse, and physical violence. In the most extreme cases homicides, 'stove burns' and suicides allow husbands to remarry and consequently receive more dowries (Niaz, 2004).

Dowry violence occurs when husbands "accidentally" burn women in kitchen fires for dowry that has not been met. An estimated four women per day are burned to death in Pakistan as a result of domestic disagreements (Burney, 1999). Acid attacks are used to disfigure and even kill women and girls over a variety of disputes, such as failure to meet dowry demands, rejection of marriage proposals, and other family disagreements (Burney, 1999). In Pakistan, many women are also killed in the name of their "family's honor."

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Honor killings are typically justified under Islamic law, including alleged adultery, premarital relationships, rape, or falling in love with someone with whom the family does not approve (UNICEF, 2000).

Female genital cutting (FGC) is another form of violence that has received significant attention in recent years worldwide and also in Pakistan. FGC involves cutting or removing portions of women's external genitalia or other injury to the female genital organs for cultural or other non-medical reasons (UNICEF, 2000). An estimated 130 million women and girls have experienced FGC, and approximately two million women are affected each year. Female genital cutting is viewed as a way to control female sexuality, preserve virginity, and enhance men's sexual pleasure (UNICEF, 2000). The health impacts of FGC are serious and may be life threatening, including many gynecological, reproductive, and childbearing problems as well as increased risk of HIV/AIDS. Depression and posttraumatic stress disorder are some of the psychological implications as a result of FGC (UNICEF, 2000).

Similar to reasons of social and cultural pressures common in other world cultures, women in Pakistan are frequently unable to flee from abuse. Divorce is highly looked down upon in the Pakistani culture, and consequently parents usually do not support their daughters' decision to return home. Furthermore, the woman's parents have to financially compensate the husband for the loss of his spouse after the divorce (Niaz, 2004). These struggles are not exclusive to Pakistani women, but are faced by women worldwide. Women in other communities are aware that family violence is not culturally inherent (Gill, 2004).

In addition, it is imperative to note that honor killings and other forms of violence against women are not inherent to Pakistani culture or Islamic faith. Some view that the media has portrayed these human rights abuses exclusively or unfairly in Islam communities. "It is important to emphasize that honor killing is not fundamentally Islamic" (Gill, 2006, pg. 5).

Domestic Violence and Mental Health Implications for Women

Discriminatory practices against women occur frequently in Pakistan, but domestic violence against women is also very common.

A United Nations research study found that 50% of the women in Pakistan are physically

battered, and 90% are mentally and verbally abused by their men. A study by Women's Division on "Battered Housewives in Pakistan" reveals that domestic violence takes place in approximately 80% of the households. More recently the Human Rights Commission Report states that 400 cases of domestic violence are reported each year and that half of the victims die (Niaz, 2004, p. 60).

More often than not the nature of a woman's abuse could be the deciding force behind whether she stays in the relationship or not. The main reasons Pakistani women tend to stay in abusive relationships are similar to those of women from other countries:

fear of retribution, lack of other means of economic support, concern for the children, emotional dependence, lack of support from family and friends and the abiding hope that the husband may change one day...About 70% of abused women have never told anyone about the abuse (Niaz, 2004, p. 61).

Domestic violence can cause significant psychological problems in women. Post-traumatic stress disorder, depression, suicide, and drug and alcohol abuse are some common risks factors that women who suffer from abuse might experience. Experiencing low self-esteem and self worth are other common problems associated with domestic violence (Niaz, 2004). The most common mental illnesses among women in domestic violence situations are PTSD and depression (Macy, Ferron, & Crosby, 2009). "A large study at Jinnah Post Graduate Medical Center, Karachi, in the early 1990's showed twice as many women as men sought psychiatric care and most of these women were between their 20's and mid-30's" (Niaz, 2004, p. 61).

Another five-year survey (1992-1996) at the University Psychiatry Department in Karachi (Agha Khan University/Hospital) showed that:

out of 212 patients receiving psychotherapy, 65% were women, 72% being married. The consultation stimuli were conflict with spouse and inlaws. Interestingly, 50% of these women had no psychiatric diagnosis and were labeled as 'distressed women'. 28% of women suffered from depression or anxiety, 5-7% had person

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ality or adjustment disorders and 17% had other disorders (Niaz, 2004, p. 61).

The 'distressed women' were between the ages of 20-45 years. A majority of them had a bachelor's degree, had arranged marriage relationships between 4 and 25 years, and had two to three children. Many of them also worked outside the home doing volunteer work, teaching, and running small businesses. Many of these women suffered from loss of hearing, headaches, numb feet, difficulties breathing, and chronic stress (Niaz, 2004).

A study looking at stress and psychological disorders in the Kindukush Mountains of North-West Frontier Province of Pakistan found prevalence rates of depression and anxiety at 46% in women compared to 15% in men (Niaz, 2004). Another study, found the majority of suicidal patients were married women. The major source of suffering was conflict with the husband, accounting for 80% of cases, and conflict with the in-laws accounted for 43% (Niaz, 2004).

The final study was a four-year survey of psychiatric outpatients at a private clinic in Karachi that found "two thirds of the patients were females and 60% of these females had a mood disorder. 70% of them were victims of violence (domestic violence, assault, sexual harassment and rape) and 80% had marital or family conflicts" (Niaz, 2004, p. 62). Together, the research shows that there is a higher prevalence of Pakistani women exhibiting a variety of stress and psychological disorders as a result of domestic violence.

Barriers to Mental Health Treatment

To address mental health illnesses, Pakistanis often use traditional healers. Yasmin Nilofer Farooqi (2006) conducted a study in which she explored the traditional healing practices sought by Muslim psychiatric patients in Lahore, Pakistan. In order to better understand why traditional healing practices were commonly used, Farooqi noted that due to a:

shortage of licensed, clinical psychologists and psychiatrists in the public hospitals in Pakistan...many Pakistanis seek the most affordable spiritual/traditional treatment from Pirs [Islamic scholars], Aamils [black magicians], Hakims [herbal doctors], magicians, palm readers, folk healers... rather than seeking medical, psychological, or psychiatric help from the licensed mental health professionals (p. 404).

The study found that in Pakistan, the most commonly used traditional healing practices are homeopathy, naturopathy, acupuncture, chiropractics, Islamic faith/spiritual healing, sorcery, and anyalism (spiritual healing techniques) (Farooqi, 2006).

As a result of a strong belief in traditional healing practices, when Pakistani women migrate to the United States and need mental health treatment, they may not be aware of available mental health professionals who can provide services that may have similar benefits as the healing practices in their homeland. In addition, awareness of mental health professionals alone may not be enough to persuade Pakistani women to seek appropriate mental health treatment. Women may also face criticism from their family members and their community if they seek mental health services. Those who do meet with mental health professionals may be labeled *pagal* (mental) or being insane (Wheeler, 1998). If labeled *pagal*, there are many negative values attached. Family members may feel that the person cannot be trusted with any responsibilities because they are seen as being 'without a brain' and 'always talking rubbish' (Wheeler, 1998). They may also be excluded from family decisions, and family members might make them believe that their feelings and opinions have little to no importance (Wheeler, 1998). For these reasons, a Pakistani person would rather speak to family members about her mental health issue first before seeking help elsewhere.

Additional reasons Pakistani women fear seeking appropriate mental health treatment may be isolation, guilt of failure, or dependence on others. Women may have less mobility and economic autonomy than men (Farooqi, 2006). Also, due to patriarchy within the family structure and the focus of a woman's domestic work, there are fewer opportunities for women to engage in social interaction (Wheeler, 1998). Traditionally women have several responsibilities within the household including: cooking, cleaning, shopping for food, and primarily taking care of the children. Such domestic tasks may leave these women without much free time for their self-care. Furthermore, traditional Pakistani women typically rely on their husbands or male family members to transport them to appointments related to their mental health treatment. Due to this dependence on the male family members, many women do not receive appropriate treatment; the male family members may refuse to take them because they are embarrassed the woman may be labeled as *pagal* (Farooqi, 2006).

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In addition, women may develop a sense of guilt if they feel they are not fulfilling their role as a woman. Seeking mental health treatment indicates the person is *pagal*; consequently, the husband may leave her if she is found to be unfit as a wife and mother. A husband may use this excuse to find a better “fit and useful” woman, especially if the woman does seek mental health treatment and is prescribed psychotropic medications. Also, women may be subjected to taunts from community members. Such humiliation and “this very public loss of respect was distressing and demeaning... for the women” (Wheeler, 1998, p. 41).

Levels of Advocacy

In spite of the difficulties addressing mental health illnesses through a clinical perspective, great degrees of mobility, grassroots organizing, media exposure, and work by women’s groups locally, nationally, and internationally have created progress in the women’s rights movement. Beginning in the 1980s, an approach based on human rights was applied to the status of women, who became more aware of their rights and asserted themselves into different fields. Indigenous solutions on micro levels, like local women’s resource and empowerment centers, became active. The Progressive Women’s Association in Islamabad, advocates for women’s rights, exposes abuses and violence against women, encourages empowerment, and houses a shelter for women. The organization has collected information from more than 7,500 “fire victims” from March 1994 to August 2005. Though only 0.1% of those women have survived, the agency investigated about three hundred cases (Progressive Women’s Association, 2009).

Another example of Pakistani women advocating for their rights can be found in the services of the AGHS Legal Aid Cell, a non-profit agency headed by two Supreme Court attorneys. This non-governmental organization offers free legal aid, education, human rights advocacy, protection from exploitation, legal research, and lobbying for new laws (ALAC, 2009). One of the human rights attorneys at AGHS Legal Aid also serves as a United Nations Special Reporter and as the chairperson of the Human Rights Commission of Pakistan, yet another non-profit organization dedicated to raising awareness of human rights on a macro level. The Human Rights Commission of Pakistan monitors the country’s implementation of human rights-related charters, resolutions, and internationally adopted norms (Human Rights Commission of Pakistan, 2004).

Through these efforts to provide women with access to direct services and with opportunities for advocacy against human rights violations, further advancement for women’s rights has occurred on the national level. For example, in February 1999 military ruler General Pervez Musharraf launched a national human rights campaign, in which the government hoped to increase domestic awareness (Hosken, 2000). In addition, the Women’s Protection Act was adopted and passed by Pakistani’s Parliament in December 2006. This law brings rape under penal code, eliminates previous requirements to validate women’s rape claims, and allows convictions based on forensic evidence (Human Rights Watch, 2008).

Not only have efforts focused on national advocacy, but also international support has joined the Pakistani women’s movement. In 1992, Asia Watch and the Women’s Rights Project, both based in New York, appealed to the Pakistani government to denounce abuse of women by state agents, end impunity for crimes of violence against women, and guarantee equality and protection within the law (Human Rights Watch, 2002b). More recently in May 2005, letters from international advocates in Thailand, Mongolia, and Australia were sent to General Pervez Musharraf when 50 human rights activists were arrested in Pakistan at a rally on violence against women. The international advocates reminded him that the country had ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women and urged him to assure equal rights for women. “The State should support the efforts of civil society in protecting and promoting the rights of women instead of suppressing such endeavors” (Women Human Rights Defenders, 2005, para. 3).

Implications for Social Work

As women become aware of their rights and equality through advocacy, the implications for social work practice and research are great across micro, meso, and macro levels of the profession. This section will use theory to explore the ways in which social workers can serve Pakistani clients at various levels of practice.

Micro-Level Practice

At the micro level, social workers provide successful treatment by applying theories of the narrative perspective, systems perspective and the strengths perspective. Practitioners should be open to learning the client’s personal perspective on their culture and reli-

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gion. An effective method to do this is by utilizing narrative theory. One of the goals of the narrative perspective is to reconstruct meaning in the client's life based on alternative realities in a wider social or cultural environment, through which the client develops a sense of self-identity (Cooper & Lesser, 2008). Consequently, the client is empowered and freed from self-blame (Nichols & Schwartz, 2007). The narrative perspective is ideal for treating Pakistani women with a history of abuse. Allowing the client to unveil her story in a way that affirms and empowers the client and informs the social worker about how to be most helpful to the client while identifying areas in need of reconfiguration can be achieved by using the narrative perspective. The narrative therapy is "a commitment to helping people rewrite the stories of their lives-- re-envisioning their pasts and rewriting their futures" (Nichols & Schwartz, 2007, p. 408).

Social workers may also benefit from using the systems perspective with Pakistani women who are victims of domestic violence. The systems perspective "is essential for developing a holistic understanding of individuals in their social, psychological, cultural, and economic contexts" (Levine, 2001, p. 355). Because the Pakistani community is ethnically family oriented, it is crucial to develop an understanding of how the client perceives the context of family.

Support groups are another method of serving Pakistani women at the micro level of social work practice. "The philosophy behind the use of the strengths perspective was to focus on the women's capacities, abilities, and skills rather than on their 'pathology' or 'deficits'" (Nicholson & Kay, 1999, p. 472). Support groups for victims of female genital mutilation and victims of domestic violence within the same culture would allow the women to share similar stories emphasizing unity through experience. In a group setting the women with a history of abuse and fear of death can empower one another. While listening to the different degrees of abuse, women with more experience in treatment can encourage the newer members that safety and independence are possible to achieve.

Working from a strengths perspective has been shown to diminish the feelings of victimization, low self-esteem, and loss of control that arise. The primary goal for this type of support groups is to help women construct meaning for their deeply painful and disruptive experience while strengthening their capacities

to adapt successfully to their new environment (Nicholson & Kay, 1999, p. 472).

Another important consideration when developing a support group is culture, as cultural traditions may support or hinder the effectiveness of the group. Beginning with the therapist, because cross-gender interaction is a great taboo in the Pakistani community, a male therapist may be more successful if he is co-leading group with a female therapist. Male practitioners should not be discouraged from providing treatment to Pakistani women, but should be aware of sensitivity to cross-gender interaction since it is viewed as disrespectful and as a concern for the women's modesty (Ross-Sheriff & Husain, 2004). Since Pakistani women are persecuted not only by their husbands but also by male family members, they are in a unique situation set apart from other cultures. In a support group, Pakistani women may develop a sense of unity through this link of similar experiences.

Meso-Level Practice

Meso-level implications for social work practice include public awareness campaigns for education and programs for economic development. The Depilex Salon in Lahore, Pakistan, offers one example of sustainable development. The Depilex Smile Again Foundation is an organization dedicated to helping female victims of acid burns and funds the salon in Lahore. It provides women with training courses and then employs them. Liaqat, a twenty-one year old beautician at the salon, is a victim of a facial acid burn caused by her husband. Yet, she has found an ability to rise above the injustice. "Every person wishes that he or she is beautiful...But in my view, your face is not everything. Real beauty lies inside a person, not outside" (Toosi, 2008, para. 6). Through helping women redefine what beauty is and providing them with skills to seek success and healing after trauma, this program provides a powerful example of empowerment.

Additionally, the Women and Sustainable Development (WSD) program of Shirkat Gah is a women's resource center dedicated to empowerment and social justice for women. In addition to establishing trainings in kitchen, gardening, and social forestry projects, the WSD program has also implemented a plant nursery in Maliwal, Punjab, run entirely by women (Shirkat Gah Women's Resource Centre, 2008).

A program in Peshawar also helps local Pakistani women learn new skills that help qualify them as

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community rehabilitation workers. Sponsored through the United Nations High Commissioner for Refugees also include Afghan refugee women who have fled to Pakistan, this four-month physiotherapy course is held at the Physiotherapy Educational Institute. Tuition fees, course materials, transportation expenses, and toolkits upon graduation are provided for all the students, which can help the women when they enter the workforce (United Nations High Commissioner for Refugees, 2009).

Macro-level Practice

Furthering these meso level implications are also broader advocacy campaigns at the macro level. Amnesty International has requested that the Pakistani government make changes in order to protect the rights of women. Requests of legal measures include making the sale of women into marriage a criminal offense; reporting all honor killings to guarantee formal investigations and prosecutions in each case; and, reviewing criminal laws for equal protection of women. Preventative measures are comprised of public awareness campaigns through the media and education system about women's rights, while protective measures incorporate the expansion of services for victims to connect them to legal aid, vocational training and provisions for children (Amnesty International, 1999).

Conclusion

Pakistani women have faced innumerable traumas and human rights abuses. Women have survived histories of domestic violence, acid and stove burns, and female genital cutting. Other women unfortunately fell victim to honor killings. Women continue to struggle for their rights in spite of such discriminatory social and familial practices. Due to their struggles, there are various implications for social work practice at the micro, meso and macro levels.

This type of work can begin at the micro level through an interpersonal approach with the implementation of culturally competent theories in clinical social work practice. Equally important is the work at the meso level. For example, public awareness campaigns, support services for victims, and educational programs need to be supported continuously at the Pakistani local and national levels. Furthermore, the alarming statistics of the prevalence of human rights abuses against Pakistani women have made international organizations advocate a multi-disciplinary approach for gender equality on a macro level. UNICEF, Human Rights Watch, and Amnesty International are some of these advocates that have put effort behind this cause. It is crucial for international social workers to encourage leaders from religious and political groups to discuss cultural practices and religious beliefs that lead to the violation of women's rights and their subordination. Social workers worldwide must continue to support advocacy efforts and accompany Pakistani women in the struggle to achieve their rights.

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Understanding Borderline Personality Disorder

By Lilly Danielson

Abstract

Borderline Personality Disorder has long been met with confusion and controversy. Often misdiagnosed, many clinicians have the perception of borderline clients as difficult, and may even avoid taking them on as clients. This paper works towards a more comprehensive understanding of the disorder. It looks at the etiology of the disorder considering factors such as an invalidating childhood environment and the effects of attachment on the developing mind. It discusses Mentalization Therapy, Dialectical Behavioral Therapy, and Transference-Based Psychotherapy as theoretical models with which to understand and treat the disorder. Finally, it looks at resources available to clients and families, specifically a DBT treatment center in a Northern Suburb of Chicago, IL.

Introduction

On my first day of Psychology 101 my professor began the class with a joke. He told us about a community mental health clinic that had a voicemail system with prompts for different departments. The voice greeting introduced the agency and then listed the prompts, “If you are depressed, press 1, if you are anxious, please press 2”, etc. The last prompt was, “If you are borderline, please hang up.”

Borderline personality disorder (BPD) as a topic of discussion is fraught with controversy. Some clinicians simply avoid treating these clients, while others soldier through. What seems daunting without background to the condition can appear much more approachable with an understanding and knowledge of new research in the area. This paper will attempt to make the subject slightly more accessible by combining knowledge from the fields of neurobiology and attachment theory and describing a cohesive theory of the development of BPD. It will also describe therapies that utilize ideas from these theories to help the client learn new and more functional ways of coping with the disorder. Finally, it will discuss resources for clients with BPD and their family members; resources that let them learn more about the disorder and find resources in their community for treatment. It will attempt to bring these ideas down to scale through a focus on a specific facility that provides therapy for clients diagnosed with BPD in a Northern suburb of Chicago.

Borderline Personality Disorder

In the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000), a personality disorder is defined as an “enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (p. 685). Personality disorders are pervasive and complicated, often exacerbated by a lifetime of trauma and crises. Cluster B disorders are characterized by an emotional, dramatic, and erratic response to the environment. Clients are unable to soothe themselves, and therefore live an emotionally hectic life, often responding to environmental cues with a visceral and emotional response. The extreme vicissitudes of their emotional responses can wreak havoc on their lives, causing crisis after crisis as they continue to try to make their environment fit their dramatic changes in affect.

Among the Cluster B Personality Disorders, Borderline Personality Disorder is often considered the most difficult to treat. It is frequently misunderstood, and is sometimes used to label difficult clients even if they do not fulfill all diagnostic criteria. This “wastebasket” approach to diagnosis has led to much controversy around the disorder, however this is not to minimize therapists’ difficult experiences treating these clients. The *DSM IV-TR* (2000) states that 75% of clients presenting with BPD are female. Clients diagnosed with BPD make up 2% of the general population, with 10% of those diagnosed treated in outpatient settings and 20% presenting with psychotic symptoms and treated in inpatient settings. They make up 30-60% of clinical populations diagnosed with personality disorders (*DSM IV-TR, 2000*). Symptoms are usually the most problematic during a client’s 20’s, and during the 30’s and 40’s symptoms can wane somewhat (*DSM IV-TR, 2000*). If therapeutic interventions are used, they can be quite helpful; however intensive therapy is necessary and usually lasts for a year or more.

The key characteristic of BPD is a pervasive pattern of unstable interpersonal relationships, closely related to a poor sense of self (*DSM IV-TR, 2000*). Clients diagnosed with BPD are caught between a need to be close to someone else and a need for independence. They fear both abandonment and being engulfed by the other. Led by an overly emotional mind, which is overloaded with these conflicting fears, they often act impulsively to avoid real or imagined consequences. In rela-

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tionships, a client diagnosed with BPD frequently begins by idealizing the new partner, spending lots of time with him or her and sharing many details early on. If the new partner lets them down, however, that person is quickly devalued in the eyes of the client (BPDFamily.com, 2009). This splitting is typical for people experiencing BPD; other people are perceived as either saviors or out to get them. Clients will also apply this to their own shaky self-identity, considering themselves either “all good” or “all bad” (S. Polachek, personal communication, March 11, 2009).

Extreme emotionality is also diagnostic of this disorder. Dr. Marsha Linehan of the University of Washington describes clients with BPD as, “the psychological equivalent of third-degree burn patients. They simply have, so to speak, no emotional skin. Even the slightest touch or movement can create immense suffering” (Cloud, 2009, ¶ 2). Unable to calm themselves internally, emotional states are quickly acted upon, causing extreme impulsivity and even self-mutilation. Self-harm can be considered a way of calming the emotional tempest inside, as it directs all attention towards the pain. This along with suicidal threats or attempts can also be utilized to engage others. While often considered manipulative, these cries for help are the attempt clients make to share the intense emotional pain they are feeling with the people in their lives (S. Polachek, personal communication, March 11, 2009).

When considering the etiology of the disorder, it is impossible to disregard the effects of early childhood on the client who is later diagnosed with BPD. Otto Kernberg, who researched BPD in the 1960’s and 70’s, linked the development of the disorder with the rapprochement phase of Margaret Mahler’s object relations theory. He wrote, “Borderline patients are repeatedly reliving an early infantile crisis in which they fear that attempts to separate from their mother will result in her disappearance and abandonment of them” (Gabbard, 2005, p.434). Children raised in an environment with abuse or neglect are unable to fully develop a sense of object constancy; they are unable to trust that their caretaker will remember them and return. In addition, caretakers are inappropriately responsive to their emotional needs. Linehan (1993) described the environment these clients are raised in as an “invalidating environment [which] does not teach the child to label private experiences, including emotions, in a manner normative in her larger social community for the same or similar experiences” (p. 51). Emotional assessment and analysis is stunted, which has critical effects later on.

As we learn more about neurobiology we find that brain development during early childhood contributes greatly to the client’s later functioning. Without delving too deeply into the structure of the brain, it is interesting to note that recent research regarding childhood attachment has benefited our understanding of

BPD. Neurobiologically, attachment can be described as an “inborn system in the brain that evolves in ways that influence and organize motivational, emotional and memory processes with respect to significant caregiving figures” (Siegel, 1999, p. 67). It is what motivates infants to seek out proximity to their caregiver, and evolutionarily speaking it increases the chances of an infant’s survival. Attachment takes place through affect attunement, in which one person’s affective state is influenced by the state of another. This “mental state resonance” allows the infant to organize their affective style based on the affective style of the parents (Siegel, 1999, p 70). Newborns are constantly scanning their environment and learning new things. By being closely aligned with their child emotionally, parents help their children organize their brain structure, so to speak, which in turn helps them function more effectively in their environment.

Emotion is critical in the process of attachment. Research in neurobiology shows that emotion plays a major role in how the brain is mapped (Siegel, 1999). Our senses, cognitive functions, and even capacity for creativity are all aided by emotional cues. It is not surprising, then, to assume that someone who was raised without a caregiver capable of being emotionally “there” for their child, who did not receive appropriate affect attunement, would grow up with a less than functional cognitive style. Children raised in this invalidating environment may spend the rest of their lives trying to find a stable attachment figure, quickly initiating intense relationships and then pulling away when these relationships do not fulfill their yearning for unconditional parental attention. A child raised in such an invalidating environment, according to Dr. Marsha Linehan and colleagues, “does not learn how to understand, label, regulate or tolerate emotional responses, and instead learns to oscillate between emotional inhibition and extreme emotional lability” (Cloud, 2009, ¶ 6). Since they are often told that their emotions are incorrect, even socially unacceptable, individuals with BPD may act out impulsively in an attempt to regulate their uncomfortable emotions.

Treatment

Therapy for clients with BPD is fraught with difficulty. Therapists are not always eager to work with these clients, given their propensity for complicated and manipulative relationships, suicidal threats, and self-mutilating behaviors. In a *Time Magazine* article from January 2009, the author even goes so far as to say that “Borderlines are the patients psychologists fear most” (Cloud, 2009, ¶ 3). These clients have strong transference reactions to the therapist, as they do in most relationships, looking for the attachment and vali-

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dition they lacked in childhood. Therapists, in turn, may have strong countertransference reactions to their clients. They may view the clients as clingy, and they may be uncomfortable with the constant phone calls and demands on their attention. On the other hand, the dependence the client has on the clinician may provide an unhealthy amount of gratification for the clinician. Without realizing, they may actually encourage the client to depend on them, fulfilling their own desire to be needed (S. Polachek, personal communication, March 11, 2009).

The inevitable transference reactions that will occur have actually been utilized in a specific form of therapy for clients diagnosed with BPD, called transference-focused psychotherapy. For “higher-level borderline patients with greater ego strengths and greater psychological mindedness”, this type of expressively-oriented psychotherapy can be quite beneficial (Gabbard, 2005, p. 454). This therapy involves techniques of clarification, confrontation, and interpretation within the evolving transference relationship between the patient and the therapist. The therapist must work carefully to make unconscious transferences and countertransferences conscious. They must also work to create and vigilantly maintain boundaries. Although difficult, for the right patients this therapy can be quite helpful. Transference therapy, along with other insight-oriented therapies, can help clients truly understand the causes of their dysfunctional patterns.

While insight-oriented therapy such as the one described above are still regularly used and successful, great gains have been made in the area of cognitive behavioral therapy. Mentalization therapy, developed by the Dr.'s Peter Fonagy and Anthony Bateman, and Dialectical Behavioral Therapy, developed by Dr. Marsha Linehan at the University of Washington, have both made impressive impacts on the treatment of BPD. Research studies have shown that these therapies are significantly effective treatments. These therapeutic treatments have developed extensively along with our increased understanding of neurobiology and the development of attachment.

Mentalization Therapy

Mentalization is described as the “mental process by which an individual implicitly and explicitly interprets the actions of himself or herself and others as meaningful” (Choi-Kain & Gunderson 2008). In everyday interactions mentalization is unconscious and automatic. We are able to understand our own and others’ mental states. This facilitates most interactions, and is crucial to normal reciprocal conversation. In the client with BPD, however, mentalization is poor. Allen, Fonagy and Bateman (2008) describe clients with BPD as compromised in their ability to understand the emotions of others while maintaining a firm grasp on their own

subjective experience. They see BPD as developing in a child whose emotions were not attuned to, someone who never learned to mentalize. These children, therefore, end up impaired in their ability to regulate affect, to control their attention, and to develop appropriate and effective social skills.

Theory of mind is an important component related to mentalization. It is used to describe the understanding that our thoughts are internal and separate from reality, and that other people also have their own internal thoughts separate from an external reality (Choi-Kain & Gunderson, 2008). Most children develop a theory of mind at approximately 4 or 5 years of age (Choi-Kain & Gunderson, 2008). An interesting test, developed by Bateman and Fonagy in the early 1990’s, can determine if a child has yet developed theory of mind. A vignette is illustrated wherein a young child named Maxi hides a candy bar in a cupboard. While Maxi is away, his mother comes into the kitchen and moves the candy bar. When Maxi returns, the child taking the test is supposed to guess where he will look for the candy bar. Children who have developed theory of mind will reply that Maxi will look in the cupboard where he originally hid the candy bar, because they realize that his internal thoughts are separate from the external reality. Children who have not developed theory of mind, however, will guess that Maxi looks in the spot where the mother placed the candy bar. They do not yet realize the disconnect between what someone believes internally and what is actually occurring in the real world (Choi-Kain & Gunderson, 2008).

This theory of mind, so crucial to mentalization and normal childhood development, is often compromised in clients with BPD. These clients do not always understand that what they are experiencing internally, such as a strong emotional response, is not a function of the external reality. To develop this capability, children need what Bateman and Fonagy refer to as a “marked and contingent” response from parents (Choi-Kain & Gunderson, 2008). A parental response to a child successfully completing a difficult task, for example, would be marked in that it would be an exaggeratedly happy facial expression, and contingent in that it is accurate and responsive to the situation (Choi-Kain & Gunderson, 2008). This has obvious connections to affect attunement, described in the section about neurobiology above. When parents are unable to provide this congruent imitation of a young child’s emotional response, development is suboptimal (Linehan, 1993).

This disorganized thinking has been categorized by Bateman and Fonagy as a part of their mentalization therapy. Clients with BPD may live in what is considered the “psychic equivalence mode,” where they confuse their own subjective mental states with physical reality (Allen, Fonagy & Bateman, 2008). To a certain extent, they believe that what they are feeling internally

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is shared with the rest of the world. They may also function within the “pretend mode,” where a thought or belief is carried on internally without any basis in reality (Allen et al., 2008). For example, clients diagnosed with BPD may believe that they are worthless, and respond to all situations with this thought, even though it is not true. Finally, clients may also have what is called a “teleological stance”, where they are only able to communicate their internal states through action (Choi-Kain & Gunderson, 2008; Allen et al., 2008). We see this in the high levels of suicidal threats, attempts and self-mutilation among this group.

Mentalization therapy’s goal is to help clients learn to mentalize, or to understand others’ emotions, while helping them navigate the treacherous waters of the attachment environment (Allen et al., 2008). It recognizes that an invalidating environment in childhood made it difficult for clients to “find themselves in the eyes of their caregivers or parents” (Gabbard, 2005, p. 449). Through a focus on developing a theory of mind through a marked and contingent response from the therapist, and an emphasis that the client is on the therapist’s mind, clients develop a new way of understanding the world. Through individual and group therapy, attachment relationships are carefully utilized in order to improve mentalization.

Dialectical Behavioral Therapy

Dialectical Behavioral Therapy (DBT) is another cognitive behavioral approach for BPD. In recent years it has garnered much attention, and rightly so. The therapy was developed by Dr. Marsha Linehan at the University of Washington. Randomized trials showed that, as of 2007, the therapy was more effective at addressing BPD than any other therapy (Singer, 2007). Originally developed in the early 1990s, DBT significantly reduced the tendency for clients with BPD to self-mutilate, and reduced the number of days spent on inpatient hospital wards (Linehan, 1993). Highly structured, it approaches specific functions in a person’s life with four modes of service delivery. Services include an hour of individual psychotherapy per week, two and a half hours of group skills training per week, telephone consultation as needed (but within the therapist’s limits), and weekly therapist consultation team meetings, where the clinicians are able to enhance each other’s motivations and skills (Singer, 2007). Described as “Zen philosophy meets tough love” (Cloud, 2009, ¶ 24), DBT strives to counter clients’ dysfunctional thought patterns by fostering healthy emotional modulation and trust in their own emotions (Linehan, 1993).

DBT is named as such because of its basis in a philosophy that encourages acceptance of two “opposite” ideas (or dialectics), that of acceptance and change. Linehan (1993) writes that in DBT, “the therapist helps the patient resolve crises by supporting simultaneously

her attempts at self-preservation and self-transformation” (p. 34). The German philosopher Hegel is credited with the idea of the dialectic, wherein a thesis is considered in relation to an antithesis, and in synthesis of the two a system is understood in relation to its parts (Lynch et al., 2006). The thesis in DBT is the need for change, and the antithesis is the client’s need for acceptance. The solution, therefore, is found within the relationship between the two (Linehan, 1993). Linehan realized that clients who are diagnosed with BPD have been urged to change all their lives, and it clearly has not worked yet. Instead of being one more voice pointing out their problems and telling them to change, she accepts them as they are at that moment. That acceptance includes acknowledging the fact that their lives are unbearable at that moment, and therefore change is necessary (Singer, 2007). The biosocial theory of BPD is based on an understanding of an interaction between a client’s biological tendency towards emotional vulnerability as well as an invalidating early childhood environment (Singer, 2007; Linehan, 1993). A therapist asking a client to change would just be a repetition of that early invalidating environment, and therefore counterproductive without the deep and genuine acceptance that is fundamental to DBT.

DBT works by “helping the patient to engage in functional, life-enhancing behavior, even when intense emotions are present” (Lynch et al., 2006, p. 459). There are five hierarchical functions which are addressed by this therapy. The primary function is increasing behavioral capabilities. This helps clients control their impulsive behaviors. A therapist who uses DBT stated that, frankly, this first step is for the client to “learn how to not kill themselves” (Singer, 2007). The second function is improving motivation for skillful behavior. After the first step, clients may be acting in a much more functional way, but they feel like they are living in quiet desperation (Singer, 2007). With the therapist’s help they learn to understand their emotions, perhaps for the first time, which can help remove the impetus for acting out. Thirdly, DBT helps clients assure generalization of therapeutic gains to the natural environment (Singer, 2007). This step helps clients build an ordinary life, realizing that they do not have to be in constant crisis to solve things. The fourth step is structuring the treatment environment so that it reinforces functional rather than dysfunctional behaviors. This is the most spiritual element of therapy, where a client moves from a sense of incompleteness to one of completeness. They might change their life to fit more cohesively with their new, more functional, mode of living (Singer, 2007). And finally, DBT pays close attention to the therapist as well as the client, emphasizing the importance of enhancing therapist capabilities and motivation to treat patients effectively. The weekly therapist consultations that take place attend to this (Singer,

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2007). While the five functions build upon each other, they are also cyclical, as each area has an impact on its counterparts.

It seems as if this therapy works so well because it addresses invalidating environmental responses which led to the client's attachment issues. Emotions may have been met by the primary caregiver with "erratic, inappropriate, and extreme responses" (Linehan, 1993, p. 49). This invalidating environment led the client to not only believe that her assessment and analysis of her emotions is incorrect, but also that her very experience of these emotions is socially unacceptable (Linehan, 1993). For example, she may appear sad in a parent's presence. An invalidating caregiver would inappropriately respond to the sadness with ridicule, and possibly attribute the sadness to a character flaw in the child. With repeated experiences such as this one, a child does not gain the ability to recognize her own emotional responses, and also learns to devalue these responses.

To tackle the issues caused by such an environment, DBT focuses on making states of mind and emotions conscious. Linehan (1993) describes different states of mindfulness as a balanced system, one that becomes unbalanced as the client acts out (Singer, 2007). Reasonable mind is the part that thinks rationally and logically, but without feeling. It is inflexible and rigid. Emotional mind is when emotions are in control, and all thinking patterns revolve around how one feels. This is helpful for creativity, but it is not always dependable, and it is affected by food, drugs, and relationships. Finally, wise mind is a combination of both. This is the balance that Linehan (1993) wants for her clients. In her opinion, all clients have the capability to balance the reasonable and the emotional, but therapy is sometimes necessary to help the client find it within themselves and use it (Singer, 2007).

There are a variety of specific techniques clinicians use in DBT to help clients achieve their goals. These techniques help to increase clients' mindfulness while also providing validation and targeting emotional dysregulation (Lynch et al., 2006). One technique is chain analysis, where the therapist persistently examines the events leading up to a client's dysfunctional behavior (Singer, 2007). For example if the client comes into therapy and states that she cut herself in the past week, the therapist will examine the events, detail by detail, to understand what emotions occurred, when those emotions became unbearable, and so on. The point is to find the catalysts that led to the dysfunctional act. Another technique is solution analysis, where the therapist helps a client understand why the solution they have found for a problem they experience is maladaptive (Singer, 2007). For example, A client might break up with a partner whenever that partner says anything critical about them. The therapist would help the client understand the

solution better by asking questions such as: Why did you choose this solution? If no other solutions seemed available to you, why not? What were you looking for that you didn't get? What would be a more appropriate solution? A therapist helps the client brainstorm for possible alternatives (Singer, 2007). One more technique of note is the idea of Devil's Advocate, wherein the therapist actually takes a counter position and argues against change. The client ends up arguing for change, which reverses the power struggle that often develops when working with this population (Singer, 2007).

DBT is complicated, but it clearly works for some clients. It emphasizes accepting clients as they are while encouraging radical change, and works to counter the negative effects of a poor attachment in childhood. It goes beyond discouraging suicide and self-harm to help the client regulate their emotions and create a "life worth living" (Singer, 2007). Linehan (1993) recognizes that many clients have experienced therapists who have given up on them because of their difficult behavior. She maintains, however, that in DBT, clients cannot fail. Therapists can fail, and relationships can fail, but the client is using what she knows and is doing her best (Singer, 2007). Within every dysfunction there is a function. It is important to recognize that the client's behavior, while uncomfortable, is understandable based on the way she was raised. DBT acknowledges the balance in therapy and in the therapeutic relationship between acceptance and change (Linehan, 1993).

Accessibility to Therapy for Clients Diagnosed with BPD

As research progresses, we are learning more about the etiology of BPD and also the effectiveness of various therapeutic techniques. A diagnosis of BPD is no longer the "death sentence" it used to be (Cloud, 2009, ¶ 8). However, how does this play out in reality? If a client is diagnosed with BPD, do they receive the care that they need? The answer is nebulous. Like many personality disorders, the client does not come into therapy presenting with a personality problem immediately. Often clients end up in the hospital due to suicidal attempts or self-harming activities. Family members are often very concerned. However due to the client's dysfunctional approach to relationships, and especially criticism, these clients do not always have positive results from long-term therapy.

Family members are often worried about their relative with BPD, but at the same time frustrated with the constant demands made on their attention and resources. It is exhausting to have someone depend on you for emotional support one moment, and then have them completely devalue you the next. Family members often feel like they are at the end of their rope. Online

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resources like www.BPDFamily.com provide message boards and articles for family members to learn and share about their experiences. They explain BPD in understandable terms, and normalize the experiences of family members. Another helpful website is www.behavioraltech.com, which is Dr. Linehan's website for DBT. In addition to directories for clinicians looking to learn more about DBT or to find training opportunities, the website has a directory of clinicians by area who have been trained to provide DBT.

In the Chicago area there are a number of places where clients can go to receive DBT. One in particular is the Mindfulness & Behavioral Therapies Program, at the Family Institute at Northwestern University. The approach used at MBTP "can offer help to individuals, families, and couples struggling to cope with intense emotions, impulsive or difficult-to-control behaviors, anxiety, depression, and many other problems" (The Family Institute, 2009, ¶ 1). The Family Institute incorporates general mindfulness training with an additional dialectical behavioral therapy program, and offers individual DBT and group skills training.

Dr. Michael Masler is the director of the MBTP program at the Family Institute. He writes that clients come to his program from a variety of different referral sources, including a network of therapists, website referrals, psychiatrists, and other treatment programs including community mental health programs and DBT residential programs. The DBT program is specifically designed for adolescent and adult women ages 13 and up, although they do accommodate men who experience symptoms of BPD (The Family Institute, 2009). According to Dr. Masler, clients represent a "widely varying socioeconomic and cultural background" (personal communication, April 15, 2009). Most clients who come to the Evanston location are from the downtown and Northern suburbs of Chicago.

While it is one thing to learn about the effectiveness of DBT in the literature, it is interesting to see how it plays out in real life. One of the key elements of effective DBT- an element important to all therapeutic interventions, in fact- is the therapeutic relationship (M. Masler, personal communication, April 14, 2009). Of prominent importance is also the client's motivation to change. Dr. Masler writes that "clients who experience

strong reinforcement through interaction with the therapist" and "clients who have a strong 'hunger' for relationship" have a better prognosis in therapy (personal communication, April 15, 2009). DBT's strengths lie in its practical, everyday applications. Problem behaviors are addressed directly as behavioral interventions. Phone consultations are available and even encouraged. For example, clients are praised for using their resources and calling their therapist before they make a suicide attempt (Singer, 2007). This emphasis on generalization to real life is extremely important, as this is often an issue of contention. Even with a good therapeutic relationship and good client motivation, however, DBT is a difficult endeavor to undertake. According to Dr. Masler, it "requires considerable commitment on the part of both therapist and client, requires a lot of hard work from both, it is complicated to learn and deliver as a treatment, and requires programmatic investment of resources" (personal communication, April 15, 2009). Dr. Linehan herself criticizes this reality of DBT in practice, reiterating that "it takes too long. There are too many components. It takes too much training for therapists" (Cloud, 2009, ¶ 29). Nevertheless, DBT remains the most empirically-tested therapy for BPD.

Conclusion

Clearly BPD is a complicated disorder to understand, and to treat. As we learn more about attachment theory through neurobiological research, we are developing a new conceptualization for this dysfunctional way of living. Hopefully the time where the label of "borderline" was used as a wastebasket diagnosis, given to the worst-behaving clients no matter their history, is gone. Hopefully we as clinicians will increasingly see clients with borderline characteristics as a product of their unstable environment, and work to accept them as they are while helping them learn the tools to enact radical change. Most importantly, however, is the hope that this type of open-minded therapeutic technique is accessible to all clients who present with borderline traits. The knowledge about their own emotions and relationships does not just positively affect a client's life, it will affect generations to come.

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Empirically Supported Treatment Interventions for Clients with Posttraumatic Stress Disorder and Comorbid Borderline Personality Disorder: A Critical Review

Empirically Supported Treatment Interventions for Clients with Posttraumatic Stress Disorder and Comorbid Borderline Personality Disorder: A Critical Review

By Megan Seliga

Abstract

The overall stigma- and gender-related controversies that surround the diagnosis of Borderline Personality Disorder (BPD) present a unique ethical mandate to the practitioner. The relationship between trauma and the BPD diagnosis strengthens the need for carefully designed treatment interventions in order to secure the benefits of trauma-focused work, while minimizing the risk of undue regression. The complexity and risk of harm introduced by a diagnosis of comorbid BPD and PTSD urges the need for clarification of optimal treatment interventions to guide practitioners. The use of adjunctive treatment modalities alongside trauma-focused interventions emerges as an empirically supported technique in the treatment of severely comorbid patients.

Introduction

The diagnostic label, Borderline Personality Disorder, evokes strong images in the mental health care provider of difficult and mentally draining patients, while carrying the added burden of such popular culture representations as Glenn Close in *Fatal Attraction*. Plagued by exasperated responses from health care providers and fearful associations in the public realm, individuals with Borderline Personality Disorder may be among the most vulnerable patients in the mental health care system, especially when one considers the undeniable link between Borderline Personality Disorder and childhood victimization. In fact, Classen, Pain, Field, and Woods (2006) describe the rates of comorbidity among Borderline Personality Disorder (BPD) and Posttraumatic Stress Disorder (PTSD) as high and refer to study results that estimate the rate of concurrence as high as 56 to 68%. Despite the fact that BPD emerges as one of the most widely researched disorders, consistent proof of validity and reliability of the diagnostic category remain conspicuously absent (Becker, 2000). Controversies related to the BPD diagnosis will be fully ad-

ressed in subsequent sections of this paper, as such controversies inform the difficulties that have plagued the treatment literature pertaining to BPD and comorbid PTSD.

The degree of vulnerability attached to the diagnosis of BPD strengthens the need for empirically validated treatment interventions for this population, especially when one considers the revictimizing potential of matching treatment interventions with a tenuously founded diagnosis. In light of this mandate, this writer wishes to clarify the optimal treatment of choice for patients with comorbid BPD and PTSD. Trauma-focused therapies, particularly Eye Movement Desensitization and Reprocessing Therapy (EMDR), tend to be the treatment of choice for PTSD; however, comorbid borderline pathology has been identified in the literature as a predictor of poorer treatment outcomes, thus lending support for the selection of an intervention tailored to the unique needs of patients diagnosed with BPD, such as Dialectical Behavior Therapy (DBT). The question that this writer seeks to clarify in this paper may be summarized as follows: If patients diagnosed with PTSD and comorbid BPD are given EMDR or DBT, which will result in more optimal treatment outcomes?

Definitions

In order to proceed with the proposed investigation, the concepts relevant to the discussion must be defined. In the case of patients diagnosed with comorbid BPD and PTSD, the relevance of such definitions has been assigned particular importance. The following concepts will be briefly defined, as exhaustive definitions and full elaboration of treatment protocols are beyond the scope of this paper: Borderline Personality Disorder (BPD); Posttraumatic Stress Disorder (PTSD); Eye Movement Desensitizing and Reprocessing Therapy (EMDR); and Dialectical Behavior Therapy (DBT).

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Borderline Personality Disorder

The political and historical implications of the BPD diagnosis will be addressed in more depth in subsequent sections. At this point, it is sufficient to recognize that BPD has been distinguished from other disorders by being the only diagnosis for which treatment resistance and strong countertransference reactions of the therapist serve as proofs of validity (Becker, 2000). The pessimism engendered by this diagnosis among helping professionals aside, the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000) provides the following list of formal symptoms, five of which must be present to constitute a diagnosis of BPD: frantic efforts to avoid real or imagined abandonment; a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; identity disturbance, defined as markedly and persistently unstable self-image or sense of self; impulsivity in at least two areas that are potentially self-damaging, such as sex and substance abuse; recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior; and affective instability due to a marked reactivity of mood; chronic feelings of emptiness; inappropriate and intense bouts of anger; and transient paranoid ideation or severe dissociative symptoms.

Posttraumatic Stress Disorder

It is interesting to note that the diagnostic criteria for PTSD recently widened to include the victimization experiences of women, as the DSM-III diagnosis of PTSD specified the need for precipitating events to be “outside the range of normal human experience” (Hodges, 2003, p. 411). The *DSM-IV-TR* (2000) has revised the definition of a traumatic event to include the following characteristics: actual or threatened death or serious injury, or a threat to the physical integrity of self and others; and the person’s response involves intense fear, helplessness, or horror. In association with the traumatic event, the *DSM-IV-TR* (2000) places PTSD symptoms within the categories of reexperiencing the event, tendencies of avoidance, and symptoms of increased arousal.

Reexperiencing of the event may involve the following symptoms, as specified in the *DSM-IV-TR* (2000): recurrent and intrusive distressing recollections of the event; recurrent distressing dreams of the event; acting or feeling as if the traumatic event were recurring; intense psychological distress at exposure to internal or external cues that symbolize or resemble an as-

pect of the traumatic event; and physiological reactivity. Persistent avoidance of stimuli associated with the traumatic event may include avoidance of thoughts, feelings, or activities associated with the trauma, coupled with a diminished interest in previously enjoyed activities and connection to others. Symptoms of arousal are listed in the *DSM-IV-TR* in the following manner: difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance; and an exaggerated startle response.

Eye Movement Desensitization and Reprocessing Therapy

EMDR was developed by Francine Shapiro to provide a structured approach guided by an information-processing model to treat PTSD-related symptoms (Shapiro & Maxfield, 2002). EMDR is based upon the Adaptive Information Processing Model (AIP), the following summary for which is taken from Shapiro and Maxfield (2002). The basic premise of the AIP model posits that if traumatic memories are not fully processed, in the manner typical of most new information, the initial perceptions will be stored with any distorted thoughts or perceptions experienced at the time of the traumatic event. It is further hypothesized that the eye movements and other dual-attention stimuli facilitate the full processing of the memory. The treatment consists of eight phases, which will be briefly summarized.

The first phase consists of assessment and the development of a treatment plan. Phase two is aimed at preparation for trauma-related work and involves such strategies as the “safe place” technique, in which clients learn to utilize visualization as a self-soothing method. Processing of the traumatic event begins in Phase three, which focuses on the identification of associated sensory, cognitive, and affective associations, with particular emphasis on the discovery of irrational negative beliefs associated with the trauma. The fourth phase begins with instructions to focus on the visual image, negative belief, and bodily sensations and then to simultaneously initiate eye movements from side to side for 15 or more seconds. Phase five centers on the consolidation of cognitive insights, while phase six is aimed at assessing any shifts in the level of distress experienced by the patient in relation to the traumatic memory. Phase seven involves a formal evaluation by the therapist of the degree of memory processing achieved by the intervention, and Phase eight focuses on the identification of any issues or needs that have not been fully met with the treatment.

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Dialectical Behavior Therapy

DBT was developed in 1993 by Marsha Linehan to address the specific treatment challenges presented by patients with Borderline Personality Disorder. The overarching goals of DBT are identified by Linehan and Harned (2008) as follows: reduce immediate life-threatening behaviors; reduce therapy-interfering behaviors; and reduce quality-of-life interfering behaviors. Linehan and Harned propose a structure for DBT that includes weekly individual psychotherapy, weekly group skills training, and phone consultation on an as needed basis. The foundational concept of DBT may be viewed as the synthesis of antithetically opposed perspectives, which resists the privileging of one viewpoint over another and promotes balanced unity. An example of a dialectic is the common tension between acceptance of one's emotions as valid and the drive to change them (Harned, Banawan, & Lynch, 2006). Mindfulness, which refers to a state of non-judgmental and suspended awareness of moment to moment experience, lies at the core of DBT-based interventions. DBT focuses on the delivery of the following four skills modules: mindfulness; interpersonal effectiveness; emotion regulation; and distress tolerance. Each module maintains a focus on achieving the broad aims outlined above with the ultimate goal of alleviating the chaos that often plagues the lives of individuals with BPD.

Historical and Contemporary Controversies

The history of the borderline diagnosis has been problematic since its inception (Classen et al., 2006). The diagnosis was first introduced by Stern in 1938, but did not appear in the DSM until 1980 (Classen et al., 2006). At the time of its inception, the term borderline represented the "border" between neurosis and psychosis. However, Becker (2000) recognizes that the diagnostic category of BPD has evolved to the point that its diagnostic criteria have been revised to capture the primarily affective nature of its associated pathology. In a poignant statement regarding the political forces that impinge on diagnostic classification, Becker (2000) draws attention, rather skeptically, to the soaring interest in funding for research on affective disorders that coincided with the reshaping of BPD. Since the introduction of BPD into the DSM, research on this disorder has been far from lacking. In fact, many authors uphold the distinction of BPD as one of the most heavily researched disorders. Classen et al. (2006) credit the pro-

liferation of research pertaining to BPD to two historical developments in psychiatry: a growing interest in data collection on the incidence and deleterious effects of child abuse, and the budding appreciation of attachment considerations in the etiology of mental illness. Despite advances in etiological research marked by a deepening respect for pathological influences in the environment, research pertaining to the treatment of comorbid BPD and PTSD remains lamentably scarce. Linehan and Harned (2008), in fact, observe that no single study has specifically evaluated the treatment of PTSD in a BPD population, which stands in notable contrast to the strength of the relationship between BPD and PTSD in etiological research. The current state of research regarding the link between BPD and trauma will be explored next.

The causal link between childhood abuse and BPD retains a degree of prominence and acceptance that has led some researchers to propose a reclassification of BPD as a form of PTSD. Allen, Fonagy and Bateman (2008) observe that, more than other personality disorders, BPD is associated with "exceptional exposure to negative life events" (p 261), especially in the realm of interpersonal experience, and add that persons with BPD are at greater risk for suicide attempts than those who suffer from other personality disorders.

A study with 379 participants with BPD by Zanarini and colleagues (1998, as cited in Clarke, Resick & Rizvi, 2008) revealed that 61% of females and 35% of males also met criteria for comorbid PTSD. Van der Kolk, McFarlane and Weisaeth (2007) found additional evidence for the connection between BPD and PTSD in a study he conducted in 1987, which revealed that more than half of all inpatient patients diagnosed with BPD had histories of severe physical or sexual abuse prior to the age of 6, and among the 13% of patients who did not report a history of sexual abuse, more than half were found to have been amnesic for most of their childhoods. Yet another support for the strength in the relationship between severity and chronicity of abuse among patients diagnosed with BPD is found in a study conducted by Paris (1994, as cited in Everett & Gallop, 2001) which revealed that patients with BPD are more likely to have been abused by multiple perpetrators and to have experienced abuse involving penetration. Assigning absolute causality to childhood trauma in the development of adult BPD violates the limits of the fallibly human activity of research and imposes an oversimplified explanation for a complex social and cultural phenomenon. Researchers have debated about the

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causal direction of the relationship between BPD and PTSD by contending that borderline personality constellations or predisposing temperaments, which may be present in childhood, may increase the vulnerability of such individuals to victimization.

Despite the lack of consensus concerning the exact nature of the relationship between BPD and PTSD, statistics concerning the comorbidity of these disorders clearly demonstrate a strong connection. Feeny, Zoellner and Foa (2002) assert that among individuals with PTSD, rates of concurrent personality disorders have reached up to 50% in some studies, with BPD emerging as the most common comorbid condition with PTSD. Feeny et al. also refer to the results of a study conducted by Zanarini and colleagues, which reveals that, among patients diagnosed with Axis II disorders, PTSD is more common among those with BPD than those with other personality disorders. Given the high rate of comorbidity among BPD and PTSD, it is not surprising that controversies have emerged related to the ethical and practical advantages of merging the two diagnostic categories, particularly in light of the stigma associated with BPD.

Individuals with Borderline Personality Disorder have earned the reputation among care providers as being particularly difficult to treat, thus contaminating the enterprise of therapy with these patients with the predetermining effects of poor prognostication. Allen et al. (2008) challenge the assumption of chronicity often associated with the borderline diagnosis based on studies that demonstrate remission rates of borderline patients to be as high as 50% after four years. The stigma and undue pessimism associated with the diagnosis of BPD infuses the controversy related to the validity of this diagnosis with important ethical and political considerations. Many feminist authors emphasize the socially constructed nature of diagnostic labels and frame the development of the borderline diagnosis as a method of "social control," which reflects an imbalance in the distribution of power within a given cultural context (Becker, 2000, p. 423). The fact that BPD is diagnosed on average seven times more frequently among females than males certainly builds a case for gender-based differences (Hodges, 2003). Brown (1994) fervently supports the practice of utilizing the diagnosis of complex PTSD, rather than BPD, and places the need for a reexamination of the validity of BPD on a human rights level, as she bluntly asserts that the diagnostic label, borderline personality, portrays the client as being "deeply flawed as a human being at the very core" (p. 132). De-

spite the well-established risk of disempowerment and marginalization associated with the use of the BPD label, obvious problems arise when one endeavors to merge the diagnosis of BPD with PTSD, the boundaries of which have already been termed hopelessly diffuse by some researchers. The practical implications of such a merger will be explored next.

While recognizing the inadequacies and controversies surrounding the BPD diagnosis, Becker (2000) warns of the error of oversimplification that may occur, should childhood abuse be identified as the root of all difficulties experienced by individuals diagnosed with Borderline Personality Disorder. Additionally, the endeavor to shift the core of BPD to the trauma spectrum poses the threat of further stigmatizing and marginalizing women who may be diagnosed with BPD and who do not have a history of abuse, thus heightening a sense of guilt and shame in such patients. Becker (2000) refers to the damaging contrast between the BPD and PTSD diagnosis by characterizing BPD and PTSD respectively as "bad girl" and "good girl" representations, given the almost full pardoning granted to the patient by the mere existence of a traumatic past. Classen et al. (2006) avoids the error of eliminating the borderline diagnosis on the basis of imperfect etiological assumptions by proposing the establishment of two additional PTSD classifications alongside BPD.

Classen et al. (2006) relies on evidence linking the prominence of attachment considerations in the development of pathology in proposing the establishment of Posttraumatic Personality Disorder (PTPD)-Disorganized Type and Posttraumatic Stress Disorder-Organized Type. According to this classification, persons who have a history of chronic traumatization, who may be differentiated as having either disorganized or organized attachment styles, would be diagnosed according to the personality-altering nature of their trauma histories, and the BPD diagnosis would be preserved to designate individuals who have trauma histories, to a lesser extent than individuals with PTPD, and disorganized attachment. Controversies regarding the ethical and political implications of preserving the BPD diagnosis will likely persist, as will micro level differences in the diagnostic practices of clinicians, who may express their opposition by avoiding the BPD label, in favor of a PTSD classification. The challenges that the above controversies present to the activity of research pertaining to these disorders will be highlighted in the next section.

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Review of the Literature

This writer's search strategy involved consultation with the following five databases: Web of Science; PsychInfo; PubMed; Cochrane Collaboration; and an online card catalogue for locating books. The search for treatment literature pertaining to comorbid PTSD and BPD was complicated by the overall breadth of literature pertaining to diagnostic considerations. Many of the articles highlighted the controversies presented by the diagnosis of BPD in the context of early childhood trauma and co-occurring PTSD, given the stigma associated with a diagnosis of BPD. Although diagnostic considerations, particularly the classification of a primary versus a secondary diagnosis, hold relevance for treatment decisions, this writer elected to focus on material directly related to treatment. This decision was driven partially by practicality, given that the volume of indirectly related material is significant, as well as the tendency of treatment-focused articles to provide adjunctive insight concerning diagnostic considerations.

The findings related to the optimal treatment for individuals with comorbid BPD and PTSD and, more specifically, the efficacy of EMDR as compared to DBT, are as complex as the question itself. Due to the overall scarcity, affirmed by Linehan and Harned (2008), of studies pertaining directly to the treatment of persons with comorbid BPD and PTSD, this writer was obligated to broaden the scope of relevant studies to include those relating to the diagnostic categories of PTSD and BPD alone, as well as those referring to the use of DBT and EMDR with persons diagnosed with either BPD or PTSD. The findings may be grouped under the following headings: research supporting the use of trauma-focused interventions, particularly EMDR, with PTSD populations; research pertaining to the use of a single intervention in the treatment of individuals with comorbid BPD and PTSD; and research relating to the benefits of employing an integrative approach in the treatment of individuals with comorbid BPD and PTSD. The writer was able to find ten articles pertaining specifically to the treatment of BPD and PTSD, the findings for which will be discussed subsequent to an elaboration of more loosely relevant findings. The most prolific category of research relates to the preferred psychological treatments for PTSD and several studies within this category, which will be discussed next, offer relevant insights, given their consideration of complex PTSD symptomology.

Schottenbauer et al. (Summer, 2008) conducted a critical review of 55 empirical studies related to the treatment of PTSD and discovered that dropout and non-response rates were fairly high with dropout rates exceeding 50% on some measures. Interestingly, they offer the hypothesis that Axis II pathology may have contributed to the low tolerability of the trauma-focused interventions, which included Cognitive Behavioral Therapy (CBT), EMDR, exposure therapy, and stress inoculation therapy. In a similar investigation, Bisson, Ehlers, Mathews, Richards and Turner (2007) conducted a review of 38 randomized controlled trials of psychological treatments for PTSD with both female only and mixed gender samples. The findings revealed the overall efficacy of CBT and EMDR, while recognizing that higher symptom acuity presented a limitation to the efficacy of the trauma-focused interventions, thus lending further support to the notion of tolerability. In yet another empirical investigation of the efficacy of prolonged exposure, which utilizes both imaginal and *in vivo* exposure aimed at lessening the psychic potency of trauma related memories, and EMDR in the treatment of PTSD rape victims, Rothbaum, Astin and Marsteller (2005) support the efficacy of both EMDR and Prolonged Exposure (PE) in producing statistically significant clinical improvements; however, it should be noted that none of the 74 female participants had a history of childhood sexual abuse, as this was adopted as a criteria for exclusion. The tendency of studies to utilize stringent exclusion criteria raises an important issue concerning the limitations of research in this area, as many patients diagnosed with BPD exhibit complex and potentially self-endangering behavior patterns, which almost automatically signify exclusion. Research in support of a unified approach to the treatment of the target population will now be explored.

Three major studies with high relevance to the topic of focus in this paper provide evidence for the benefits of employing trauma-focused interventions with individuals diagnosed with both PTSD and BPD, thus reinforcing the primary role of trauma in contributing to and maintaining pathology. Clarke et al. (2008) conducted a study with 171 female rape survivors, among whom some also had BPD, in an effort to compare the efficacy of trauma-focused CBT and Prolonged Exposure among individuals with and without comorbid BPD. The results of the study demonstrate comparable treatment gains over time among participants with PTSD alone and participants with PTSD and comorbid BPD; however, it should be noted that the exclusion cri-

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teria for this investigation, which included current involvement in an abusive relationship, suicidal intent, and/or parasuicidal behavior, limit the generalizability of this study to patients with moderate to severe borderline pathology. Shapiro and Brown (2006) strengthen the case for trauma-focused interventions with their documentation of a case study in which a 43-year-old Caucasian female with comorbid diagnoses of BPD and Major Depressive Disorder participated in 20 sessions of EMDR, which resulted in significant improvements in affect regulation, interpersonal stability, and a remission of “rage attacks” (p. 414). Shapiro and Brown make special reference to EMDR-based techniques, such as the safe-place exercise, that are incorporated into the structure of treatment to increase tolerability of trauma-focused interventions.

Feeny et al. (2002) conducted an investigation similar to that of Shapiro and Brown (2006), in which they investigated the response of 72 female rape victims, all of whom met criteria for PTSD and 17% of whom met criteria for comorbid BPD, to one of the following four, randomly assigned interventions: Prolonged Exposure (PE); Stress Inoculation Training (SI); combined PE/SI; and wait list. Based upon the results, Feeny et al. conclude that participants with and without comorbid BPD benefited significantly from PE, SI, and combined treatments, although fewer participants with BPD met criteria for good end-state functioning compared to participants without BPD. A notable limitation of this study consists in the lack of generalizability of these findings to individuals with moderate to severe borderline pathology, as this investigation employed exclusion criteria similar to that of Clarke et al. (2008). Two additional studies, Schottenbauer, Glass, Arnkoff and Gray (2008) and Sachsse, Vogel and Leichsenring (2006), move toward therapeutic integration by advocating for the implementation of flexible, psychodynamic approaches in the treatment of individuals with PTSD and BPD, due to the diagnostic complexity presented by this population. Of note, Sachsse et al. (2006) refer to the relative efficacy of EMDR with high acuity patients yet offer the caution that trauma-focused work should be conducted on an inpatient unit for patients with active symptoms of self-harm. Research related to therapeutic integration offers notable contributions and will be discussed subsequently.

The diagnostic complexity and therapeutic challenges introduced by a comorbid diagnosis of PTSD and BPD urge a sophisticated response, which may be offered by therapeutic integration. Becker and Zayfert

(2001) forward a compelling conceptual argument for the integration of DBT with trauma-focused interventions by delineating the following benefits of such integration: increased confidence of the therapist in client resilience; emphasis on validation of the client, thus strengthening rapport; resolution of the paradox inherent in the treatment expectation that “avoidant” patients have the capacity to engage in exposure to traumatic material without supportive skill-building. Becker (2002) enhances his argument by conducting a case study of a 43-year-old female with Obsessive-Compulsive Disorder (OCD), PTSD, and BPD, who participated in trauma-focused CBT blended with DBT. The participant achieved impressive remission of OCD-, Borderline-, and PTSD-related symptomology at three year follow-up, thus allowing Becker to conclude that DBT may critically augment the tolerability of trauma-focused interventions among severely comorbid patients.

Korn and Leeds (2002) offer additional support for the notion of flexible methods in the treatment of complex pathology with the publication of two single subject design case studies, which demonstrated the effectiveness of incorporating the Resource Development and Installation technique into the course of EMDR. Korn and Leeds conclude that rigid and unyielding adherence to manualized treatments in the treatment of complex pathology may severely inhibit successful outcomes. Perhaps the most compelling evidence for integration may be found in the case formulations offered by Wagner, Rizvi and Harned (2007) and Linehan and Harned (2008), who provide anecdotal evidence for the efficacy of integrating Prolonged Exposure into traditional DBT treatment for individuals with comorbid PTSD and BPD. In recognition of the need for research pertaining to the treatment of moderate to severe Borderline pathology, Linehan and Harned (2008) describe two cases involving women with PTSD and severe Borderline pathology, as evidenced by the patients’ endorsement of recent self-mutilation and histories significant for multiple suicide attempts. The blended intervention of DBT and Prolonged Exposure, which was introduced subsequent to the achievement of initial stabilization via DBT, produced a significant decrease in PTSD-related symptoms, as well as symptoms of BPD at two year follow-up. Wagner et al. (2007) achieved similar results from two case studies, one of which was identical to a case referred to by Linehan and Harned (2008), which utilized a blending of DBT and Prolonged Exposure in a manner similar to that employed by Linehan and Harned. Despite the fact that the most

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compelling evidence for therapeutic integration derives from anecdotal case studies with limited generalizability, the argument for flexible, integrative methods certainly aligns with clinical intuition regarding the necessity of tailoring treatment to the unique needs of individual clients.

Conclusions

The above findings reflect the complexity of the question under investigation, thus rendering a unified analysis difficult; however, a central theme emerges from the findings. The degree of severity of borderline symptoms in patients with comorbid PTSD holds primary relevance to the current investigation, and, in fact, is explicitly identified by several studies as the dominant consideration in establishing optimal treatment interventions for patients with comorbid PTSD and BPD. The primary relevance of this theme extends to research lacking in an explicit reference to comorbid BPD, as many of such investigations make reference to the “tolerability” of trauma-focused interventions and, in some cases, hypothesize about the confounding influence of Axis II pathology on treatment outcomes. Based upon the findings included in this investigation, trauma-focused interventions, such as EMDR, carry moderate limitations due to the high rates of dropout and non-response associated with these interventions. Although the factors owing to these statistics are certainly multifaceted and complex, the evidence in support of utilizing “priming” techniques to increase tolerability of trauma-focused work is compelling. The observation of Becker and Zayfert (2001) strengthens the case for assessing the palatability of trauma-focused work, given that such an endeavor violates clinical knowledge concerning the avoidant and dissociative tendencies of individuals who have been traumatized, who may require preparatory work.

The exclusion criteria utilized by Clarke et al. (2008) and Feeny et al. (2002), whose findings support

the efficacy of trauma-focused interventions with borderline patients, loom large, especially when one considers the potential for harm posed by interventions imbued with a high potential for client regression. The caution of Sachsse et al. (2006) prompts important ethical considerations in the evaluation of treatment interventions with patients diagnosed with BPD, especially when one considers the high level of acuity associated with the diagnostic criteria for BPD. One might argue that the formal criteria for a diagnosis of Borderline Personality Disorder contained within the *DSM-IV-TR* (2000) excludes the possibility of a “mild” sub-group of borderline patients, given the prominence of self-endangering behavioral markers and high intensity thought and identity disturbances.

Despite the potential for harm engendered by trauma-focused work, the long-term benefits of such interventions, both for low and high acuity patients, have been demonstrated by formal investigation. In addition to providing critical support for the integration of trauma-focused work with severely comorbid patients, the case studies of Linehan and Harned (2008) and Wagner et al. (2007) identify the explicit goal of addressing a notable gap in the treatment literature pertaining to patients with BPD. Further research is needed to clarify the impact of severe and comorbid borderline pathology on the treatment of patients with PTSD. Despite the ambiguities revealed by the empirical treatment literature, the need for advocacy and empowerment of individuals who have been traumatized and subsequently diagnosed with BPD reigns conclusive. The commitment to social justice embraced by the field of social work endows the social work practitioner with the critical lens needed to identify and mitigate institutional sources of disenfranchisement. Whether an integrative or a manualized treatment intervention achieves selection, social work practitioners are well suited to execute the fundamental task of deciphering the intrapsychic, familial, and cultural sources of our patients’ wounds.

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Grief Support Group for Spouses of Deceased Iraq War Veterans

By Aaron J. George, Amanda Elliott, Jennifer Jennings, Kristin Cleland,
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Abstract

More than 4,000 U.S. soldiers have died in Iraq since the start of the Iraq War in March 2003. Many of these deceased military personnel have left behind spouses to grieve their losses. This article discusses the need for appropriate psychosocial services for these grieving spouses that neither re-traumatize them nor ignore the complex emotions they are experiencing. To this end, following is a description of this problem and a grief support model intended to help address it.

Introduction

“One of the greatest challenges of being human is dealing with the grief caused by the death of a loved one” (Castle & Phillips, 2002, p. 41). In American culture, the funeral serves as an important ritual in facilitating closure and helping family members and close friends deal with the complicated feelings of grief (Iri- on, 1990, 1991, as cited in Castle & Phillips, 2002). Not long after the service, however, people are expected to summon their strength and move forward. This is not always easy. Grief resulting from an expected death can be difficult to process. Murder can result in an even more complicated grief, a grief that feels especially unexpected and unnatural (Anderson, Marwit, & Vander- berg, 2005, as cited in Matthews & Marwit, 2006; Wort- man, Battle, & Lemkau, 1997, as cited in Matthews & Marwit, 2006). The death of a spouse or loved one due to war may also feel unnatural and unfair. As of May 11, 2009, there have been 4,287 American military deaths in Iraq since the start of the Iraq War in March 2003 (United States Department of Defense, 2009). Many of these deaths were brutal combat deaths. Spouses and loved ones of the deceased are frequently reminded of their losses by the media, making it difficult for their pain to heal.

Group Purpose and Guiding Principles

As healing professionals, it is critical for social workers to support individuals who grieve the loss of a spouse who died in combat. Support groups with specif-

ic parameters tailored to such a group may be essential. Some research suggests that survivors need to discuss their feelings in order to process their grief in an effective manner (Worden, 2002, as cited in Young, 2007–2008). Denial of emotions related to bereavement often leads survivors to feel burdened and overwhelmed. It is critical to create a safe group environment where members can discuss their thoughts and emotions in an effort to process their grief. By limiting the group to spouses of deceased Iraq war veterans, members should be better able to relate to each other’s experiences. This paves the way for the essential therapeutic factors of univer- sality and group cohesiveness.

Universality is the realization that one is not alone in one’s suffering. Such a realization is critical to the therapeutic process because it lessens members’ feelings of isolation and despair and connects them with people who share their struggles (Yalom & Leszcz, 2005).

Cohesiveness, the attractiveness of the group to its members, helps participants dedicate themselves to the healing work of the group (Yalom & Leszcz, 2005). The degree to which grieving individuals heal may depend on how well others receive their attempts to disclose their grief-related thoughts and feelings (Calhoun & Tedeschi, 2006; Dyregor, 2003–2004, as cited in Tedeschi & Calhoun, 2006). One necessary dimension of this group is to create an accepting environment where members feel free to tell their stories and to discuss memories of their deceased loved ones. Another requirement is that, with the use of proper therapeutic structure and techniques, the group will be better able to process grief in an adaptive manner.

Meeting Place

The support group can be facilitated in a therapist’s office, if large enough, or a meeting room. It may also be conducted in a free public space such as a church, community center, library meeting room, or any space quiet enough and private enough for members to feel comfortable disclosing personal information without outside interruptions. Because members may present with disrupted functioning due to their grief (Boelen,

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2006), a quiet, soothing atmosphere is essential. “The setting for the group can have a profound effect on the behavior of the group members and the conduct of group meetings” (Toseland & Rivas, 2005, p. 178).

Importance of Support Group

When an individual copes with a traumatic experience, such as spousal loss, it is common for the individual to feel isolated. The loss of a person, such as a spouse who was intimately familiar with the survivor’s past, can undermine the survivor’s self-definition and make it difficult for him or her to relate to others. This is the case because grieving persons often feel that a part of them died with their loved one and that others will be unable to relate to them on the deep level reserved for their spouse. Rather than engaging in social interaction, surviving partners may turn to isolation by ignoring or emotionally numbing a stressor (Neimeyer, 2002).

Support groups not only help minimize feelings of isolation but also foster an environment where normalization can occur. They are meant to help members manage traumatic life events and cultivate existing abilities—such as communicating verbally or processing feelings in written form—to cope with such events through mutual aid within the group (Toseland & Rivas, 2005). Groups that foster mutual aid create a shared environment where group members are at least temporarily alleviated of their feelings of isolation.

Accompanied by an experienced, skilled, empathic leader who is familiar with the military lifestyle (M. Harvey, personal communication, October 14, 2008) and who can facilitate a healthy, supportive environment, participants can safely share their experiences of loss and progress through the grief process. Further research suggests that the leader should convey “positive affect and attend “to positive aspects of a loss and surrounding circumstances,” as these actions “are associated with well-being” (Bonanno & Keltner, 1997; Davis et al., 1998; Folkman, 1997; Folkman, Chesney, Collette, Boccellari, & Cooke, 1996; as cited in Capps & Bonanno, 2000, p. 2) “and appear to help engender interpersonal support” (Keltner & Bonanno, 1997, as cited in Capps & Bonanno, 2000, p. 2). A healthy, supportive environment is necessary, one where members are attracted to the group and believe that what they say will be validated and kept within the group (Yalom & Leszcz, 2005).

There are some unique aspects to grieving the loss of a soldier. Military functions, systems, customs,

and processes affect the lives of those close to the soldier, and especially the surviving spouse, long after the death has passed because any reference to the armed forces may trigger memories of the military life, and therefore, memories of the deceased soldier. American flags, patriotic songs, military commercials, and other previously innocent sights and sounds become traumatic after the death occurs (M. Harvey, personal communication, October 14, 2008).

Description and Recruitment of Participants

The Iraq War casualty statistics noted in the introduction suggest a need for support of widows and widowers of deceased veterans. Moreover, the authors’ research uncovered limited grief support resources for spouses of deceased Iraq War veterans.

When composing such groups, it is advisable that the group be representative of the population and include demographic statistics for surviving spouses. This is done to ensure that no member is isolated racially, culturally, or on the basis of gender or sexual preference. For example, it is likely that the vast majority of the support group participants will be women, as approximately 98% of the U.S. soldiers killed in Iraq have been men (White, 2009). Thus, program coordinators must ensure that there are either several members of each sex, or that only one sex is represented. Otherwise, the lone representative of a particular gender will be vulnerable to isolation and potential scapegoating. Scapegoated members typically feel alienated and unsafe and are less likely to share with the group (Toseland & Rivas, 2005).

The leader must consider which characteristics may make people appropriate for the group and which may disqualify them (Yalom & Leszcz, 2005). To broaden the experiences of the group, ethnic and gender diversity should be welcomed. However, the facilitator must be aware of potential conflicts, such as the participation of a widow of Middle Eastern descent, which may trigger hostile reactions from members whose spouses died fighting a Middle Eastern enemy. In short, facilitators and program directors should use their judgment while striving for diversity without compromising the cohesiveness and compatibility of the group. Ideally, the group’s composition should emulate that of the outside world (Yalom & Leszcz, 2005).

In addition to the aforementioned potential for the scapegoating of male group members, men often have more difficulty adjusting to the grieving process (Stroebe, Stroebe, & Schut, 2001, as cited in Stroebe,

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Folkman, Hansson, & Schut, 2006), so the leader should encourage female members to be supportive of any male participants. If a leader believes a member would not fit in, due to the presence of antisocial or psychotic symptoms, or for any other clinical reason, appropriate services may be offered. Some people may not possess the interpersonal characteristics best suited for success in a therapy group. For individuals to participate most effectively, they “must have a capacity and willingness to examine their interpersonal behaviors, to self-disclose, and to give and receive feedback” (Yalom & Leszcz, 2005, p. 234). Verbal, social, and cognitive functioning levels, observed through standard pre-group screening and assessment, could be used to determine such a capacity.

The recruiting of group members could occur through veterans’ organizations such as the Veterans of Foreign Wars (VFW), United Service Organizations (USO), Tragedy Assistance Program for Survivors (TAPS), Gold Star Wives, and Blue Star Moms. Recruiting also can be done through other military-affiliated channels, such as military bases, chaplain services, and mental health programs. To facilitate referrals or the creation of need-based groups, community mental health and social service agencies near military bases should be informed of the group model.

Literature Review

Grief theorists have traditionally suggested that negative thoughts and feelings early in the bereavement process are central to mourning and that discussing these loss-related experiences is essential to future recovery (Bowlby, 1980; Lazare, 1989; Lindemann, 1944; Parkes & Weiss, 1983; Raphael, 1983, as cited in Capps & Bonanno, 2000). Traditional theorists have also held that failure to express strong negative feelings leads to long-term maladjustment (for reviews see Pennebaker, 1993a; Windholdz, Marmar, & Horowitz, 1985, as cited in Capps & Bonanno, 2000).

These traditional theories have been called into question, as recent research suggests that severe distress while grieving may not be as pervasive as once believed and that extreme negative expression in the months after a loss tends to indicate holding onto symptoms rather than resolving them (Bonanno & Kaltman, 1999; Bonanno & Keltner, 1997; Davis, Nolen-Hoeksema, & Larson, 1998; Lehman et al., 1987; Nolen-Hoeksema, McBride, & Larson, 1997; Wortman & Silver, 1989, 1990; Stroebe & Stroebe, 1993, as cited in Capps & Bonanno, 2000). Instead, expressing positive emotion and

recognizing the positive effects of a loss are linked with recovery (Bonanno & Keltner 1997; Davis et al. 1998; Folkman, 1997; Folkman, Chesney, Collette, Boccellari, & Cooke, 1996, as cited in Capps & Bonanno, 2000) and seem to help lead to interpersonal support (Keltner & Bonanno, 1997; as cited in Capps & Bonanno, 2000).

A quantitative review of grief support interventions suggests that therapy for the bereft is not effective and may even cause harm for those suffering from normal bereavement. However, the evidence does suggest that grief therapy is more helpful and safer for sufferers of traumatic grief (Neimeyer, 2000). Traumatic grief is defined as “grief resulting from the loss of a loved one (natural or transportation disaster, act of terrorism or mass murder, etc.)” (Free Online Medical Dictionary, 2009). This definition clearly fits the situation facing bereaved spouses of deceased Iraq War veterans.

The contrasting literature findings underscore the sensitive nature of grief support and suggest that each person is unique in his or her bereavement. According to Stroebe, Folkman, Hansson, and Schut (2006), there is no empirical evidence suggesting all people who suffer a loss require intervention. Thus, interventions must focus on those who are likely to suffer severe consequences. In a study of grieving spouses, Stroebe et al. (2006) identified three types of risk factors. Situational risk factors include the mode of death and the type of loss. For example, a sudden, unexpected loss would yield greater risk than the death of a person with a terminal illness. Personal risk factors include the personality of the griever and the relationship with the deceased. The sudden loss of a child or spouse entails more risk than that of a work colleague. Interpersonal risk factors include attachment style, gender, environment, and religious beliefs.

In their Dual Process Model, Stroebe et al. (2006) held that two types of stressors add to risk: loss-oriented stressors such as making funeral arrangements, and restoration-oriented stressors. These secondary stressors may include loss in economic status and role changes.

Golan (1975) asserted that the violent death of a soldier is both traumatic and sudden, regardless of the psychological preparedness of the widow. It is irreversible and unexpected and compounded by the young age, 24 years on average (Endelman, 2009). This suggests that most spouses of deceased soldiers are in their twenties as well, although no statistics were located. If this is the case, it seems likely that grieving spouses have had little experience with the sudden loss of a close family

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member. After the death, the spouse faces a transition crisis in which he or she must move from husband or wife to widow or widower and eventually must engage in personal involvement with others. The restoration issues are distinct. Widows must navigate a complicated bureaucratic system to apply for and receive government benefits due to them based on their loss. This causes the armed-conflict-related grief process to take years longer than for other mourners.

Boelen (2006) describes complicated grief (CG) as persistent symptoms of separation distress, such as yearning and preoccupation with the loss and traumatic stress that includes emotional detachment lasting longer than two months. Due to the aforementioned external stressors facing bereaved military widows, this population may fit the criteria for CG.

Three processes are identified as exacerbating CG: the insufficient integration of the loss into autobiographical knowledge, negative beliefs and catastrophic misinterpretations of grief reactions, and anxious and depressive avoidance strategies (Boelen, 2006). The three processes are co-occurring and persistent and need to be addressed for CG to be alleviated. A cognitive behavioral approach targets these processes.

Thus, a cognitive behavioral approach to grief therapy will be used, based on the notion that thoughts can supersede external stimuli—from situations, people, and events—in determining one's behavior and feelings (<http://www.nacbt.org/whatisbcbt.htm>, 2009). Through activities such as breathing techniques, self-soothing, and journal writing, the cognitive behavioral approach strives to change how grieving widows think, regardless of external circumstances.

Group Preparation

Leaders of any support group should consider a number of group elements as far in advance as possible to limit first-meeting glitches and to ensure fluidity of subsequent meetings. Most important, the group's purpose should be established. Compatibility between the sponsoring agency's resources, goals, and objectives and the group's purpose also must be assessed (Toseland & Rivas, 2005). The physical setting, size of the group, whether the group will be open or closed to new members after the first few meetings, and how often and for how long the group will meet should be decided before members are recruited. Payment and insurance coverage should be considered and discussed. A standard clinical assessment interview is suggested for each po-

tential participant before he or she is selected for participation. Such an interview may reduce the likelihood of premature termination, which can disrupt the therapeutic process for other members. Selected members should be prepared on the general expectations and procedures of their group (Yalom & Leszcz, 2005). Care should be taken to consider and implement all necessary pre-group tasks before the first meeting. Below is a detailed description of how this might occur.

Most groups meet once weekly (Yalom & Leszcz, 2005). Due to cost and time constraints, it is believed that weekly 90-minute sessions would be most effective. It is important to create continuity from meeting to meeting while keeping in mind that lengthy sessions may become taxing for leaders and participants. Yalom and Leszcz state that a number of therapists have found that at least 60 minutes is required for "the warm-up interval and for the unfolding and working through of the major themes of the session" (p. 283). Recognizing the time and cost limitations of managed care, the group will meet for a maximum of 12 weeks. This is clinically consistent with Yalom and Leszcz's suggestion that short-term bereavement groups may last from 12 to 20 weeks. Due to the intimate and sensitive nature of the subject matter, roughly eight participants should be recruited for a closed-meeting format that does not allow new participants to enter after the first two sessions.

Yalom and Leszcz (2005) suggest that a group composition of seven or eight members will prevent the richness and variety of interactions from being compromised. A group of more than eight may result in members feeling overwhelmed. Closed meetings will be necessary for cohesion, as well as for other therapeutic factors to bloom. Because the first two group sessions ideally see significant progress in the areas of trust-building and role identification, participants may regress to earlier group developmental stages if new, unfamiliar members are admitted after the first or second session. Later introduction of new members may cause other members to resist participation and to revert to approach-avoid behaviors that normally occur in the beginning sessions (Toseland & Rivas, 2005). Group meetings should be held in a private room with minimal distractions. Chairs should be positioned in a circular fashion so that each member can see all other members and the leader. The leader should be physically positioned as a member in the group, and nothing about the leader's position should indicate higher status (Yalom & Leszcz, 2005).

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Yalom and Leszcz (2005) stressed the importance of preparing the client for what is to be expected in the group. They suggested that the therapist work individually with potential group members in pre-group sessions to “clarify misconceptions, unrealistic fears and expectations; anticipate and diminish the emergence of problems in the group’s development; provide clients with a cognitive structure that facilitates effective group participation; generate realistic and positive expectations about group therapy” (pp. 294–295).

During the individual pre-group meetings, therapists may find it useful to include information on informed consent, to clarify the group’s purpose, and to work with each client on forming individual goals. Main points should be repeated, and therapists may send each client home with written information on the most important issues discussed. It also may be useful to role-play a possible group interaction and to explain the expectations of clients’ behavior during group sessions. The importance of attending each group session should be emphasized, and the therapist may ask the client to sign an attendance contract. The following original model of a grief and loss support group for spouses of military personnel who died in Iraq has been created for replication.

Beginning Phase

The primary goals of the first three group sessions are to create a sense of shared belonging between group members, to define the group’s purpose, to create a productive and cooperative environment, to discuss confidentiality, and to set and discuss all goals for the group. A skilled leader strives to anticipate obstacles to achieving these objectives. Most important, cohesion must be present before moving to the middle phase of the group process. Cohesion is made apparent through increased member disclosure, openness, and support for other participants. Without cohesion, the group will be unable to progress in a productive manner (Toseland and Rivas, 2005).

The group leader also must be aware of the aforementioned sensitivities that constantly surround widowed spouses after their loss has occurred, such as flags, news programs, references to the Veterans’ Association, and any other object that may be associated with the military or patriotism (M. Harvey, personal communication, October 14, 2008). The aforementioned individual pre-group sessions will alert the facilitator of each member’s sensitivities. These everyday occurrences are seen differently in the eyes of the widowed. Any

discussion of emotionally charged issues without the proper knowledge and skills to appropriately address them—such as crisis prevention and intervention techniques—can be detrimental to the group (Yalom & Leszcz, 2005).

The first group session is primarily focused on defining the group’s purpose of providing support and coping skills for grieving widows, introducing all members of the group, and creating an initial sense of shared belongingness by modeling empathic interactions (Toseland and Rivas, 2005). To foster a safe atmosphere, the leader facilitates simple round-robin introductions in which members are free to disclose as much or as little information as they desire. The leader may state or list possible information for members to share—such as name, age, how long the member’s partner has been deceased, and the reason for joining the group—but he or she should make it clear that nobody is required to disclose this information. Given the specific nature of this group, members may be interested to know whether the leader has shared their experience of losing a spouse and the accompanying hardships. Thus, the leader is advised to disclose this information during introductions.

It is important that the leader be a veteran, have experience working with widowed spouses, know a military widow or widower, or find other connections to members’ experiences. After introductions, the leader must define the purpose of the group and his or her role in it. Since grief is sensitive and painful, the leader must immediately begin to instill hope by presenting the group’s purpose in the most positive fashion possible. To do so, the leader should focus on objectives to be accomplished (Toseland and Rivas, 2005), rather than on the avoidance of painful environmental stressors that are unlikely to disappear. The leader begins with an overview of the agency sponsoring the support group and its mission and rules for members, then discusses the importance of confidentiality and its limits, and concludes with a contract for participation.

Becker-Weidman (2006), studying children with attachment disorders, found that dyadic therapy is effective for treating traumatized patients. Dyadic therapy seeks to help traumatized individuals learn to self-regulate their emotions through working in pairs. Given that repressed grief often causes neurotic behaviors and regression to previous developmental stages, adult participants may be functioning at childhood psychosocial levels (Aiken, 2001). Thus, dyadic therapy may be helpful in working with this client base. (However, the

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group leader must assess the functioning levels of each member and the group as a whole to test the appropriateness of working in dyads. For example, high-functioning adults may not be as enthusiastic about engaging in dyadic work.) Further, dyads are recommended to help members grow comfortable with sharing in the physical space and to help them overcome fear of speaking in front of a large group, which 56% of Americans possess (Scaredy cats, 1997).

Given the trauma experienced by grieving participants as they begin the support group, a trust-building icebreaker activity with the members arranged in dyads is recommended. To begin the activity, each member may pick a fruit that is most like them and describe how he or she is like that fruit ("I picked a pineapple because I have a prickly, defensive shell on the outside, but I am sweet and complex on the inside."). Next, members of each dyad will discuss with the entire group what they learned about each other. Because members are likely to reveal something about themselves in their comparison to a particular fruit, they are displaying trust in the other members to receive this personal information in an accepting manner and are fostering an atmosphere of trust in the group.

Once each member has had a chance to speak, the leader should facilitate a discussion regarding trust, as Yalom and Leszcz (2005) believe successful group therapy is "characterized by trust, warmth, empathic understanding, and acceptance" (p. 54). The worker will cover how shared learning and understanding can create the trust that is needed for members to profit from the group experience. The leader should also discuss how trust is vital to the progress of individual members and the group as a whole. The final goal for this meeting is for all participants to begin to feel comfortable with other group members.

At the end of the session, the members will be asked to complete the Inventory of Traumatic Grief (Boelen, van den Bout, de Keijser, & Hoijsink, 2003). This inventory will be readministered in the final group stage to assess members' progress through the course of the treatment.

The second session is focused on fostering cohesion through understanding the needs and goals of each member. The following activity was created by Dallam (2008) to form trust, gauge members' needs, and assess group dynamics in the early stages of a grief support group. The worker begins by giving each member a large sheet of paper with a list of statements to complete (Appendix A). If a member does not wish to

participate, this is an opportunity for the leader to engage the participant by gently inquiring about his or her abstention from the activity. After members have answered and written their responses on the sheet, the leader asks all members to hang their sheets on a wall and then to sit back down. Next, the leader will read aloud each sheet and ask whether anyone was impacted by the answers of another member. If so, they are to stand by that sheet of paper for the entire group to see. If there is an imbalance in the support for particular papers, the leader must support and validate the feelings of those who submitted the less relatable answers. This is a vital step in mitigating any conflict or isolation that may arise for certain members. In the end, the leader should be able to indicate at least one shared experience by each member, paving the way for a discussion about how nobody is alone and how each participant has something to offer and to gain.

For a related homework assignment, the leader may instruct members to think about their reactions to the activity and to record them on paper. The members should focus on the goals they want to achieve before the group disbands and should be asked to outline the steps they believe will help them achieve their individual goals. This assignment will act as a preliminary needs assessment that will allow each member to privately reflect on deep issues surrounding his or her grief. It will also assess how well members can set goals on their own and how much the leader must intervene. Each member needs to set goals that he or she can achieve. If an individual sets goals that are too lofty, he or she may become overwhelmed and find progress difficult (Yalom & Leszcz, 2005). The worker should discuss with each participant the attainability of his or her goals.

The third session will include identifying the needs of each member and determining how they will be met. The leader should briefly recap the previous session, stressing members' reactions to the group activity. The worker should then ask members to share their homework assignments if they are comfortable doing so. To cultivate a sense of shared experience, similarities between presented goals should be emphasized. If no goals are similar, the worker should acknowledge that while the members have different goals, they all likely share the common experiences of being separated from their spouse during the war, losing a loved one, and struggling to recover from the loss.

At this time, the worker should facilitate the discussion and direct the planning process for each member. The leader should also help members identify

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how they plan to measure success in achieving their goals. When the exercise concludes, members should be aware of their needs and goals and should have a comprehensive understanding of their individual plans. Members likely will be ready to proceed to the next group phase. If not, the leader must adjust the timeline accordingly, taking care not to rush the grieving process.

Middle Phase

The literature does not support the application of one particular theoretical model for treating persons experiencing complicated grief. However, Boelen, van den Hout, and van den Bout (2006) introduced a cognitive behavioral framework for developing hypotheses for understanding complicated grief and the factors that underlie it and which can be addressed in therapy. Boelen, van den Hout, and van den Bout's research suggests that three processes are critical to the development and maintenance of complicated grief: "(a) poor elaboration and integration of the loss into the database of autobiographical knowledge, (b) negative global beliefs and misinterpretations of grief reactions, and (c) anxious and depressive avoidance strategies" (p. 111). Cognitive behavioral therapy's ability to target maladaptive thinking and behavior patterns is believed to be helpful in facilitating positive change for survivors of complicated grief (Boelen, de Keijser, van den Hout, & van den Bout, 2007). The five cognitive-behavioral factors, explained below, will be utilized for adult bereavement treatment as described by Powers and Wampold (1994). Coping strategies and activities based on the five factors will be implemented to provide members with tools for progressing through complicated grief.

The first coping strategy relates to the survivor's ability to execute physical self-care. Survivors of grief are especially vulnerable to cognitive disruption and disorientation related to self-care. A survivor is at high risk for abusing alcohol or other drugs, as well as for failing to get proper rest and nutrition. Self-care is vital to the survivor's adjustment process; without it the negative effects of his or her loss will be compounded (Powers & Wampold, 1994). The fourth session will focus on helping members identify thoughts, feelings, and behaviors related to their grief and how these may hinder their ability to care for themselves.

The leader should also help members become aware of their tendencies to associate everyday events with the trauma and to monitor themselves when they

are doing so (Toseland & Rivas, 2005). This builds awareness about external stressors, helping members gain control of their responses to the environment. The leader will facilitate this self-monitoring by guiding members to record the thoughts they deem negative and to document the feelings and behaviors that occur immediately following those thoughts. The data from this exercise should be utilized for group discussion with the goal of revealing thoughts that are "exacerbating or maintaining unwanted feeling states and behavioral patterns" (Toseland & Rivas, 2005, p. 286). Members also will be asked to select one self-caring behavior they would like to implement, desist, or change. They may share the behavior with the group or keep it private. The worker will assign the self-care behavior change as homework. Members will be asked to identify positive or negative thoughts they may experience prior to engagement in the behavior. The goal of this exercise is to increase awareness of how thoughts directly impact behavior. When an individual becomes aware of the negative thoughts, the thoughts lose control over the individual. This awareness of negative thoughts is critical to the healing process, as "a preponderance of negative thoughts and emotions early in the grief course predicted more severe disruption in daily functioning over time" (Bonanno & Keltner, 1997; Davis et al., 1998; Lehman et al., 1987; Nolen-Hoeksema et al., 1997; Stroebe & Stroebe, 1993; Wortman & Silver, 1990; as cited in Capps & Bonanno, 2000, p. 17).

The fifth session will begin with a 30-minute discussion of the self-care behavior assignment from the previous week. Members are encouraged to share their experiences and to continue to monitor and/or modify the self-care behaviors they wish to target. Next, the leader will introduce the second coping strategy: the "survivor's ability to identify predominant themes of grief" (Powers & Wampold, 1994, p. 3). This strategy provides members with a proactive approach to becoming aware of their reactions and responses to their grief, "thus minimizing their sense of helplessness and disorganization" (p. 4).

Teaching a technique known as *cognitive self-instruction*, the leader asks members to consider the predominant themes of grief they endure and to describe their subsequent feelings and behaviors. Since "cognitive self-instruction refers to helping members use internal dialogues and covert self-statements for solving problems and coping with difficult life events" (Toseland and Rivas, 2005, p. 289), the members will be asked to choose a statement or mantra that they will re-

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peat to themselves when encountering stressful reminders of their loss. Examples may include “I can get through this,” “I am proud of my spouse’s courage,” or “I can continue forward in my life.” Members will be encouraged to share their self-statements with the group and to utilize them when faced with a stressor.

After briefly recapping the previous meeting, the leader will present during this sixth session the third cognitive grief-management strategy, the “attribution of personal meaning to the loss” (Powers & Wampold, 1994, p.4). The leader presents the following example of what it means to attribute personal meanings: In many cultures, families partake in a ritual—such as a shiva or a wake—that symbolizes the passing of a loved one. The purpose of this ritual is to ascribe personal meaning to the loss of a loved one. Personal meanings do not need to include religious or spiritual content and may occur with regular frequency, such as keeping a picture of the deceased close at hand, visiting a special place that is reminiscent of the deceased, or speaking of the deceased to friends and family. The attribution of personal meaning to loss can also include the survivor’s finding solace and reward in helping others as well as attempting to prevent the tragic experience from happening to others. Groups such as Mothers Against Drunk Driving and Gold Star Wives (wives of deceased Iraq War veterans) are examples of attributing personal meaning to loss by helping others. Cathy Patterson-Sterling (n.d.) noted that “when people find value in painful experiences, then these situations somehow become worthwhile and the heartache that they endured relates to a higher purpose. The result is that magnificent spiritual meaning can emerge from the darkness or despair of tragedy.” Members will be asked to create at home a symbol or to write a brief description of how they attribute personal meaning to their loss and/or help others progress through their suffering.

The seventh session will begin with members sharing their symbols or short essays regarding their personal attributions to their losses. The leader will then introduce the fourth coping strategy: the ability to cognitively differentiate letting go of the grief from forgetting the loved one. This strategy helps the survivor tolerate feelings of relief without feeling he or she is devaluing the importance of the deceased spouse (Powers & Wampold, 1994). The worker will engage members in a discussion pertaining to memories of their loved ones. This strategy should be accompanied by asking members to record and challenge automatic thoughts, which helps connects thoughts to moods and behaviors. The

leader also needs to challenge the automatic thoughts, which helps members identify distorted thinking and explore the deeper personal assumptions underlying their automatic thoughts (Yalom & Leszcz, 2005).

Participants will be directed to document in their journals the negative automatic thoughts they can identify when they find themselves experiencing relief from distress. They will then challenge the automatic thoughts with a more positive, self-accepting thought. For example, the thought “how can I be feeling pleasure when my spouse just died?” is identified and countered with a more accepting thought such as “My spouse would want me to experience feelings of relief and pleasure.” This is aimed at encouraging survivors to accept positive thoughts without guilt.

The facilitator begins the eighth session by inviting members to share their journaling activities, allowing them to present the automatic thoughts they recorded and how they challenged these thoughts. The worker will then explain the fifth coping strategy, which involves “the ability of the survivor to modulate the experience of the distressing components of grief” (Powers & Wampold, 1994, p. 5). This strategy examines the survivor’s ability to incorporate grief-related activities—such as crying, thinking about the deceased, or visiting the cemetery—with normal, day-to-day activities. To help members cultivate this capacity, the leader asks the group to create a list of adaptive coping skills. The worker might obtain members’ permission to record, photocopy, and distribute the coping skills that are presented. The list will assist members in participating in daily activities while continuing through the grieving process (See Appendix B for a sample list of coping skills.).

Termination Phase

Several goals accompany the final stage of this support group. First, the leader will focus on reducing members’ dependence on the leader and on one another. The leader should also strive to help members identify areas of progress and help them recognize that they may continue to use adaptive personal techniques after the group has reached completion. Also, the termination period is intended to prepare clients to face and overcome—without group support—potential triggers to maladaptive thought patterns and behaviors. The leader must also lessen the attractiveness of the group, so that members are not dependent on it, and ensure that no

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feelings or issues that members wish to discuss are left unaddressed (Yalom & Leszcz, 2005).

The leader should allow four sessions for the termination process. As Toseland and Rivas (2005) noted, participants should be notified as early as possible and should be frequently reminded of when termination will occur. This helps prepare members for completion and allows ample opportunity to address everything they wish to share. The transition from feeling supported by the group to experiencing greater self-reliance should be as smooth as possible.

Beginning with the ninth session, the leader will engage the group in a discussion aimed at encouraging members to acknowledge the finite nature of their time together. One approach is to direct clients to draw or write down an image of how they see themselves in five weeks—one week after the group has concluded. The goal is for members to portray themselves in a stable, self-autonomous light. The leader should encourage supportive sharing from all members, as they will hopefully reassure one another based on growth that has been witnessed over the past several weeks. The group may challenge a member in a supportive way, asking the person to articulate a plan for confronting the inevitable environmental stressors to come.

The 10th session may include a final check-in time for members to look back and determine their efficacy in achieving group and individual goals. The objective at this point is for members to be very close to meeting their goals—although the leader must be supportive and reassuring to those who are not close—as the final two sessions are focused on closure and preparation for the future. By being less available to and less protecting of the members, the leader successfully decreases the attractiveness of the group and lessens the intensity of relationships among members. Due to a likely disruption in members' functioning as a result of their grief (Boelen, 2006), however, the worker must take care to avoid completely isolating members. The leader should ensure that all members are given attention without allowing a single issue or individual to obstruct the termination process. To this end, the worker must limit discussion time, briefly summarize contributions, and strive for closure on each issue (Toseland & Rivas, 2005).

By the 11th session, members should be nearly ready to leave the group behind. The leader needs to monitor clients' progress, assessing how attached to the group each person appears to be. Those who are less de-

pendent are better prepared for termination (Yalom & Leszcz, 2005).

If the Inventory of Traumatic Grief (Boelen et al., 2003) was issued as a pre-test during the beginning group phase, it should now be readministered as a post-test. Before and after responses are compared to provide evidence of progress and to instill confidence in each member and his or her ability to cope with the loss without group support. In the event that a member is not ready to move on, the leader should be prepared to provide referrals for appropriate services such as case management, individual therapy, and psychiatric evaluation.

The 12th and final session should bring closure to the group and leave members feeling positive. A possible closure activity is to share in a final meal in which each member comments on how the group experience felt. In addition to sharing their feelings and praising the other members for their progress, speakers should mention triggers likely to lead themselves and others to maladaptive behaviors. As noted in the cognitive behavioral-based plan for the middle phase of treatment, members reinforce hope in their peers by challenging and correcting irrationally negative thought patterns and by encouraging positive thoughts and behaviors (Powers & Wampold, 1994). The leader is likely to experience strong feelings at this time as well. Whatever he or she decides to share, it must be directed toward goal achievement.

Members may also write letters addressed to themselves or to their deceased spouse, touching on their current feelings, the struggles they have overcome through the course of treatment, and how they plan to deal with future struggles related to their loss. Each group member may then place his or her letter in an envelope and seal it, to be opened at a later date. As Young (2007–2008) noted, bereavement writing groups have helped members identify and deal with challenging aspects of grief. Reading the letter in itself may provide healing, and it may also encourage the practice of writing as a therapeutic tool after completion of the group.

The leader should avoid bringing up new items of business when closing the group (Toseland & Rivas, 2005). However, he or she should make individual members aware that they may contact the sponsoring agency for future services. The leader may also consider scheduling reunions that allow group members to periodically reconnect with one another. Whatever is decided, it is imperative that members be treated with sensitivity and that they do not perceive the leader is abandoning them, given the intense emotions associated with

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the death or separation of a loved one (Cardenal, Sanchez-Lopez, & Ortiz-Tallo, 2005).

Addressing Self-Termination

As with any group, clients may self terminate for various reasons. Although there does not appear to be a “typical” grieving person (Breen & O’Connor, 2007), the research suggests that grief does tend to lead to vulnerability (Briller, Schim, Meert, & Thurston, 2007–2008). This makes it especially critical for the leader to work toward some measure of closure with the individual who self-terminates. Ideally, the leader will be able to convince the person to participate in one more session. Given the universality and instillation of hope (Yalom & Leszcz, 2005) offered by members in a support group, the facilitator is more likely to be effective if he or she is able to involve the group in an intervention aimed at achieving closure. The group members may write letters to the person, highlighting stories shared and progress made during the group’s time, as well as advising on where to turn for help.

After Care

Post-group support may come from interactions with former fellow group members. The leader may discuss this possibility with the group during one of the last sessions, making clear that any interaction among members is separate from the group that was sponsored by the agency and led by the worker. Since the leader and agency cannot be involved in the personal interactions between former members, safety and confidentiality cannot be guaranteed. However, a study by Caserta and Lund (1996) concluded that people who reestablished contact with former fellow group members were less lonely than they had been prior to these interactions. The members also reported finding continued contact satisfying, and 58% of participants continued contact with former group members two years after the group’s conclusion. Many said they valued sharing and maintaining relations with others who had also experienced loss, even if they did not often discuss their losses. Thus, there is evidence suggesting that maintaining contact may be a protective factor for individuals after termination. The leader must also help members find support from other outside sources, including friends, family, social workers, therapists, psychiatrists, physicians, neighbors, churches, and veterans’ associations.

Indicators of Success

In an Internet-based trial of cognitive behavioral therapy for complicated grievers, Wagner, Knaevseldrud, and Maercker (2006) identified three symptoms of complicated grief: intrusion, avoidance, and failure to adapt. The study required grieving subjects to participate in three phases: exposure to bereavement cues, cognitive reappraisal, and integration and restoration. In exposure to bereavement cues, subjects wrote a narrative of their story in the first person and present tense. In the cognitive reappraisal stage, they were instructed to write an encouraging letter to a friend in order to define a new role for themselves. In the final stage, subjects reflected on the process, how the loss had changed them, and how they planned to cope in the future. The study concluded that cognitive behavioral therapy resulted in a statistically significant reduction of intrusion, avoidance, and failure to adapt. (These changes were measured using the Impact of Events Scale, Appendix C).

The participants became grief-support experts and shared their narrative with others suffering from complicated grief (Wagner et al., 2006). Gold Star Wives exemplifies this type of support, as it relies on the participation of members and their sharing of grief narratives to help others who are experiencing loss. Using chat rooms, clients discuss their loss, their roles, and the system they find themselves navigating (Phillips, 2005).

Discussion

The biopsychosocial-spiritual burdens carried by spouses of deceased Iraq War veterans are many, and a multitude of hurdles stand in the way of their well-being. Two of the most common obstacles are reliving trauma daily and struggling to become financially stable as they attempt to navigate a large, unequipped bureaucratic system. While concern for the well being of these widows and widowers was the primary impetus for this grief support group model, one cannot help but wonder what burden society at large may have to bear for the deaths of thousands of spouses, and, in many cases, parents.

It appears the social work profession is uniquely situated to address this potential social problem, given its commitment to social justice and the person-in-environment dictum. It is the authors’ hope that social workers, veterans’ groups, medical professionals, service agencies, and the government become aware of the model presented in this article and seek to borrow from and improve on it. No less important, the authors hope

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that awareness of this model will foster dialogue and research that addresses the critical social issues linked to treating the surviving victims of war-related loss. Finally, the model may be considered for application to the

larger population of any individuals confronting the loss of loved ones who have been killed on American soil or elsewhere.

Aaron George is scheduled to complete the MSW program in December 2009. His second-year internship was with the Mental Health and Addiction Services department of Heartland Health Outreach in Chicago's Uptown neighborhood. He worked primarily with low-income dual-diagnosis participants, facilitating treatment groups, counseling individuals, and assisting with case management services. He is primarily interested in working with adults who have mental health and/or substance abuse issues.

Amanda Elliott is an MSW student specializing in Mental Health. She has over 8 years experience in the social service field with experience working with developmentally disabled adults, at-risk youth and teens and adults who have suffered from eating disorders. She is currently interning at St. Mary's of Nazareth where she provides counseling to individuals, families, couples, and groups. Ms. Elliot will be graduating from Loyola in December of 2009. She has an interest in working with adults with mental illness in the future and has a strong passion for feminist theory/women's issues.

Jennifer Jennings is an MSW student with Loyola University Chicago. She began her career in Social Services at the age of fifteen when she volunteered at a homeless shelter for women. Since then Jennifer has been particularly interested in working with at risk populations. For the past four years she has served as administrative support to the Illinois Department of Children and Family Services/ Erikson Institute Early Childhood Unit, a collaboration which monitors and ensures the developmental and social emotional well being of children in care ages 0-5 across the state of Illinois. Upon graduation, Ms. Jennings plans to pursue her doctorate and continue to work amongst vulnerable populations.

Kristin Cleland graduated from Loyola University in 1994 with a BSW, and worked in the field of social work for 14 years as a case manager for the mentally ill adult population. She worked in Psycho Social Rehab programs, with an emphasis on dually diagnosed clients, among the homeless at Safe Haven in Uptown, in a long term group home in the Uptown community, and then in Evanston at an Intermediate Care Facility. She recently completed her 1st year internship at a housing program in Evanston, assessing homeless individuals and nursing home residents on their ability to live independently. Ms. Cleland has approximately 6 years combined experience working among the mentally challenged and developmentally disabled adults and adolescents, from both prior to her BSW and afterward.

Matthew Brown completed the MSW program at Loyola University Chicago in August 2009, specializing in Leadership and Development in the Social Services. His second year internship was with Corporation for Supportive Housing, where he assisted their Re-entry Initiative. He worked side-by-side with program managers organizing the second Governor's Reentry Collaborative Housing Committee meeting, along with developing numerous resource websites, a statewide model for Re-Entry Community Profiles used by legislators, and a Chain of Custody Model for State IDs lost in the correctional system. He is currently employed as the new Program and Operations Manager at EZRA Multi-service Center in Uptown.

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Appendix A

Dallam questions (revised for the purposes of this group)

I feel most scared when _____

I have the hardest time talking about _____

I feel responsible for _____

I blame _____

Something I have not done since the passing is _____

What I miss the most is _____

The most important thing I want to tell other spouses in my situation is _____

I just want to be able to feel _____

(From Dallam, 2008)

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Appendix B

Coping Skills for Difficult Moments

- 1) Be patient with yourself. Healing is a process.
- 2) Call a friend or family member for support.
- 3) Pray or meditate.
- 4) Breathe deeply while focusing on inhaling and exhaling.
- 5) Write down positive memories of your lost loved one.
- 6) Write a letter to your grief (visualize grief as an entity separate from you).
- 7) Write a list of what you are thankful for in your life.
- 8) Speak an inspirational quote out loud as your mantra or write the words repeatedly.
- 9) Post quotes/affirmations on your bathroom mirror or refrigerator.
- 10) Consider individual therapy to supplement support group meetings.
- 11) Call your therapist for an extra session, if needed.
- 12) Use message boards and/or chat rooms for those struggling with grief.
- 13) Take a walk, stretch, or do yoga.
- 14) Allow yourself to relax—listen to music or take a bath.
- 15) Pamper yourself with a pedicure, manicure, massage, or facial mask.
- 16) Write down your thoughts/struggles in preparation for the next group meeting.
- 17) Imagine the words you would offer another who is struggling with grief.
- 18) Speak the words (derived from #17) aloud to yourself.
- 19) Lose yourself in a book—possibly an inspirational piece of literature.
- 20) Read a self-help book—keep the most helpful pages bookmarked!
- 21) Contact your pastor or attend a religious/spiritual service.
- 22) Sing loudly—whether you sing well or not (promotes catharsis).
- 23) Drum—African drums are wonderful for expelling frustration.
- 24) Challenge negative thoughts by writing or speaking opposite positive thoughts.
- 26) Speak positive thoughts out loud, record and listen to them repeatedly.
- 27) Involve yourself in volunteer work—focus on helping another.

For those who are still struggling:

- 28) Contact your group leader for additional supportive resources.

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Appendix C

Impact of Events Scale—Revised

Instructions: The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you *during the past 7 days* with respect to the disaster. How much were you distressed or bothered by these difficulties

		Not at all	A little bit	Mod- erately	Quite a bit	Extremely
1	Any reminder brought back feelings about it.	0	1	2	3	4
2	I had trouble staying asleep.	0	1	2	3	4
3	Other things kept making me think about it.	0	1	2	3	4
4	I felt irritable and angry.	0	1	2	3	4
5	I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6	I thought about it when I didn't mean to.	0	1	2	3	4
7	I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8	I stayed away from reminders about it.	0	1	2	3	4
9	Pictures about it popped into my mind.	0	1	2	3	4

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10	I was jumpy and easily startled.	0	1	2	3	4
11	I tried not to think about it.	0	1	2	3	4
12	I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13	My feelings about it were kind of numb.	0	1	2	3	4
14	I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15	I had trouble falling asleep.	0	1	2	3	4
16	I had waves of strong feelings about it.	0	1	2	3	4
17	I tried to remove it from my memory.	0	1	2	3	4
18	I had trouble concentrating.	0	1	2	3	4
19	Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20	I had dreams about it.	0	1	2	3	4
21	I felt watchful and on guard.	0	1	2	3	4
22	I tried not to talk about it.	0	1	2	3	4

(Horowitz, Wilner, & Alvarez, 1979)

Dissertation Abstracts

Congratulations and best wishes to Shamma Juma AlGendi Al Falasy, Jacqueline R. Anderson , Jeffrey J. Bulanda, Kyung Mee Choi, Gretchen Witte Glader , Cynthia Grant, Frederick W. Gross, Carol Jarvis, Heather Jones, Alexandra Jane McCourt, and Louise Presley. 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.

Perceiving and Utilizing Western American Social Work Theories in the Muslim Arabic World

By Shamma Juma AlGendi Al Falasy

Using grounded theory method, five Muslim Arab social workers/educators in the United Arab Emirates, were interviewed to determine how do they perceive and utilize western American social work theories in their practice and teaching. The study indicated that there is an absence of using and teaching Western American social work theories in the Muslim Arabic World. Two reasons were behind the absence of theories in the Muslim Arabic World, first is the differences between the Western American Social Work Theories and the Islamic Arabic Values. Second is, the inadequate knowledge sources. As a result the study suggests the need for forming an Islamic Arabic Social Work Model for the Muslim Arabic world. The construction of the new Islamic Arabic social work model requires the combination of Islamic Arabic values and modified Western American social work theories.

The Nature of Hope Among Women who Have Experienced Homelessness

By Jacqueline R. Anderson

As found in the literature review, hope is a multi-faceted, multi-dimensional concept that is unique to the human experience. Hope has been found to be a significant factor in the quality of life of persons who have debilitating and/or terminal illnesses, severe mental illnesses, and those who have experienced trauma and loss. However, this dissertation attempts to explore how hope is experienced by women who are, or who have been homeless in an effort to understand how hope “operates” in this population of marginalized and unaccommodated women. How does hope “look” in this population? Has hopefulness been fleeting or constant through the journey of homelessness? What kinds of things have instilled and/or facilitated hope for these women? Not overtly stated, but implied is the theme of what clinicians can do to be purveyors of hope for women who experience homelessness.

Women who experience homelessness often live with many issues including poverty, compromised physical and mental health, substance abuse and dependence, and problems with their primary support network. Gaps in homeless services contribute to the problems that are faced by these women. This dissertation attempts identify the nature of hope and the ways in which hope is manifested for these women as they struggle to exit homelessness successfully and permanently. Fifteen women who receive services at a social services agency in Chicago, Illinois are administered the Herth Hope Scale (1992), and an open-ended interview. Both quantitative and qualitative methods were utilized to explore each woman’s experience of hope in the context of homelessness. In addition, a consideration of the policies that inform homeless services were discussed and reviewed to shed light on homelessness as an internal, interpersonal, and societal phenomenon.

“Real Talk:” Findings From a Youth-Led Evaluation of an After School Program

By Jeffrey J. Bulanda

After school and mentoring programs are increasingly seen as instrumental in serving as protective factors for disadvantaged youth. The present study has utilized an innovative approach to evaluating an after school program: youth participatory evaluation. Findings from this evaluation not only provide feedback about the program, but also information about the nature of self-determination amongst inner city adolescents and considerations in using youth-led evaluation methods. Central findings include: 1) Severely disadvantaged youth have identifiable strengths and greatly benefit from programs supportive of their basic psychological needs in order to tap into their full capabilities; 2) Youth participation shows the capacity to shift from extrinsically motivated to

intrinsically motivated when a program meets the basic psychological needs of the youth; 3) Healthy caregiving and caregetting experiences help facilitate the development of youth's capacity for empathy and compassion in relationships; 4) Self-determination theory has practical implications for youth program development and clinical interventions; 5) Youth are capable of participating in program evaluation and youth-led program evaluation has both positive effects on the youth and the program. Implications of the findings are considered for the micro-, meso-, and macrolevels of intervention.

Transcultural Psychotherapy: Clinical Issues in Working With Korean Immigrant Women

By Kyung Mee Choi

This study examined clinical issues relevant in working with Korean immigrant women through analysis of two cases using in-depth case studies with secondary data. The sample cases for the study consisted of two Korean immigrant women who received psychological treatment from transcultural perspectives. The cases were analyzed by two inter-raters who have more than ten years of clinical experience and are bilingual in both Korean and English. There were twelve themes, including twenty-two sub-themes, which emerged from the data analysis: acculturation, separation-individuation, parent-child relationships, self-esteem in Confucianism, sexuality, shame, guilt, *chemyŏn*, *han*, *hwa-byŏng*, *hanpuri*, and culturally sensitive practice.

The following clinical issues presented by thematic analysis of the two cases were examined: (1) Applicability of psychodynamic theories from transcultural perspectives in working with Korean immigrant women, (2) Influence of acculturation and separation-individuation of Korean immigrant women and conflicts with their children, (3) Conceptualization of the terms of self-esteem, sexuality, shame, guilt, *chemyŏn*, *han*, *hwa-byŏng*, and *hanpuri* in intervening with Korean immigrant women.

Implications for the study were presented in terms of social work practice and education, including modification of Western theories, conceptualization of cultural norms, as well as community education and mental health policy. The findings of this study suggested that psychodynamic approaches such as self-psychology and object relations theory, as well as non-psychodynamic approaches such as Bowen systems theory based in culturally sensitive practice are applicable to Korean clients, although the two Korean study participants would not necessarily be representative of Asian groups as a whole. The study presented the necessity for social work practitioners to conceptualize cultural phenomena that have been seen in Korean culture such as *han*, *hwa-byŏng*, and *hanpuri* through developing understanding of the unique backgrounds of their Korean clients, considering the historical, political, social, and cultural factors which Korean American women bring to the treatment setting. Social work practitioners need to network with Korean churches to provide mental health education for Korean immigrants because Korean Americans are more likely to cope with problems by engaging in religious activities. The findings suggested that social work practitioners should advocate for public policies that create more mental health resources and develop prevention programs for Asian Americans by funding more research studies. The limitation of the study and future research were also addressed.

The study addressed intergenerational and intercultural conflict that Korean American women experienced with their children, and psychological pain that they have accumulated in the relationships with their husbands in Confucian society. The effectiveness of psychodynamic approaches for Korean immigrant families based on Asian cultural values of therapeutic approaches to Asian immigrant families was demonstrated.

Understanding Children's Communications in the Diagnostic Formulation of Treatment: How Do We Hear What Children Want?

By Gretchen Witte Glader

This is a content analysis of published case histories specifically designed to examine the way in which practitioners understand and interpret children's communication in the therapeutic sessions in order to explore how clinicians discuss what they think the child client wants to get out of therapy and how clinicians use their understanding of those expressions in their diagnostic formulations. This comparative analysis focuses on explicit theories and diagnostic formulations within the practice of several highly respected and long studied clinicians who have oriented themselves within different theoretical perspectives.

**An Exploration of the Interpersonal Research Experience of
Participants with Schizophrenic Disorders: A Mixed Method Study**
By Cynthia Grant

This retrospective mixed-method study explored the subjective experiences of 36 individuals with a schizophrenic disorder who had previously participated in face-to-face social, behavioral or psychological research. Participants completed an in-person semi-structured interview containing quantitative rating scales with concurrent qualitative explanations to describe their prior research experience, perceptions of the research relationship, and similarities and differences between research and therapy. Subjects described an overwhelmingly positive experience participating in research, yet reported higher levels of stress associated with research than identified in previous studies. Subjects acknowledged clear demarcation between the roles of a researcher and a psychotherapist. Study results provide direction for future researchers regarding the ethics and relational dynamics of research participation for subjects living with a schizophrenic disorder.

**A Phenomenological Study of the Experiences in Coping with Critical Events by Urban
First Responders in a Metropolitan Area**
By Frederick W. Gross

This grounded theory study explored the coping experiences of twenty male urban first responders. Participants were asked to describe their significant critical incidents and how they coped and made meaning (Van Manen, 1990) in their lives. The researcher analyzed narrative data from single, intensive, semi-structured interviews lasting ninety to one-hundred twenty minutes (Charmaz, 2006). The study embraced a qualitative phenomenological tradition. Participants were from police, fire and paramedic branches of emergency services and averaged fourteen years of service. A comparative data analysis was performed and significant concepts and categories developed (Strauss & Corbin, 1998). A partial grounded theory of coping with critical events concluded that responders demonstrated resilient traits (Flach, 1990) and were detrimentally affected by the psychological and physical proximity of the event, especially critical events involving children, colleagues, or fatalities. Victims in close approximation to their own relatives were universally mentioned as the most damaging to the responder's equilibrium status. Events that occurred early in their careers were mentioned as presenting more difficulty than later events. Non-emotion based coping strategies such as the use of humor, depersonalization, and compartmentalization were preferred. Acute physical challenges were met with actions such as physical conditioning, dieting and reducing alcohol consumption.

**Assessing Grief Centers' Outreach Efforts to Ethnoracial Minority Groups: A Quantitative
and Qualitative Inquiry**
By Carol Jarvis

Families experiencing grief become members of "the club no one wants to join" (Schurman, 2004, para 1)¹. A popular model of bereavement care to assist these families is the self-help/mutual aid group, known as The Dougy Center model, named after The Dougy Center, a non-profit grief center located in Portland, Oregon. Through a national survey of grief centers based on The Dougy Center model, as well as follow-up interviews with the staff of these centers, this study assessed ways in which grief centers are providing outreach to ethnoracial minority groups, and identified successful strategies in reaching these client groups. Themes identified from data in the quantitative phase were also found in the qualitative phase. Respondents reported collaboration, especially with schools, to be a useful strategy in providing outreach to racial and ethnic minority groups. At the same time, grief centers faced challenges in providing outreach, primary among these being issues pertaining to cultural differences between the dominant culture and those populations grief centers were attempting to reach.

¹ Schuurman, D. (2004). *The club no one wants to join: A dozen lessons I've learned from grieving children and adolescents*. Retrieved May 2, 2006, from <http://www.dougy.org/default.asp?pid=4985010>

The Importance of Comprehensive Clinical Social Work Assessments for Older Adult Guardianship Petitions in Cook County, Illinois

By Heather C. Jones

As our population ages there seems to be a strong current toward seeking surrogate decision-makers for individuals, who appear unable to manage their lives and make clear choices. Guardianship is the most profound course of action when determining that an older adult lacks decisional capacity. Older adults make up the majority of persons adjudicated incapacitated and, in turn, are assigned guardians (Crampton, 2004; Teaster, Schmidt, and Roberto, 2004). There is limited research about older adult guardianship, so this study is opportune because of the increased longevity of the population, with the most rapid growth among the very old, who likely will have the greatest needs for protective services (Iris, 1991).

Literature about the use of social work in the guardianship system has typically been focused around collaborating with guardians (private – family/paid guardian or public or state agency) or the court system to assist with service linkage and care planning, and protection from abuse after adjudication of incompetence (Paveza, VandeWeerd, and Berko, 2002; Veith, Blair, Leonard, Bouma, and Pazda, 1996; Sonntag, 1995; Staudt, 1985).

This qualitative dissertation research explored if social workers can serve in the role of guardian ad litem in effort to complete comprehensive clinical assessment for older adult guardianship petitions brought forth in Cook County Probate Court, Chicago, Illinois. The research involved exploration of legal case files and interviews with both mental health and legal professionals.

Comprehensive clinical social work assessments seem necessary in older adult guardianship cases in order to provide a clearer picture of the individual, his or her needs, if any, supports, etc. It is within the social work profession's realm to complete in-home or facility-based comprehensive clinical assessments, which explore biopsychosocial components of an individual, to investigate family relationships, dynamics, and issues, to provide service linkage, psychoeducation, advocacy and support, and to partner with individuals and families to develop the least restrictive, acceptable plan of care.

Assessments will allow for the human to be seen within the mass of documents within probate court. The older adult will have a voice, which will change the process of having something "done" to him or her by the courts to collaboration and exploration of who he or she is and what are the real needs of the individual. If a person is found to be in need of a guardian, social workers can continue to explore services that would allow for a safe, tailor-made, limited guardianship. It is a social worker's role to determine less restrictive ways of helping those who are failing physically and cognitively. The addition of social work expertise in the adult guardianship court system could enhance the preservation of individual rights.

Research of this nature is paramount to our aging population in the United States as a means of trying to safeguard rights. Our society is growing older and these concerns cannot be ignored. It is important that guardianship policies and practices meet the needs of the individual, not the timeframes of the court. Providing an in-depth, comprehensive, clinical assessment allows for a well rounded picture of the respondent, his or her abilities, resources, and needs, which is essential in the adjudication process, especially when determining either a limited or plenary (full) guardianship. Having a clear understanding about the respondent will allow a judge to make an informed decision about the future of the individual, and may make a case for preservation of rights and creation of a less restrictive plan of care. Most importantly, it provides the respondent a better opportunity for due process and therapeutic jurisprudence. This research is essential to the values of social work, as social workers have an ethical obligation to advocate for and protect the self-determination of others. Fighting for justice and policy reformation is a hallmark of the profession.

The heart of the study was exploring if there is a role for comprehensive clinical social work assessments for older adult guardianship petitions and if social workers could function in the role of guardian ad litem. Salient themes include aging in America, American social structure, ageism in the United States, Families, history of adult guardianship in the United States, beneficence, personhood, rights, and ethics, Uniform Probate Code, State of Illinois Probate Act of 1975 and the Cook County Probate System, strengths and weaknesses of guardianship, due process and therapeutic jurisprudence, third party interests, limited vs. plenary guardianship, medical model, assessment for adjudication of incompetency and the Cook County Probate Court Guardian ad Litem role, and the role

Spirituality In Marital Therapy: A Phenomenological Approach

By Alexandra Jane McCourt

There is general agreement in social work literature today, that spirituality is a valuable but often underutilized and unrecognized resource for therapists in clinical settings. From within the context of marital therapy, this exploratory study seeks to understand the experience of spirituality that licensed clinical social workers have in their work with couples. As most married couples began their marriage with some type of sacred ceremony uniting them, it seems logical to bring that same sense of the sacred to marital therapy. Many models of marital therapy in common use today are amenable to the integration of spirituality and as this study indicates, many therapists consider themselves spiritual and incorporate spiritual themes and interventions in their work. Yet, some reluctance to identify and include spirituality directly still exists among therapists and clients alike. The findings in this study offer some direction in addressing this reluctance and suggest some implications for including spirituality more thoroughly in social work education and practice.

Connection, Caretaking, and Conflict: The Recalled, Lived Experience of Adult Daughters of Bipolar Mothers

By Louise Presley

At present in the United States approximately four million people (one and six tenths percent) suffer from Bipolar I and Bipolar II disorders. Twenty percent of bipolar persons are not helped by medication. Each bipolar person has two parents, and may have siblings, friends, spouses, and children. All of these people are affected by the feelings and behavior of the bipolar person. The children are particularly vulnerable to behavior disorders, depression and anxiety, even if protective factors mitigate the family situation.

This qualitative research addresses the events recalled by adult daughters whose mothers are bipolar: what they recalled of what they thought, felt, and did in response. Events from early childhood to the time of the interview were explored. Seidman's phenomenological interview series was the model for the interview, both in the pilot study and later when it was modified into one long interview as suggested by McCracken. This study was not retrospective. It focused on the daughters' recollections and how these affected their development, their relationships, and their work or careers.

The transcripts from the two pilot study participants interviewed in two-thousand-two were included as archival material and analyzed with the transcripts from the two thousand-five interviews with the dissertation participants. The pilot study participants were recruited from a clinical setting. One dissertation participant heard about the study by word of mouth. The others responded to a newspaper advertisement. Two were twenty five, two were in their early fifties, and the rest were between thirty four and thirty nine. Two were African American, one was biracial. The remaining seven came from a wide variety of ethnic backgrounds.

The data was analyzed using N'Vivo. It enabled comparison of themes from each life stage addressed in the interviews. These themes were recorded in forty-one tables. The most populated and enduring were role reversal, beginning in early childhood, and conflict, beginning in the high school years. Each theme persisted in the presence of the other until the time of the interviews, profoundly interfering with development, trust, intimacy, and work. These conclusions suggested both needed services and further research.