

PRAXIS

Where Reflection & Practice Meet

VOLUME 15

*In Honor of the Advocates, Teachers, Clients, and Scholars from
Whom We Have Come by This Knowledge*

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EDITORIAL

A Tribute to Those Who Have Come Before Us

This edition of Praxis is dedicated to all who have taken the time to offer their wisdom and knowledge, in hopes of creating a society built upon respect for the inherent dignity, value, and worth of each person. We honor the individuals who have assisted us in becoming advocates and scholars in the field of social work. Above all else, the work of our forbearers has given us insight into the ways in which we can provide better care for one another.

Clinicians, therapists, and advocates from around the globe have been asked the following question, “What is it that social workers actually *do*?” Some responses to this question include political advocacy or violence prevention; others include caring for individuals impacted by mental illness or facilitating a discussion on best practice for one-on-one therapy. Each of these avenues of social work practice provide evidence of ways in which we seek to affect change in the micro, mezzo, and macro levels of societal institutions. However, each of these practice methods also reveals another aspect about the role of social workers. As advocates and agents for social change, one of our overarching goals is to say, “You are not invisible”. We see you, we care, and we want to collaborate with you to make our neighborhoods and communities fun, safe, and equitable places to thrive.

Our client’s needs are not invisible to us. Those who came before us and those who will fill our shoes after we are gone are not invisible. Social change is upon us, whether we open the door to those changes or not. Social workers are continually mediating change, advocating for social justice and the tearing down of intersecting systems of oppression.

Ferguson, you are not invisible. Leelah Alcorn, Eric Garner, Senator Clementa Pinckney, victims and survivors of war, and our friends to the South, you are not invisible to us.

The articles presented in Volume 15 represent the different ways we as advocates reveal that we see and care for our clients. With topics such as mindfulness, balancing the medical and social model, exploring ways to assist couples in creating trust and communication, advocating for survivors of torture, reclaiming sexual agency, and partnering with clients to treat insomnia, the field of social work is given innovative ideas for how to expand our definitions of what it means to care for an entire person and the larger community.

This edition is for our teachers, mentors, families, colleagues, and kin- the rabble rousers who refuse to sit down while racism, sexism, ableism, and classism remain unchecked. These individuals have shown us the power of stepping forward to advocate with others, for we each possess the talent and information necessary to enact change in our world. We cannot wait for someone else to step forward to make this world a more compassionate and beautiful place to live in.

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Mindfulness-Based Psychotherapy with HIV Patients

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Abstract

This research paper aims to explore the effects of mindfulness-based psychotherapy on patients living with HIV. The goal of this paper is to suggest that a positive link may exist between incorporating religious and spiritual-inspired interventions into therapy and seeing improvement in physiological and psychological health of patients, particularly those diagnosed with HIV. This review first examines the connection between religious and spiritual-based treatments and patients' mental health, then proceeds to elaborate further on the specific types of religious and spiritual-based interventions that exist and how exactly those interventions impact the health and overall well-being of patients living with HIV.

Keywords: mindfulness, psychotherapy, HIV, patients, religious, spiritual, treatment

Introduction

This literature review aims to examine both the nature and effect of mindfulness-based psychotherapy on patients living with HIV. More specifically, the purpose of this review is to explore whether or not spiritual-based interventions, such as the practices of mindfulness and meditation, have proven effective in improving the quality of life, and even health, of one vulnerable and at risk population: patients living with HIV. The American Psychological Association (APA) reports that countless empirical studies of people dealing with major life stressors (i.e. illness) have shown religion and spirituality to be helpful in assisting individuals cope with major life stressors, especially those individuals with the fewest resources facing the most uncontrollable of problems (APA, 2013, p.1). "Emerging research shows that spiritually-integrated approaches to treatment are as effective as other treatments" (APA, 2013, p.2). For the purposes of this paper, when discussing "religion and spirituality," the author refers to traditions that have deep roots in Eastern philosophies and Eastern-inspired religious beliefs, such as meditation, forgiveness, mindfulness and yoga. The connection between religion and spirituality

and coping is applicable to all types of patients irrespective of religious orientation. As Dr. Pargament, an expert in the field of religion and mental health, states: "You don't have to be religious to meditate" (APA, 2013, p.2). In other words, an individual does not need to be religious in order to potentially benefit from spiritually-inspired interventions in psychotherapy. Likewise, those who are religious and follow non-secular traditions may benefit in a similar fashion because "research has shown that mantra-based meditation to a spiritual phrase is more effective in reducing physical pain than meditation to a secular phrase" (APA, 2013, p. 2). Perhaps this is the most unique aspect of such religious and spiritual based treatments after all, that they can be applicable to both believers and non-believers and still have the same positive outcomes in the end. In fact, "the role of religion and spirituality in psychotherapy has received growing attention in the last two decades, with a large focus on understanding the ways that religion and spirituality relate to therapists, clients, and treatment methods" (Post & Wade, 2009, p.131).

This captivating trend can be attributed to recent research that has shown a positive correlation between religion and health (Hage, S., Hopson, A., Siegel, M., Payton, G., & DeFanti, E., 2006). In other words, according to Hage et al. (2006), findings in the fields of psychology and psychotherapy indicate that treatment methods utilizing spiritual-based interventions and/or incorporating religion and spirituality into their discussions have been linked to improvements in the overall physical and emotional health of many patients. Numerous outpatient psychotherapy clients have been reporting a desire to discuss religious or spiritual topics in their therapy and indicate that religion and spirituality are of central importance to their healing and growth (Rose et al., 2001, in Knox et al., 2005, p. 1). However, despite the growing understanding of the pervasiveness and importance of spirituality and religion in psychotherapy, most psychologists have little training in dealing with religious and spiritual issues (Shafranske & Malony, 1990, as cited in Knox et al., 2005, p. 5). Mack (1994) states that many more may be ambivalent about bringing concepts of religion and spirituality into the

counseling setting for fear of imposing the therapist's own values on the client (as cited in Knox et al., 2005, p. 2).

Irrespective of the personal stance a clinician takes in regards to incorporating religion and spirituality into treatment, when vulnerable populations are concerned and people are battling life-threatening illnesses, it is of vital importance on the part of all clinical professionals to stay informed on a myriad of topics and interventions shown to be effective. Therefore, another purpose of this paper is to shed light on the profound importance of understanding and staying informed on the topic of religion and spirituality in psychotherapy for all clinicians, regardless of whether they use it or plan to use it in practice. Knowing the recent trends in one's field of work and being aware of relevant, scientific research with strong implications for the field is a vital and even mandatory duty of any true professional. This is a suggestion that is especially true for social work clinicians and psychotherapists, who often deal with such intangible topics as religion and spirituality. As the NASW Code of Ethics states, "social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice (National Association of Social Workers, 1999). If incorporating measures inspired by religion and spirituality into treatment is truly helping HIV patients live better, happier lives, then it is simply the rightful duty of clinicians and social workers to become more educated and knowledgeable on this topic. The next section provides an overview of the research on the connection between religious and spiritual-based treatments and mental health. The section that follows addresses literature specific to the HIV population.

Mental Health and Spirituality

In recent years, it has become well known in the fields of both psychology and psychotherapy that religiosity and spirituality are empirically associated with more positive than negative psychological functioning in clinical patients (Plante & Sharma, 2001, in Knox et al., 2005, p. 288). Researchers Rose, Westefeld, and Ansley (2001) surveyed 74 individuals who were receiving counseling and found that 55% of them wanted to discuss religious and spiritual issues because they believed religion and spirituality were (a) essential for health and growth, (b)

personally important, (c) central to human personality, behavior and worldview, and (d) relevant to problems (as cited in Nickles, 2011, p. 9). Although such a percentage is not statistically significant on a grand scale due to its small sample size, it is still worthy of note and consideration that more than half of those participants felt strongly about the positive link between religion and healing. It serves as a reminder that no form of treatment should go overlooked or under-researched in clinical work.

In another study by Rose et al. (2001), clients' beliefs and preferences in examining spiritual issues in counseling were researched. The results "suggested the majority of these general outpatient psycho-therapy clients wanted to discuss religious or spiritual issues in counseling. Additionally, more than one quarter stated that religions and spirituality were important to them and essential for healing and growth" (as cited in Knox et al., 2005, p. 289). Similarly, in yet another study from 2001, researcher Goedde interviewed several clients of different religious backgrounds who were receiving therapy from a secular psychologist, and studied their views on discussing religion and spirituality in therapy. He found that "clients felt that spirituality was important to discuss in therapy and felt validated and acknowledged by therapists' explicit and implicit religious or spiritual interventions" (as cited in Knox et al., 2005, p. 289). In other words, those clients "felt validated" because they did not feel judged or inaccurately perceived by their therapist, a concern that Goedde explains is common among patients wanting to discuss religion and spirituality in therapy (as cited in Knox et al., 2005, p. 289). The most fascinating takeaway from this study in particular is that Goedde found that "religion and spirituality entered therapy through the clients' psychological issues or through the healing aspects of the therapeutic relationship and were perceived by clients as a healing force in therapy" (as cited in Knox et al., 2005, p. 289). Essentially, this indicates that regardless of how the topic of religion and spirituality makes its way into therapy, or whether the psychologist at hand is secular or religious, it has the potential to be truly effective in providing a blanket of meaning, comfort, and support to all types of patients.

A later study conducted in 2007 by Smith et al. combined data from 1,845 clients to examine the effects of various religious and spiritual interventions (as cited in Post & Wade, 2009, p. 142). These types of interventions

included acts such as client prayer, reading sacred texts, instruction on religious imagery, meditation, and teaching clients spiritual concepts such as mindfulness. The results of this study showed that research involving interventions in which the therapist explicitly taught clients spiritual concepts and related the concepts to the clients' situations were more effective than those that did not (Post & Wade, 2009, p. 142). Those clients that learned the practices of mindfulness, for instance, were more successful in helping improve their own well-being than those who did not. Furthermore, "in the 16 studies in which a religious/spiritual intervention was compared to a secular intervention, the religious/spiritual interventions were more effective" (Post & Wade, 2009, p. 142).

Overall, research discussed in this section highlights a strong correlation between religious and spiritual-based therapies and positive outcomes in the health and emotional well-being of those patients who receive them. It also reveals that religious or spiritual-based interventions may be carried out by secular and non-secular psychologists alike. Such interventions can have applications for religious and non-religious patients and have positive effects. In fact, this is evident in the report that even patients themselves are observed to be adamant about incorporating religion and spirituality into their therapies in recent years, in one way or another. As Rose et al. (2001) summarized, clients report that religion and spirituality are ultimately vital for their healing and growth (as cited in Knox et al., 2005, p. 1). This is significant and indicative of the fact that this topic needs to be more heavily and closely researched, for the benefit of both professionals and patients. Therapists working in the field of social work and psychology are constantly advocating for their patients. They should naturally make note of the fact that countless patients have expressed a desire in discussing religion and spirituality in therapy. They must also remember that individuals who have a healthy spiritual identity heal at faster rates and are able to establish healthier lifestyles (Richards & Potts, 1995, in Nickles, 2011, p. 5), solidifying the importance of religion and spirituality in therapy.

Mindfulness-Based Interventions with HIV Patients: A Literature Review

According to the American Psychological Association, "psychology has begun to encompass and explore a number of exciting new topics – meditation, forgiveness, acceptance, gratitude, hope and love, and research on these aspects of life has begun to yield vitally important psychological and social insights, with powerful implications for human change and growth" (2013, p. 1). One of those implications is the possibility that spiritual-based interventions, such as mindfulness, can actually be effective in the improvement of both health and quality of life of vulnerable populations, such as HIV patients. What is mindfulness exactly? As one source describes it, "mindfulness is the ability to be present in each moment, experiencing everyday life, consciously connecting with the present" (The Mindful Word, 2015). In regards to therapy, the way in which mindfulness can assist in treating certain side effects of major life stressors in patients is through disciplined training of the mind to think positively and eliminate negative thoughts and emotions associated with said stressors, i.e. depression from HIV positive status. The reason mindfulness is so deeply connected to spirituality is that it stems from many Eastern-inspired traditions and philosophies, such as meditation in Buddhism or yoga in Hinduism, which have always believed in the power of the mind to influence the body and one's biological health. If such mindfulness-based and mindfulness-inspired therapies could actually be proven to help HIV patients improve their quality of life and biological health, close attention must be paid and proper investigation conducted.

One of the primary reasons for this is due to considerable research indicating that people living with HIV/AIDS suffer from elevated anxiety and feel more distressed as compared to the general population (Rapid Response, 2012). Another vital reason is because as HIV treatments continue to advance, people living with HIV will inevitably be confronted with negative physical and emotional side effects that can adversely impact their quality of life and adherence to care (National Center for Complimentary and Integrative Health [NCCIH], 2013). With mortality rates from HIV dramatically reduced in the US, side effects emerge as one of the most critical factors in the HIV epidemic, which include high stress levels, depressive symptoms, anxiety symptoms and overall poor quality of life (NCCIH, 2013). Reducing the negative impact of these side effects may significantly improve quality of life,

help reduce missed days from work and maximize benefit from treatment for people living with HIV (NCCIH, 2013). Therefore it is incredibly important to assess if spiritual-based interventions are indeed helpful for HIV patients and capable of eliminating their side effects (The Mindful Word, 2015). Such a discovery could potentially mean better, healthier lives for millions of people around the world.

A study undertaken in 2004 by Ventegodt et al. is important for this type of research in particular because of how well it supports the mindfulness-health connection and validates its significance. In this study several HIV positive patients had to rate their own quality of life based on a questionnaire distributed by researchers. The study focused specifically on the association between the immunological impact of HIV (measured by CD4 count) and global self-assessed quality of life (QOL) (measured with QOL1) for people suffering from HIV (Ventegodt et al., 2004). The study found a large and clinically significant correlation between the number of T-helper cells (CD4) and global self-assessed quality of life (QOL1), when controlled for age, gender, and years of infection (Ventegodt et al., 2004). These findings ultimately determined that HIV patients who reported higher global QOL also had improved CD4 counts, meaning that holistic treatment practices such as mindfulness and meditation, that can help patients improve quality of their thoughts, had sufficient biological effects on patients' CD4 counts and helped avoid or postpone development of AIDS in them altogether (Ventegodt et al., 2004). These results are astounding and have significant implications for the fields of psychology and psychotherapy. They are also vital for the future of all HIV patients hoping to live fulfilling, happy lives.

Similar to the above research, other studies have also shown a positive correlation between spiritual-based treatment methods and improvement in health of people living with HIV. Specifically, one treatment method known as "Mindfulness Meditation" has been especially effective in clinical work with patients living with HIV (Fulton, 2013). As Fulton (2013) defines it, mindfulness is "the cultivation of the capacity for direct, open, non-reactive, and close attention" (p.208). It is also described as "psychological therapy focused on the cultivation of self-regulated attention, acceptance and openness to experiences gained through reflective and structured exercises/practices like

meditation or yoga" (Rapid Response, 2012). The reason it is so often tied to spirituality is that "mindfulness has its origins in contemplative practices that go back thousands of years, including Buddhism, Hinduism, Taoism and Stoicism" (Beach, 2014, p.2). Fulton asserts that integrating mindfulness in clinical settings has already gained acceptance by clinicians for its capacity to alleviate psychological distress (2013, p. 208). For instance, a study conducted by Dr. Fumaz in 2003 "showed that quality of life, psychological stress and symptoms of depression and anxiety in HIV patients improved significantly in the group following a mindfulness program compared to the control group" (The Mindful Word, 2015). These types of symptoms are some of the most prevalent among HIV patients; being able to alleviate them with such practices as mindfulness is an extraordinary discovery. "Participants of mindfulness also had a significant increase in their CD4 cells, which are fundamental in the evolution of HIV infection" (The Mindful Word, 2015). A unique finding like this indicates that mindfulness has the capacity to potentially improve not only one's emotional and psychological health, but also one's *physiological* health, too. This biological link between spiritual-based therapies and patients' improvement in health, as demonstrated by higher CD4 counts, is a powerful piece of evidence in support of their effect and positive impact.

Additionally, in a review of four different studies that investigated physiological and immune responses to Mindfulness Meditation programs for people with HIV, researchers at Rapid Response found that not only did participants experience reduced frequency, severity, and distress from symptoms, but mindfulness-based treatments also helped stabilize and even increase patients' CD4 counts over time (2012) This is fascinating because as recently as only ten years ago, there was hardly any research or literature on this subject. In fact, in 2005, only 365 peer-reviewed articles on mindfulness appeared in psychological literature. By 2013, however, there were over 2,200 articles and over 60 mindfulness treatment and research centers in the United States alone (Germer et al., 2013). This sudden expansion in literature and growing interest in mindfulness-based interventions may very well be attributed to the increasing role that religion and spirituality in general has played in psychotherapy over recent years. As already noted, patients have been requesting that religion and spirituality be discussed or

incorporated into their therapy sessions as they have felt this topic would help them. Focusing on adults living with HIV/AIDS, Tarakeshwar, Pearce, and Sikkema (2005) created a psycho-educational group that discussed different topics including the effects of spirituality on mental and physical health and spiritual coping methods. This focus on religion helped to increase self-rated religiosity, increase positive spiritual coping while decreasing negative spiritual coping and depression (Nickles, 2011). Also, seeing as research has shown time again that religious and spiritual interventions are effective; it is no wonder that methods like mindfulness have proven successful and gained much esteem in the clinical world. According to Germer et al. (2013), there are now many mindfulness-based interventions for other mental and physical disorders as well, “because sophisticated neurobiological research is demonstrating the power of mind training to change the structure and function of the brain” (p.12).

Conclusion

Ultimately, what can be learned from this research on religious and spiritual-based interventions and the specific impacts these interventions have on the HIV community? After much examination of the appropriate literature, it can be deduced that spiritual-based interventions, such as mindfulness, have been shown to be effective in improving the health and quality of life of patients living with HIV. The findings from Ventegodt et al.’s study in 2004 are a powerful example of this undeniable link between religion and spiritual-based interventions and patient’s improvement in psychological and physiological health. The authors ultimately determined that HIV patients who reported higher global QOL also had improved CD4 counts, meaning that holistic treatment practices such as mindfulness and meditation, that can help patients improve quality of their thoughts, had sufficient biological effects on patients’ CD4 counts and helped avoid or postpone development of AIDS in them altogether (Ventegodt et al., 2004). Utilizing mindfulness-based therapies with HIV patients has been scientifically linked to an increase in their CD4 count; these therapies were able to cause actual,

biological and positive health changes within patients (Ventegodt et al., 2004).

Furthermore, mindfulness-based interventions have also been found to contribute to positive results in enhancing the perception of available social support and self-reported well-being among participants (Rapid Response, 2012). Practices such as discussion of religion and spirituality in sessions, teaching clients the practice of mindfulness or meditation and present self-awareness, engaging in prayer or reading of religious scripts with clients, talking about mindful consciousness and positive thinking, etc., are all aspects of incorporating spiritual-inspired material into therapy. Furthermore, such therapies have been found to increase momentary positive emotions and teach patients with long-term history of depressive symptoms to capitalize on the natural rewards in day-to-day life (Rapid Response, 2012).

As the American Psychological Association explains, “because religion and spirituality elicit deep feelings in people and because they speak to people’s deepest values, practicing psychologists must be careful to approach these processes with knowledge, sensitivity and care” (APA, 2013, p. 2). It is highly recommended that all present and future clinicians take good care in educating themselves extensively on the topic of religion and spirituality as it pertains to psychotherapy. Even if one does not plan to use spiritual-based interventions in their own practice, simply having knowledge and background information on the topic is extremely important. Clinicians must be able to discuss such a topic with patients, should it unexpectedly be brought up in session. This is another way in which they demonstrate their skill and competence; by being prepared in all situations and staying open-minded to all topics of conversation, in turn ensuring that patients always feel safe and comfortable. Ultimately, more research in this field of study is still necessary and required in order to solidify any conclusive findings.

Zoya Abdikulov is a MSW and former graduate of Loyola University Chicago, class of 2015. She received her BA in Communications from the University of Pennsylvania in 2008. Her first internship as a MSW student was at Astoria Place Living and Rehabilitation, where she was first introduced to gerontology and quickly developed a passion for it. Her second internship was at Northwestern Memorial Hospital, in the Infectious Disease Clinic, where she was able to work with patients diagnosed with a variety of infectious diseases, including HIV. This experience, and all the ways in which it taught Zoya the importance of continuous research and discovering new treatment options for patients from all walks of life, was the basis and inspiration for this literature review.

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Meeting the Torture Survivor and Asylum Seeker: Directions for Clinical Treatment and Political Advocacy

Margaret J. Hunter, Brittany Austin, and Garrett Gundlach, SJ

Abstract

This article will explore the political asylum regime in the United States as it pertains to survivors of torture. The article begins with an explanation of the current pathways to seeking asylum in the United States and provides details about the eligibility criteria for various categories of State protection under international law. The process of filing and awaiting the adjudication of an asylum claim is a lengthy and taxing experience for any individual, but can be particularly difficult for someone who has survived torture. The article details the various ways in which the asylum process can be re-traumatizing for torture survivors by offering insight into PTSD symptomology and neurobiology. Finally, the article offers suggestions for the clinical treatment of torture survivors, as well as stressing the important role that social workers and other mental health providers can play as client advocates for changing the ways in which asylum claims are treated in the United States, moving toward an integration of trauma-informed best practices in both clinical and legal realms.

Keywords: Torture survivor, asylum seeker, social work, best practice, political advocacy, Convention Against Torture, Trauma, PTSD

Pathways to Asylum

There is a significant distinction between asylum seekers and refugees. The UN General Assembly's 1951 Convention and Protocol relating to the Status of Refugees defines a refugee as "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (United Nations, 1951, p. 3). Refugees are individuals whose status has been qualified by a host country prior to their arrival. Asylum seekers do move across borders in search of protection for reasons parallel to the experience of refugees, but the distinction lies in the fact that an asylum seeker

is an applicant seeking protection and *awaiting* the determination of their status as a refugee. An asylum seeker in the United States, for example, applies for refugee status either within the U.S. or upon arrival at a U.S. port of entry (United Nations High Commissioner for Refugees, 2013).

According to UNHCR, in 2013, 612,700 asylum claims were filed worldwide, among the 44 industrialized countries that accept asylum applications. Second to Germany, the United States was the largest recipient of new asylum claims, receiving 88,400 asylum applications. This represents a startling 25% increase from 2012 and it is important to note that for the previous 7 years, the United States has been the lead recipient of asylum requests. The top 10 countries of origin for U.S. asylum seekers in 2013 were, respectively: China, Mexico, various/unknown, El Salvador, Guatemala, Egypt, Honduras, Haiti, Ecuador, and the Syrian Arab Republic (UNHCR, 2013, p. 3). Similar to refugees, asylum seekers cite previous experiences of torture or persecution in their country of origin or well-founded fear of the same should they be forced to return. Many arrive in the United States from war-torn regions and areas experiencing extreme political unrest. Despite the life-threatening circumstances which necessitate these individuals to flee their homes and seek protection elsewhere, the United States granted asylum to only 25,199 persons in 2013, approving only 28.5% of received asylum claims (UNHCR, 2013).

There is a significant group of individuals within the asylum population who are survivors of torture. According to the UN (1987), torture is defined as:

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him, or a third person, information or a confession, punishing him for an act he or a third person has committed, or is suspected of having committed, or intimi-

dating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions. (p.1)

The worldwide prevalence of the egregious act of torture is startling. The Center for Victims of Torture (CVT) (2013) reports that “despite its universal condemnation and absolute prohibition, approximately 117 countries worldwide still practice torture” (p. 5). It is estimated there are currently over 500,000 survivors of politically motivated torture living in the United States and that in 2012 alone, 10,319 of the 29,484 refugees granted asylum in the United States were survivors of torture (CVT, 2013). In order to more fully grasp their post-migration experience, one must also understand the complexities of the United States asylum-seeking process these individuals must navigate upon arrival.

Political Asylum

There are two avenues to obtaining asylum in the United States. Asylum seekers can apply to the United States Citizenship and Immigration Services (USCIS) through affirmative or defensive processing. The affirmative asylum process is available to individuals who are physically present in the United States, regardless of their method of arrival or current immigration status. Applications must be received within one year of their most recent arrival in the United States, with certain exceptions being provided. Affirmative asylum applicants may live in the United States while their application is reviewed by USCIS, but are not eligible to seek employment authorization until 150 days after their application is filed. Those who are approved for employment authorization are only granted a work permit if an additional 30 days pass without receiving a decision on their asylum claim. Applicants who are denied asylum by USCIS at this first stage and lack legal immigration status may remain in the United States while their case is referred to and reviewed by an Immigration Judge: this is a transition from affirmative to defensive processing (USCIS, 2015).

Defensive asylum applicants request asylum as a defense against deportation from the United

States. Individuals who are seeking asylum while concurrently in removal proceedings with the Executive Office for Immigration Review (EOIR) fall under this category. These applicants enter the defensive asylum process because they were placed in removal proceedings for being apprehended without legal documentation or status at a US port of entry, claiming a credible fear of prosecution or torture in their country of origin (USCIS, 2015).

Defensive asylum cases are heard by Immigration Judges and decisions are issued independent of any prior ineligible determination made by USCIS after hearing from both the asylum seeker and his or her attorney, if represented, as well as an attorney representing Immigration and Customs Enforcement (ICE). Individuals who are not granted asylum will be reviewed for eligibility for alternative forms of relief from removal, which include withholding of removal and protection under the UN Convention Against Torture (CAT). Individuals deemed ineligible for these forms of relief are scheduled for deportation (USCIS, 2015).

Convention Against Torture (CAT)

Survivors of torture are eligible to seek protection under the Convention Against Torture (CAT), an international treaty provision under which the United States agrees not to “expel, return or extradite” (United Nations, 1984, p. 2) individuals to a country where they would experience torture. Two types of protections are provided under CAT: withholding of removal and deferral of removal. Both types prohibit torture survivors from being returned to a county where they may experience torture.

Protections under CAT have certain limitations, however: Individuals who are granted protection under CAT may be detained in the United States or may be removed to a third party host country. Furthermore, while *recipients* are eligible to apply for work authorization, their *family members* are not extended the same benefits. In the meantime, recipients cannot petition to bring family members to the United States and are not permitted to travel outside the United States. Protections under CAT do not provide a path to lawful residency for survivors of torture (U.S. Department of Justice, 2009). Political asylum is, for these reasons, often preferred.

Retraumatization

The asylum process can be long, arduous and wrought with uncertainty – often mirroring challenging circumstances pre-migration. This is often the case for torture survivors seeking defensive asylum, who may be held in dehumanizing conditions by CBP or ICE. A 2013 report by the Center for Victims of Torture (CVT), estimates that between October 2012 and February 2013, 6,000 survivors of torture were detained during their asylum seeking process (CVT, 2013, p. 6). Detention notwithstanding, at the second author's internship site at the Heartland Alliance Marjorie Kovler Center in Chicago, Illinois, wait times are only increasing for asylum-seekers in the legal process. Some applicants for affirmative asylum are waiting upwards of one year for their initial interview, and, if they are not granted asylum then, can wait three years to stand before a judge. The associated feelings of helplessness and loss of control in this process can contribute to severe psychological distress for torture survivors, already vulnerable (CVT, 2013).

The Complex Aftermath of Torture

Torture is a weapon meant to send a message. Torture is employed to disempower, to silence an individual or a community. It is a deliberately destructive act whose seemingly simple – but sadistic - intent brings complex consequences that manifest not only in the mind of a survivor, but in her body and intimate relationships, her beliefs about herself and her world. Posttraumatic Stress Disorder (PTSD) is a common mental health diagnosis offered to guide the treatment and support of torture survivors, providing a nexus between reported traumas and their psychobiological effects manifest in symptoms (Kinzie, 2011). PTSD, however, falls short in articulating a survivor's full experience, which often includes pervasive depression, religious and existential imbalance, and social impairments that transcend the diagnostic categories of PTSD. The deliberate decision to begin with the psychobiological effects of torture is not to pathologize a torture *victim*; on the contrary, this psychoeducation can normalize the symptoms and thus empower a torture *survivor* to rally skills, interventions, strengths, and social supports to compassionately meet and overcome them.

Trauma and PTSD Psychobiology

Psychobiology can be very simply defined as the intersection of biology and behavior; in this case, abrupt and overwhelming changes in biology (trauma) enact behavioral changes (PTSD symptoms) (Van der Kolk, 2006). Trauma survivors' symptoms thus represent often-involuntary responses of the brain and body. Understanding these connections can help a clinician to reassure a client that "It's not about what's wrong with you, but about what happened to you."

Intense traumatic experiences, such as torture, flood the body and the brain at the time of the trauma- a survival response to perceived danger. Not all danger necessarily leads to clinically-significant PTSD, however. A survivor's body and brain characteristically remain flooded weeks, months and diagnostically, a *year* after the original traumatic event (Yoder, 2005, p. 31). PTSD's symptoms represent the observable effects of this prolonged flooding. These symptom sets represent not only the direct consequences of massive trauma on the brain, but also the brain's subsequent attempts to re-stabilize (Weiss, 2007, p. 114). These "neurobiological underpinnings" are what render trauma symptoms so consistent from one survivor to another (Van der Kolk, 2003, p. 177).

Hyperarousal. When the brain initially responds to a dangerous situation, it secretes chemicals that prepare the body for survival through fight or flight (Weiss, 2007). These chemicals increase the heart rate, respiration, metabolism, rush blood to muscles for strength, shut down non-essential functions (e.g. digestion), and trigger dissociation that protects the person from the direct experience of the trauma; at this time there is less physical feeling and time is distorted (Yoder, 2005, p. 19). In traumatic experiences that accentuate victim powerlessness, notably in physical torture, the victim's inability to fight or to flee often leads, instead, to a victim's "freezing" (Solomon & Heide, 2005, p. 53). In this "freeze", the brain does not receive a signal to stop releasing these powerful chemicals, which will continue to be released long after the initial threat has been "resolved" (Levine, 2008, p. 27; Weiss, 2007, p. 117). Whereas a successful "fight" or "flight" will expend the released chemicals and thus cathartically signal the danger's resolution, "freezing" prevents such communication.

The resultantly-prolonged high levels of these chemicals in the system of the trauma survivor perpetuate symptoms of hyperarousal that

were once adaptive in the moment of trauma, but become invasive and overwhelming when the survivor returns to a more neutral environment, feeling exaggerated threats to safety by involuntarily misperceiving stimuli. This fear and hyperarousal can become the body's default mode (Yoder, 2005, p. 34). In short, the intense and prolonged release of powerful chemicals in the brain affects the way that a trauma survivor perceives the world thereafter, often with involuntary and exaggerated fear, anxiety and hypervigilance. Because of the way these chemicals disrupt the activity of the prefrontal cortex (responsible for rationality), even survivors' articulated, rational recognition of safety in a particular environment can be overridden by psychobiologically-prompted fear (Weiss, 2007, p. 115). Additionally, this hyperarousal not only affects activity but also the body's subsequent ability to both concentrate and rest, leading to frustration in classrooms or during nighttime routines.

Re-experiencing Symptoms. Extreme amounts of secreted chemicals over a prolonged time after initial trauma can also disrupt normally-routine processes in the brain, such as storing memory (Van der Kolk, 2006, p. 228). The neurons in the hippocampus, specifically, can be damaged by high levels of secreted chemicals; this can lead to fragmented memories (Kimble, 2007, p. 64; Van der Kolk, 2003, p. 180; Weiss, 2007, p. 115). When this normal sequence for interpreting, integrating and *storing* memories is disrupted, so also can the methods for subsequent *retrieval* be disrupted: traumatic memories thus (mis-)processed can later be triggered more easily, unexpectedly, and intensely when external reminders of the original trauma are encountered (Solomon & Heide, 2005, p. 54). In this way, survivors can become stuck in reliving, uncontrollably, memories of the past (Van der Kolk, 2006, p. 222) at even the same as original intensity (Solomon & Heide, 2005, p. 54) when anxiety or memories trigger such an event (Kimble, 2007, p. 65). Furthermore, *tiny* trauma reminders can trigger *full-blown* hormonal releases (Van der Kolk, 2003, p. 182), flooding the mind of the survivor with intrusive memories or flashbacks (Yoder, 2005, p. 21). These intrusive memories also recur in sleep as nightmares.

PTSD is characterized by a widely recognized dialectic between psychological states of intrusion and constriction. Whereas the foregoing sections have explained the roots of hyperarousal and intrusive re-experiencing, the following two sections include constrictive attempts of

the body to cope through reallocation of internal resources and avoidance. Constrictive behaviors such as avoidance are often employed by the body to cope with the foregoing hyperaroused and invasive states; negative alterations in cognitions, beliefs, and moods, while also bearing the biological marks of trauma, match such constrictions with corresponding and explicative mind states ("I am broken" or "The whole world is dangerous").

Avoidance. Avoidance is a coping mechanism that seeks to compensate for a hyperaroused nervous system; survivors both involuntarily and actively avoid overwhelming reminders of trauma that can intrude on daily living with unexpected and totalizing intensity (Solomon & Heide, 2005, p. 54). This avoidance can be external or internal. By "shutting down" behaviorally, numbing, and withdrawing from uncertain social and physical environments, survivors are exercising control over their environment, involuntarily or intentionally hoping to avoid the most distressing effects of the hyperarousal and intrusive symptoms exacerbated when 'out-and-about' (Malta, 2012, p. 246). Socially, it is not uncommon for survivors to withdraw, preferring solitude in a home environment to the uncertainty of the outside world (Malta, 2012, p. 248). Furthermore, even in controlled environments or with trusted friends or family, survivors will avoid thinking or talking about traumatic events because of terror that these thoughts will trigger flashbacks and intrusive memories (Solomon & Heide, 2005, p. 54).

Negative Alterations in Cognition or Mood. Because of the traumatic impact on the brain, survivors may notice new patterns of emotional processing and social interaction after their trauma (Lanius, Bluhm, & Frewen, 2011, p. 336); these reflect damage done to relevant areas of the brain by the abnormally-large quantities of stress-responsive chemicals, released in the traumatic event and thereafter. Furthermore, Trauma can shatter survivor core beliefs and self-understanding, especially when survivors may shamefully reflect on changes in their social competency and in their intellectual capacities of learning and habit formation – all due to neu-

ronal damage (Van der Kolk, 2003, p. 181). Trauma, especially torture, can imprint “indelible emotional memories” (Van der Kolk, 2003, p. 187) on the internal landscape of the survivor, leading to feelings of guilt or shame that are “endemic” to PTSD patients (Kimble, 2007, p. 71; Lanius et al., 2011, p. 336).

It was already mentioned that extreme levels of secreted chemicals can disrupt the storage and recollection of memories (Van der Kolk, 2006, p. 228); ironically, this disruption may not only selectively strengthen memories, but it can also baffle their recollection! Whereas secreted glutamate, for example, can actually *intensify* the firing-and-wiring together of neurons for *extra-strong memories*, glutamate can also incite cell *destruction* in these same cerebral regions, leading to the opposite effect of survivors being bafflingly *unable to recall* seemingly simple or essential details of their trauma at prompted times (Weiss, 2007, p. 117).

Trauma, Depression, and Communal disintegration

Torture survivors are often diagnosed with Major Depressive Disorder comorbid to PTSD (Kinzie, 2011). This clinical depression can arise from the same chemical imbalance upset by a traumatic event, leading to persistent sadness, shame, and hopelessness. Asylum-seeking survivors of torture in the United States are particularly vulnerable, often having sparse social support and limited opportunities for employment and education – indeed asylees are not eligible to apply for work authorization until 150 days after the ‘clock has started’ with the submission of their asylum application I-589 form. Work brings dignity, social interaction and meaning; many asylees are long not able to work to ease a transnational transition or soothe/distract from their trauma symptoms. This social isolation only exacerbates aforementioned challenges with self-understanding and overwhelmed hopelessness, often elevating these emotions and cognitions to a persistent, clinical level, further isolating and despairing a survivor (Akinsulure-Smith, 2012).

Related to a survivor’s potential isolation and depression is the parallel damage torture can directly inflict on community and communal relationships. Most obviously, in the case of many asylees, torture has forced them to flee their community and thus jettison important relationships. Even psychologically, however, Bill Gorman (2001) notes that torture explicitly at-

tacks not only someone’s “sense of personhood...” but also their “social bonds” and values” (p. 446). Perhaps as an extension of aforementioned hyperarousal, survivors can become suspicious of their social environments, less able to trust new acquaintances: in torture, they were betrayed by another human being enacting unspeakable horrors, and this betrayal can live on in the mind, fearing repeat in any passerby. Again, this is primarily a psychobiological reality, overriding even rational self-talk that another person is trustworthy. Naming and identifying these habits and their neurobiological underpinnings in gentle psychoeducation can mutually strengthen a therapeutic alliance for healing; it can also inform appropriate advocacy for changes in the United States asylum process that are currently insensitive to survivors’ needs.

Treatment

Safety and Trust

When working clinically with survivors of torture, the first priority must be to create a safe space that can help to foster a sense of safety in the client (Fabri, 2001). The fact that torture often carried out by authority figures in a climate of impunity constitutes a “betrayal of absolute safety” (Fabri, 2001, p. 453) for the survivor. When a heinous crime is committed against an individual, this person can ostensibly seek retribution through the State to bring the perpetrator to justice; in the context of State-sponsored violence, there is no safe place to go for this protection and the survivor is left on her own in a state of profound disempowerment (Fabri, 2001; Fischman, 1998; Gonsalves et al., 1993).

The creation of safety in a therapeutic environment may consist of changing the pace to a slower one than usual, or allowing more flexibility in the timing or setting of sessions (Fabri, 2001). Modifications to the “therapeutic frame” may be necessary, such as taking a walk in the fresh air together during session rather than sitting in a room that may be reminiscent of an interrogation chamber (Fabri, 2001). Establishing trust in the therapeutic relationship is equally important. A client who has been subject to deliberate and malicious violence has valid reasons to distrust others. Therapy should be a collaborative and non-directive process in which the survivor has a sense of control (Blackwell, 2005; Fabri, 2001; Kinzie, 2001). Experiences of torture and captivity strip a human being of all

sense of control; an important part of therapy is allowing the survivor to regain this lost sense of control. A therapist can assist a survivor regain power and control through seemingly small measures, such as asking the survivor where in the room he would like to sit or whether he prefers the door to be open or closed. Such measures can add up to create an overall environment of greater safety and comfort for the survivor (Fabri, 2001).

Solidarity

When intervening with survivors of torture, it is key for clinicians to show solidarity with the client (Fischman, 1998; Gorman, 2001). Kinzie (2001) states that the therapist working with torture survivors must display the ability to “listen, stay, receive, and believe”. Many details of torture can be so horrific that it can be difficult for clinicians to truly comprehend what has happened to their clients; in response to this, they can become implicit in a process of “collective denial” (Fischman, 1998). Displaying “therapeutic neutrality” in the context of political torture runs the risk of tacitly placing oneself on the side of the oppressor. Therapists working with survivors of torture can and should be firm about being on the side of the survivor in relation to the injustice that occurred (Fabri, 2001). While Western therapists can often remain cautious against using moral terms such as “right” and “wrong”, telling a client explicitly that what happened to them was wrong can be instrumental in beginning to heal the shame that can come with having been tortured (Fabri, 2001; Herman, 1997). Clinicians who choose to do this sort of work must be especially attuned to their own political beliefs and motivations, and be willing to examine the role that the United States government, for instance, plays in bolstering many of the regimes that torture their citizens (Boehnlein, Kinzie & Leung, 1998; Comas-Diaz & Padilla, 1990). For a survivor of torture, the therapist becomes both private listener and public witness; the act of listening thus takes on a political character that should not be minimized (Fischman, 1998).

Best Practices

A commonly accepted trajectory of care for torture survivors across different intervention strategies is based on Judith Herman’s three-stage model of trauma recovery: establishing safety, reconstruction, and reconnection (Fabri,

2001; Gorman, 2001; Herman, 1997). In the first stage, the therapist develops a therapeutic alliance with the client, establishing rapport and building confidence in the relationship. In addition, this first stage involves the introduction and/or bolstering of social supports in the life of a survivor (Gorman, 2001). As many survivors of torture who are currently undergoing or have undergone the asylum process may now find themselves exiled in a foreign country, the clinician must take care to link clients with resources and referrals to culturally relevant community groups and agencies, if the client so desires (Fischman & Ross, 1990; Kira et al., 2012).

Herman’s second stage of trauma recovery involves the reconstruction and re-telling of the trauma narrative so the survivor may come to view the trauma as a part of her story, keeping in mind that the trauma is a part that exists in the past and does not constitute her entire identity. This is the stage at which the trauma is addressed the most directly, giving the client time to work through grief and mourning (Gorman, 2001). During this stage, the therapist is an ally in the survivor’s retelling of her narrative, encouraging the patient to overcome fear, denial and repression in order to “speak of the unspeakable” (Gorman, 2001, p. 447). One notable intervention model for use at this stage was developed in the late 1980’s by a team of Chilean therapists who had survived the Pinochet regime. In Testimony therapy, or Testimonio, the therapist works with the client to produce a written document that could be symbolically used as a legal indictment—the written testimony stands against the impunity that many survivors of political violence face at the hands of an oppressive regime. Testimonio usually involves recording and transcribing sessions and typically occurs across 12-20 sessions in total (Herman, 1997). Testimony therapy was originally developed as individual therapy but has also been adapted to a group work setting (Fischman & Ross, 1990). In a group context where all of the clients have experienced torture at the hands of the same regime, the collective power of a testimony narrating the stories of multiple individuals can hold particular salience.

Herman’s third stage of trauma recovery helps survivors move toward creating a future, integrating the trauma as one part of an individual’s story but not allowing it to subsume a person’s entire narrative of self (Herman, 1997). Here, clients display the capacity to “bear the past as history” (Blackwell, 2005, p. 320) rather than being trapped within it. Group work is an

emerging and promising practice for use with torture survivors at this stage (Akinsulture-Smith, 2012; Fischman & Ross, 1990; Kira et al., 2012). Many political trauma survivors come from collectivistic cultures, where healing takes place within the community (Akinsulture-Smith, 2012). Furthermore, political violence and repression often targets an individual due to his or her membership in a certain social group. Being around others who have gone through similar ordeals and are able to at least in part understand or relate can in and of itself be a healing experience (Fischman & Ross, 1990). There is also a judicial, transformative character to speaking one's truth in a public or semi-public setting. Collective empowerment is crucial in the reconnection stage of recovery for torture survivors in particular because it recognizes the collective nature of the trauma itself (Gonsalves et al., 1993).

Gonsalves et al. (1993) outline four principles underlying the theory of torture *as a sociopolitical act*: 1) torture is a systematic and deliberate policy that can be conceptualized as an institution 2) torture is directed not only at an individual but against the entire social and political fabric of a society 3) torture is an assault on a core of a society, creating a "reign of fear" and 4) torture induces massive psychic trauma on both the individual and collective level, in the form of social collapse (Gonsalves et al., 1993). As torture involves political as well as personal trauma, healing from this torture must thus also include a social component. Therapists can encourage their clients to become integrated into safe forms of sociopolitical life, at the client's own pace. Activity groups, in which clients can engage in walking, crafting, cooking, or gardening together, can be particularly healing during the reconnection phase (Kira et al., 2012). We must always remember that every client is different; some will wish to throw themselves into advocacy work in the United States as a form of healing, while others may wish to never again discuss their trauma. Clinicians must respect their clients by honoring the client's expression of what makes them feel safe and whole, as they heal from the trauma(s) they have experienced (Boehnlein, Kinzie, & Leung, 1998).

Conclusion: Directions for Accompaniment and Advocacy

"One of the fundamental fears experienced by survivors of torture, both at the time of

the trauma and even long thereafter, is that their stories will not be comprehended or worse still, their testimony will not be believed" (Silove, Tarn, Bowles, & Reid, 1991, p. 484).

Knowing all that we now know about the impacts of trauma and complex PTSD on torture survivors seeking asylum, it becomes clear that clinicians must not only serve asylum seeking clients in treatment, but also through advocacy. The U.S. asylum regime is currently set up in direct opposition to the best practice recommendations for working with survivors of political trauma. Torture survivors are individuals who have been massively mistreated by individuals often affiliated or directly linked with the government of their home country. Those who are able to escape and seek asylum in the United States are then placed in detention facilities reminiscent of political captivity and are then forced to tell their trauma stories to a foreign government body, which will scrutinize and pick apart their stories, relying on the existence of explicit memory that may very well have been wiped clean in the midst of the very trauma for which he is seeking asylum.

While best practice for therapeutic treatment of torture survivors emphasizes the creation of safety, attentive listening, believing and affirming a client's story, and not pushing her to share more than she is ready, the asylum process—from detention to courtroom testimony—stands in direct opposition to these recommendations. The structure of an asylum hearing does not take into account new scientific knowledge on PTSD and the brain, and the ways in which trauma impacts memory systems, nor on the potential for re-traumatization of torture survivors in an adversarial institutional setting. The system emerges as thoroughly and fundamentally blind to the needs of those that it is meant to serve.

It is clear to clinicians who work directly with survivors of political violence that the asylum system in the United States is broken. An overhaul of that system will never take place, however, without the zealous advocacy of clinicians and advocates working most closely with asylee populations. Social workers hold a vast amount of practical knowledge about the human experience, the phenomenology of our clients' life worlds, and the ways in which clients experience these worlds. If we do not advocate for our clients by sharing this knowledge with others then it can never be used to change the oppressive systems in which we find ourselves. Furthermore, through focusing on strengths, resiliencies, and the human capacities of our clients,

we can help to empower asylees to tell their own stories, to level their own critiques of a system that places men and women in an adversarial position before the Law. By working together with our clients, we can set out to change the

current asylum system and move it toward its potential of empowering rather than re-traumatizing some of the world's most vulnerable populations.

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Treating Borderline Personality in Adolescence Using CAT: Adapting HYPE into an Interprofessional Model

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Abstract

While there has been historical opposition against diagnosing borderline personality disorder (BPD) during childhood and adolescence, the following paper argues that adolescents can present with borderline symptomatology and that postponing diagnosis and evidenced-based treatments for BPD until an individual turns 18 can not only be harmful but can also place the individual at risk for more complex problems in the future. The authors discuss various reasons to consider diagnosing and treating adolescents who present with BPD symptomatology, as well as an evidence-based approach (Cognitive Analytic Therapy) that has been shown to be effective when treating adolescents with symptoms of BPD and has exhibited potential to be included in an integrated primary care and behavioral health model. Finally, the authors present a case example and highlight how Cognitive Analytic Therapy could be an effective treatment modality for this individual.

Keywords: Cognitive Analytic Therapy, interprofessional practice, adolescents, borderline personality disorder, social work values

Borderline Personality in Adolescence

According to the American Psychiatric Association (2013), borderline personality disorder (BPD) is characterized by “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts” (p. 663). Instability permeates BPD and is manifested in sudden changes in behavior, mood, personal values, and relationships. An individual with BPD may initially idealize a friend, family member, or romantic partner, then, abruptly devalue that person and their relationship. This change can be explained as an extreme effort to avoid real or perceived abandonment, which is a measure to protect against being alone, feeling like a bad person, or experiencing aversive emotional states (American Psychiatric

Association, 2013; Kaess, Brunner, & Chanen, 2014). Individuals with BPD exhibit identity disturbance through dramatic changes in self-image, including changes “in opinions and plans about career, sexual identity, values, and types of friends” (American Psychiatric Association, 2013, p. 664). Experiencing episodes of anger and panic are common and can be explained as reactions to interpersonal instability; affective instability is correlated with fluctuating moods. Individuals with BPD also often exhibit impulsivity through harmful and risky behaviors, including gambling, binge eating, abusing substances, practicing unsafe sex, and exhibiting suicidal or self-harming behaviors (American Psychiatric Association, 2013; Kaess et al., 2014; Chanen, Jovev, McCutcheon, Jackson, & McGorry, 2008).

While it is possible to diagnose criteria for BPD in individuals younger than age 18, there has been opposition against making this diagnosis during childhood and adolescence. Kaess et al. (2014) cite wanting to protect youth against societal stigma of having a personality disorder and the fact that “affective instability or disturbed self-image are normative among adolescents” as reasons to delay diagnosis (p. 783). However, in recent years evidence has emerged that supports making personality disorder diagnoses during adolescence, specifically for BPD diagnoses. BPD has been described as a lifespan developmental disorder that can be diagnosed in adolescence (Chanen & McCutcheon, 2013; Chanen et al., 2008). BPD symptoms often emerge during this developmental stage and remain stable in the transition to adulthood (Hughes, Crowell, Uyeji, & Coan, 2012; Kaess et al., 2014; Chanen et al., 2008). A 2011 review of the Minnesota BPD Scale revealed that 14 to 17-year-olds exhibited more symptoms of BPD (including antisocial behavior, behavioral disinhibition, and internalizing distress) than did 17 to 24-year-olds (Bornovalova, Hicks, Patrick, Iacono, & McGue, 2011). Such results provide further support to the claim that it is clinically appropriate to diagnose BPD during adolescence (Stepp, Whalen, Scott, Zalewski, Loeber, & Hipwell, 2014).

Though BPD has historically been considered an adult disorder, postponing a diagnosis of BPD until age 18 can result in clients receiving inadequate treatment for years. Delaying diagnosis can exacerbate symptoms and result in long-term negative consequences including suicidality and non-suicidal self-injury, substance abuse, academic failure, increased risk for additional mental health disorders, interpersonal problems, and reduced quality of life (Miller, Muehlenkamp, & Jacobson, 2008; Chanen et al., 2008). Early intervention efforts that focus on “averting associated adverse outcomes and promoting more adaptive developmental pathways” can help alter the life-course trajectory of adolescents with BPD (Chanen & McCutcheon, 2013, p. 24).

Risk and Protective Factors for BPD

Many of the risk factors of BPD stem from childhood and adolescence. Family history of BPD increases the likelihood of developing the disorder, although it is unknown if this is due to genetic or environmental influences (American Psychiatric Association, 2013; Kaess et al., 2014). Gender is another risk factor for BPD; about 75 percent of adults diagnosed with BPD are female (American Psychiatric Association, 2013). Perhaps the greatest risk factor for BPD is experiencing trauma during childhood: studies have shown that adults with BPD report histories of adverse childhood experiences, including abuse, parental psychopathology, and various forms of maltreatment (Chanen & Kaess, 2012; Kaess et al., 2014). One study of individuals with BPD revealed that 81 percent had experienced extensive trauma during childhood, including physical abuse, sexual abuse, and domestic violence (Goodwin, 1990). Baird (2008) argues that when these traumas are caused by primary caregiver(s) a child may adapt by dysregulation of affect or by developing disorganized/disoriented attachment patterns, both of which are symptoms of BPD. The trauma itself is a risk factor, but the source of the trauma as well as caregiver(s) attunement to helping the child process the trauma are also risk factors for BPD.

A multitude of risk factors have been identified for adolescent BPD, including: difficult temperament, maltreatment, experience of separation and loss, parental temperament, parental psychopathology, dysfunctional family environments, single-parent families, parental illness and/or death, poor parenting practices,

history of neglect and abuse, disturbed attachments with caregivers, biomedical problems, genetic vulnerability, parents having BPD, being bullied, maladaptive school experiences, and poor relationships with peers (Stepp et al., 2014; Sharp & Romero, 2007; Kaess et al., 2014; Chanen & Kaess, 2012). Adolescent girls are at an increased risk of developing BPD and often experience comorbid psychiatric diagnoses and diminished psychosocial functioning in comparison to boys (Stepp et al., 2014; Kaess et al., 2013). The interplay of these individual characteristics, family factors, and peer factors make it challenging to pinpoint developmental pathways to BPD in adolescence, and further research into risk factors is needed.

In terms of structural inequalities, being from a lower income family is a risk factor for adolescent BPD; one study of adolescents with BPD symptoms revealed that their families were of lower socioeconomic status compared with adolescents without BPD symptoms (Kaess et al., 2013). However, it is important to note that these results are only indicated by the participants of this particular study and cannot be applied to all adolescents with BPD symptoms. Data on the prevalence of BPD among different ethnic groups is mixed; one study by Chavira et al. (2003) found that rates of BPD are higher among Hispanics, while another study by Castaneda and Franco (1985) found no differences in the prevalence of BPD among ethnic groups. Becker et al. (2010) and Long and Martinez (1997) highlight how aspects of Hispanic culture may influence BPD symptoms, including valuing trust and intimacy in relationships, avoiding interpersonal conflict, the importance of the family unit, and gender role distinctions. This information highlights how culture definitively plays a role in BPD, even if research on prevalence rates is inconsistent.

There is very limited research on protective factors for BPD diagnoses at any age, including during adolescence. A study by Helgeland and Torgersen (2004) defined protective factors as “artistic talents, superior school performance, above average intellectual skills, and talents in other areas,” and found that adults with BPD reported few such factors (p. 143). One could argue that once corrected or reversed, many of the risk factors for adolescent BPD could become protective factors. For example, since poor parenting practices such as being punitive and inconsistent are risk factors, effective parenting practices such as being

consistent and warm could be protective factors (Stormshak, Bierman, McMahon, & Lengua, 2000). Protective factors can also mediate the effects of risk factors. For example, an individual who has a genetic vulnerability for BPD (risk factor), yet demonstrates superior academic performance and whose parents utilize effective parenting practices (protective factors), could ultimately be at a decreased likelihood of developing BPD. Ultimately, more research on the developmental pathways to BPD diagnoses is necessary for preventing and diminishing such symptomology in adolescence.

Cognitive Analytic Theory (CAT): An Early Intervention for Adolescents with BPD

Cognitive Analytic Therapy (CAT) is a time-limited, integrative psychotherapy that combines theoretical and practical elements of psychoanalytic object relations theory and cognitive psychology and has been used in the treatment of adolescents with BPD (Chanen, McCutcheon, & Kerr, 2014). CAT is a practical, collaborative approach that focuses on understanding individuals' self-management problems and interpersonal relationships as well as the thoughts, feelings, and behaviors that manifest as a result of these patterns (Chanen et al., 2014). In CAT, the self is characterized as an "internalized repertoire of relationship patterns," which is acquired throughout the developmental lifespan and which influence the ways that individuals behave with others (Chanen et al., 2014, p. 366). If early caregiving interactions lack nurturance and predictability, or are destructive to children in various stages of development, these individuals may internalize negative relationship patterns which are "used or reenacted inappropriately and/or inflexibly," as seen in BPD (Chanen et al., 2014, p. 366). CAT therapists work collaboratively with their clients to map out the various splintered self-states that have been created through this process, as well as to identify triggers that provoke switches between these states (Kellett et al., 2013).

In CAT, dissociation is seen as a defense mechanism for coping with trauma experienced in youths' pasts (Chanen et al., 2014). The exploratory process of therapy is used to cultivate a non-judgmental description of the maladaptive interpersonal schemas that youth with BPD have developed over time, which may cause youth to dissociate into different self-states

when under stress (Chanen et al., 2014). Diagramming and reformulating these dysfunctional patterns also allows therapists to predict and prevent potential threats to the therapeutic alliance, reducing the number and severity of therapeutic ruptures and subsequent repairs frequently experienced by therapists working with BPD clients (Kellett et al., 2013). Over the course of about 16 sessions, CAT utilizes a variety of interventions including behavioral experiments, mindfulness exercises, processing of traumatic memories, and enactments in both the outside world and in the context of the therapy relationship (Chanen et al., 2014). Additionally, clients are offered follow-up sessions at one, two, four, and six month intervals after therapy has ended to observe their improvements (Chanen et al., 2014).

Data has suggested that adolescent features of borderline personality have been shown to respond well to treatment (Chanen et al., 2014). As adolescence is the time when these symptoms often begin to appear, this developmental period is an ideal time to intervene with CAT. Not only does such intervention enable a client to receive treatment earlier, but as previously mentioned, intervening during adolescence can also alter the trajectory of BPD to diminish negative outcomes later on (Chanen et al., 2014).

Evidence for CAT's Effectiveness

Research demonstrates that CAT is an effective intervention for BPD in adolescence (Biskin, 2014; Chanen et al., 2008; Kellett, Bennett, Ryle, & Thake, 2013). In a randomized controlled trial of CAT's effects on BPD in adolescents, Chanen et al. (2009) found significant and clinically substantial improvement for clients—those clients who received CAT as opposed to manualized good clinical care (the treatment normally provided for these clients by the HYPE clinic) tended to improve more swiftly, demonstrated lower levels of externalizing pathology, and showed the greatest median improvement on outcome measures after two years post-treatment. In a study by Kellett et al. (2013), CAT was demonstrated to reduce psychological distress, dissociation, personality disturbance, and borderline severity and risk. Clients reported experiencing increased personality integration over time, and they directly attributed the reduction of their negative symptoms to CAT (Kellett et al., 2013). CAT has been shown to

have a lower dropout rate than other treatments for BPD, which makes it a desirable choice for providers and clients alike (Kellest et al., 2013).

One limitation of the research available on the effectiveness of CAT is that the main studies to date have had relatively low sample sizes, and most have been quasi-experimental; the authors could locate only one study that utilized a randomized controlled trial (Chanen et al., 2009). Additionally, in the study by Kellet et al. (2013), one patient experienced clinically significant deterioration of psychological well-being; it is unclear what caused this poor outcome, but clinicians and researchers should be mindful of potential iatrogenic problems associated with CAT interventions. Further research must be conducted to verify previous findings and to add substantial support for more widespread use of CAT with adolescents experiencing BPD symptoms.

CAT's Relation to Social Work Values

Not only is there strong evidence for the effectiveness of CAT with adolescents showing symptoms of BPD, but its theoretical foundation and treatment techniques are also strongly aligned with social work values, making it an ideal treatment choice. CAT meets the client where he or she is, operates from a developmental and contextual lens, and emphasizes the importance of relationships, both positive and negative, in clients' lives. CAT "sees 'psychological mindedness' as a goal of therapy, rather than a prerequisite," which allows the therapist to adapt to the client's level of readiness for change. This is particularly important for work with adolescents, as many youth with BPD have had limited or negative experiences with mental health services in the past and may be apprehensive about seeking treatment (Chanen et al., 2014, p. 366). As mentioned above, a central feature of CAT is an active, collaborative undertaking by both the therapist and the client to understand the developmental origin and nature of the client's difficulties (Chanen et al., 2014). The CAT model views the self as fundamentally relational and social in nature—as such, "individual psychopathology cannot be considered apart from the sociocultural context in which it arose and within which it is currently located," a viewpoint clearly aligned with the social work concept of person-in-environment practice

(Chanen et al., 2014, p. 367). Active engagement of families and other caretakers is another important component of CAT, notable because many youth with BPD are estranged from their families and need support reconnecting with them (Chanen et al., 2014). Finally, though CAT is at its core a talk-based therapy intervention, it uses simple language and can be modified for use with a variety of at-risk youth, including persons with intellectual and learning disabilities (Chanen et al., 2014). This makes CAT accessible for a diverse range of clients, and provides these clients with the agency to tell their stories in their own voices and develop their own innate strengths in the pursuit of therapeutic progress.

Interprofessional Practice and Cognitive Analytic Therapy

Since CAT interventions work so closely exploring relationship patterns in young peoples' lives, integrating CAT interventions within an interprofessional practice framework is promising. Typically, individuals with BPD are classified as difficult patients to work with (Caruso et al., 2013). Thus, it is imperative that professionals treating this type of client are working under the same treatment model and philosophy to ensure seamless service delivery and safeguard against the risk of clients abandoning treatment or frustrating their service providers to the point of terminating care (Caruso et al., 2013). One promising example of a successful adolescent BPD treatment center is The HYPE clinic, a part of ORYGEN Youth Health in Australia (Chanen et al., 2009). The HYPE clinic has created an early intervention program for adolescents with borderline personality disorder that operates under an integrated, team based model (Chanen et al., 2009). This model can serve as an initial reference point for creating an interprofessional adolescent BPD intervention that incorporates medical providers (Chanen et al., 2009).

The HYPE clinic serves adolescents who meet three or more of the DSM-IV diagnostic criteria for BPD (Chanen et al., 2009). According to Chanen et al. (2009), the HYPE clinic not only provides CAT services, but also employs a team of professionals to address other areas of need affecting the adolescent's functioning. Additional team members include assertive case managers who have an active partnership with outside providers involved in

the young person's care, crisis workers, and generalist psychiatric care and medication management professionals (Chanen et al., 2009). While studies of the HYPE clinic suggest that it is an effective intervention, it is notable that there are not any pediatricians or primary care practitioners incorporated into the HYPE treatment model.

Level of Integration

Utilizing Heath, Wise Romero, and Reynolds' (2013) framework for integrated care delivery, the HYPE clinic model is at a level two. This means that while the clinic has made distinct efforts to communicate with outside providers to address fragmentation of patient care, because they are not operating within the same structure, distance is still maintained. Chanen et al. (2009) acknowledge the challenges such a setup presents, stating that one of the reasons that working with young people displaying BPD symptomatology is particularly challenging is because of their typical involvement in multiple, complex systems, including primary care. While the HYPE case managers are actively communicating with other service providers involved in the client's care, it can be difficult to avoid service delivery fragmentation (Heath et al., 2013) when professionals are not on the same team. Chanen et al. (2009) state that it is the role of the case manager to ensure that other professionals are knowledgeable of the CAT model so that "everyone is singing from the same song sheet" (p. 170). However, without formal opportunities for communication between professionals operating in separate systems, gaps in knowledge are inevitable. Although it would be impossible to suggest that the HYPE clinic employ practitioners from all areas in which the young person might be involved (e.g., child protection, schools, juvenile justice, foster care), given the implications that BPD has on physical health outcomes, it would certainly increase the efficacy of service delivery to have a primary care practitioner on staff. Having a primary care physician included in the HYPE model would increase the level of integration to at least a level three (Heath et al., 2013). This would allow for more direct communication among providers, alleviate the stress of being involved with multiple healthcare systems, and would increase healthcare service delivery as the client's physician would be well aware of the specific

needs and relationship issues that arise when treating the physical health of this particular type of client.

Barriers to Implementation

The authors recognize that adding primary care practitioners into the HYPE clinic model of CAT is idealistic. It would take time, funding, training, and agency buy-in for individual practitioners to adopt the HYPE clinic model (even without primary care) with their patients. However, for individuals who are working primarily with adolescents presenting with borderline symptomatology, it might be helpful to incorporate elements of CAT into working with such clients. Additionally, if an agency does not have access to assertive case management services, social workers can be attuned to the needs of adolescents with BPD beyond psychotherapy, and can strive to decrease service fragmentation by obtaining consent to speak with other providers involved in the young person's treatment. Practitioners can adopt elements of the HYPE clinic's CAT model into their practice even if they do not have the luxury of working on a fully integrated team. With the patient's consent, social workers can actively seek communication with the young person's medical team and other social service providers and educate them on the principles of the CAT model, increasing the probability that the client will stay positively and consistently connected with all facets of their mental and physical health care system.

Case Example

Melissa is a 15-year-old Hispanic American female who lives with her mother, stepfather, brother, and sister. Melissa is the oldest of three siblings and expresses having a fairly good relationship with her family. Her family is of lower socioeconomic status and lives in a suburb of Chicago, Illinois. Melissa denies a family history of mental health issues or substance use. She has a tumultuous relationship with her extended family that lives nearby, whom she describes as verbally abusive toward her.

Melissa was referred to intensive outpatient services due to negative behaviors at school. These behaviors include fighting—both physical and verbal altercations with students and teachers—failing grades, and mood

instability. Melissa describes periods of emotional dysregulation marked by unstable, impulsive, and intense behaviors in addition to symptoms of depression and anxiety. She reported that these behaviors have impacted her ability to perform in school and, as a result, she is currently failing all of her classes. She states that she will often refuse to go to school because she believes teachers do not like her and states that students instigate fights with her after school. Melissa has described that she often dissociates, or “blacks out,” when she becomes escalated. She has one or two friends in school, but does not identify them as healthy, trusting relationships. Her mother describes her mood as unstable—one moment she will be fine but then will be easily triggered to intense emotions. She reports suicidal ideation without intent, self-harm, poor self-image, and hopelessness. She does not report any positive interests or life goals. She states that she currently has a boyfriend but has strong feelings regarding abstaining from sexual activity. She reports no history of trauma, substance use, or chronic medical conditions. She is currently taking 100 mg of Seroquel once daily.

Based on the assessment of Melissa’s identified issues, family history, and community context, some risk and protective factors can be identified which align with BPD. Individual risk factors include female gender, poor self-image, suicidal ideation, self-harm, and affective instability. Familial risk factors include conflict with extended family members and low socioeconomic status. Societal risk factors include maladaptive school experiences and poor interpersonal relationships with peers. Some protective factors include the presence of caring adults and good family cohesion. The authors note that the absence of risk factors such as substance use, physical or sexual abuse, family history of mental illness, and community violence can be seen as protective factors. The authors believe more information is also needed to further expand upon risk and protective factors, including parental psychopathology and cultural context.

Melissa received intensive outpatient services three times a week for one month at a community mental health center. Counselors reported that she often had anxious mood and labile affect. Moreover, counselors identified her behaviors as manic, hyper-verbal, and attention-seeking. Melissa struggled with interpersonal relationships in the group—she would become close to some members and then pit them against

one another. After a month her behaviors were deemed too disruptive and she was dismissed from group treatment and asked to begin individual therapy instead. The authors have deemed Melissa to be a good candidate for CAT based on HYPE’s research and treatment model.

Treatment Model

The treatment plan for Melissa will include more extensive assessments to identify personality disorder traits, individual CAT, integrated case management, family therapy, and psychiatric care with an added medical health component (Chanen et al., 2009). The authors’ rationale for selecting this intervention plan is based on the success of HYPE’s integrated, team-based treatment model as an effective intervention for BPD in adolescence (Bislin, 2014; Chanen et al., 2008; Kellett et al., 2013). Research on CAT indicates that a high engagement and low drop-out rate would benefit Melissa, particularly after being asked to leave a treatment group. Moreover, Melissa’s case meets the inclusion criteria for HYPE’s selection of adolescents who meet three or more DSM-IV BPD diagnostic criteria, indicating that positive outcomes are likely (Chanen et al., 2009). Based on DSM-IV-TR criteria for BPD (the version of the DSM last used by the HYPE clinic), Melissa has demonstrated a pattern of impaired interpersonal functioning, identity disturbance, affect instability, difficulty controlling anger, and significant dissociative symptoms (American Psychiatric Association, 2000).

Individual CAT will include an agreed-upon number of sessions, likely the typical 16 sessions. Initial sessions will focus on Melissa and the therapist jointly diagramming and reformulating dysfunctional relationship patterns. The therapist will utilize “The Psychotherapy File,” a questionnaire that Melissa will take to identify traps, dilemmas, snags, and unstable states of mind (Association for Cognitive Analytic Therapy [ACAT], 2000). Melissa and the therapist will agree on which mood switches or symptom to monitor, which will become the central theme of all sessions. The authors speculate that a central pattern for Melissa will involve interpersonal conflict. The therapist will also create a “Reformulation Letter,” a written account of the clinician and client’s shared understanding of the problem (Chanen et al., 2009; Ryle & Kerr, 2003). The remaining sessions will include therapeutic interventions such as mindfulness exercises,

processing of traumatic memories, and enactments in both the outside world and in the context of the therapeutic relationship to assist Melissa with recognizing, monitoring, and revising her central pattern (Ryle & Kerr, 2003). Family involvement will be integrated into treatment planning and psychoeducation through four family sessions. Upon discharge, Melissa and her clinician will write a “goodbye letter” and meet four times—at one, two, four, and six months (Chanen et al., 2009; ACAT, 2000).

The treatment team will include a social worker and psychiatrist. To include an interprofessional practice framework, the treatment team will also request consent from Melissa and her parents to communicate with her primary care provider and other doctors. Clinicians will meet weekly with the psychiatrist to discuss updates to treatment goals and will pass on pertinent information to Melissa’s team of medical professionals. Moreover, clinicians will receive weekly psychotherapy and case management supervision individually or in small groups to maintain fidelity and ensure quality of care (Chanen et al., 2009).

prodromal symptoms of BPD in adolescence indicates that attention should be given to early intervention; failure to do so can result in negative long-term outcomes. CAT is an effective evidence-based early intervention for adolescents with symptoms of BPD (Biskin, 2014; Chanen et al., 2008; Kellett, Bennett, Ryle, & Thake, 2013). Research findings on CAT show low dropout rates and significant improvements, making it a desirable intervention for clinicians and clients alike (Kellett et al., 2013). Moreover, CAT aligns with the social work value of meeting the client where they are, and emphasizes relationship-building and collaborative treatment planning. The authors have demonstrated how this framework can be altered for interprofessional practice purposes as well; the integration of medical professionals into the intervention will further benefit clients. Finally, the application of this model to a case example highlights the exciting potential of using an interprofessional iteration of CAT with adolescent clients demonstrating BPD symptomology.

Conclusion

While diagnostic criteria stipulate diagnosing BPD after 18-years-old, research on

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Clinical Implications for Working with Couples Experiencing Infidelity

Kristen Okrzesik

Abstract

In postmodern, Western society, interpersonal relationships come in a variety of forms and couples may face an even greater variety of problems for which they seek therapy. In pop culture, the relationships and break ups of the rich and famous are followed on a daily basis. This article discusses the implications for clinicians working with couples who are struggling with infidelity in their relationships. An exploration of the definition of infidelity and the presence of infidelity in the media and in history will be conducted. In addition this article explores the current research on working with couples experiencing infidelity, along with suggestions and considerations clinicians must give when it comes to intervention planning and treatment.

Keywords: infidelity, media, couples, therapy, relationships, partners, cheating

Introduction

In today's society, infidelity seems commonplace: on television shows, in the news, among celebrities, and even in politics. A person can turn on the television and see a number of talk shows with unfaithful husbands and wives. Movies such as *Unfaithful* (2002) and *The Kids are All Right* (2010) show the difficulties that both heterosexual and homosexual couples face when one partner decides to cross the line of remaining faithful. Infidelity in a relationship can occur for many reasons, and the act of infidelity can affect many systems in a couple's environment. Because of its complexity, infidelity is an issue that clinicians must approach carefully, not only for the sake of avoiding countertransference, but also because of the complications infidelity can cause to partners in a committed relationship.

Defining Infidelity

One of the first issues a clinician encounters in working with couples experiencing infidelity is defining the term "infidelity."

Infidelity may mean something different to each partner. One individual may include sending a text message to someone outside of the relationships as an example of cheating, while another individual might define it as one partner having sex or speaking with someone outside of the relationship. A partner may not even realize that he or she is breaking the boundaries of the relationship if he or she does not understand their partner's views on specific components then lead to a definition of infidelity. According to Whitty and Quigley (2008),

Many researchers have come to the conclusion that there are two main types of infidelity: sexual and emotional... Sexual infidelity is considered to be engaging in sexual intercourse with someone other than one's partner. Emotional infidelity is understood to be falling in love with another individual other than one's partner. (p. 461)

While this definition seems to give a specific explanation of infidelity, couples may define the elements of infidelity in a myriad of different ways, irrespective of the ways researchers define and classify this practice.

However a couple may choose to define infidelity, it is important that therapists are aware of the many acts a person might consider to be an example of cheating. One couple's definition of cheating might not be the same as another couple's; infidelity might not be defined by cheating at all, but another act. Infidelity is a violation of an assumed or stated contract in a relationship; when there is not a stated contract, one member of a couple may assume what he or she is doing outside of the relationship is not a violation. Ratus, Nevid, and Fichner-Ratus (2014) attempt to portray the complexity of infidelity by stating, "Extramarital sex is usually conducted without the spouse's knowledge or approval. Secret affairs are referred to as conventional adultery, infidelity, or simply 'cheating'. Conventional adultery runs the gamut from the 'one-night stand' to the affair that persists for years" (p. 420). All of these actions help to define the term infidelity, but the issue becomes more complicated because not all

couples consider sexual relationships to be acts of infidelity: For example, “in consensual adultery, extramarital relationships are conducted openly – that is, with the knowledge and consent of the partner. In what is called *swinging*, or *mate-swapping*, the partner participates” (Rathus et al., 2014, p. 420). If a couple is open to extramarital relationships, it is important to help them define instances in which the agreed upon “contract” might be broken. A clinician should understand the boundaries a couple has defined, and whether or not one or both partners have violated those boundaries.

In today’s Internet world, technological advances have further complicated the definition of infidelity. For example, couples may consider online relationships as acts of infidelity. Whitty’s follow up study in 2005 found that “cybersex was rated very highly and almost as severe as sexual intercourse... She concluded from this study that some online interactions could potentially have serious repercussions for the offline relationship” (Whitty & Quigley, 2008, p. 463). As society advances, the perception of the specific elements pertaining to infidelity becomes more complex. Blow and Hartnett (2005) explain that “infidelity is defined in a myriad of ways and can comprise a number of activities including: having an affair, extramarital relationship, cheating, sexual intercourse, oral sex, kissing, fondling, emotional connections that are beyond friendships, internet relationships(s), pornography, and others” (p. 186). Betrayal of a boundary is not a universal concept that each individual automatically recognizes as such. Not to mention the fact that some couples might agree to certain behaviors that others might define as infidelity themselves.

Motivations for Infidelity

The definitions for infidelity are many, but the motives for infidelity are just as complex. Choosing to break the relationship contract is a decision that leads to a number of difficult outcomes for both partners in a relationship, so understanding why people cheat is an important task. According to Rathus et al. (2014), “Some people engage in extramarital sex for variety...Some have affairs to break the routine of a confining marriage... Others enter affairs for reasons similar to the nonsexual reasons adolescents often have for sex: as a way of expressing hostility toward a spouse or

retaliating for injustice” (p. 419). Mark et al. (2011) list relationship status, religiosity, education, socio-economic status, gender, relationship satisfaction, and personality as key factors according to current research on why a partner in a committed relationship may choose to be unfaithful. Others may suggest sex addiction as a motive for infidelity; however, the *Diagnostic and Statistical Manual of Mental Disorders* does not recognize sex addiction as a diagnosable disorder, and rather lists it as an addiction that requires more research (American Psychiatric Association, 2013). The motives that researchers list range from physical needs to emotional needs, and whatever the case, it seems that the motive usually begins when a person feels he/she is lacking something from his/her partner.

Research suggests that women tend to seek emotional closeness, whereas men seek sexual satisfaction when they choose to cheat on their partner. For example, “Many times the sexual motive is less pressing than the desire for emotional closeness. Some women say they are seeking someone whom they can talk to or communicate with... Women are usually seeking ‘soul mates,’ whereas men are seeking ‘play-mates’ (Rathus et al., 2014, p. 419). Though research might offer a stereotyped and gendered view on the reasons for infidelity ultimately the therapist would need to ascertain the roots of infidelity as they pertain to the therapist’s clients.

Infidelity in the Media

In the media, infidelity is an issue that drives public attention. In recent history, Tiger Woods admitted to having a sex addiction (Goldman, 2010); Jesse James cheated on his wife, Sandra Bullock (Daily Mail, 2013); and former President Clinton cheated on his wife while in office (Vanity Fair, 2014). While acts of infidelity are painful and devastating for the individual cheated upon, the public seems to find stories of infidelity entertaining. Blow and Hartnett (2005) explain,

For the public, the attraction [of infidelity] lies more in the sordid details and often bizarre twists of these kinds of relationships; after all, realities of infidelity in public life range from broken hearts to murder to exposures and resignations of high-profile leaders. (p. 183)

The media's sensationalism of infidelity leads confusion toward beliefs about how individuals view infidelity and could lead into further conversations that blame one individual for not being "good enough" or "attractive enough" to keep the interest of their partner.

Historical Influence

Infidelity is not a modern issue facing committed couples. In fact, couples have faced problems with infidelity for centuries, and some theorists suggest that infidelity dates back to our earliest ancestors. According to Whitty and Quigley (2008), researchers found that:

...ancestral man faced a grave threat from cuckoldry—that being uncertainty about the paternity of their partner's children. Consequently, men are more likely to respond with more intense jealousy to sexual infidelity than women. Ancestral woman...faced the risk that an unfaithful male partner might divert his resources to another woman and her children. Therefore, women have developed an innate jealousy toward emotional infidelity. (p. 462)

This theory suggests that the interactions and concerns of ancestral men and women influence the way modern day men and women feel about infidelity in their relationships. Of significance for clinicians to recognize is this theory might not apply to couples that identify as part of the LGBTQ community in the same fashion as it might give insight on heterosexual relationships. In a study conducted by Brewer (2014), awareness of the diversity that comprises the makeup of a family is addressed: "[The study's] findings may reflect beliefs that heterosexual infidelity can be addressed by strengthening the relationship or confronting the rival, where homosexual infidelity indicates the partner's preferred sex of partner which cannot be similarly reconciled" (p. 99). Earlier research placed most of its focus on heterosexual couples, but more current research reminds therapists to consider straying from a heteronormative understanding of who infidelity impacts and the reasons for it.

Current Research

Factors in current research suggest infidelity is an issue that seems to be increasing, both in number of couples experiencing infidelity and in the complexity of defining it. According to Rathus et al. (2014),

Results from [a recent study] find that the lifetime rate of infidelity for men aged 60 and above increased to 28% in 2006, up from 20% in 1991... For older women, the lifetime incidence rose to 15%, up from 5% in 1991... A USA today/Gallup Poll found that 54% of respondents said they personally knew someone who had been unfaithful. (p. 420)

This research clearly shows that infidelity is an issue in society. According to the growing numbers, infidelity is a persisting challenge for couples, and therefore could become an issue that more therapists will encounter in clinical practice.

In recent decades, the divorce rate in the United States has skyrocketed, and numbers suggest that infidelity plays a significant role in the destruction of marriage and committed relationships (Mark, Janssen, & Milhausen, 2011). According to Mark et al. (2011), "In Western countries, it has been estimated that between 25% and 50% of divorces cited a spouse's infidelity as the primary cause of the divorce" (p. 971). Levine (2010) explains, "From the 50% American divorce rate, it is safe to assume that many individuals are not satisfied in their marriage... However they arrived at their judgment, they may find themselves preoccupied with the perception that love for their partner is diminishing" (p. 93). According to these numbers, it seems that if a partner's love "diminishes" or he or she becomes dissatisfied with some aspect of his or her marriage, the choice to cheat does not seem to be unlikely. Despite the increasing divorce rates and lifetime infidelity rates, studies have also shown that people claim to still value the idea of committed relationships. According to Rathus et al. (2014), "About nine out of ten Americans say that affairs are 'always wrong' or 'almost always wrong'. Three out of four Americans say that infidelity is 'always wrong'... Only about 1% say that extramarital sex is 'not at all wrong'" (p. 420). As stated earlier, society seems to be exposed to infidelity in the media, but the

numbers show that people still value committed relationships and view infidelity as wrong.

Another important aspect of current research is the idea that sexual infidelity seems to be more harmful than other acts of infidelity. According to Mark et al. (2011), "Sexual infidelity, which can be defined as extradyadic sex within the context of a monogamous relationship, is considered to be among the most significant threats to the stability of adult relationships, including marriage" (p. 971). While not all couples practice monogamy within their relationship, this author utilizes Mark et al. (2011) to bolster the point that sexual infidelity can have devastating effects for a couple that specifically utilizes the perimeter of monogamy in an intimate relationship.

Role of Therapist

Therapists must follow certain steps when working with infidelity cases. Levine (2010) suggests that therapists discern the following three things: their clients' motivations for infidelity, if there are any present psychiatric disorders that may have contributed to infidelity, and the consequences of enacting infidelity (p. 91). In doing so, therapists will understand both the background leading up to and the aftermath of the act of infidelity. Furthermore, Levine (2010) encourages therapists to "recognize the power of [their] values and life experiences in organizing [their] clinical perceptions in this arena, remain empathic without certainty regarding what the individual or couple should do, [and] regard [their] role as clarifying the private struggles in people's lives" (p. 87). Lastly, therapists must "restrain [themselves] from being authoritative" (p. 87). Whether the couple decides to divorce or continue building communication and intimacy in a marriage, the therapist is a figure of support, not of gatekeeping. The clinician's opinions and beliefs about the couple's choices should remain neutral, unless there is a threat of harm.

In working with couples experiencing infidelity, the therapist should remain neutral and help the couple through their difficulties and pain. According to Blow and Hartnett (2005), "couple therapists are too well aware of the tremendous pain and heartache expressed by clients caught up in the throes of an affair...Infidelity is undeniably harmful – often devastating – to individuals and relationships, and its repercussions present significant

treatment challenges"(p. 183). The therapist must work to understand both partners' needs and potentially different or conflicting definitions of infidelity in order to provide successful therapy. Allowing both partners to express their feelings is important, and working to help the couple understand each other's boundaries should be evidenced in the treatment plan.

Avoiding Countertransference

As with any individual, couple, or family, therapists must be constantly aware of countertransference issues and attempt to remain neutral in order to best help the client (Levine, 2010). If a therapist can understand his or her own values and avoid stereotypes, he or she will avoid countertransference issues and be able to provide empathy for his or her clients while working to help them heal. If a therapist is triggered by the client's story of infidelity or if he or she begins to oppose the individual who practiced infidelity, it is important to a) seek appropriate consultation and supervision from a supervisor and/or b) refer couples with infidelity issues to a clinician who can provide therapeutic services.

It is also vitally important for clinicians to be prepared to work with a variety of couples who might be influenced by infidelity in different ways. According to Martell and Prince (2005), "working with infidelity in lesbian and gay relationships is not vastly different from mixed-gender couples, but therapists must be aware of cultural norms that vary with same-sex couples. [In addition,] there will probably be even greater variation in same-sex couples from different cultural and ethnic groups" (p. 1437). As with any type of therapy, "[each] needs to be tailored to the particular context in which the couple lives"(Martell & Prince, 2005, p. 1437). Infidelity can occur in many types of relationships, and is not strictly limited to heterosexual, married relationships. Every couple's situation is different and it is the therapist's job to understand the couple's values, background, and goals for therapy.

Further Challenges

As stated throughout this essay, the challenges in defining, understanding and working with those experiencing infidelity are vast. Infidelity is not only a difficult topic to research and explain, but it also an act that can

have many effects on a number of different systems involved in couples' lives, including a couple's children and career pursuits. The effects on these systems might be harmful or they may bring couples/families together, spurring the family to make improvements in their relationship. For example, a couple might decide to negotiate or renegotiate certain boundaries as they pertain to intimacy with individuals outside the terms of the couple's relationship. If children are involved, the therapist would assist the parents in determining what effect a parent's infidelity might have had on the child, if any. For therapists, understanding the myriad of systems in a couple's life will assist the therapist in understanding ways to approach issues of infidelity with the couple.

Another challenge in working with infidelity as a presenting concern is the difficulty in conducting thorough research. According to Rathus et al. (2014), "Only 1% of women said they had been unfaithful during the previous year in the face-to-face interviews. However, 6% of the same sample admitted to infidelity on the computer questionnaire" (p. 420). Blow and Hartnett (2005) also explain, "Those who participate in infidelity usually go to great lengths to conceal its discovery... Infidelity is more challenging because it involves betrayal and secrecy" (p. 188). Because those who participate in infidelity may want to "conceal its discovery," it is difficult for researchers to obtain clear and concise data, and therefore it is difficult to conduct further research on infidelity issues.

Conclusion

Despite the exposure that society and the media has brought to issues of infidelity, it is important for therapists to recognize how a couple views infidelity and the actions individuals wish to take in response to their presenting issues around the acts involved in the infidelity. Couples therapists work with individuals on a variety of issues, but "infidelity is perhaps the most complex issue encountered by couple therapists" (Blow & Hartnett, 2005, p. 183). It is of utmost importance for the therapist to understand infidelity as the couple defines it and to assess any areas of countertransference that might occur throughout the session(s). Above all, the therapist should be prepared to listen empathically to each truth an individual presents and be prepared to assist the client(s) in improving communication, setting boundaries, and formulating clear goals for the future of the couple's relationship. From a macro perspective, the therapist should lend time outside the session to conduct further research on treatment models and methods for working with clients experiencing infidelity, the holistic effects of infidelity, and the ways clients can separate or remain together while initiating efforts to understand another's point of view.

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A Theological Reclamation of Feminine Icons in Latin@ Culture: An Empowerment Model

Lorena Ornelas

Abstract

Mexicanas are reclaiming the story of Malinche and the reshaping the narrative that has historically portrayed her as a traitor for helping Hernan Cortez. The vilification of her story is analyzed through the lens of modern feminist scholarship that seeks to re-center Malinche as a symbol of empowerment rather than denigration. This article examines the mischaracterization of feminine icons that contributes to a form of male domination over women in Mexican culture. Focus is also given to the U.S. Mexican border where six women are murdered each day, police complicity runs rampant, and the exploitation of workers and presence of US. corporations contribute to modern colonization and sanctioned femicide.

Keywords: Catholicism, feminine sexuality, cultural hegemony, patriarchy, conquest of Mexico, subjugation of women, empowerment, Chicana feminist scholarship, identity politics, misogyny, sexual agency, church hierarchy, goddess worship, resistance, Juarez, femicide, maquiladora, NAFTA, gender-based violence, female labor force, U.S.-Mexican border, domestic roles, border economy, liberation theology, faith communities, historical narrative

Central to the argument in Kelly Brown Douglas's *Sexuality and the Black Church: A Womanist Perspective* (1999) is the idea that through years of control and inescapable cultural dominance, the Black Church has replicated much of the example of white culture, inheriting a belief in the inferiority of women and the idea that feminine sexuality is a commodity. This idea, while independent to Brown Douglas's study, may cause one to consider other instances of cultural hegemony and how one dominant society influences another, resulting in examples of feminine repression. In this instance, among others, one can see the manner in which religious practices promote patriarchal oppression of women.

The conquest of Mexico by the Spanish in 1519 provides an example that relates to the

ideas explored in Douglas' study. The legacy of the conquest is evident in the European languages spoken throughout Latin America. However, perhaps the biggest example of European culture being exported to the "New World" is in the form of religion. When the conquistadors absorbed the Mesoamerican religions, making their feminine gods look like La Virgen de Guadalupe, they did more than create a new pack of zealots. They laid the groundwork for a society that would simultaneously worship the maternal figure of La Virgen de Guadalupe and subjugate women, limiting their roles to mothers, domestic servants, and obedient wives when once there were goddesses of fertility and sacrifice (Blake, 2008, p. 28). This model of what it means to be a proper woman has extended beyond the Church and is the template for much of Latino society, reinforced through practice and sanctified by tradition (Blake, 2008, pp. 48-56, 58; Castilo, 1994, p. 63). The results, aside from the obvious inequality, can be dire, as gendered images dating from the European conquest serve to circumscribe women's lives, roles, and sexuality. In spite of this, today's Mexicanas¹ are reclaiming and reinterpreting these feminine icons in richer and more empowering ways.

Before examining the conquest and its numerous implications for women, one must

¹ The terms "mestiza", "chicana", "feminista", "mestiza", "Mexicana", "U.S. Mexicana" appear throughout the many sources used in this article (specifically Debra Blake's *Chicana Sexuality and Gender: Cultural Refiguring in Literature, Oral History and Art*, and Ada Maria Isazi-Diaz uses "Hispanic", "Hispanic women", "Mujeres Hispanas", "Hispanas" and "Latina" interchangeably in her book *Hispanic Women: Prophetic Voice in the Church*). The author, self-identifying as a U.S. born Mexicana, will use this term to refer to the ethnic group of American-born women who are born in a different country than their parents but are raised in the same manner as those born in Mexico and are thus exposed to all the rich traditions and nuances of both cultures.

take a look at pre-conquest Mesoamerican society in order to understand the significance of female goddesses and their importance to that culture. To the Mesoamericans, femininity was a symbol of fertility and renewal. The goddesses represented this important life force and were revered for their procreative powers (Blake, 2008, p. 28). While these powerful figures were supplanted with war gods and later Christian icons, modern day Chicana feminists have unearthed the fertility goddesses of their ancient ancestors to add these important figures into the pantheon of powerful female representations, thereby revitalizing the role they play within their culture. Blake (2008) writes, "The Chicana and U.S. Mexicana written and oral narratives recuperate ancient myths, legends, and histories to formulate stories that represent their contemporary view of themselves and the roles of women" (p. 17). While the history of Mesoamerica pre-conquest is indeed as bloody and imbalanced as post-conquest Mexico, the cultural roots, which saw value rather than danger in femininity, are of significant use to modern day Latina feminists. They seek to realign themselves with their ancestry and provide an alternative to the patriarchal tradition fortified by the introduction of Christianity.

Looking back at the history of Mexico, a woman named Malintzin Tenepal, or La Malinche as she is more commonly known in Mexico, provides an example of masculine views of women. Long considered the deceitful woman who sold out her people, La Malinche, lover of the infamous Spanish Conquistador Hernán Cortés, has come to symbolize the treacherous female who used her sexuality as protection from the Spaniards while her people were slaughtered. To this day, few names pack less venom than hers, and when a Mexican woman hears the word, it is always as an insult (Blake, 2008 p. 41, 175). Although the overwhelming cultural tradition is to treat La Malinche as a treasonous whore, recent interpretation by the indigenous woman's community has painted her as a woman forced to trade in her only stock, her sexuality, in order to assure better treatment for her people by the cruel Spaniards and ensure her survival (Blake, 2008, p. 6). It seems plausible that were it not for Malinche, who also served as interpreter for Cortés, the indigenous people might have suffered a worse fate. Chicana feminist scholars and intellectuals now assert that Malinche is nothing more than a scapegoat for the brutal conquest of Mexico (Castillo, 1994, p. 166). Hence, Malinche can be viewed as

the first woman in Mexican history to be shouldered with an impossible burden. Forces beyond her control were at play between the Europeans and the Aztecs, yet Malinche, by merit of her dealings with the Spaniards, is saddled with so much of the blame for the spreading of Christianity and the fall of the Aztec empire. In Debra Blake's *Chicana Sexuality and Gender* (2008), the author analyzes goddesses as being "re-membered" depictions of women who have historically been maligned or ignored. She also examines how those messages of silenced female representations of the divine have been given new life and new meaning by working/middle class Mexicanas. Even though these figures have been historically silenced, modern day Mexicanas and Chicanas have used them as symbols of empowerment. These women have "recuperated ancient myths, legends, and histories that represent their contemporary view of themselves and the roles of women" (Blake, 2008, p. 17). What modern Chicanas are doing is putting forth a much more accurate portrayal of themselves that speaks to their struggles and embodiment as descendants of a rich history of ancient womanhood. Malinche may have been seen as a traitor and a whore by many, including respected men such as Mexican poet and scholar Octavio Paz in his book, *The Labyrinth of Solitude* (1961), but there are women who read her actions as a means of survival. She is the ultimate symbol of feminine transgression (Castillo, 1994, p. 166). Further, she is a symbol for Mexicanas/modern Mestizas (of half indigenous and half European ancestry) who have to negotiate between two worlds and speak multiple languages in order to exist and survive (Blake, 2008, p. 43).

The lingering idea in many Mexican hearts is not of Malinche as a pragmatist or a misunderstood woman. She is still largely considered the ultimate traitor and whore. One can, therefore, see the misogynist tendencies bred into the culture from the onset of the conquest. Women who use their sexuality for any purpose other than procreation are whores. The Malinche example dictates that men must control women's sexuality in order to prevent an implied tragedy on the level of the conquest. Women are not to be trusted with their own bodies lest society pay the price.

Malinche is also thought to have been the link between pre- and post- conquest Mexico, best exemplified by the initial introduction of Christianity, which she is said to have helped spread through her association with the

Spaniards. It is evident that Christianity has absolute control over much of Latin America (Blake, 2008, pp. 17-18; Isasi-Díaz, 1992, p. 65). Catholicism is especially dominant throughout Central and South America. When one examines the gender hierarchy of the Church, roles of power are clearly delineated. Starting with the Pope and the cardinals, to the bishops and priests, all of these men wield total control over the Church. Women who take vows are granted the lowest status of the Church: nuns. Considered brides of Christ, nuns are not permitted to marry or exhibit any form of outward sexuality. While it is true that men who take vows also are denied sexual agency, there is still a gender bias toward women in the form of power. Women religious spend much of their lives working directly with the disadvantaged or offering educational instruction in parochial schools. Despite such important duties, these women rarely dictate their own destinies, always observing the directives of the men in the Church who hold superior positions of authority. When women religious defy or question the authority of their male counterparts, they are dealt with dismissively, or, in the recent case of the Leadership Council of Women Religious who defied the Vatican, they are condemned as pointlessly rebellious women in need of correction for their “serious doctrinal problems” (Uebbing, 2013).

While the Church presents a clear hierarchy in which men dominate women, another example from a bygone Mexico offers a view of the Church as the sole sanctuary for a defiant woman. Sor Juana Inés de la Cruz, born in 1651, was a nun famous for her poetry. A gifted child, she was composing original work at the age of eight. A born scholar, she was denied the freedom to study, a privilege not given to women. In defiance to the life expected of her, that of a subservient wife, she undertook religious vows in order to provide for herself a place where she could study, devoting her life to the Church but more so to her own education. Regarded as one of Mexico’s greatest poets and a symbol for contemporary feminists, Sor Juana has obtained significant status in Mexico and abroad (Paz, 1988, p. 64).

Sor Juana is an example of an important woman of great intellectual capacity who was forced to conform to one of only a few available roles. Rather than serve domestically, she chose to serve the Church in exchange for intellectual freedom. The rigid norms of 17th century Mexico may not exist today, but the example remains

relevant in the sense that the Church and the culture have yet to shake the image of an independent woman as a threat to social structure.

The manner in which men portray women contributes to these enduring gender roles. Depictions of La Virgen de Guadalupe, or Lupita, as she is more commonly known in Mexico, provide evidence of this. The ultimate female personification of the divine, her apparition on the hill of Tepeyac occurred eleven years after the fall of the Aztec empire and ushered in Catholicism to the indigenous population, supplanting their ancient feminine gods (Blake, 2008, p. 55-61). Tepeyac was also the site of Tonantzin, goddess revered by the people of the ancient Mexican capital. The Spaniards knew that the best way of introducing their religion was by absorbing the holy sites and rituals and fusing them with their Catholic icons. Unlike white depictions of saints, with blue eyes and pale skin, Lupita is olive-skinned with black hair and dark eyes, a figure whose physical features are similar to those of the conquered. Although she represents Catholicism, the religion of the invaders (Blake, 2008, p. 17), her appearance, from skin color to modest dress, seems intentionally conceived to demonstrate the manner in which women must display themselves: gentle, demure, content while looking down, her gaze averted, a sign of submissiveness. La Virgen de Guadalupe is the ultimate Mestiza, born of European and indigenous blood, and has been employed to create an image of the ideal woman as kind and subservient, an image reaffirmed through years of patriarchal practice.

Though Lupita represents Catholicism and the bitter history of the conquest, women today have refashioned La Virgen to be an agent of female empowerment and transformation. On this point, Gloria Anzaldúa conflates numerous goddess of the Aztec culture into Lupita, seeing her as “desexed Guadalupe, taking Coatlatlopeuh, the serpent/sexuality, out of her” (Blake, 2008, p. 97). Anzaldúa is appropriating Lupita and assigning her numerous pre-conquest identities to go along with her Catholic roots. In doing so, Anzaldúa reclaims her past as a Meztiza: “I will no longer be made to feel ashamed of existing. I will have my voice: Indian, Spanish, white. I will have my serpent’s tongue- my woman’s voice, my sexual voice, my poet’s voice. I will overcome the tradition of silence” (Blake, 2008, p. 97).

In Latino culture, this dichotomy of the virgin and the whore is exemplified by these two very important Mexican figures, La Malinche and Lupita. Although one cannot ignore the manner in which men have used these two feminine figures to reiterate and normalize the limited roles women can play, both have been reclaimed by Mexicanas as “active agents with a purpose and vision beyond patriarchal domination” (Blake, 2008, p. 43). Anzaldúa’s idea of re-sexing Lupita by fusing her with the sexualized goddesses of the Aztecs merges the opposing ideas of virgin and whore, removing the stigma of sexuality and allowing for a deeper appreciation and understanding of womanhood, one that can be both demure and sexual. Women must fight against the binary of virgin/whore, if they are going to reclaim a full embodiment of their sexuality. Reclamation of these feminine icons will help Latinas develop a fuller sense of womanhood without oppressive judgment of their sexuality.

Present day Mexico is still very much a patriarchal society that privileges men. As previously mentioned, Mexican and Mexican-American society models femininity and womanhood on the Virgen de Guadalupe and rebelliousness and transgression on La Malinche. Women who have defined domestic expectations have encountered greater penalties than a quiet life of religious structure. Since as early as the 1990s, the city of Juárez, just over the border in Mexico, has been plagued with femicides, murders of women. The number of victims is incalculable, but conservative estimates are upwards of 300-400 deaths, from the early 1990’s to 2006 (Ensalaco, 2006, p. 418; Gaspar de Alba, 2001). The women who fall victim to these atrocities are mostly workers in the maquiladoras, the factories that sprung up in the desert after the North American Free Trade Agreement went into effect in 1994 (Taylor, 2010 p. 349). Many of the women are last seen leaving or going to the factories, a commute that often requires miles of walking through dimly lit streets. Feminist study by such scholars as Elvia R. Arriola, Mark Ensalaco, Melissa Wright, and Linda Fregoso has suggested that the rise of murders has to do with the reversal of gender roles where women, who constitute the majority of the maquiladora’s workforce, leave the home to earn more money than men. This “stepping out” of prescribed roles represents a subconscious breach of protocol, a transgression that must be addressed. If one is to accept this theory, it becomes clear that the prevailing

dominance of religious and cultural norms can have grisly consequences. It is within this employment of Mexico’s women by outsiders that the Malinche archetype is easily drugged up. The women of Juárez are seen as courting the foreign invading force and simultaneously breaking away from the pure, virginal role to which they are supposed to adhere. What is most ironic, however, is that without the ripe labor source provided by Mexican women in Juárez, the maquilas would not thrive and the U.S. corporations could not profit. Juárez offers the perfect surrounding for gender-based violence. The female maquila worker represents a role reversal in Mexican culture where men are traditionally the predominant breadwinners, and where women are mostly the symbol of domesticity by a social order that imposes those perceptions. The violence committed on over 400 women can also be seen as a byproduct of NAFTA’s presence in Mexico, a major player in the distorting of Mexican society in the border town. “Corporate indifference and corporate irresponsibility” manifest in the creation of factories since NAFTA has destroyed Mexican farms, increased pollution, and paid Mexican workers wages on par with Mexican poverty levels that are not consistent with U.S. wages (Pearson, 2007, p. 741- 745). Perhaps this is awakening in the visiting United States corporations a sense of colonial entitlement as “guests” who make all the rules but contribute nothing of value in exchange for the exploitation of their workers and their families. In this sense, the factories that appeared after NAFTA, evidence of the economic control of the United States over Mexico, is another example of how a dominant culture affects the lives of Mexican women.

All over Juárez there are flyers and posters cautioning women against going out alone at night un-chaperoned or visiting a nightclub, the message being: “good girls stay home ... bad girls get killed” (Livingston, 2004, p. 65). The meaning of public versus private women those “good girls” who stay home and those “bad girls” who go to clubs, is also evident from people, such as the spokesperson for the Maquiladora Association of Ciudad Juárez. In response to criticism that factory owners were doing too little too late in connection with the deaths of many of their employees, he asked, “Where were these young ladies when they were last seen? Were they drinking? Were they partying? Were they on a dark street?” (Wright, 2006, p. 685). Unfortunately, this is a sentiment

shared not only by this private individual but also by two Chihuahua state governors, mayors, and even a visiting Spanish criminologist (Fregoso, 2007, p. 38), who find the victims responsible for their own deaths, somehow provoking the violence they suffer. The implication is that they were not innocent victims:

...as a result, women are joining the workforce at an earlier age and therefore discover independence. This means young women could become more promiscuous. Some of these independent women have maintained sexual relations with more than one person. This behavior leads to danger. (Fregoso, 2007, p. 38)

It would appear the alleged “promiscuousness” of hundreds of women in Juárez, rather than concern over whomever might be killing them, provokes the anxiety of individuals such as Fregoso. The judgment call by this criminologist calls into question the morality of the dead women, but one wonders how he would account for his comment with respect to the murdered girls, ages 15 and under, whose remains have also been attributed to the femicide? In particular, cases such as the murder of five year old Alma Mireya Chavarría Fávila’s, whose remains revealed that she was raped and strangled; or seven year old Airis Estrella Enriquez Pando, whose remains were found in a cement-filled drum, are ignored by Fregoso (Washington Valdez, 2006, pp. 353-363).

The palpable threat of death or mutilation that is constant in Juárez, upheld by curfews and distinctions between “public” or “private” women and the “checking” of their morality, maintains a state of panic internalized by women in that city, keeping them in a “state of fear” or “profound dread” (Caputi, 1987, p. 118). This state of fear is what sentences women to home confinement, to sit home and question their actions. A lesser but still significant number of women experience the repression of their femininity evident in the curfew that forces them to think of femininity as transgressive. This subliminal message to women, that they should be afraid of themselves, shifts attention away from what is really the issue: the indiscriminate killing of women. In Jane Caputi’s *Age of Sex Crime* (1987), she examines a psychological hierarchy of patriarchal domination evident in elevating figures like Jack the Ripper, the Son of Sam, the Yorkshire Ripper, the Hillside

Strangler, the Boston Strangler and other misogynist killers as cultural icons. Their killings are the basis of walking tours in those cities and whose celebratory status omits one thing: they derive their fame from the murders of women.

The Church and Latino culture are not fully culpable for the oppression of and violence toward women. Similar to the manner in which the Europeans conquered Mexico, the United States of America, through the controversial North American Free Trade Agreement, is also culpable. The passing of NAFTA ushered in a new source of revenue for the economically prosperous U.S. And while it is true that the factories created economic opportunities for Mexican workers, the outcome of these jobs has cost the lives of women who migrate from all over Mexico to Ciudad Juárez. This human cost for doing business is one that most of the United States chooses to ignore, but the mechanics of industry require a sacrificial class. The U.S. has been the dominant neighbor to the north of Mexico, serving as hegemonic and economically superior. The hierarchy of cultures, wherein the United States dominates much of Mexico via the blocking of borders and exploitation of workers, becomes internalized in the consciousness of the Mexicana, furthering the idea of a natural order where one entity is subservient to another. Deprived of power and reminded of the hierarchical model, the male/female roles become increasingly normalized where men are seen as naturally dominant to women. When women break the seemingly natural order, they are punished.

That so many of the femicides of Juárez involve rape is also telling. Rape, often referred to as a crime of power, is another reaffirmation of the natural order of male dominance over women. The power dynamic is revealed via the rape victim, as is the idea that women’s sexuality is a commodity to be taken when a man pleases. These victims are punished first with sexual violence before meeting their deaths. Their rape and murder serves as an example of what occurs when women transgress the inherent laws of gender positions. They are further silenced by the ineffectiveness of the police and the poor investigation by authorities. The message is that their demise is unworthy of due process, that their breaking from normal roles as domestic servants and their subsequent murder is all part of the proper social structure.

Though so much of the Latina experience seems mired in oppression and

struggle, there is hope. There are women who are insisting on “personal experience as the starting point in the process of liberation” (Isasi-Díaz & Tarango, 1992, p. xiii) in the context of theology, seeking to share their stories as a means of transcending patriarchal reality in order to reach a shared understanding. Organized by Cuban-born feminist theologian Ada Maria Isasi-Díaz and Chicana feminist Yolanda Tarango, the adherents of Hispanic Women’s Liberation Theology gather together to create a “praxis” by which to analyze the “historic reality done through a lens of an option for and commitment to liberation of Hispanic Women” (Isasi-Díaz & Tarango, 1992, p. 1). These women may not be theologians but they find comfort in their faith as a source of tradition that reflects back on these women’s cultural heritage, strengthening their union. Aside from their religion, these women see an intersection between “classism, ethnic prejudice/racism, and sexism [which] form a network of prejudices that victimizes them” (Isasi-Díaz & Tarango, 1992, p. 61). Through the sharing of their lived experiences, and reclaiming their faith and traditions, they find hope in “the connections between their everyday lives and the social institutions that oppress them and influence them” (Isasi-Díaz & Tarango, 1992, p. 61). Essential to their understanding of themselves, their culture, and their faith is the sharing of their lives in a safe, open space. Sheltered but not vulnerable, these women find strength and support in this praxis. Thus, one of the outcomes of Hispanic Women’s Liberation Theology is that these women become “agents of their own history” (Isasi-Díaz & Tarango, 1992, p. 98).

Similar to the manner in which present day Chicana feminists have reclaimed Malinche, the participants of Hispanic Women’s Liberation Theology have reaffirmed their faith. Blake wrote of the Chicanas who have reclaimed Malinche, traditionally the most hated woman in Mexican history, recasting her as “the Mexican Eve” (Blake, 2008, p. 41), a woman who gave birth to the present day country. Malinche is now seen as a figure of female empowerment, her story one of survival and advancement in the face of being sold into slavery by her family and sexual exploitation at the hands of the Spanish. Feminist scholarship has sought to restore this important symbol of the complexity of the Latina feminine experience. Isasi-Díaz and Tarango (1992), in the development of Hispanic Women’s Liberation Theology, gather women together, formulating a theology rooted in the

“communal” context of gathering to say that faith has value; faith is inherited from family, community, culture, and intergenerational messages that allow a woman a sacred stillness in the Church and out of it. Faith is transformative and uniting; women of disparate locations are united by their lived-realities and find support in their conversation. Action and reflection are employed in this union: Action in the coming together and discussion of experience, and reflection being the product of their discussion. Action and reflection, part of the same methodology, cannot be separated. The coming together of these women thus takes on equal importance as that of the traditional gathering of congregates to partake in cherished religious practices. The lesson is that reflection can occur within the walls of Church, but it need not be limited to such a structure. The land, the animals, and the earth itself are equally worthwhile environments for spiritual expression (Isasi-Díaz & Tarango, 1992, p. 82). While not seeking to invalidate traditional places of worship, Hispanic Women’s Liberation Theology de-centers the Church and institutional religion to bring to the forefront women’s lived experiences rather than an already existing doctrine. The Church and the priests have very little to do with these women’s view of faith; their lives are the place from which they find hope and healing.

Hispanic Women’s Liberation Theology is a tool for liberation, a practice of sharing and bringing community together in stark contrast to the idea of institutionalized religion that is all too often a tool for oppression. Isasi-Díaz and Tarango (1992) see “the community of Hispanic Women” as “the real theologian” as opposed to the manner in which many are trained to think of theologians as academics, or, as the authors see them, “a theology done by technicians for a community of which they are not a part of” (p. 109). By incorporating their faith into the discussion of their lives, these women find strength, whereas the Church, through the male dominated hierarchy and reinforcement of gender roles, imposes limitations. The ability to break free of these gender confines, while recognizing faith as a means of freedom, allows for the praxis to achieve its ultimate goal: liberation.

The gendered oppression of women in Juárez manifests in the still unsolved femicides, the dualistic view of the virgin/whore paradigm, and the silencing of women’s voices in the Church have roots in patriarchy. The common

thread through all of the experiences of these women can be measured in contrast to the experiences of their male counterparts. And while these examples of the subjugation of feminine sexuality may seem like a minefield from which to draw examples of oppression, these stories are real; the true reality of Latinas struggling against ethnic and gender discrimination, a two-fold battle. The roots of the struggle are easily traced back to the conquest and its forced exporting of the Catholic religion, a faith rife with gender issues, double-standards, and a hierarchal power dynamic where the structure of the Church (nuns being subservient to priests) is mirrored in the home (wives and daughters subservient to fathers and brothers). Breaking out of this frame takes too great a toll and, in the case of the female maquila workers of Juárez, the price may very well be one's life.

Still, through the union of women, (evident in Isasi-Díaz & Tarango's 1992 Hispanic Women's Liberation Theology, the Chicana feminists, and the wider awareness of the struggle of Latinas, through scholarly research and artistic expression) there is hope that a reversing of these trends can occur. If Latinas are to be afforded their right to sexual agency, a shift in attitude needs to happen not only within a praxis such as the one formed by Isasi-Díaz and Tarango (1992), but also by all members of the Church. Chicana feminists and Mexicanas have done important work toward reversing the misunderstanding of feminine sexuality and gender roles, but the effort may never reach full fruition until a greater change is enacted in the Church hierarchy and in the cultural and domestic domains over which the Church has long been an influence.

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Cognitive Behavioral Therapy for Insomnia

Bobbi Marie Pollard

Abstract

Cognitive behavioral therapy (CBT) for insomnia is a recent framework developed to address the dysfunctional cognitions and behaviors that contribute to poor sleeping patterns (Morin & Benca, 2012). Insomnia often presents as a comorbidity to a medical or psychiatric disorder, but may also be an isolated diagnosis (Siebern, Suh, & Nowakowski, 2012). According to research studies, benzodiazepine-receptor agonists (BzRAs) and cognitive behavioral therapy (CBT) are the two most effective therapies for treatment and management of insomnia (Morin & Benca, 2012). While both treatments are beneficial for short-term management of insomnia, cognitive behavioral therapy for insomnia (CBTi) produces long-term sustained benefits with no side effects, thus being more advantageous than prescription drug use only (Morin & Benca, 2012). CBTi involves five components: stimulus control, sleep restriction, relaxation training, cognitive therapy and sleep hygiene education (Bélanger, LeBlanc, & Morin, 2012). CBTi is a fairly new approach therefore, trained professionals may be difficult to find; creative delivery of therapy through telephone or Skype appointments may be necessary due to the limited number of professionals with formal training (Morin & Benca, 2012).

Keywords: insomnia, sleep, cognitive, behavioral, CBTi, sleep therapy, stimulus control, sleep restriction, relaxation training

Introduction

Cognitive behavioral therapy for insomnia (CBTi) is a new and effective technique, aimed at addressing and alleviating the symptoms of insomnia. An estimated 70-80% of patients demonstrate a therapeutic response, while 40% experience remission (Morin & Benca, 2012). According to Siebern et al. (2012), "It is important to note that general psychotherapy is not effective for intervention for insomnia" (p. 719). Mental health providers should be adequately trained in this technique in

order to successfully administer CBTi and to receive efficacious results (Siebern et al., 2012). CBTi can be implemented alongside medications, or by itself; however, prescription drug use often declines even without direct encouragement from the provider (Dolan, Taylor, Bramoweth, & Rosenthal, 2010).

Insomnia

Insomnia is the most common sleep disorder (Bélanger et al., 2012). It can have a devastating impact on one's emotional, physical, occupational and social life (Morin & Benca, 2012). While insomnia occasionally can be seen in the clinical setting as a primary diagnosis, it most often presents as being comorbid to a medical or psychiatric issue; it is estimated that 75-90% of individuals with insomnia have a medical disorder, and 40% have a psychiatric diagnosis (Dolan et al., 2010). Insomnia is characterized by the dissatisfaction of quality of sleep, along with one of the following: difficulty in initiating sleep; difficulty maintaining sleep characterized by frequent awakenings or difficulty falling back to sleep after an awakening; early morning rising with difficulty reinitiating sleep; and non-restorative sleep (American Psychiatric Association, 2013). One of the following also causes distress and impairment of daytime functioning: fatigue; daytime sleepiness; difficulty with attention, concentration, memory; mood disruption; behavior issues, i.e. aggression, hyperactivity; reduced occupational or scholastic functioning; and poor effects on familial system or relationships (American Psychiatric Association, 2013).

In cases of acute insomnia, the sleep disorder presents in the midst of a stressor, e.g. death of a loved one or unemployment; however, after the stressor has resolved or passed, regular sleep patterns reemerge (Morin & Benca, 2012). Sometimes maladaptive behaviors or cognitions develop in order to ameliorate the acute insomnia, but instead of alleviating the issue, those maladaptive behaviors or cognitions enable the issue to persist and chronic insomnia develops (Rogojanski, Carney, & Monson, 2013). Acute insomnia lasts less than one month;

sub-chronic insomnia has a duration of one to three months; persistent or chronic insomnia lasts more than three months (American Psychiatric Association, 2013).

Insomnia is twice as common in females as in men, and is more likely in anxious or hyper-aroused individuals (Morin & Benca, 2012). Age is another predisposing factor; insomnia complaints are more common in the elderly, often due to an increase in medical illnesses (Bélanger et al., 2012). According to Morin and Benca (2012), “About 25% of adults are dissatisfied with their sleep, 10-15% report symptoms of insomnia associated with daytime consequences and 6-10% meet criteria for an insomnia disorder” (p. 1129).

CBTi

Cognitive behavioral therapy (CBT) for insomnia is a brief treatment aimed at adjusting cognitions and behaviors that perpetuate poor sleep practices (Morin & Benca, 2012). Although treatment is “brief,” it does require ample effort and a genuine commitment from the client in order to be effective (Dolan et al., 2010). According to Rogojanski et al. (2013), CBTi should be considered the primary intervention for insomnia. There is a multitude of research confirming the approach’s efficacy and enduring relief. CBTi is ideal because as opposed to medication treatment, this intervention has very few side effects (Smith, Huang, & Manber, 2005). CBTi should be used with discretion for bipolar and seizure-prone patients (Smith et al., 2005). The component of sleep restriction, discussed in detail later, may prompt a manic episode or result in a seizure (Smith et al., 2005). According to Smith et al. (2005), “Another documented side effect of CBTi is the paradoxical phenomenon of relaxation-induced anxiety, which is estimated to occur in about 15% of individuals attempted relaxation therapies” (p. 562).

CBTi Components

CBTi is generally delivered over the course of eight sessions by a certified psychotherapist or other professional specially trained in the field (Dolan et al., 2010). Sessions are on a weekly basis at the onset of treatment (Pigeon, 2010), generally lasting one hour in length (Dolan et al., 2010). Then, in accordance to the provider’s discretion and patient’s

availability, may be altered appropriately (Dolan et al., 2010). Most patients experience the greatest improvement in sleep patterns, according to the analysis of their sleep diary, within the first two sessions as the concepts of stimulus control and sleep restriction are presented (Dolan et al., 2010). The primary components of CBTi are as follows: stimulus control, sleep restriction, relaxation training, cognitive therapy, and sleep hygiene education (Bélanger et al., 2012).

Stimulus Control

The focus is on realigning the association of the bedroom/bed with sleeping. Patients are instructed to not distract themselves with television, reading, worrying, or other activities while in bed (Bélanger et al., 2012). Also, if a patient wakes in the middle of the night, he/she is encouraged to get out of bed if he/she does not fall back asleep within 15 or 20 minutes (Bélanger et al., 2012).

Sleep Restriction

The amount of time in bed should equate closely to the amount of time slept (Siebern et al., 2012). Clients are encouraged to reserve bedtime until they feel sleepy (Siebern et al., 2012). Initially, clients will be instructed to sleep a set amount of hours each night based on an average of total sleep time (TST); the TST is calculated by the client keeping track of his/her sleep schedule for one to two weeks (Siebern et al., 2012). Gradually, the amount of time in bed increases until it equates to the desired amount of necessary sleep (Bélanger et al., 2012). Although the patient may feel deprived for a period of time, this often fuels the sleep/wake cycle, and shifts the focus from concern about falling asleep to concern about whether or not he/she can stay up until prescribed bedtime (Bélanger et al., 2012). Patients are instructed to adhere to a concrete bedtime and rising time (Pigeon, 2010). Naps are strongly discouraged (Bélanger et al., 2012). If a nap is necessary, patients are instructed to nap at the same time each day, and only for a brief pre-allotted amount of time (Bélanger et al., 2012).

Relaxation Training

Different techniques are taught to address muscle tension and/or anxiety and intrusive thoughts prior to bedtime (Bélanger et

al., 2012). This may include imagery or meditation (Bélanger et al., 2012). The best relaxation technique to implement should be the one the client feels most comfortable using (Pigeon, 2010). According to Siebern et al. (2012), some common techniques include the following: progressive muscle relaxation, deep breathing techniques, body scanning, and visualization coupled with autogenic phrases which allow from increasing bodily relaxation.

Cognitive Therapy

The aim of cognitive therapy in the realm of CBTi is to challenge erroneous conceptions, beliefs and attitudes about one's sleep, and to adjust these maladaptive patterns when possible (Bélanger et al., 2012). This is primarily done through education and discussion (Bélanger et al., 2012). Furthermore, the provider may encourage the patient decrease preoccupations with sleep through CBT that may present before bedtime which can often produce negative emotions, further prohibiting sleep (Siebern et al., 2012). This can be achieved through use of a sleep diary (Bélanger et al., 2012).

Sleep Hygiene Education

Health factors and external stimuli may play a role in insomnia, but it is unlikely that they are the primary factors (Bélanger et al., 2012). Still, they should be addressed. Food, fluid and substance (e.g. caffeine, nicotine) intake, and excessive exercise should be curtailed several hours prior to sleep (Siebern et al., 2012). However, to increase health and positive sleep patterns, daily exercise is beneficial (Bélanger et al., 2012). Also, outside stimuli such as temperature and noise should be monitored, if feasible (Bélanger et al., 2012).

Alternative Treatments

According to Morin and Benca (2012), "The 2005 National Institutes of Health state-of-the-science conference on insomnia concluded that only two treatment modalities (CBT and benzodiazepine-receptor agonists [BzRAs]) had adequate evidence to support their use in the management of chronic insomnia" (p. 1132). Additionally, in one clinical study, "Use of sleep medication declined significantly from 87.5% pre-treatment to 54% post-treatment, despite no active efforts to encourage patients to withdraw"

(Dolan et al., 2010, p. 321). Individuals experiencing insomnia may first resort to hypnotic medications, over the counter medications (OTC), natural remedies or other substances to alleviate symptoms (Morin & Benca, 2012).

Prescription Hypnotic Medication

Hypnotic medications are commonly used, but can result in daytime sleepiness (Morin & Benca, 2012). Individuals may use stimulants to maintain alertness and then have difficulty falling asleep at night, thus continuing the cycle of insomnia (Morin & Benca, 2012). Some hypnotic medications have short half-lives, thus allowing the individual to take them with limited daytime side effects (Morin & Benca, 2012). Furthermore, there are sometimes moderate to severe nocturnal side effects experienced with these medications, such as driving, binge eating and engaging in sexual activity while asleep (Morin & Benca, 2012). Other side effects may include the following: dizziness, drowsiness, gastrointestinal symptoms, dry mouth, back pain, irritability, blurred vision, weight gain, increased appetite, reduced intellectual ability, new-onset seizures in patients without epilepsy, and new-onset diabetes mellitus. (Morin & Benca, 2012).

Over-the-Counter Medications

Antihistamines are sometimes used to induce sleep, but are often mixed with pain relievers (Morin & Benca, 2012). Some side effects of using antihistamines are as follows: agitation, dry mouth, urinary retention and increased restless leg syndrome (Morin & Benca, 2012). "Rebound insomnia" may develop when one ceases OTC medications and experiences withdrawal (Morin & Benca, 2012, p. 1134). Synthetic melatonin is available OTC in America; however, in some countries it is only obtainable by prescription (Morin & Benca, 2012). Some experience nightmares, drowsiness, and headaches in response to melatonin (Morin & Benca, 2012).

Substances

Alcohol may be used as a sedative to initiate sleep (Bélanger et al., 2012); however, individuals will often experience disrupted sleep as the night progresses (Morin & Benca, 2012). Other stimulants, such as caffeine and nicotine

may negatively influence sleep patterns (Bélanger et al., 2012).

Significance in Psychiatric Conditions

For individuals living with comorbid psychiatric illnesses, preliminary research shows that CBTi may be effective at treating insomnia (Smith et al., 2005). According to Smith et al. (2005), “Disturbed sleep is listed as a diagnostic symptom of mood and anxiety disorders and is an associated symptom of most other psychiatric disorders” (p. 571). According to Pigeon (2010), 50% of clients in a clinical setting report disturbed sleep. Furthermore,

Population-based studies suggest that about 30% of the general population complains of sleep disruption, while approximately 10% has associated symptoms of daytime functional impairment consistent with the diagnosis of insomnia, though it is unclear what proportion of that 10% suffers from chronic insomnia. (p. 323)

Some medications prescribed for psychiatric reasons may further disrupt sleep as well (Morin & Benca, 2012).

Major Depressive Disorder

According to Smith et al. (2005), “Most individuals with major depressive disorder (MDD) report that their sleep is of poor overall quality with specific symptoms of difficulties initiating sleep, multiple or prolonged awakenings after sleep onset, and/or awakening in the morning earlier than desired” (p. 572). Additionally, it is stated in this article that 44% of individuals completing antidepressant treatment still experience insomnia, making it the most common residual symptom of depression. Insomnia can also adversely affect antidepressant treatment (Smith et al., 2005). While healthy REM sleep patterns may develop due to psychotherapy, some individuals are not responsive to therapy alone and may need treatment specifically designed to target sleep issues (Smith et al., 2005). While one night of sleep deprivation has shown to increase mood in depressed individuals, prolonging sleep deprivation can have hazardous consequences to one’s health (Smith et al., 2005). In one clinical

study, a sample of individuals experiencing insomnia was monitored while undergoing CBTi; of this sample, one third reported no symptoms of depression, one third reported mild depression, and one third reported moderate to severe depression (Smith et al., 2005). “Substantial improvement” of sleep was reported by participants, with no difference between the depressed and non-depressed participants (Smith et al., 2005, p. 574). Furthermore, 70% of responding participants that had a comorbidity of depression saw “clinically significant improvement” of their depression (Smith et al., 2005, p. 574). It is important to consider that compliance may be an issue with CBTi in depressed patients, as it requires cooperation and implementation of the treatment’s components. CBTi may be more easily integrated with someone already receiving CBT (Smith et al., 2005).

Bipolar Disorder

There is little clinical data on the efficacy of CBTi in bipolar disorder (Smith et al., 2005). As mentioned before, this technique should be used with discretion, as sleep deprivation can trigger a manic episode. CBTi may need to be altered if used in this population (Smith et al., 2005).

Generalized Anxiety Disorder

Individuals with generalized anxiety disorder (GAD) may have intrusive and persistent thoughts that interfere with their sleep. According to one insomnia clinic’s report, GAD was the most common psychiatric condition presenting with insomnia (Pigeon, 2010). It is common for this population to experience difficulty falling asleep (47.7%) and maintaining sleep (63.6%) (Smith et al., 2005). According to Pigeon (2010), “Anxiety disorders overall are equally or more prevalent than depression among insomnia subsamples in a number of reports” (p. 326). Restricting sleep may increase anxiety, so special emphasis should be given to relaxation techniques (Smith et al., 2005). Also, “scheduled worry” is an example of stimulus control; instead of persistent anxious thoughts at night or in the bedroom occurring, patients can be encouraged to set aside a place and time for such thoughts, thus helping to re-associate the bedroom with sleeping and not “a racing mind” (Smith et al., 2005, p. 576).

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a state of hyper-arousal and is often accompanied by sleep difficulty, specifically with REM disruptions due to nightmares (Smith et al., 2005). Fear of going to sleep due to these nightmares may contribute to insomnia. A technique called “dream rehearsal” has been found effective in nightmare intensity and frequency, as it encourages patients to recall their nightmare in vivid detail and then change any part of the nightmare they find distressing (Smith et al., 2005, p. 478). In turn, they are creating a new dream. According to Smith et al. (2005), “Not only did subjects report improvement on sleep parameters, but they also demonstrated significant, moderate effects for measures of posttraumatic stress disorder severity, anxiety and depression” (p. 578). If the individual experienced the trauma during sleep, i.e. sexual abuse, there may need to be additional support (Smith et al., 2005).

Alcohol Dependence Disorder

Alcohol consumption can affect sleep even if a diagnosable disorder is not present (Smith et al., 2005). Alcohol changes one’s REM patterns; therefore, while it can help to initiate sleep, it may disrupt REM later in the evening, thus increasing sleep fragmentation (Smith et al., 2005). Insomnia is reported by 36%-72% of alcoholics (Smith et al., 2005). Symptoms may continue even three to fourteen months after sobriety (Smith et al., 2005). It may be difficult to distinguish between the mental health issues of alcoholism versus insomnia when determining which is perpetuating the other. Because mild sleep disturbances can persist even after two years of sobriety, the CBT component can be especially beneficial by helping patients develop realistic sleep expectations (Smith et al., 2005). Insomnia and poor fragmented sleep forecasted relapse, according to two sample studies of alcoholics in recovery (Pigeon, 2010). Pigeon (2010) further notes, “Based on limited data, insomnia may be a risk indicator for the development of alcoholism as well as a risk factor for relapse in alcohol dependence” (p. 326).

Efficacy

Almost two thirds of patients taking pharmaceuticals for sleep discontinued their use

after the therapeutic intervention (Dolan et al., 2010). According to Dolan et al. (2010), “Indeed, one study found the presence of comorbid psychological symptoms such as depression and anxiety prior to treatment may indicate an even better prognosis (p. 321). Clinical trials have shown that CBTi is beneficial and effective for physiological disorders comorbid with insomnia, such as fibromyalgia and chronic pain (Dolan et al., 2010). Dolan et al. (2010) state the following:

Outcome measures included daily sleep diaries, self-reported measures on insomnia severity, dysfunctional beliefs and attitudes about sleep, daytime sleepiness, as well as medication usage. Patients showed *significant* [emphasis by me] improvements in sleep onset latency, wake time after sleep onset, sleep efficiency, insomnia severity and dysfunctional sleep beliefs from pre- to post- treatment (p. 321).

Chronic insomnia can be treated with pharmaceutical therapy however, once the client ceases taking medications, CBTi is the “superior” technique (Pigeon, 2010, p. 329). Pigeon (2010) directly states, “Treatment gains achieved with CBTi are more resilient than those achieved with hypnotics once they are discontinued” (p. 329). Sleep improvement is consistent at 6-month follow-ups, as well as at 24-month follow-ups (Morin & Benca, 2012). Smith et al. (2005) cite that benefits are evident even at two year follow-ups. Insomnia relapse may result, especially in the implementation of short-term CBTi (Morin & Benca, 2012). Currently, no maintenance therapy has been developed (Morin & Benca, 2012).

Conclusion and Further Considerations

CBTi is a fairly new approach; some health care and mental health providers may not be aware of it, let alone know how to connect patients with trained specialists (Smith et al., 2005). While CBTi is a therapeutic technique most often associated with the psychology/mental health field, it would be beneficial to train medical doctors, nurses and other primary care clinic professionals on how to administer CBTi, or at least provide the key concepts (Morin & Benca, 2012). These professionals should be

competent in identifying symptoms of insomnia; however, it is often underdiagnosed and undertreated (Morin & Benca, 2012). In some areas, there may be no professionals trained in CBTi. Additionally, some individuals experiencing insomnia may not be able to afford services. In these scenarios, it is beneficial to think creatively: telephone therapy, Skype therapy, group therapy, and self-help approaches may be suggested (Morin & Benca, 2012).

Some patients may be wary of stopping use of prescription drugs for insomnia. They may fear that CBTi requires complete cessation of pharmaceuticals. While literature has confirmed that many patients significantly cut back or stop using sleep medications, it should be explained clearly to the patient that this is not a requirement for CBTi and that he/she is still considered an excellent candidate for treatment (Dolan et al., 2010). It would be beneficial to have more research on adapting CBTi for specific diagnoses and conditions (Smith et al., 2005). Additionally, future research should

consider the benefits of using short-term CBTi (four or more sessions) versus full-length treatment (eight sessions) (Dolan et al., 2010). It would be worthwhile to explore the efficacy of implementing CBTi in real-life settings, not just controlled studies, as well.

In conclusion, clinical studies show promising data for the benefits of CBTi in numerous diagnoses, although, additional empirical information is needed for specific disorders (Smith et al., 2005). Treatment of insomnia often equates to higher functioning, which can impact many facets of a person's life, such as health, mood, and alertness (Pigeon, 2010). CBTi does not have side-effects like many prescription and homeopathic medications, thus making it a healthier alternative (Morin & Benca, 2012). It is aligned with the current cultural push toward non-pharmacological approaches to health. With the prevalence of insomnia throughout the population, this can be a life-changing form of treatment for many individuals.

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Polyamory: The Clinical Importance of Understanding this Community

Roslyn Turner

Abstract

Bruce Jenner's transformation to Caitlyn and the recent victory of marriage equality reflect clear examples that non-normative and non-traditional lifestyles in western, mainstream, heteronormative society are growing rapidly. Polyamory is one of those growing lifestyles by which individuals have chosen in order to live into an expression of their identity. However, polyamory in and of itself is very complex and exemplifies multiple variations. Understanding one's own biases and performing the due diligence of becoming more educated about polyamory are beginning steps mental health professionals should take in order to provide competent and ethical support and services to individuals who identify as polyamorous.

Keywords: polyamory, polyamorous lifestyle, non-monogamy, therapy, mental health

Introduction

Polyamory in and of itself is more than just a word or a way of life. It has complexities and intricacies that are constantly evolving. An individual actively choosing to be polyamorous may, at some point in time, need support and assistance from a clinical mental health provider. However, research suggests that many times polyamorous clients hesitate to reveal this lifestyle choice for fear of being misunderstood and ultimately judged (Weitzman, Davidson, & Phillips, 2009; Graham, 2014). For those reasons, it is extremely important for seasoned and new clinicians to examine their own personal feelings and make a conscious effort to better understand this growing community. This paper aims to give a general picture of polyamory, describe societal and therapeutic misconceptions of the lifestyle, and highlight both benefits and concerns of polyamory. It will also focus on the overall clinical implications of being knowledgeable about this topic and the ultimate need for further research to provide this community with quality mental health services.

What is Polyamory?

Polyamory, as defined by the Oxford dictionary, is “the philosophy or state of being in love or romantically involved with more than one person at the same time” (“Polyamory”, n.d.). While a great deal of research utilizes the above definition, (Graham, 2014; Fierman & Poulsen, 2014) other concepts to help characterize this lifestyle include discussions of openness, honesty, consensual agreement among partners and, above all, communication (Weitzman, Davidson, & Phillips, 2009). Valerie White, a self-identified polyamorous Humanist, helps define polyamory by what it is not. She states, “Polyamory is not infidelity. Polyamory is not promiscuous, superficial, unthinking, irresponsible sex” and continues to include descriptive adjectives to define polyamory including “ethical, responsible, honorable, open, honest, intentional and principled” (White, 2004, p. 20).

Most importantly, polyamory is not practiced in one specific way. Therefore, it is important to have an understanding of the different ways potential clients may present their chosen lifestyle. Weitzman, as cited in Graham (2014), highlights three common types including:

- 1) An individual having one main or primary partner and one or more other intimate relationships where the different partners do not have a significant relationship with each other;
- 2) An individual having more than one partner whom they are equally intimate with and those different partners do not have a significant relationship with each other; and
- 3) A “poly family” which includes three or more individuals who have intimate relationships with each other that may or may not include sex. (p. 1031)

Weitzman, Davidson, and Phillips (2009) also lay out typical forms found within the polyamorous community. These consist of primary-plus, triad, individual with multiple primaries, group marriage or poly family, intimate networks and poly-dating among singles. Fierman and Poulsen (2014) include structures of partnered non-monogamy, swinging, polyamory, and monogamous/non-monogamous combinations (p. 152). Clearly, the many different forms call to attention the multifaceted complexity of polyamory.

Societal and Therapeutic Misconceptions

We live in a heteronormative society. Longstanding views on “normal” relationships are constantly bombarding us from mainstream media to the utilization of modern-day dating apps. Therefore, “consensual romantic and sexual relationships that are open and nonmonogamous challenge the norms of exclusive relationships and have largely been overlooked by the scholarly literature” (Fierman & Poulsen, 2014, p. 151). There are many benefits to a polyamorous lifestyle; however, the strengths and positives drawn from those benefits are overlooked because of the societal preoccupation with defining monogamy as the norm (McCoy, Stinson, Ross, & Hjelmstad, 2015). Monogamy as the norm is a misconception improperly imposed upon individuals who choose not to live that way. This can lead to individuals feeling alone and isolated which can ultimately have distressing implications on their mental health.

There is very little current research on the prevalence of those choosing to live a polyamorous lifestyle. A study by Rubin and Adams (1986) revealed that 15-26% of married couples had an “understanding that allowed non-monogamy under some circumstance” (p. 312). The lack of data and research insinuates that polyamory is not a widely accepted lifestyle choice. However, the Rubin and Adam’s (1986) study does provide insight to the fact that there is indeed a community of individuals who have chosen to live a polyamorous lifestyle. A point of confusion regarding the polyamorous community is the utilization of current data to provide information about the needs of the individuals ascribing to this lifestyle. As reflected in many of the studies cited in this paper, most data available is grossly outdated.

This disparity elicits an understanding that many misconceptions, even the popularity of this lifestyle, exist today. Therefore, a significant need exists to further research this community and understand their needs.

Another point of confusion is the question of how it is possible for individuals to truly “love” multiple people or be engaged in several relationships at one time. But, do we not all already have love for many people in our lives? As White (2004) better explains, “To polyfolk, loving more than one partner comes as naturally as loving more than one child; you don’t stop loving your firstborn when your next child comes along” (p. 18). Looking at it from this perspective helps to give a better understanding of the concept, however, it does not remove the impression that with multiple relationships comes jealousy. White (2004) explains that yes, jealousy exists, but, “we know that jealousy is the fear of losing something valued and so, when jealousy arises, all parties rally round to reassure the jealous one” (p. 18). Rather than being viewed negatively, jealousy can be seen as a positive feeling. Fierman and Poulsen (2014) suggest that jealousy can be “viewed as an emotion that needs to be acknowledged and worked through” (p. 154) and explain that therapists can assist in this process and explore jealousy, as long as their goal is not to encourage clients to turn to monogamy to resolve it. Fierman and Poulsen (2014) also discuss the concept of compersion, which “occurs when one partner has positive feelings about a partner’s other intimate relationships” (p. 153). Compersion can be a helpful tool for therapists to help clients reframe the misconception of jealousy.

Another misconception is that polyamorous couples do not have the same stability or happiness as monogamous relationships. The Rubin and Adams study (1986) concluded that there was “no reliable evidence of differences between the two groups” (p. 318). Weitzman (1999) discussed other examples of empirical evidence that also found no difference in adjustment, marriage satisfaction or self-esteem between monogamous and polyamorous relationships. Therefore, it is unfair and unfounded to assume that polyamory leads to infidelity, cheating or lying and cannot produce healthy, stable relationships because they are not “traditional or normal”.

Graham (2014), McCoy et al. (2015), and Weitzman (1999) all discuss common, incorrect perceptions of polyamory that greatly

affect polyamorous individuals and their ability to receive quality mental health services. These misconceptions include, but are not limited to, judgment, attributing mental health symptoms such as depression on a polyamorous lifestyle, causing fear of being pathologized, being thought of as having a personality disorder or neurotic tendencies, and therapists attempting to persuade individuals to abandon their polyamorous lifestyle for a more “traditional” one like monogamy. Weitzman (1999) elaborates on therapists’ views and explains that since the polyamorous community’s perception is that therapists are not well-informed about their lifestyle and needs, individuals are reluctant to even seek out services in the first place due to fear of potential biases. A study by Hymer and Rubin (as cited in Weitzman, 1999) identified additional imagined traits of a typical polyamorous person to include feared intimacy, marriages that were not fulfilling, identity problems, personality disorders and antisocial personalities. They go as far as to state that some therapists revealed they would use their professional skills to try and influence clients to abandon their open lifestyle, which goes against many ethical stances, such as self-determination in the NASW Code of Ethics. While the Hymer and Rubin (1999) study is again outdated, it elicits the need for research on 1) the current prevalence of polyamorous individuals and couples seeking out therapy and 2) their barriers to treatment. Ultimately, it is the job of therapeutic clinicians to support clients’ choices and decisions, not use their role to influence anyone to follow personal values or beliefs.

Benefits and Concerns

There are many cited benefits to polyamory. White (2004) explains that some individuals “are poly because they don’t find that one person can meet their emotional needs while others are poly because they don’t want to be solely responsible for one person’s emotional needs” (p. 19). This was a common benefit found in literature. McCoy et al. (2015) echoed this sentiment and explained “polyamorous individuals are not as likely to feel as pressured to meet all of their primary partner’s relationship needs” (p. 136). Releasing of the expectation and pressure to be responsible for one’s personal needs can help alleviate anxiety and stress in a relationship as well. Other noted major benefits include joy in having close relationships with

multiple people, personal growth, benefits of household cooperation, decreases in cost of living with more financial stability and a sense of extended family (Weitzman, Davidson, & Phillips, 2009, p. 9).

However, with all these benefits on the individual, couple and community level, come relational concerns that polyamorous individuals and couples may experience. Some of the biggest issues stem from the overarching societal views mentioned earlier. Weitzman (1999) and Weitzman et al. (2009) list potential concerns including: being labeled as a deviant, being shunned by members of society as well as their own family members, fear of rejection, negative repercussions, criticism, legal discrimination (including not receiving benefits and rights due to not being a primary, married partner), and risk of character assassination and perceived non-acceptance. Going a step further, holding onto these fears and concerns can cause individuals to keep their lifestyle a secret, thus causing individuals to have stress and anxiety, which presents a different layer of concerns and clinical issues.

Clinical Implications

It is important to begin this section noting that while an individual might practice a polyamorous lifestyle, the presenting concern that brings them to therapy might have absolutely nothing to do with their chosen relational practices. Therefore, the first steps to working with this population is to make no assumptions and be open; “the knowledge that their [the client’s] therapist is supportive of their lifestyle as a whole will facilitate a more successful therapeutic rapport” (Weitzman, 1999, para. 4).

Polyamorous individuals may seek therapy to help cope with issues related to their romantic relationships, for example, helping to foster communication between partners or managing emotions. Clients may also seek therapy for the same concerns as any monogamous individuals. As noted earlier, there are complexities with polyamorous lifestyles and two people may not practice in the same way, “Therefore, all mental health professionals need to become familiar with polyamory and other non-traditional relationship practices in order to provide the best possible treatment to our patients” (Graham, 2014, p. 1034). Overall, being non-judgmental and educated will help clients feel more secure in opening up, which can

allow a therapist to provide beneficial services to the client.

A main tenant of polyamory is open and honest communication (Weitzman, 1999; White, 2004; Graham 2014). When looking at this through a clinical lens, treatment for individuals who identify as polyamorous fits with the core tenants of therapy, as much of the work we do as clinicians is help individuals to communicate better. This is unfortunately vague and generic as there is limited research to document which specific evidenced-based techniques would work best with this population. Thus providing another example of further research needed to best serve others. Clients may seek a clinician's help facilitating conversations and learning skills/techniques to communicate in regards to deciding what form of polyamory is best for them and their partner(s), negotiating agreements and boundaries in their relationship(s), approaching the coming out process, helping negotiate relationship parameters, and developing exit strategies if necessary (Weitzman, Davidson, & Phillips, 2009, pp. 19-22). Being prepared with understanding how these ideas intersect in polyamorous relationships can go a long way in providing quality therapy.

Culturally Sensitive and Competent Practice

There are many different ways a clinician can actively show potential clients that they are understanding and supportive of all lifestyle choices. Fierman and Poulsen (2014) suggest making intake and assessment forms reflective of the natural diversity of all relationships. Also, more inclusive language, like "relationship status" instead of "marital status" can be very meaningful to clients. Having visible signs, like a book about polyamory on a bookshelf, can be useful in helping the client feel confident in bringing up the topic of their preferred lifestyle. And in the end, being open and explaining that you would like to discuss different world views to make sure you are on the same page with the client can also make them feel more comfortable (Fierman & Poulsen, (2014).

Another important aspect to practicing competently and sensitively is being aware of one's own biases, therefore. Weitzman (1999) states, "therapists who maintain that monogamy is inherently preferable to polyamory may be reflecting their own cultural biases, rather than considering what is best for their client's

individual needs" (p. 12). Self-awareness is the first step to taking a culturally sensitive approach in working with this population. Overall "lack of exposure to and comfort with variations in sexuality is correlated with poor treatment efficacy" (Graham, 2014, p. 1032). Thus the lack of research and available education of the polyamory community, for mental health providers, causes therapists have a gap in knowledge about this populations' needs. Therefore clinicians need to explore their true feelings and as McCoy et al. (2015) explain, "therapists working with polyamorous couples need to make sure that they do some preliminary research so that they uncover their own biases and assumptions" (p. 141). In the end, if a therapist realizes they ultimately cannot work with a client because of conflicting values, they need to make sure to ethically broach the topic with the client and have quality referrals available to assist the client in receiving help (Fierman & Poulsen, 2014, p. 156).

Future Work

Unfortunately, as previously noted, the prevalence of polyamory is unknown due to the limited amount of empirical research available. Most research is from decades ago and much of the current research has focused on the popularity of this lifestyle among the gay, lesbian and bisexual communities (McCoy et al., 2015, p. 135). Thus, that is not a fair and representative sample of society overall. For clinicians to begin to be more culturally competent and sensitive, "more research is needed to understand the therapeutic needs of this population" (McCoy et al., 2015, p. 135).

Also as noted earlier, lacking in research is evidence-based theories and models to utilize with this population. Many of the current models can be applied in practice, however, understanding the needs of the individuals can allow a clinician to tweak or co-create with the client techniques that will best suite their needs. This is definitely a needed area for research and one that can help facilitate better clinical services and change the perception that therapists do not understand this community's needs.

Conclusion

As stated, the intent of this paper was to display a picture of polyamory and its

complexities. There is confusion and misunderstanding of the lifestyle due to an overarching, traditional societal narrative and preexisting clinical misconceptions. These misconceptions also cause distress to individuals who would benefit from therapeutic interventions, but often shy away from seeking services due to perceived judgment from clinicians. Understanding the benefits to polyamory and potential clinical concerns can aid in one's confidence in working competently

with this population. Becoming more knowledgeable and exploring one's own biases can have major clinical implications in helping to give this population a greater voice and confidence in seeking mental health services that will be supportive of their lifestyle choice. In the end, what is most needed is increased research to understand the polyamorous community in greater depth and create more culturally sensitive therapeutic interventions.

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Question of Reason: Questioning the Ashley Treatment

Hilary White

Abstract

Under the medical model of disability, an individual's functioning is impaired because of her disability, and that impairment should be cured within the individual (Student Support Service of the University of Leicester, 2008). Consequently, medical interventions are employed to remedy the functioning of people who are differently abled. One such medical intervention is the "Ashley Treatment," which stunts the growth of children who are profoundly disabled. This treatment seeks to modify the disabled individual physically to make caregiving tasks easier for parents. While the Ashley Treatment can provide benefits to individuals with disabilities and their families, it also furthers the oppression of people with disabilities because it seeks to solve the problem of disability by modifying the individual rather than breaking down societal barriers to caregiving. Accordingly, this paper proposes a process and a test to apply the "reasonable person" standard from the field of law, and justified in the fields of medicine and social work, to identify cases where the Ashley Treatment would be inappropriate.

Keywords: Ashley Treatment, growth attenuation, law, medicine, social work, reasonable person, profound developmental disability, medical model, social model, social justice, disability issues, Ashley X, ethics, human dignity.

Introduction

Despite the empowering quality of the social model of disability (described below), the medical model prevails. Even parents of children who are disabled, who ostensibly have the best intentions, turn to the medical model in caring for their children. Children who have "profound" developmental disabilities (IQ of 20 or below) depend on their caregivers for all daily living activities (Boeree, 2003). As such, their parents seek ways to make their caregiving tasks less burdensome (PillowAngel.org, 2012). One such method is the Ashley Treatment, which is a surgical and therapeutic growth-attenuation proce-

dures that stunt the child's growth at a young age, making the child permanently small and easier to transport (i.e. care for) (Gunther & Diekema, 2006). When parents opt for this treatment for their children, they make a statement: the burden of caring for a disabled person outweighs the human dignity of the person. This statement may not be intentional, and it is probable that parents have the best intentions when considering how to care for their disabled children. The problem is that the Ashley Treatment has been imposed on children under the medical model. It is possible that the Ashley Treatment would not always violate the dignity of the person, so long as it was the result of social model tenets.

This paper proposes a test under the social model of disability that is relevant in the professional fields of law, medicine, and social work, to be applied on a case-by-case basis for individuals who may become subject to the Ashley Treatment. The proposed test seeks to apply the "reasonable person" standard, which originated in the field of law, to the medical field (Fain v. Smith, 1985). Specifically, the test asks this question: Would a reasonable person standing in the place of the patient reasonably opt for the Ashley Treatment, provided that he or she had the mental capacity to do so? The process by which that test would be applied is for the Ashley Treatment to be approved by a medical ethics board, then approved by the local court by way of court order, where a guardian ad litem would serve as the child's advocate. As such, the validation for the reasonable person standard will be justified using the tenets of each professional field. In the legal field, the history and meaning of the "reasonable person" will be presented. In the medical field, the meaning of "reasonable person" will be explored under the American Medical Association's Principles of Medical Ethics. Finally, the "reasonable person" standard will be justified in the field of Social Work using the National Association of Social Workers' Code of Ethics.

The Need for a New Standard

A disability is viewed by society as a problem for the person that has a disability (Student Support Service of the University of Leicester, 2008). Under the medical model of disability, the individual's quality of life is impaired because of her disability, and that impairment should be cured within the individual (Student Support Service of the University of Leicester, 2008). For example, if a person using a wheelchair is hindered from entering a building because of stairs, the medical model assigns the problem to the individual using a wheelchair instead of the stairs (Student Support Service of the University of Leicester, 2008). This dominant view in society is disempowering to people with disabilities, and does not recognize the human dignity of those people (Egan, 2012).

In reality, society disables people. Lisa Egan (2012), who uses a wheelchair, explains the medical model of disability when she states that she is "prevented from functioning" when she encounters barriers to her wheelchair mobility. (Egan, 2012). The problem lies outside of the individual, particularly in the absence of an elevator for a wheelchair user. The barriers vary from disability to disability, but the fact remains that disability is a social construct (Fischer, 2014). Often when a person is disabled, the person could utilize accommodations that would allow her to resume function. A person who is blind can read a sign as long as it posted in braille. A person who is deaf can communicate with others through sign language, body language, and lip reading. Under the social model of disability, those barriers are, "cultural and not related to the *disability* so much as the historic treatment of people with disabilities as afterthoughts" (Fischer, 2014, para 21). Approaching disabilities by ameliorating the barriers to independence not only empowers people with disabilities, but also emphasizes their human dignity. As such, the proposed test seeks to uphold the human dignity of people with disabilities, while also acknowledging the needs of caregivers.

The Ashley Treatment

In 2006, the treatment of a girl with a rare disability became a subject of great controversy in the media (Kirschner et al., 2009). The girl, Ashley, was diagnosed with a "profound developmental disability", meaning her body would grow and develop normally, but her mental and cognitive functions would be inhibited. Ashley was six years and seven months old when

her parents sought what is now being called "the Ashley Treatment." It was determined that Ashley's development would not advance beyond that of a three-month-old infant's, and she would require a high level of care for the rest of her life. Ashley's parents, who have chosen to remain anonymous, became concerned about her premature physical development when Ashley began to show signs of early puberty. They were also concerned about their ability to care for Ashley once she was fully-grown (Kirschner et al., 2009).

The treatment included estrogen therapy that would close the growth plates, a hysterectomy, and the bilateral removal of Ashley's breast buds (Gunther & Diekema, 2006). The removal of Ashley's uterus and breast buds, especially when combined with her small stature, would ensure that she remained in a child's body for the rest of her life. Due to the fact that Ashley is dependent on others for all activities of daily living, ensuring a permanent child-like figure through this treatment would make it more convenient for her parents to lift, move, and care for her. Ashley's parents also opted for this treatment because it would prevent discomfort from feminine problems, and potentially protect her from sexual abuse (PillowAngel.org, 2012). Additionally, this treatment has the potential to extend the amount of time family members can care for children who are disabled in their own homes rather than institutionalizing them. Though this was not a consideration for Ashley's parents, the treatment remains available for other children who are similarly disabled and whose parents may desire to care for their children at home no matter what it takes (PillowAngel.org, 2012).

In their blog, Ashley's parents listed three goals for the treatment she received (PillowAngel.org, 2012). The first was limiting her final height, which was achieved using estrogen therapy. This reduced final height also reduced her final weight, which made it easier for them to move her without the assistance of ropes or other mechanisms. The second goal was to avoid "menstruation and cramps by removing the uterus" (PillowAngel.org, 2012). Menstruation is a naturally occurring phenomenon among all healthy women (Gunther & Diekema, 2006). There was no evidence that Ashley's menstruation would be particularly problematic, aside from her early puberty (Gunther & Diekema, 2006). The third goal was to limit "growth of the breasts by removing early breast buds" (PillowAngel.org, 2012, p. 6). The parents claim that evading large breasts would increase Ash-

ley's quality of life because the chest strap of her wheel chair would result in discomfort for Ashley's budding breasts.

While it can be said that increasing the convenience of caregiving tasks for Ashley's parents would result (and has resulted) in benefits for Ashley, the intended benefits were for Ashley's parents. By decreasing Ashley's final height and weight, she remained easier to lift and handle. By removing Ashley's uterus, discharge from menstruation would never need to be cleaned. By removing her breast buds, Ashley was prevented from developing the body of a woman. All of these factors combine to result in the medical alteration of a young body that is inhibited from growing into an adult human being, thus culminating in the permanent infantilization of Ashley. An indirect result of these outcomes is that Ashley is likely to experience more movement, more stimulation, and more social activity because it will be easier to move her from bed to chair, from chair to lap, or from home to social outing. The question is whether these perceived possible benefits outweigh the risks and harms suffered by patients who undergo the Ashley Treatment. To answer this question, it is vital to establish an objective standard by which cases involving the Ashley Treatment can be evaluated. To establish this standard, the "reasonable person" standard as it pertains to the legal field will first be discussed, followed by an analysis of how this legal standard would interact with the code of ethics for both the medical and social work professions.

The Reasonable Person Standard

Legal Field

One of the most important concepts of law in the United States is the "reasonable person" (Nourse, 2008). The reasonable person concept has served as the objective standard for judging whether a person acted negligently, criminally, competently, or reasonably. The standard states that as long as a reasonable person could have acted in the same way as the defendant, the defendant did not act negligently or criminally. This standard has been applied to many areas of law, including criminal law, tort law, and administrative law (Nourse, 2008). Because this reasonable person standard has been useful in determining an objective standard for acceptable behavior in society, this paper proposes to apply the standard to patients who may

become subject to the Ashley Treatment. Since the reasonable person standard has been applied to numerous fields of law, this paper will narrow its scope of the application of the reasonable person standard as applied in tort law, specifically medical malpractice cases. These cases will set forth the most relevant definition of reasonable person because they establish an objective standard for rational decision-making practices in the field of medicine (Fain v. Smith, 1985).

In the United States, the legal system builds on itself by following precedent from previously established laws, including the definition of the reasonable person. The Supreme Court of Alabama set forth a comprehensible definition of reasonable person in *Fain v. Smith* (1985). In that case, the patient's heart was punctured when he underwent a pulmonary arteriogram. He claimed that he was not fully informed of the risks involved with the procedure. As such, the patient argued that the court should use a subjective standard, whether the patient himself (not just any reasonable person) would have gone through with the operation had he been fully informed, to determine liability. Instead, the court instructed the jury to apply the objective standard, which established that a reasonable person would have gone through with the procedure if he had been fully informed of the risks involved, and the jury decided in favor of the doctors. On appeal, the Supreme Court of Alabama upheld the objective standard because it was fair to the doctors and to the patients. The court notes that, "What a reasonable person would agree to depends in large measure on the facts and surrounding circumstances of an individual case" (Fain v. Smith, 1985, p. 1155).

When applying an objective standard to patients who may become subject to the Ashley Treatment, the question should be whether a reasonable person in the patient's position would opt for the treatment, considering all the facts and circumstances of her individual case. Several factors would need to be considered in this evaluation. The risks, costs, duration, and benefits of the treatment as would be perceived by the patient and the patient's prognosis provide basic criteria. However, other factors must also be considered. What harm would the patient suffer if the Ashley Treatment were not employed? Is the patient receiving adequate care and support for daily living activities? Will continued care and support be unmanageable in the foreseeable future? These are questions that a reasonable person would consider when deciding whether she should undergo the Ashley Treatment.

Medical Field

A profession is set apart from other groups in society because it has expertise (Ozar, 1995). A profession seeks to advance certain values, such as maintaining a good reputation, competency, and rigor. As such, it is necessary for a professional field to have some code of professional conduct. In the medical field, that code is produced and disseminated by the American Medical Association (AMA, 2015b). Since the organization was formed, “the AMA’s Code of Medical Ethics has been the authoritative ethics guide for practicing physicians” (AMA, 2015b, p. 1). Furthermore, the code “defines medicines integrity and the source of the profession’s authority to self-regulate” (AMA, 2015b, para 2). Likewise, this code will be utilized in justifying the proposed reasonable person standard when considering the Ashley Treatment.

The AMA Code of Ethics begins with a preamble and summary of principles of medical ethics (AMA, 2015a). The preamble explicitly states that the Code exists “primarily for the benefit of the patient,” and “as a member of this profession, a physician must recognize responsibility to patients first and foremost” (AMA, 2015a, p. 1). This introduction to the Code exemplifies the importance of prioritizing the patient. This value is also included in the Principles of Medical Ethics. The first principle states, “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights” (AMA, 2015a, p. 1). The importance of prioritizing the patient is interwoven in each principle as the list continues.

In a case such as Ashley’s, it is difficult to discern where to draw the line when remaining loyal to the patient. After all, Ashley’s parents serve as her legal guardians, and they have a right to make choices about Ashley’s life. However, the wishes of the parents are not always compatible with the responsibilities of the physician. Particularly, physicians have an ethical duty to prioritize the patient and her needs, not the patient’s parents and their needs. Convenience to the parents does not automatically translate to the best interest of the physician’s patient. In Ashley’s case, her parents wanted to have an easier time lifting Ashley, and they did not want to have to clean menstruation discharge or see their daughter as a fully developed adult woman (PillowAngel.org, 2012). The Ashley Treatment was performed to advance these goals, which were explicitly the goals of the parents, not of the patient undergoing the treatment. Specifi-

ly, Ashley’s parents list three goals to be achieved by the Ashley Treatment: “1- Limiting final height using high-dose estrogen therapy, 2- Avoiding menstruation and cramps by removing the uterus (hysterectomy), 3-Limiting growth of the breasts by removing the early breast buds” (PillowAngel.org, 2012, p. 6). There is no report of Ashley formulating her own goals for this treatment. Such a report in Ashley’s case would not be possible because Ashley is profoundly mentally disabled. This demonstrates the need for the reasonable person standard to be applied to individuals who may undergo the Ashley Treatment, as it would facilitate the physician’s prioritization of the patient according to the ethical standards set forth by the AMA Code of Ethics.

The Field of Social Work

The field of social work is relevant to this discussion as it is expected that the *guardian ad litem* serving as the child’s advocate will often be a professional social worker. Similar to professionals in the medical field, social workers are expected to adhere to certain professional standards. The National Association of Social Workers (NASW) has developed a Code of Ethics, including core values and ethical principles that guide professional social workers in ethical conduct (NASW, 2015b). As the largest organization of professional social workers, “NASW has the responsibility of reviewing and resolving complaints of alleged violations of the NASW Code of Ethics,” which maintains professional standards for social workers (NASW, 2015a, para 1).

The Preamble of the NASW Code of Ethics lists six core values central to the social work profession: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 2015b). Of note are the values of social justice, and dignity and worth of the person. “Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people” (NASW, 2015b, para 19). As discussed above, the medical model of disability hinders the functioning of people with disabilities, whereas the social model empowers people with disabilities (Egan, 2012). It logically follows that social workers must work toward social justice by advocating for the social model of disability. This change would frame the problem of disability in the barriers to functioning, rather than in the individual herself.

Social workers also value the inherent dignity and worth of the person, which means they “treat each person in a caring and respectful fashion, mindful of individual differences . . .” (NASW, 2015b, p. 1). While social workers consider the individual’s environment (loved ones, resources, etc.), they also value the individual. The reasonable person standard would be helpful in putting this value to practice because it considers the factors present in the individual’s circumstances, while also considering what a sensible person would do in the same situation. This prevents the imposition of the parents’ wishes on a child’s body.

Challenges of the Reasonable Person Standard

While the reasonable person standard would be pivotal in defending the dignity of the person who is disabled and likely subject to the Ashley Treatment, this standard is not without challenges. This reasonable person standard takes into account the needs and desires of the parents, though it does not prioritize the parents over the needs and dignity of the child. Furthermore, parents have a fundamental right to raise their children as they see fit (ParentalRights.org, n.d.). The reasonable person standard stymies that right, because it would require the courts, physicians, and caregivers to consider whether a reasonable person in the position of the patient would opt for the Ashley Treatment. The reasonable person’s choice would prevail over the desires of the parents. However, the parents’ rights are not negated. The reasonable person standard presents a sensible compromise between the desires of the parents and the human dignity of the patient, and it is justifiable because parents do not have an absolute right of decision-making power over the upbringing of their children. Parents do not have a fundamental right to abuse their children, to withhold basic needs such as food and shelter or education and medical care (McCoy & Keen, 2009). Instead of giving parents free reign to impose the Ashley Treatment on a child who is disabled, which also has socio-political implications (by promoting the medical model of disability), the reasonable person standard ensures that the choice respects the dignity and worth of the person, and prioritizes the patient over the parent(s).

The Process

Overall, the proposed process of applying the reasonable person standard will be on a case-by-case basis. The facts and circumstances of each individual will be considered when making a decision about whether or not to employ the Ashley Treatment. Such considerations will include factors such as the child’s prognosis, the risks, costs, duration, and benefits of the Ashley Treatment, and the needs, desires, and abilities of the parents. The process will include two main phases. The first phase will take place in the medical field; the second phase will take place in the legal field. This two-phase process will address the challenges listed above, and will consider the needs of all parties.

The first phase of the process will begin when the parents seek medical treatment for their child. Most importantly, the parents must be fully informed about what the treatment entails, including the costs, benefits and risks. Once the doctor and the parents have collaboratively decided that the Ashley Treatment is a viable option, the child’s case should be presented to a multidisciplinary ethics board of the hospital where the Ashley Treatment will take place. At a minimum, the ethics board should include a professional familiar with the child’s specific disability, a social worker, a bioethicist, and an attorney. The board will consider all relevant circumstances, and will prioritize the needs of the patient as it applies the reasonable person test to the case. Once a decision has been reached, the ethics board will submit a report including its reasoning for the decision to the hospital and to the child’s parents. The ethics board will have the choice of deciding that the Ashley Treatment is inappropriate for the child, or recommending the child for treatment. If the Ashley Treatment is recommended, the hospital must obtain a court order to move forward with the Treatment, which is currently the standard practice in many states (Kirschner, et al., 2009).

The second phase of the process begins when the hospital seeks a court order to administer the Ashley Treatment to the child. Given the nature of the Ashley Treatment, an expedited court hearing will be necessary. The child will receive a *guardian ad litem* who will advocate for the child’s best interests. The *guardian ad litem* will have access to the ethics board report, as well as relevant medical records, and will be able to conduct interviews and other investigations. This will enable the advocate to apply the reasonable person test while respecting the human dignity and worth of the child and uphold-

ing social justice. The *guardian ad litem* will present her findings at a hearing in front of a judge. The hearing will also include the testimony of the parents, the child's treating doctor, and any other evidence the judge needs to make an informed decision. The judge will then apply the reasonable person test to the case: Would a reasonable person standing in the place of the patient reasonably opt for the Ashley Treatment if he or she had the mental capacity to do so? If the answer is yes, the judge will enter a court order for the Treatment. If the answer is no, a court order will not be issued, and the Ashley Treatment will not be imposed.

Conclusion

Not all patients will receive the Ashley Treatment, and not all patients will forgo the Ashley Treatment. Medical advances are respon-

sible for increased functioning in people who would have (or do have) disabilities. Such medical advances have resulted in the Ashley Treatment, and have arguably provided some benefit to children and their parents. If the Ashley Treatment increases some form of functioning for the child, it may be a reasonable option. Therefore, it would be inappropriate to ban the Ashley Treatment completely. However, it is imperative that the reasonable person standard (whether a reasonable person standing in the place of the patient reasonably opt for the Ashley Treatment if he or she had the mental capacity to do so) be applied at all stages of the process. This will ensure the prioritization of the patient, the respect for the dignity and worth of the patient, and refrain from infringing on parental rights. Furthermore, this process will work to advance the social model of disability in the medical sphere and in society as a whole.

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