PRAXIS

Where Reflection & Practice Meet

VOLUME 18

Through A Different Lens

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

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

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EDITORIAL

Through A Different Lens

As social workers, much of the work we do involves seeing people, particularly marginalized and disadvantaged people, through different lenses. Where conventional wisdom might see pathology or inadequacy, we see personal strength and resilience in the face of the often unspoken challenges posed by dehumanizing social systems. Where social mores might privilege materialism or traditional notions of beauty or morality, we as social workers question relentlessly that status quo. We are, at our best, skeptics, rebels, and visionaries. And we may also be the one voice in the room with a professional obligation to keep everyone focused on the humanity of the people we serve.

In keeping with this notion of what it means to be a social worker, each article in this volume of *Praxis* examines a pressing issue in social work and social justice through just such a lens. From the stigmatization of people with borderline personality disorder to western biases against the religiosity that can come with schizophrenia, these articles question the status quo of what the mental health profession and society at-large currently define as “normal” or “preferable.” And as with the articles focusing on community violence as a cause of PTSD or the practice of circumcision or the sexual abuse of children in Thailand, the authors pose alternative ideas to prevailing cultural norms, such as the Thai focus on restorative justice circles as a means of helping survivors, communities, and perpetrators heal after abuse. These articles also provide a different lens through which to look at issues affecting children and adolescents, whether it is the best way to help adolescents build social skills, the under diagnosis of bipolar in children, or the ways we feed low-income children in school. This willingness to question, to see what others do not, and to look for strengths, especially when it comes to people who are generally the subject of marginalization, dehumanization, and, at times, scorn, is a key part of what sets our profession apart.

As Co-Editors-in-Chief, we witnessed the commitment of our fellow editorial board members and authors as they juggled editing, writing, and revising these articles for publication in the midst of busy and demanding personal and professional lives. Their passion for seeing things “through a different lens” – questioning the status quo, upholding the values for which social work stands, and proposing new, intriguing solutions that recognize the vibrancy and wholeness of the human spirit – leaves us feeling honored and inspired. We want to express our gratitude to both the editorial board and the authors for making this volume possible. We hope this volume causes readers to see all the issues represented here through lenses that defy the status quo and reify the human spirit, just as it did for us.

In Service,

Amy Markley, JD
Jason A. Pica II
Co-Editors-in-Chief

Living in a Lego World: Children and Adolescents with Bipolar Brains and the Risk of Comorbid Substance Abuse

Dorcas A. Acevedo
(MSW Candidate, 2019)

Abstract

This article will explore signs and symptoms of early onset bipolar disorder in children and adolescents and address the risk of comorbid substance abuse disorders. It will also explore the role that social workers can play in the early detection of bipolar disorder. According to the Diagnostic and Statistical Manual of Mental Disorders, bipolar disorder is the diagnosis that has the highest correlation with substance abuse. Numerous studies have found that adults with bipolar disorder report symptoms as early as nine years old, and often the symptoms of an affect disorder contribute to substance abuse, which significantly heightens suicide risk. The detection of bipolar disorder before adolescence decreases the risk of comorbid substance abuse disorders. Therefore, clinicians, caretakers, and other professionals should closely monitor substance use in adolescents who present with significant mood impairment. This article will use a specific case study to demonstrate the importance of interprofessional collaboration in early detection and treatment of bipolar disorder to prevent substance addiction and other residual impairments.

Keywords: bipolar disorder, cognitive behavioral therapy, dialectical behavioral therapy, pharmacotherapy, substance abuse, suicidal ideation

Early Onset Bipolar Spectrum Disorders

Only in the last 15 years have researchers begun to study symptoms of bipolar disorder in children and adolescents. Judy Wozniak, one of the leading advocates for the study of early onset bipolar disorder, says that people began looking for symptoms in children because adults with bipolar disorder were reporting that their symptoms started very early in life. Numerous studies have shown that individuals diagnosed with bipolar disorder in adulthood report symptom onset as early as nine years old. One published research study showed that 37.6% of individuals with bipolar disorder reported that they were 13 to 17 at onset. Another study showed that 14% of individuals with bipolar disorder were 12 years old at onset and 35% were 13 to 18 (Ladson, Kornegay, & Lesane, 2014). Wozniak (2013) reported that the numbers startled her. She further explained that people normally underreport symptoms experienced in childhood so that the numbers are probably even higher.

The Bipolar Brain

According to the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition, characteristics of bipolar spectrum disorders may include symptoms of depression, psychosis, suicidality, inflated self-esteem, decreased need for sleep, and obsessive goal-directed activity (American Psychiatric Association, 2013). Type I bipolar disorder is diagnosed if a person has experienced a full-blown manic episode (manic symptoms that have lasted for at least one week) with or without a depressive episode. Type II bipolar disorder is diagnosed in individuals who have had a major depressive episode and symptoms of mania that did not require hospitalization and did not last up to one week (referred to as hypomania). Cyclothymia is also on the bipolar spectrum and is diagnosed when an individual has fluctuating depressive and manic symptoms but is not impaired. Bipolar NOS (not otherwise specified) applies to individuals who have depressive and manic symptoms that are impairing but do not meet the criteria for either type I or type II bipolar disorder. As demonstrated by the spectrum of symptoms and presentations, bipolar disorder can look very different among individuals. Symptoms are even more varied and difficult to recognize in children.

Bipolar symptoms in children look different from adult symptoms and often are misdiagnosed as unipolar depression, oppositional defiant disorder (ODD), attention-deficit/hyperactivity disorder (ADHD), and conduct disorder (CD). Bipolar symptoms in

children may include an extremely irritable mood, sudden rage episodes, vulgar language, or hostile behavior.

Children with bipolar disorder may have hypersexual behaviors, leading the adults in their lives to suspect sexual abuse. However, one study of children with bipolar disorder showed that 43% exhibited hypersexuality whereas only 1.1% had a history of sexual abuse or overstimulation (Pavaluri, 2008, p. 30). Other symptoms may include inflated self-esteem that does not have the age-appropriate reality check. For example, a child with bipolar disorder may persist in trying to convince his parents that, if they let him out of school, he could become a billionaire.

Following is a case study of a child on a bipolar roller coaster: Aidan is a 10-year-old with a diagnosis of bipolar disorder. (Note that Aidan's name has been changed to preserve confidentiality.) In describing his bipolar brain, Aidan said, "My brain becomes Darth Vader, when it used to be Luke." That is how Aidan reported that he felt when the "dark side" took him over (Aidan W., personal communication, October 2, 2017). Aidan was hospitalized for a major depressive episode after multiple suicide attempts when he was seven years old. His mother reported that he experienced suicidal ideation as early as four years old. The severe depressive symptoms subsided after he began taking Prozac. Within two months of his first hospitalization, however, he was hospitalized again. This time he was hearing voices and having visual hallucinations. His mother also reported that Aidan had several days with minimal sleep and nonstop goal-directed activity. He was stabilized with antipsychotics and referred to a pediatric mood specialist who gave him a diagnosis of bipolar NOS, generalized anxiety disorder, and ADHD. For three years, Aidan's symptoms remained mostly stable with the support of pharmacotherapy and child- and family-focused cognitive behavioral therapy (Aidan W. and mother of Aidan W., personal communication, October 2, 2017).

At 10 years old, Aidan was hospitalized again for suicidal ideation. Relationships with peers are extremely difficult to navigate for children and adolescents with bipolar disorder like Aidan. This can make school a major stressor for them. Aidan described what life in fifth grade was like for him:

Basically, it's like everyone else is a Lego person and when they get bumped by other people they're like plastic and they don't feel it. But when someone bumps me, I am softer than plastic and it hurts my feelings so bad that I can't stop thinking about it. I get stuck. (Aidan W., personal communication, October 2, 2017)

Risk Factors

One to three percent of children and adolescents have bipolar disorder (Ladson et al., 2014). Genetic factors are a risk and are, in fact, one of the best predictors of the development of bipolar disorder. Smoller and Finn (2003) found that 59% to 87% of children whose parent has a bipolar diagnosis will also develop the disorder. Whitney and colleagues (2013) compared children of parents with a bipolar diagnosis to children of parents who had no psychiatric disorders and found a significant difference in the social-emotional processes between these two groups: "The children with bipolar parents had significant impairment in social reciprocity, including impairments in social awareness, social cognition, social communication, social motivation, and autistic mannerisms" (p. 112). Significant deficits in social-emotional functioning are associated with the bipolar brain. Deficits may include social withdrawal, excessive dependency, social inhibition, and impaired social skills (Whitney et al., 2013). Reniecke and Ginsburg (2008) reported that "[interpersonal deficits] can put individuals at risk for depression and increase the likelihood of relapse and recurrence" (p. 190).

Trauma in childhood or adolescence is believed to trigger the early onset of symptoms in bipolar brains (Aas et al., 2016). Risk of manic or depressive episodes is increased with family stressors such as death, illness, divorce, poverty, and hunger. External stressors such as exposure to violence in the community or in the media are also risk factors (Ladson et al., 2014). Individuals with a bipolar diagnosis are known to display symptoms of posttraumatic stress disorder (PTSD) years after life stressors occur (Ladson et al., 2014). The way a child experiences a stressor may be the first indication that caregivers need to seek screening for bipolar disorder. Although many children can return to a stable emotional baseline after a traumatic experience, children with bipolar disorder may be significantly impaired or even require hospitalization. This is precisely the phenomenon of the Lego world that Aidan described. In Aidan's case, his first hospitalization at age seven coincided with his parents' divorce after years of an unstable domestic setting due to his biological father's alcoholism and periodic disappearances.

Other risks for children with bipolar disorder are delayed treatment, mismanaged pharmacotherapy, and misdiagnosis. These factors are associated with poor outcomes in childhood-onset bipolar disorder. When Leverich and colleagues (2007) surveyed 408 carefully assessed patients with bipolar disorder, those with onset in childhood and adolescence reported more episodes of impairment, more comorbidities, and more rapid cycling in their histories than those whose symptoms started after age 19. Furthermore, as Leverich and colleagues (2007) continued to follow those patients over a one-year period, the patients demonstrated more severe mania and depression and fewer days well. This same study also found that longer delay of treatment, averaging 16 years to the first treatment, was associated with early onset.

Of all the risks associated with the diagnosis of bipolar disorder, substance abuse is perhaps the most prevalent (Regier et al., 1990). Furthermore, substance abuse is associated with a significantly greater risk of suicide in adolescents and children with bipolar disorder (Pavaluri, 2008, p. 79). Lorber, Wilens, Martelon, Wong, and Parcell (2010) described substance abuse in individuals with bipolar disorder as “one of the main sources of resistance [to treatment] and impairment” (p. 478). This study further found that adolescents with bipolar disorder had reasons significantly different from those of a control group for starting substance: adolescents with bipolar disorder used substances not for the euphorigenic properties, but rather to control mood and other psychiatric symptoms.

Recent findings on substance use in high schoolers published by the U.S. Department of Health and Human Services (2017) showed that one in 17 high school students used tobacco in 2015. However, further data collected in 2015 showed that alcohol use was even more common than marijuana or tobacco use among high school students. Of high school seniors, three in 10 self-reported drinking some alcohol in the past four weeks and one in six reported recent binge drinking. These numbers do not reflect the rates of high-school-age adolescents who were not attending classes. Individuals who drop out of high school are at an even higher risk for substance abuse (McWhirter, McWhirter, McWhirter, & McWhirter, 1993, p. 119).

Substance use alters normal functioning and can lead to tragic accidents and risky choices that can create serious problems such as early sexual involvement, legal troubles, and missed educational or work opportunities that follow adolescents into their adult years. However, for a subset of adolescents, substance use is also a marker of comorbid affective disorders. Adolescents with mood disorders who use substances are at a much higher risk of abusing their drug of choice (Baker, Piper, McCarthy, Majeskie, & Fiore., 2004), and the risk of suicide is significantly heightened (Pavaluri, 2008, pp. 181–182). Clinicians screening and treating substance use in an adolescent should pay close attention to symptoms that indicate that the adolescent is using substances for their pharmacological effects.

In 1985, Edward Khantzian presented a self-medication hypothesis that demonstrated how individuals with psychiatric disorders used substances to relieve symptoms. Although much of his original hypothesis has been dismantled, many substance abuse researchers continue to examine the correlation between substance abuse and comorbid affective disorders. Ladson and colleagues (2014) presented several different findings from contemporary research that demonstrated how individuals with substance abuse who experienced periods of depression and mania were much more likely to develop substance dependence. Those with major depressive episodes were three times more likely to develop substance dependence and those who experienced mania were six times more likely. Further, Baker and colleagues (2004) postulated that negative affect is not only a precursor to addiction, but it also inhibits the treatment of addiction. Individuals who have used substances to self-medicate for mood symptoms have an impoverished array of coping responses for negative affect. In addition, severe negative affect influences executive functioning. Therefore, individuals with substance use and depression may not benefit from some evidence-based interventions for substance abuse (such as motivational interviewing) because their mood inhibits their ability to plan and process information. This is why Pavaluri (2008), a leader in pediatric bipolar research, asserted that it is an essential preventive measure for parents of bipolar children with suicidality to talk to their children about their predisposition to abuse substances (p. 79).

Interventions

One of the greatest protective factors for individuals with bipolar disorder is early treatment and intervention (Ladson et al., 2014). Because bipolar symptoms are so influenced by

environment, one of the most effective interventions for a child with bipolar disorder is educating the family, the school, and *the child* about the child's brain chemistry. Simply giving a rationale for behaviors can elicit feelings of hopefulness in everyone involved, leading to a more supportive and positive environment (Pavaluri, 2008, p. 73). Families who participate in interventions with children vulnerable to depressive episodes can change the trajectory of their child's illness (Ladson, et al., 2014). Given tools for coping, problem solving, and goal setting within a supportive environment, a child with a bipolar diagnosis is more likely to thrive.

Cognitive behavioral therapy (CBT) is considered the best behavioral model for intervention with mood disorders. It is strategic and problem focused, and meaningful change is expected after 12 to 16 sessions (Reinecke et al., 2008). Treatment is individually tailored and collaborative. The therapist seeks to reveal the client's tendency to focus on negative thoughts, anticipate rejection, and harbor harmful beliefs about himself or herself. The therapist also teaches cognitive strategies to shift the maladaptive ruminating that can immobilize the adolescent. Interventions may include in-session practice of coping techniques such as problem solving, relaxation, mindfulness, and role playing of social situations (Reinecke et al., 2008).

Pavaluri (2008) created a model of CBT that incorporates the family: child- and family-focused cognitive behavioral therapy (CFF-CBT). Her evidence-based model includes an educational group component in addition to individual therapy and family therapy sessions. Families with children who have symptoms of bipolar disorder are trained as coaches in order to create a positive environment and increase positive affect. Siblings are given strategies to use in crisis situations. Parents are given tools to help their child, to educate their schools, to act knowledgeably and collaboratively in medication management with their child's psychiatrist, and to practice self-care (Pavaluri, 2008, pp. 71–84).

Another growing trend in treating bipolar disorder, especially with patients who have suicidality, is dialectical behavioral therapy (DBT). A long-term treatment for severe affect dysregulation, DBT focuses on managing overwhelming affect through interventions similar to CBT: problem solving and emotional regulation. The theory is that suicidal ideations come from a deficit of coping mechanisms. Unlike CBT, however, DBT is very relationally focused. The relationship between the therapist and the client is of great importance. The client frequently checks in with the therapist to report problems or successes (Feigenbaum, 2010). Dialectical behavioral therapy is believed to be the most effective intervention for borderline personality disorder and for adolescents who exhibit self-harming behaviors.

Social rhythm therapies (SRTs) are a less researched but promising treatment for bipolar disorder. There is strong evidence to support the fact that circadian abnormalities or disturbances are a significant component of bipolar disorder (Husseini et al., 2003). In brief, SRT interventions target daily activities with the goal of establishing moderately active daily and weekly routines. The purpose of SRTs is to change the biological circadian rhythms that contribute to dysfunctional behavior and mood symptoms (Haynes, Gengler, & Kelly, 2016).

If the child or adolescent is enrolled in school, educating the school to create a 504 or IEP (individualized education plan) based on best practice is an important intervention. School can be an extremely stressful place for a child with bipolar disorder, and unless the child is receiving social-emotional supports throughout the day, it may be impossible for him/her to succeed academically. The untreated child with symptoms of bipolar disorder is frequently misdiagnosed in the school setting as having CD, ODD, or ADHD. With the proper social-emotional supports, symptoms of CD, ODD, and ADHD often disappear within two or three weeks (Pavaluri, 2008).

The best behavioral strategies and psychotherapy cannot achieve their fullest potential without appropriate pharmacotherapy to help stabilize moods of individuals with bipolar disorder. Leading research on the bipolar brain has found significant differences in brain chemicals and neurobiology at the molecular, cellular, and behavioral levels in individuals with bipolar diagnoses (Palaniyappan & Cousins, 2010). There have been great advances in successful pharmacotherapy for bipolar disorder. However, Pavaluri (2008) warned that, although we understand much more about pharmacological treatments today, "there is still a lot of trial and error involved" (p. 89).

If a patient presents with a comorbid substance abuse disorder, medication management is important due to the deficit in coping strategies (Baker et al., 2004). When a person with an underlying mood disorder has long used a substance to self-medicate, it is important to prescribe medication for both the withdrawal

symptoms and the negative affect that caused the addiction in the first place. Experts in the field now recognize that antidepressants often do not help. Unfortunately, due to misdiagnosis of depressive symptoms, clinicians often make this mistake (Lloyd, Giaroli, Taylor, & Tracy, 2011). Muneer (2017) published an up-to-date comprehensive review of successful pharmacotherapy for bipolar disorder. Antipsychotics and mood stabilizers are currently shown to be most effective in the treatment of bipolar disorder.

Of all these interventions, family and community support are the most imperative for successful treatment. Unfortunately, when treatment is delayed until adulthood, many families have exhausted hope and are vexed by the individual with bipolar disorder. The individual with bipolar disorder has often burned bridges and developed a deeply rooted self-perception of failure.

Implications for Social Workers

Social workers are not only clinicians but also advocates, as impelled by their code of ethics. Raising awareness about the devastating effects of untreated or belatedly treated bipolar disorder, advocating for equal rights to treatment, and educating the public about mental health in order to negate harmful stigma are all part of the social worker's mission.

Social workers are trained to consider the person in environment, and much of the research on bipolar disorder has shown the necessity of understanding the environment and not just the psychopathology of a bipolar child's brain in order to prevent relapse and rapid cycling. For example, Geller and colleagues (2000) found that of children with bipolar disorder those who experienced low maternal warmth were 4.1 times more likely to relapse after recovery from a mood episode. In addition, children with bipolar disorder who were in intact biological families, as opposed to split families or single-parent homes, had 2.2 times the recovery rate. Because bipolar disorder is extremely environmentally sensitive, social workers can be key players in recognizing how environmental systems affect mood.

Many people with mental health disorders are high functioning and thrive in our communities, but there are inconsistencies in terms of who gets mental health services. Kilbourne and colleagues (2004) found that, among adult clients with bipolar disorder, minorities were more likely than whites to have cocaine addiction or alcohol use disorders. In addition to raising awareness, social workers must continue to advocate for victims of oppression and to participate in the transformation of justice in our communities.

Leverich and colleagues (2007) and Ladson and colleagues (2014) focused on the harmful impact of misdiagnosis and the need for collaboration to properly diagnose and treat individuals according to best practices. They stressed the importance of educating professionals about early-onset bipolar disorder and using tools for screening. They encouraged their fellow social workers to be aware of the need to screen for bipolar disorder when symptoms of ADHD, depression, and a family history of the disorder coexist.

The following case study shows how a lack of interprofessional and interagency collaboration contributed to ill-informed treatment and misguided interventions for a client whose early history showed clear indications of his risk for developing bipolar disorder. Years later, when the client was 18 years old and involved with the criminal justice system, multiple agencies attempted to change his trajectory and support healing for this young man.

Tristan: A Case of Collaboration

Tristan was 18 years old when he was incarcerated. His charges included theft and violating a restraining order against an ex-girlfriend. These were Tristan's first adult charges, and his mother hired an attorney at the legal center where the author was employed as a mitigation/reentry specialist. The author's job was to gain a thorough understanding of Tristan's history in order to support the legal team in preparing a comprehensive background and reentry plan to present to the court. The information in the investigation came from records obtained from schools Tristan attended from kindergarten to high school and medical and mental health records obtained from a family/pediatric physician, an independent neuropsychologist, psychiatrists, nurse practitioners, and a substance abuse treatment center.

Tristan identified as white-Hispanic and grew up in a middle-class suburb of Chicago with his mother, brother, and grandparents. His father was a self-described alcoholic who had come and gone several times over the years. At the time of the author's investigation, Tristan's mother was negotiating a divorce settlement, and the father

was estranged from the family. There was no expectation of child support because the father was often unemployed for long periods of time. Tristan's mother had worked as a legal secretary for 10 years, and her parents—Tristan's grandparents—helped her with childcare and living expenses. Tristan's mother and the children had lived with her parents as long as Tristan could remember. Tristan said that his dad had an apartment space set up in the basement from times when he had lived with his wife and children. Tristan's grandfather used to be alcoholic, according to family members. The adult members of Tristan's family expressed some discomfort with mental health treatment, particularly pharmacotherapy. They frequently referenced the grandfather's ability to get sober without medicine or other treatments. The family identified as Catholic, but only the grandmother attended services regularly, and they were not active participants in any other religious community.

Tristan struggled in every academic area as early as kindergarten. He was diagnosed with ADHD and depressive disorder not otherwise specified in fifth grade by a psychiatrist after the school referred him for pharmacotherapy due to inattention. That psychiatrist referred Tristan to a specialist in children with mood disorders so that Tristan could receive a full neuropsychological evaluation. Tristan's mother reported to the evaluator that Tristan was a worrier, and some days they could not get him out of bed because he was hating himself. He would say things like "I am stupid . . . everyone would be better off if I was dead." Tristan's mother felt that these intense negative moods were due to Tristan's learning disabilities and his academic failure at school. She and the school reported that he was liked by other kids, and the school reported that he was a sweet but sometimes silly boy who liked attention. Tristan's mother reported that on some days Tristan would jump on the couch, lift and push furniture around the room, and exhaust the rest of the family. At times his energy would turn to aggression—he would use explicit language and sometimes lunge at his mother in a rage.

In 2008, the specialist, Dr. R., confirmed a diagnosis of ADHD and depressive disorder and added a diagnosis of dyslexia. In her recommendations, she encouraged the family to consider pharmacotherapy to treat the mood disorder and also recommended that Tristan be trained in coping skills with a CBT therapist. Dr. R. advised that Tristan's mood and anxiety symptoms should be closely monitored as he developed.

In a 2012 IEP evaluation, Tristan was reported to have severe deficits in all academic areas that were "highly discrepant from his intellectual potential." The corresponding psychological evaluation indicated that Tristan had "emotional and behavioral problems that appear to be chronic in nature and when combined with his significant academic difficulties he is a most frustrated and unhappy student at that this time." For unknown reasons, Tristan's psychiatric care was discontinued in November 2012.

In the fall of 2013 Tristan participated in a 45-day drug rehabilitation program upon referral by his school counselor. Leading up to the referral, Tristan had received a five-day suspension after he was observed under the influence of marijuana for multiple days at school. He was also showing more defiant behavior and impulsive angry outbursts. He was discharged from the rehabilitation program with the diagnoses of cannabis dependence, alcohol abuse, and ADHD. After his discharge, Tristan began seeing a new psychiatrist, who diagnosed cannabis abuse and ADHD. However, records from this period denied any history of behavioral problems, learning disabilities, or mood-related concerns.

The year of Tristan's incarceration was 2016. The author was aware that Dr. R still worked as a specialist in evaluating children with mood-related symptoms. With Tristan's permission, the author contacted Dr. R in order to report Tristan's history since the 2008 evaluation and to request support for considering a reentry treatment plan. Dr. R enthusiastically agreed to participate on Tristan's behalf. With permission from Dr. R and Tristan, the author was able to turn over more than 700 pages of records with a summarized chronology of Tristan's history since 2008.

After Dr. R's review and initial evaluations with Tristan and his mother, and pending a full neuropsychological evaluation, Dr. R included the following diagnoses in a report for the court:

296.32 (F33.1) Major Depressive Disorder, Moderate, Recurrent, with Anxious Distress

304.30 (F12.20) Cannabis Use Disorder, Severe

308.3 (F43.0) Acute Stress Disorder

314.01 (F90.2) ADHD Combined Presentation, Moderate

315.00 (F81.0) Specific Learning Disorder, with Impairment in Reading (Dyslexia), Severe; Additional specifiers deferred, pending neuropsychological reevaluation

115.2(F81.81) Specific Learning Disorder, with Impairment in Written Expression, Severe; Additional specifiers deferred, pending neuropsychological reevaluation

315.1 (F81.2) Specific Learning Disorder, with Impairment in Mathematics, Severe; Additional specifiers deferred, pending neuropsychological reevaluation

RULE OUT: Posttraumatic Stress Disorder (PTSD), Deferred to Treating Physicians/Clinicians[1]

RULE OUT: Bipolar Disorder, Deferred to Treating Physicians/Clinicians

The representing attorney filed a motion to release Tristan on electronic home monitoring (EHM) so that he could enter treatment for substance abuse and comorbid disorders as well as complete the neuropsychological assessment. A licensed clinical social worker (LCSW) was recruited to meet with Tristan weekly. A substance abuse treatment center accepted Tristan into its partial hospitalization program (PHP). All these agencies and individuals were willing to collaborate with one another and with the Cook County Sheriff's EHM Unit to arrange for movement to and from appointments.

The judge agreed to the plan and ordered Tristan to be placed on EHM so that he could begin his collaborative treatment. Tristan completed three weeks of the PHP with an attending psychiatrist and also attended sessions with the LCSW. The author is unaware of what medications or follow-up care with a psychiatrist were put into place. (Dr. R offered to assist in giving a referral for a psychiatrist.) Three months following Tristan's release from jail, his attorney secured TASC probation for Tristan in place of further jail or prison time. (Treatment Alternatives for Safe Communities [TASC] is a service Cook County makes available to those who have substance use disorders [see http://www2.tasc.org/program/adult-court-and-probation-services for further information].)

Because Tristan's symptoms of a mood disorder were not monitored and properly communicated between agencies when he was 15, his risk for substance abuse increased. He began using marijuana to self-medicate, and this led to negative consequences that could have been avoided if care had been coordinated.

The author received word from a TASC representative that Tristan successfully completed his probation requirements one year later, in November 2017. The TASC supervisor reported that Tristan had made a complete turnaround. The successful completion of TASC vacated criminal charges so that Tristan had a clean record. Additionally, the author spoke with Tristan's mother and grandfather in January 2018 and was informed that he had been employed at a construction site for the past three months—the longest period of time he had ever been employed.

Although this seems like a positive outcome from a legal perspective, reaching this point in Tristan's healing journey was not without struggles for him and his family. At the time of EHM, both Tristan and his family were under extreme financial and emotional stress. At first, his attendance and cooperation with treatment plans were less than seamless. Tristan even picked up a new domestic abuse charge during treatment. Fortunately, his attorney was able to have that case dismissed. It now seems that Tristan has the tools that he needs to thrive in his community.

Discussion

Currently, one-third of inmates incarcerated in Cook County Jail suffer from psychological disorders (Ford, 2015), and nearly 66% of state prisoners in the United States are minorities (Nellis, 2016). Tristan's case brings up an important question about how trusted connections already established between clients and legal or other agencies may support mental health services for individuals who may be culturally opposed to or feel stigmatized by mental health diagnoses.

Collaboration appears essential for accurate diagnosis and treatment of early-onset bipolar disorders. Collaborating agencies and individuals may include psychiatrists, schools, counselors, the Department of Child and Family Services, legal agencies, social service agencies, and the family or community members. School counselors and social workers who provide counseling for substance abuse need to be informed about the 1% to 3% of their client

[1] Tristan was displaying symptoms of PTSD related to incidents that happened during the months he spent at Cook County Jail.

population who may be using substances to cope with dysregulated mood. Simply including questions about biological family history of mental illness or substance use, screening for ADHD symptoms, and screening for a history of severe negative affect during substance use assessments could help to rule out bipolar disorder or show cause for further screening.

In addition, although medications are an important intervention, they can have a highly detrimental impact if wrongly prescribed, triggering cycling in bipolar brains and negatively impacting individuals' lives. For this reason, clinicians must rule out bipolar disorder before prescribing for ADHD or depressive symptoms, especially if they are coexisting. Furthermore, any prescribing physician should be aware of other psychotropic medications that have been tried in the past and not rely on the memory of the patient. Because of their diverse roles and agency affiliations, social workers have a unique opportunity to facilitate interprofessional collaborations. When clinicians, caretakers, and other professionals collaborate, children and adolescents with bipolar spectrum and other mood disorders are more likely to receive early interventions and a reduced risk of substance abuse.

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Exploring Thailand's Systems and Politics Regarding Child and Adolescent Protection

Nicole Betteridge, MSW

Abstract

Historically, Thailand has had one of the highest rates of child abuse and violence worldwide. Thai social workers are at the forefront of protecting children and adolescents who experience sexual or physical abuse. They play intricate roles in working with children, families, communities, and government leaders to ensure that children remain safe and that policies continue to be written and enforced aimed at eradicating child abuse and violence. Through the hard work of Thai social workers, policies are slowly beginning to be enacted and enforced, such as the Child Abuse and Neglect Act of 2003. Interventions are essential in working with vulnerable children and their families in cases of abuse. Some of the most common and important interventions used by Thai social workers are play therapy, restorative justice, and family and community group conferencing. More work through peace initiatives and education is still needed to protect Thai children and adolescents.

Keywords: child and adolescent protection, rape, restorative justice, peace

Introduction

As Marian Edelman, child activist and founder of the Children's Defense Fund, once said, "If we do not stand up for children, then we do not stand for much" (1999, p. 34). As they grow and develop, children and adolescents worldwide need to be nurtured and loved by parents or other adults. While many children are raised by caring adults, other innocent children become the victims of abuse and violence. Thailand is a country whose number of reported child abuse cases has dramatically risen, perhaps because in 2003 Thailand enacted its first Child Abuse and Neglect Protection Act (Center for the Protection of Children's Rights, n.d.). This act was an important first step in advancing Thailand's capacity to defend children's human rights. It resulted from the efforts of many professionals in Thai organizations and institutions who work hard to protect the rights and safety of children.

Social workers at Siriraj Hospital are one important group of professionals working to combat child abuse and violence in Thailand. As a social work intern in Bangkok at Siriraj Hospital, I have not only learned the magnitude and severity of child abuse and violence in Thailand, but I have also witnessed how different peace- and justice-building practices are used in partnership with Thai communities. In this article, I will describe efforts I witnessed in Thailand to aid children and their families with problems of child abuse using case studies from my clinical experience.

Factors Affecting Prostitution in Thailand

According to the Diagnostic and Child prostitution and sexual abuse in Thailand increased significantly during the time of the Vietnam War from 1955 until 1975. During this time, the United States used Thailand as a relaxation and recuperation (R&R) destination for army personnel granted leave outside of Vietnam (Dapin, 2015). For some military men, time in Thailand was simply a space to relax away from the sounds and violence of war. For others, however, Thailand became a destination to engage in child prostitution. During the war, many Thai families struggled financially; therefore, if a military man arrived and offered a young Thai girl money for having sex, she would reluctantly accept.

In particular, Pattaya Beach was most affected by incidents of child prostitution involving men on R&R. Before the Vietnam War, Pattaya Beach was a fishing village, but during the war thousands of troops arrived there for rest and recuperation. Soldiers often referred to their break time at Pattaya Beach and other locations in Thailand, not as R&R, but rather as I&I (intoxication and intercourse; Dapin, 2015). The aftermath of what occurred on Pattaya Beach is still evident there today. The area grew to house a large number of prostitution and sex shops and sex-oriented businesses. Today Pattaya Beach, Thailand continues to be one of the largest red-light district areas in the world (Dapin, 2015).

The high rates of exploitation and child violence in Thailand can also be attributed to religious beliefs and the socioeconomic levels of many Thai citizens. Thai families often are large and having enough money to care for all their needs can be challenging. Many Thai people work as house cleaners or in markets selling produce. These jobs produce minimal salaries that make it difficult to afford school fees or everyday necessities, such as food, rent, or clothing. Therefore, having their child take part in child labor or prostitution has become a simple means for a family to earn more money.

Additionally, religious beliefs in Thailand, a primarily Buddhist nation, have impacted the rates of child abuse. In Buddhism it is believed that all life is equal, that the suffering of others must be recognized, and that all people have the right to compassion from others (Fuchuan, 2006). These views are different from Western approaches and Western society, which give children the elevated status of "protected minors" due to their increased vulnerability. In Buddhist traditions, by contrast, all people are considered worthy of the same compassion. Therefore, Buddhist monks and leaders in Thailand do not usually discourage child prostitution because they see that it may be a form of compassion and relief for a family (Fuchuan, 2006). They recognize the economic benefits prostitution can have for a Thai family living in poverty, and they often see child prostitution as a solution to a family's suffering.

The rate of AIDS cases in Thailand can be linked to child sexual abuse and violence. In Thailand, there are currently more than 600,000 people living with AIDS and about 700,000 people who are HIV-positive. Furthermore, there are approximately 300,000 Thai children who have lost a parent or family member to AIDS. In other cases, a child is HIV-infected (Safman, 2004). Children suffering from HIV or living as orphans become more vulnerable to abuse and neglect. They lack the resources needed to distance or separate themselves from concerns in their family or environment. They also often lack knowledge about how to protect themselves from discrimination or abuse. Having a child with HIV can be a financial burden on families or caregivers. Child care and medical expenses can be high for a child with HIV, and many schools and childcare facilities reject HIV-infected children out of fear of contagion. If children are orphaned, they may go to live at a children's home where they are vulnerable to the abuse and neglect of employees, volunteers, and visitors. In other instances, Thai children living with HIV are cared for by another adult whose health is already declining . The young child must therefore take on more of a leadership role to provide for the family. In many of these cases the young child sees prostitution as a possible way of earning income (Safman, 2004).

The use of technology and the Internet has had a large impact on child prostitution and sexual abuse throughout Thailand. In the early 1990s, the use of personal computers and the Internet became popular worldwide. The Internet made it easier to market and procure child prostitutes internationally. Furthermore, the Internet helped to create a network of wealthy international pedophiles and connect them to Thailand. The movement of more wealthy foreigners to Thailand has significantly increased rates of sex tourism. All these factors explain why child sexual abuse and incest have become such large concerns among Thai adults and children in recent years.

Historical Context

Thai social workers have focused their work on issues of child abuse for many decades. Since Thailand is a collective community-based society, organizations and parties often work jointly on the same cases. Child protection is therefore a multidisciplinary task in Thailand. As employees of a government hospital, Siriraj Hospital social workers are mandated to report cases of child abuse to the government, specifically the Ministry of Social Development and Human Security. Other Thai government officials and agencies also work in partnership on issues of child protection. These include the Department of Social Development and Welfare, the Ministry of Education, the Ministry of Public Health, the Department of Mental Health, and the Bangkok Metropolitan Administration).

Siriraj Hospital and its social workers also partner closely with the United Nations International Children's Emergency Fund (UNICEF) and the Center for the Protection of Children's Rights Foundation (CPCR). Since 1946 UNICEF has been working to eliminate child abuse in Thailand, and it has worked with Siriraj Hospital for approximately 20 years. Since 1981, CPCR has also been working to rescue and protect children faced with abuse. Through collaboration with police and legal officials, hospitals, and schools, employees of CPCR have also increased awareness of the social injustices

of child labor and exploitation (Center for the Protection of Children's Rights Foundation, n.d.).

Not only have social workers at Siriraj Hospital, UNICEF, and CPCR been responsible for child abuse cases, but clerics at places of worship (e.g., Buddhist monks and Christian pastors) and employees in law enforcement offices (e.g., police, legal agencies, and schools (e.g., teachers) have also historically played a role in child protection. Children and youth can be susceptible to abuse and violence while in the classroom or at a religious ceremony. Police officers and judges are responsible for reporting cases of abuse and determining the outcome of a case based on the welfare of the child.

Professionals need to recognize how abuse can impact a child's mental health (Center for the Protection of Children's Rights Foundation, n.d.). Thai social workers, in partnership with hospitals and nonprofit organizations such as UNICEF or CPCR, can continue to offer and expand trainings on mental health for other professionals and community members. Children who have been sexually abused often experience posttraumatic stress disorder later in life. Professionals must be aware of issues that arise in their workplaces as well as in the community and how to protect children in various situations.

In many sectors of Thailand there is a lack of mental health services for children and a lack of awareness of child protection issues therefore, multidisciplinary services are important for vulnerable children. Each professional brings his or her own perspective to a child's life and needs after that child has suffered from child abuse. Social workers, however, bring a unique perspective when working with individuals and communities. Thai social workers have historically been able to navigate between individual families and the larger community and government systems. They can network with organizations and help teach and spread awareness about child protection (Center for the Protection of Children's Rights Foundation, n.d.). Therefore, Thai social workers continue to assume important roles in advocating for vulnerable children and helping to increase community knowledge of mental health and child protection.

Policy Context

Child protection social workers at Siriraj Hospital and other Thai professionals working with children must abide by the Thai Child Protection Act of 2003, as well as the United Nations Convention on the Rights of the Child, ratified by Thailand in 1992 (United Nations,1989). In this regard, Thailand has progressed more than many countries, including the United States, which has not ratified the Convention on the Rights of the Child. These documents outline the human rights that are granted to all children under the law. The United Nations Convention on the Rights of the Child explains that every child is entitled to basic health care; security; a good education; a loving home; and protection from exploitation, neglect, sex trafficking, and child labor. Similarly, the Thai Child Protection Act of 2003 seeks to protect Thai children under the age of 18 from all forms of abuse, exploitation, or violence (United Nations Economic and Social Commission for Asia and the Pacific, 2003).

Regardless of Thailand's adherence to national and international human rights documents, the country continues to have one of the highest prevalences of child abuse and violence worldwide (United Nations Economic and Social Commission for Asia and the Pacific, 2003). Each year an estimated 6,000 to 7,000 child abuse cases are reported, most frequently involving sexual abuse (World Health Organization, n.d.). Between 1998 and 2007 there were 17,529 reported cases of abuse in Thailand. Thirty-eight percent of these reported cases involved rape of girls under the age of 18 (World Health Organization, n.d.). Many other incidents of child abuse occur, but are never reported. In these cases, children are either afraid of the punishment they (or their family members) may receive or they simply do not have access to the systems and officials that could help them report violence. Professionals may hesitate to become involved because the child welfare system infrastructure for responding constructively to child abuse reporting is still developing. It is the role of Thai social workers to help bring awareness of systems that can help Thai families and children affected by abuse.

Child abuse, trafficking, and sexual violence happen primarily among abusers who are older Thai citizens or foreigners in a variety of locations. Most commonly, children are raped, inappropriately touched, or harassed in brothels, barber shops, schools, hotel rooms, or a family's home. The abuser may be another family member (often a father or stepfather), a neighbor, a teacher, another adult at the child's school, or a foreigner who bribes a child with money in

exchange for sex (Center on the Protection of Children's Rights Foundation, 2017).

To provide child protection, Thai social workers must have a strong understanding of the Thai legal system. Thai laws and hospital regulations differ from those in the United States in that a person certified as a competent officer can determine the outcome of a child abuse or violence case. In Thailand a social worker or lawyer can become certified as a competent officer by completing a series of courses on Thai laws and policies. As a third-party social worker or lawyer for the hospital, a Thai competent officer is powerful enough to make legal decisions on behalf of a child victim of abuse or violence without the court's approval.. To gather more evidence on the case, an interview with a child victim of sexual abuse may include a hospital social worker, a child protection worker from an outside agency (specifically the Center for the Protection of Children's Rights Foundation), a competent officer, a psychologist, a doctor, and the child's parent/s or other family member.

Case Studies

To better explain child abuse in Thailand, three case studies based on experiences of patients of Siriraj Hospital will be presented. Social workers at Siriraj Hospital monitored these cases. Names and specific details have been changed to protect confidentiality.

Case Study #1: Sarah

Sarah, female, age four, currently resides in a local market in the Sathorn District of Bangkok. Her father left the family when Sarah was two years old. The family no longer has contact with him, and it is unknown if he is still living in Bangkok. Sarah's mother is young (23 years old) and is rarely present to care for Sarah's needs. Sarah has other family members, but they live in other provinces of Thailand. Therefore, Sarah stays with her maternal grandmother and relies on her grandmother to care for her needs. Sarah's grandmother earns her income by selling produce at the local market. She must work hard every day to have enough money for her family. Each night Sarah's grandmother goes to a larger market to buy and bargain for food that she brings to sell at her local market. During the night Sarah waits for her grandmother and sleeps on a woven mat at the edge of the market. Sarah's grandmother believes others in the market will look out for Sarah while she is away buying produce. Sarah's grandmother is older and too weak to carry Sarah in addition to the food she buys. She fears that Sarah is too young to have the stamina required for all the walking. Since Sarah's grandmother must work most of the night, she goes back to sleep at the local market and prepares for sales to open at 5:30 a.m. The markets are not a safe or clean place for Sarah to stay. Not only is she often left alone and vulnerable to the abuse of older adults, but the open-air market is dirty and the raw foods often carry diseases.

The hospital social worker recently met with the family after a market stall owner reported seeing Sarah raped by a market goer during the night. The offender was sent to jail, but Sarah's grandmother still appears tense and stressed. She wishes to move their sales to another market, but she cannot afford to move at this time. The social worker will work with the grandmother and the entire market community using restorative justice and family and community group conferencing to help restore peace and harmony among the people in the market. Restorative justice techniques will also help the community to brainstorm alternative solutions for keeping Sarah safe in the markets. Through family and community group conferencing, the community will also work together to explore alternatives that protect children from abuse and to build a stronger sense of peace and respect among themselves.

Case Study #2: Nov

Noyis a female, age 16, who lives with her brother and mother in the Watthana District of Bangkok. The family lives in an abandoned building they inherited from other family members. They could not stay in the house if they had to pay rent because they do not have enough money. Noy's mother often goes outside the house to socialize with friends. She is currently unemployed. Noy's father is in jail and no longer in contact with the family. Noy's brother studies art at a university and is also rarely at home. Many cats live in Noy's family home, producing a lot of animal hair and a distinct odor throughout the house. Since her mother is rarely home, cleaning and maintenance of their home are often overlooked. Siriraj Hospital recognizes the financial struggles of Noy's family and supports the family with 2,000 Thai baht each month (approximately US$60). As a government

hospital, Siriraj is able to use national funds to support low-income Thai families.

Noy has severe anxiety as well as schizophrenia. She stopped attending school after the fourth grade because it became too challenging socially and academically. She explained to the social worker that she wants to return to school, but knows it is not possible at this time. As a result of Noy's mental state, she also has a challenging time managing her weight and eating healthy food. The hospital social workers have helped to support Noy by teaching her healthy life skills.

Recently, the hospital social workers received a report that Noy had been raped by her neighbor while she was home alone at night. The hospital social workers have been contacted and are now working to gain more evidence about the incident. They will use restorative justice techniques and family and community group conferencing with Noy's family and community. Restorative justice and family and community group conferencing will help spread awareness to the community about sexual abuse and how to keep the neighborhood safe and peaceful.

Case Study #3: Malai

Malai, is a female, age 10, who lives in the Yan Nawa District of Bangkok with her mother, father, and older sister. Malai's older sister studies business at Mahidol University. Her mother works as a house cleaner for a foreign family, and her father is a Thai soldier. Her family moves around Thailand a lot because of her father's job as a soldier. They have lived in their current house for only three months. Her parents and sister are rarely home, and so Malai often takes care of her needs on her own. Malai works hard, but since she has little support or mentorship from older adults she is falling behind in school.

Last month Malai's teacher made a referral for Malai to see the social workers and doctors at Siriraj Hospital because she saw that Malai was more worried and nervous in the classroom than her peers. Malai also had crying spells, seemed to be unhappy in the classroom, and performed poorly on school work. The multidisciplinary hospital team at Siriraj Hospital diagnosed Malai with an adjustment disorder.

Recently, Malai's school contacted the social workers at Siriraj Hospital again, this time with an incident of sexual assault. Malai reported that an older boy at school had stuck his finger inside her vagina in the bathroom. The hospital social workers have returned to the school to gain more evidence about the incident. The hospital social workers will use restorative justice and family and community group conferencing techniques to educate the school staff and help implement safety precautions to reduce incidents of sexual assault in the school. Family and community group conferencing will help involve the entire community in Malai's case. The school staff and community will learn peace-building techniques as well as how to care for Malai after the sexual assault and ensure that fewer sexual assaults occur in the school. Family and community group conferencing will provide a space for all the parties involved in Malai's incident, particularly Malai, to voice their thoughts and feelings regarding the incident. Family group counseling is an important technique to use with Malai and other people in her life as sexual assault is not an individual concern, but one that the entire home and school community must participate in together.

Intervention Approaches in Thailand

Play Therapy Tools for Evidence Gathering

The social worker plays an essential role in interviews with children. Play therapy is an effective approach used by Thai social workers in homes, schools, or hospitals to interview children. Play is a child's natural way of interpreting the world. Thai children often play with male and female dolls during play therapy sessions with Thai social workers. For example, the dolls allow a female child to explain and show to the social worker how the male touched her or how he put his penis inside of her without the child having to use words (Landreth, 2012). The social worker can use a dollhouse to help teach the child responses to use if someone asks for unwanted sex. For example, the social worker can make the female doll say "No! I have to go now!" if a male doll grabs a female doll's arm and tries to initiate sex (). By using a dollhouse, the child or teenager can reenact the sexual violence. For example, he or she can show the social worker whether the incident occurred on the floor or in a bed.

Social workers use several other toys with children in play therapy involving sexual violence. Medical social workers often use art as a way to help children tell about what happened to them and how it made them feel (Landreth, 2012). Using art, children are encouraged to draw pictures illustrating how they felt when they were sexually abused. Play therapy can be beneficial

for children who feel too scared or nervous to verbally communicate what happened to them.

Interviews with all the parties involved in a sexual abuse case are vital in gaining evidence, but this can be challenging. Many children are raped by a parent or other family member. In these cases, other family members often feel ashamed to share the facts with hospital professionals. Parents often become frustrated by others' rendition of the abuse story and abruptly walk out of the hospital. At other times parents get angry with each other and will not look at one another or communicate with each other during the interview. These behaviors and attitudes make it difficult to reach a consensus about where the child should live and who should care for the child after the abuse.

Thai people are generally calm and peaceful; therefore, interventions that encourage peace such as restorative justice and family and community group conferencing work well in Thai cases of child abuse. Nevertheless, Thai people generally do not like to lose face or feel ashamed; therefore, working as a social worker with sexual victims and abusers can be challenging. It is important for the social workers to use constructive feedback with the families, always considering their strengths.

In Western cultures, specifically the United States, the need for social workers or counselors can arouse feelings of shame. Cultural and minority groups living in the United States often face additional humiliation and shame regarding issues of sexual abuse. In the United States, however, there are television shows and public humor about psychotherapy (Landreth, 2012). The use of technology and public humor in the United States reminds people that they are not alone in their struggles and that asking for help, rather than keeping silent out of fear or shame, is acceptable. In Thailand, however, psychotherapy is a new concept and people who need it are often stigmatized.

When social workers work with Thai families, it is valuable to explain clearly the purposes of using play therapy with the child. When family members recognize that play is the natural way of allowing the child to heal and explain his or her feelings after sexual abuse, they are often more open to working with social work professionals (Landreth, 2012). Families are hesitant to go to therapy because they are unsure what it is and they do not want to be stigmatized by their communities for needing a counselor. It is important in these situations for social workers to share with families that children with mental illness or abuse victims cannot heal with medication alone but need alternative ways of processing their thoughts and feelings. When a social worker explains what psychotherapy tools will be used to help their child heal from abuse, Thai families are often curious and willing to try working with the hospital social worker (Landreth, 2012).

Culturally Appropriate Approaches to Care

Thai social workers have different methods than their counterparts in the United States for completing hospital child abuse interviews. As a social work intern, it was important that I observe and learn from Thai methods rather than trying to impose Western techniques (Doyle & Nicholas, 2000). One example is the use of contracts in Thai interviews. These contracts are developed between the parents and family members, the psychologist, the doctor, the social worker, and the competent officer. All parties involved must sign the contract to make it a binding agreement and they must fulfill the tasks in the contract. For the majority of the time, family members follow the contract because they do not want further conflict with the law and they want to keep the rights to their child (Center on the Protection of Children's Rights Foundation, 2017).

Thai medical social workers must also handle many child protection cases in primary schools. Unlike schools in the United States, Thai primary schools do not often employ a social worker on their school staff. Therefore, hospital social workers must deal with many cases of children who have been sexually harassed or raped in primary schools (Save the Children, 2016; United Nations Economic and Social Commission for Asia and the Pacific, 2003). For example, reports of older male students sticking their fingers inside the vaginas of younger female students are common. Sometimes a case of rape or sexual harassment involves a child with learning disabilities or impaired development, thus making him or her more vulnerable (Save the Children, 2016). Medical social workers handle these cases by visiting the schools and homes to gather more information from parents, teachers, and other school staff. In these situations, the medical social worker acts as an important link among the school staff, the family members, and the competent officer or court system (United Nations Economic and Social Commission for Asia and the Pacific, 2003).

Home visits, along with school visits, are an important task that a social worker at Siriraj Hospital must complete weekly. Sometimes the hospital social worker who is investigating a case at a home discovers an abandoned house . In these situations, the abuser may run away (often still with the child), afraid of being caught by the police and sentenced to prison. The legal record of a rape offender often includes production and sale of drugs, specifically methamphetamine. If the offender is apprehended for a second offense, the charges may be worse and the jail sentence may be lengthened (Center for the Protection of Children's Rights Foundation, n.d.).

If the address is documented incorrectly, the case goes directly to the competent officer, who can access the location of an abuser through the police and Thai legal databases (Center for the Protection of Children's Rights Foundation, n.d.). In other cases, after a child has been sexually abused, the hospital social worker is able to safely remove him or her from the home until after the abuser has gone to prison. The social worker first tries to contact other family members with whom the child could live. If there are no other family members for a child to live with, hospital social workers will help transfer the child to a shelter (Center for the Protection of Children's Rights Foundation, n.d.). Shelters are located in many districts of Thailand, but their locations are confidential. because many offenders continue to search for the rape victim after he or she has been removed from the home. They commonly look for the victim in different neighborhoods and ask friends and family of the victim for help in finding (or contacting) him or her. Therefore, it is critical that shelter locations remain confidential. Although the shelters are safe and secure, they are still frightening and confusing places for young children or adolescents. It is the role of the social worker to help the child stay calm during the transition period after a case of abuse.

Restorative Justice

A beneficial practice used in Thailand to help identify and reduce child abuse, restorative justice is the practice of bringing victims of crime or violence and offenders or abusers together in dialogue. Providing space for communication between the victim and the offender allows everyone to work to repair the conflict, forgive, rebuild trust, and find solutions (Roujanavong, 2005). Although the civil and common law system began slowly replacing restorative justice practices in the nineteenth century, elements of the restorative justice approach are still valuable when used with Thai children and their families, and Thai medical social workers often use restorative justice with the community involved in child abuse or violence cases.

Restorative justice in Thailand is conducted with five main purposes: (1) to encourage full participation and consensus from the parties involved in the violence, (2) to heal injured victims (3) to seek complete accountability from the family members or other parties involved, (4) to reunite what has been hurt, and (5) to strengthen the community in hopes of preventing future harm and violence. Using restorative justice in cases of child abuse and violence offers many benefits. First, restorative justice practices are based on open problem-solving dialogue rather than threats to or from the criminal justice system. Furthermore, restorative justice allows face-to-face contact between victims and offenders, which is essential to rebuilding relationships within a community. The abuser has time to explain his wrongdoings with the child or his or her family and time to begin to change his or her behaviors (Reddy, 2012). For many Thai children, attending court can be a terrifying experience in which they must explain an embarrassing or horrific event in front of many people (Center for the Protection of Children's Rights Foundation, n.d.; Reddy, 2012). When there has already been open communication within the community about the event, the child may feel more relaxed at court. Restorative justice is also beneficial because it is a cost-effective healing method for the child, family, and other parties involved in the abuse or violence.

Restorative justice has worked well in Thailand for several reasons. First, Thailand is a collective and community-focused society. People work together to solve problems and complete tasks. Thai culture places less emphasis on individuality than the United States (Bonta, 1997). There is less of a focus on competing over what someone may know that another person does not. Cooperation, shared knowledge, and socialization are important (Bonta, 1997). These cultural traits create more peace, reconciliation, and harmony among people and are one reason why restorative justice works well in a Thai context (Bonta,1997; Moaz, 2004). Furthermore, many people live with their extended family members and prefer discussing concerns with a community of people rather than struggling alone. Thai people have also been known to enjoy

negotiating conflicts with others rather than going to authorities for resolution.

Restorative justice techniques have also worked well in Thailand because the country is primarily Buddhist. Buddhism is associated with nonviolence and *ahimsa* or "the practice of no harm" (Keenapan, 2009). Buddhists believe that, to create inner peace, forgiveness and a sense of detachment from a situation must occur. These Buddhist principles are exemplified in Siriraj Hospital's work with families and children who have been sexually abused. For example, in one case in which I was involved, a three-year-old girl had been raped by an older neighbor man. The man went to prison, but after only a few weeks the prison staff realized that he was in poor health and aging quickly so they released him. Now he is back living near the girl he raped and her family. While the girl's family ensures that she is never left alone, they have forgiven the man who raped her. They are now often seen bringing food to him from the temple and sharing their own rations. By forgiving the man for raping their daughter, they are better able to rebuild their lives and live in harmony with each other again.

Family and Community Group Conferencing

In recent years, Thai hospital social workers have adopted the family and community group conferencing (FCGC) method that originated in New Zealand. In contrast to restorative justice approaches, FCGC focuses on the community at large playing a significant role in the counseling process. Participants in an FCGC session will include representatives from the community where the sexual abuse occurred, the child victim, the family members, the police, a social worker, a psychologist, and the abuser (Roukanaavong, 2005). This method is often used for juvenile delinquency, but it is also applicable to abuse cases (Roujanavong, 2005). It is useful primarily because it allows victims to voice their anger and pain to the offender, thus providing healing and releasing some posttraumatic stress.

The use of FCGC and its acceptance by the justice system have been positive. The Thai Justice and Family Court Act also supports FCGC practices. These practices have been widely accepted because they allow the community to be more involved in and aware of issues facing their neighbors. Community members are thus able to "walk with" the victim as he or she heals from the sexual assault. Use of the FCGC also assists the Thai criminal justice system by reducing the large workload in the courts, the quantity of court cases, and the costs associated with the criminal justice system (Roujanavong, 2005).

Conclusions

Sexual abuse continues to be a serious concern among many children and young adults in Thailand. In recent years there has not been an increase in sexual abuse cases, but rather an increase in cases that have been reported nationally (U.S. Department of State, 2015). With the enactment of the 2003 Child Protection and Neglect Act more actions are being taken to prevent further cases of child abuse in Thailand. Play therapy, restorative justice, and family group counseling are three important tools social workers use with child victims of prostitution as well as with families and communities to develop a safer and more peaceful existence for all people living in Thailand. Although FCGC and restorative justice approaches are useful in abuse cases, more work needs to be done to target the growing number of reported child abuse and sexual violence cases in Thailand (U.S. Department of State, 2015).

Social workers often look at situations through a broad lens, considering many aspects of a person's life as well as community strengths. In addition to using play therapy, restorative justice, and family group counseling in working with child victims of prostitution, their families, and communities, Thai social workers are working closely with government leaders to change child abuse policies on a national level and to reverse the status quo of child abuse and sanctioned prostitution in Thailand. For example, Thai social workers played key roles in writing the Child Abuse and Neglect Act of 2003. Social workers can also continue to be productive leaders in educating community and government leaders and instigating new ideas to target child abuse in Thailand.

A beneficial addition to Thai society would be more peace circles and centers (Grodofsky, 2007). These circles and centers would teach children and adults alike to remain tranquil and rational with each other throughout sexual abuse cases. Establishing circles and centers where people could seek protection and discuss the connections between Thai laws and the role of social work child protection would help make it easier to settle disputes between family members of a child who has been abused. Furthermore, the creation of such circles and centers would guarantee that the abuser was punished appropriately (most commonly with a

prison sentence) and that the child remained safe. Ideally, cases of sexual abuse would decrease drastically with the operation of more peace centers.

The implementation of more child abuse trainings in Thai schools is another important step to prevent child abuse. Child abuse trainings would provide educators with more awareness and knowledge. Teachers would benefit from more education on how best to counsel children who may have been sexually abused, as well as techniques for teaching children how to communicate with someone who might initiate abuse. With more child abuse trainings in schools, classrooms and communities would become safer.

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When Tradition Negates a Child's Rights: A Brief Look at the Intersection of Religion and Circumcision

Amanda M. Hodge, MSW, MJ

Abstract

This article will explore the relationship between religious traditions and circumcision procedures for both male and female children. The history of religious beliefs related to circumcision will be examined for three of the world's major religions (Christianity, Islam, and Hinduism) and contradictions in belief systems will be highlighted. Personal stories of female genital mutilation survivors will be included and the author will briefly analyze the physical effects of the procedure, focusing on the idea that circumcision is a violation of a child's human rights. The author will conclude with recommendations for action, both domestically and internationally, and will provide a summary that includes a call to action to protect genital autonomy.

Keywords: religion, circumcision, belief

Introduction

For many, the practice of religion has been known to serve as a protective. However, for some it can also serve as a risk factor, even leading to physical or psychological trauma. One religious risk factor is the belief that children should be circumcised at a young age. Because of this, male and female children across the globe have no agency in this process and can suffer both physically and psychologically. Since the majority of circumcisions are usually performed due to religious beliefs and cultural practices, this topic is both sensitive and personal for many families (Morris et al., 2016). However, many of the procedures occur solely based on decades or centuries of tradition and without any consideration for the risks, complications, or long-term effects for the child. Furthermore, there is not only a lack of research on the negative effects of circumcision, but there are also inconsistencies in the studies that claim benefits for the procedure (Aggleton, 2007). Therefore, despite known medical risks and the question of the child's rights, children's bodies continue to be subject to this mutilation, without their consent, because of religious tradition and cultural norms. This article will explore the background of religious-based circumcision (with a focus on the world's three major religions), address the physical effects of circumcision (including medical benefits and risks), highlight how circumcision violates the human rights of the child, and recommend future actions to protect children from this procedure.

Background and Context

The National Center for Biotechnology Information (NCBI) estimates that approximately 37.7% of males worldwide are circumcised, with more than half of those circumcisions performed for religious or cultural reasons (Morris et al., 2016). Jewish tradition still holds firmly to this belief, and Morris and colleagues estimate that 99.9% of all Jewish male children are circumcised, usually by a *mohel* (a man of Jewish faith trained to perform circumcisions), when they are eight days old as prescribed in the Torah. However, the world's major religions are not as clear on the topic, and many believers interpret religious rules and laws in different ways. According to the Pew Research Center, the three major religions in the world are Christianity, with 2.3 billion believers; Islam, with 1.8 billion believers; and Hinduism, with 1.1 billion believers (Hackett & McClendon, 2017). Since the practice is not universal within each religion and is subject to cultural differences, there are contrasting beliefs for both male and female circumcision within the religions.

In Christianity, the Bible speaks of circumcising male children in both the Old Testament and the New Testament. In the Old Testament, God commanded Abraham and his descendants to be circumcised as a sign of a covenant between them. Genesis 17:10-12 states

Every male among you shall be circumcised. And you shall be circumcised in the flesh of your foreskin, and it shall be the sign of the covenant between Me and you. And every male among you who is eight days old shall be circumcised throughout your generations. (New American Standard Version). The command in this scripture is clear and could still be used to justify the decision to circumcise infant males. However,

contrasting scriptures exist in the New Testament. Colossians 3:10-11 states Colossians 3:10-11 describes "a renewal in which there is no distinction between Greek and Jew, circumcised and uncircumcised . . . but Christ is all, and in all" (New American Standard Version). This New Testament scripture could be used to argue that the law of circumcision was made obsolete with the coming of Jesus Chist. Furthermore, in the period after Jesus was crucified and ascended back into heaven, there was controversy (commonly referred to as the Galatian Controversy) in which circumcision could be seen as a deterrent to conversion to Christianity (Aggleton, 2007). In response to this controversy, the Apostle Paul wrote in the book of Galatians 5:6 that "in Christ Jesus, neither circumcision nor uncircumcision has any value. The only thing that counts is faith expressing itself through love" (New International Version). Because of these inconsistencies, it can be argued that modern-day Christians do not circumcise their sons due to religious beliefs but rather due to cultural beliefs based on perceived social norms.

In Islam, there is no mention of circumcision in the Qu'ran; however, Muslims make up the largest group of circumcised males in the world, and the NCBI estimates that 92.6% of Muslim men have been circumcised for religious reasons (Anwer, Samad, Iftikhar, and Baig-Ansari, 2017). The Prophet Muhammed recommended that male circumcision take place at an early age (even though there are rumors that the prophet himself was uncircumcised), and other Shia authors like Ali and Al-Sadiq had strong views regarding male circumcision. Ali said that a man must submit to circumcision if he becomes a Muslim, even if he is 80 years old, and Al-Sadiq was known for saying that it is cleaner to circumcise sons when they are seven days old because the flesh grows faster and because the earth hates the urine of uncircumcised males. The age of the child and type of procedure varies among different cultures within the Islamic religion, and some boys are circumcised at 10 or 11 years old, marking their entry into puberty. In fact, 54.1% of boys have delayed circumcision, meaning that the procedure is performed when they are between the ages of 2.5 months and 13 years (Anwer et al., 2017).

Female genital mutilation (FGM) is also common in the Islamic faith despite there being no requirement under Sharia law. The World Health Organization (WHO) estimates that worldwide 100 to 140 million women and girls have undergone FGM and that three million girls are at risk of undergoing one of these procedures every year (Rouzi, 2013). But there is a small population of Muslims that is devoted to the Qu'ran and its teachings and believes that circumcision is in direct violation of the religious law. Qu'ran 4:119 forbids altering one's body and 95:4 says man was created perfectly. Some devout Muslims use these passages as the reasoning behind their decision not to circumcise their male or female infants.

Hinduism has no religious rules on circumcision, and the NCBI estimates that only 0.2% of Hindus (male or female) have been circumcised. However, regional practices dictate whether a circumcision will take place, and there are multiple areas in India where Hindu girls are circumcised and FGM is common. In her article in the *Hindustan Times*, Harinder Baweja (2016) interviewed women who have been victims of this practice. One woman, Masooma Ranalvi, described the day when, at six years old, her grandmother asked if she could take her out and buy her some chocolates. Her grandmother took her to an old run-down building where they went into a dark room where a strange woman was waiting. They told Masooma to lie down as the strange woman removed her undergarments. Masooma remembers crying in fear and then shrieking in pain as she felt a hot sensation followed by an intense pain that she could not describe. She stated that the strange woman put black powder on the wound and then her Grandmother took her home, where she remembers crying for the rest of the day because of the pain. Baweja said,

> The sad truth to this painful process is the fact that it is a practice being done to women by other women. Most women we spoke to initially blamed their mothers, til they realized they, too, were victims of the same mindless tradition (2016).

Brave women like Baweja—in their efforts to highlight the practice of FGM and remove the social taboo that surrounds it—are slowly moving the topic of FGM to the forefront of global discussions.

Physical Effects of Circumcision

There are many risks associated with male circumcision and a few medical benefits as well. Female circumcision also has many risks but no medical benefits, only cultural benefits that result from tight knit communities. For males and

females, the risk of excessive bleeding and infection top the list of complications and are the most frequent. The risk of these complications increases as the child gets older. According to the NCBI, complications of male circumcision can include loss of skin; trapped/concealed penis; inadequate circumcision, leading to excess foreskin; adhesions; glandular necrosis or amputation; injury to the urethra; and in rare cases, penile amputation or death from complications (Krill, Palmer, & Palmer, 2016). Known medical benefits include "easier hygiene, decreased risk of urinary tract infections, decreased risk of sexually transmitted infections, and decreased risk of penile cancer" (Mayo Clinic, 2018). As stated above, FGM has zero health benefits but can have immediate and lasting risks and consequences. Immediate complications include genital tissue swelling, fever, urinary problems, wound healing problems, shock, and death. Long-term consequences include painful urination, vaginal problems, menstrual problems, scar tissue and keloid formation, sexual problems, childbirth complications, need for later surgeries, and psychological problems (World Health Organization, 2017).

The Human Rights of the Child

Circumcision is not simply a religious practice but is instead an irreversible procedure based on religious traditions. Most children have no personal agency in this irreparable, painful, and risk-filled act against their bodies. It is performed without their consent, has permanent consequences, and is a violation of their human rights, particularly article 5 of the Universal Declaration of Human Rights (UDHR), which states that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment" (United Nations, 1948). However, the UDHR also states in Article 18 that "everyone has the right to freedom of thought, conscience, and religion . . . to manifest his religion or belief in teaching, practice, worship and observance." Prohibiting circumcision of nonconsenting children does not violate article 18 of the UDHR because circumcision moves from a religious practice (which is protected) to a religious-based medical procedure that, given its irreparability, violates not only children's protections against cruel, inhuman, and degrading treatment, but also their human right of being able to practice freedom of religion themselves.

Soraya Mire, FGM survivor and human rights activist born in Somalia, spoke on this topic in a 2011 interview on human rights to bodily integrity (Nocirc, 2011):

> The thing that really shocked me when I came to America was the reaction I got when people f[ound] out what was happening in Somalia, Sudan, Ethiopia, those parts of the world (Egypt) about female genital mutilation, and people were horrified, they were shocked, they were angered . . . but behind closed doors they were mutilating their own young boys . . . and it's everyday a ritual here but people don't see it as a ritual . . . mutilation is mutilation . . . . I feel it is really wrong when it comes to child's rights, this is a human rights issue, and I think that all of us need to protect young children's bodily integrity.

Mire pointed out the inconsistencies in the way that Americans view their own rituals in comparison to those of other countries. She asserted that all circumcision practices should be obsolete, and she is not the only one who feels this way. Baweja interviewed Zehra Patwa, a U.S.-based technology project manager who, at the age of 44, found out that she had undergone FGM when she was a child. Because of the trauma, she had blocked out the memories until a family video surfaced, after which she was told what had been done to her: "I was kind of in an emotional state. It is so traumatic for young girls and does not fit with our educated community. It seems like one of those things that we should just let go of and move on" (Baweja, 2016). The UN has declared that FGM is a human rights violation and it is recognized internationally as a violation of the human rights of girls and women. However, FGM is still occurring at alarming rates and is the subject of many human rights collaborations and campaigns.

Recommended Actions

Although circumcision is a sensitive topic, it must be addressed in order to protect the rights of children across the globe. The UN's Convention on the Rights of the Child (CRC; United Nations, 1989) addresses the issue of child maltreatment in article 19, which says that state parties must take legislative action to protect all children from all forms of abuse, injury, physical violence, or maltreatment. However, prohibiting the practice of circumcision will be a long and arduous process, especially in the United States,

which is the only country in the world that has not ratified the CRC (United Nations, n.d.). For the United States, prenatal education on the multitude of risks of circumcision could be beneficial as well as including information on waiting until children are old enough to have agency in the decision so that their human rights can be protected. Social workers can play a significant role in these changes by educating parents on the risks involved in the procedure and by advocating for hospital policy changes that require a parent or legal guardian to be present when their child is circumcised.

For countries that have ratified the CRC, an amendment that addresses circumcision could be beneficial because circumcision is one, if not the only, religious practice that causes irreparable harm to one's physical body. Since the child has no agency in the procedure, the procedure is a violation of the human rights outlined in both the UDHR and the CRC. This amendment could serve as both a suggestion and a public awareness movement for consideration by countries that have ratified the CRC. All across the globe, public awareness campaigns directed toward educating communities on the medical risks and complications associated with these procedures will be a crucial step in decreasing the number of male and female circumcisions.

Conclusions

Throughout the world, activists and journalists (like Baweja and Mire) are joining together and creating workshops, videos, and campaigns in order to educate communities and thereby reduce the number of girls who fall victim to the barbaric practice of FGM. In addition, the United States is seeing a decline in rates of male circumcision; the Centers for Disease Control estimated that the rate of male circumcision decreased by 10% between 1979 and 2010. According to the same study, these fluctuations coincided with recommendation changes from the American Academy of Pediatrics and revisions to insurance reimbursement rates (Owings, Uddin, & Williams, 2013). However, even with the progress that has been made, an alarming number of children still succumb to genital mutilation. Rates of FGM in the countries of Somalia, Guinea, Djibouti, and Egypt are still higher than 90% (World Health Organization, 2018, and circumcision of Muslim and Jewish boys remains at an estimated rate of 99.9% (Morris et al., 2016). As discussed, because circumcision is a medical procedure based on religious and cultural beliefs, there are many barriers to its eradication because of the sensitivity of the topic. However, despite these challenges, raising awareness and educating parents on the rights of the child is a battle worth fighting. The involuntary removal of all or part of a child's external genitalia should be prohibited, and every single child should have the right to genital autonomy.

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Social, Coping and Social Problem-Solving Skills in Teen-Focused Programming

Alyssa Kelly, MSW

Abstract

This research article aims to promote further research on social, coping, and social problem-solving skills as they are utilized together in the at-risk adolescent population. Research should present effective interventions in order to interact with and provide adequate care for at-risk adolescents. This article argues that implementation of these skills together, rather than individually, could produce more favorable outcomes in this population. This review will first examine the literature associated with the characteristics of risk, social and coping skills, social problem solving, restorative justice, and community service and their effects on adolescents. Lastly, it will advocate for further research and examine how simultaneously implementing social, coping, and social problem-solving skills can positively affect at-risk adolescents in micro, mezzo, and macro levels of society.

Keywords: at-risk adolescents, social skills, coping skills, social problem-solving skills, restorative justice

Introduction

Little to no research conducted with the at-risk teen population in the United States has focused on the implication of teen-oriented programming that combines social, coping, and social problem-solving skills. There is research available that examines adolescents using these skills individually in other settings and situations. What is needed is research that examines the effectiveness of all three skills used together in the United States. Utilizing social, coping, and social problem-solving skills for at-risk adolescent populations may lead to a reduction in risky behaviors, not only for the adolescent themselves, but also for the community in which they reside. This literature review will help explore previously conducted research on social, coping, and social problem-solving skills. It will help promote the need for more research on evidence-based interventions that focus on teen programing utilizing these skills collectively in at-risk adolescent populations in the United States.

Characteristics of Risk in Adolescents

It is important to determine what constitutes risk within the adolescent population. Etzion and Romi (2015) tried to determine the type of adolescents who were most likely to have characteristics that make them more likely to be at risk. These factors included life satisfaction, deviant behavior, self-esteem, sociodemographics, family and social ties, school experiences, leisure activities, and attachment. This typology research was done through questionnaires and interviews. The population used in this study consisted of 282 adolescents between the ages of 12 and 18 years old from many different institutions in Israel. The questionnaires asked these adolescents to self-report on their demographics, personal and social experiences, and behavioral and emotional adjustment as well as life satisfaction. Through these questionnaires, four categories of at-risk youth were created: suspended, sociablist, alienated, and loner.

Adolescents who fell within the suspended category had high adjustment scores, few deviant behaviors, and relatively few differences from those in the control group. However, the researchers believe that adolescents fell within this group based on social choice. Another subgroup, sociablists, have some positive and negative adjustments as well as deviant behaviors and suspensions. It was found that peer groups have a large influence over this group. The third subgroup, alienated adolescents, have low adjustment scores and deviant behaviors. They have more negative life events and seem to have lower self-esteem compared to the other groups. Lastly, loners have low social adjustment, low self-esteem and attachment, and weak ties with their peers.

The results of this study indicated that these typologies were found in all settings and that specific interventions should be utilized when working with this population. The study connects to furthering research because it shows that there are certain characteristics associated with youth who are at risk. Although this study was conducted in Israel, it allows researchers to better understand what factors are related to risk in a youth population. This evidence further promotes

the need for more research on at-risk adolescents in the United States.

Social Skills

Harrell, Mercer, and DeRosier (2008) conducted a study on the effectiveness of social skills groups on poorly adjusted adolescents. Poor adjustment in adolescents has been connected to poor social skills that can lead to negative outcomes and behaviors. The sample from this study included 74 adolescents from the ages of 13 to 16 years old who were considered to have difficulties in social relationships. The sample was split into a wait-listed control group and a treatment group. The treatment group received the 12-week Social Skills Group Intervention-Adolescents (SSGRIN-A) training. This training group was taught role playing and modeling, as well as awareness of themselves and impulse control, for example. The study found that the SSGRIN-A 12-week program was effective in improving adolescents' social skills.

This study is important in that it shows how a similar intervention could be implemented in a teen-focused setting. This further promotes the idea that more research should be conducted to identify the effectiveness of social skills in teen-focused programing.

Coping Skills

Chua, Milfont, and Jose (2015) studied the effect of coping skills on future-oriented adolescents. They were interested in this research since previous studies had shown that teens who are future oriented are less likely to engage in risk-taking behaviors. It is thought that being future oriented is related to adaptive rather than maladaptive coping strategies. The study was conducted in New Zealand and consisted of 1,774 preadolescents and early adolescents, ranging from 10 to 15 years old. Adolescents took a survey that had about 350 questions and measured future orientation; coping strategies (adaptive and maladaptive); negative behaviors, such as self-harm and substance abuse; and perceptions of self through weight, energy, and sleep. The study found that future orientation is connected to an increased use of adaptive coping strategies and reduction in maladaptive coping strategies. However, the study also found that adaptive coping does not necessarily correlate with teens being less likely to engage in risky behaviors. Although this research found that teens who are focused on the future are more likely to use positive coping skills than teens who are not, it did not prove that positive coping skills are a protective factor discouraging teens from engaging in risky behaviors. More research needs to be done to examine these effects, but this study supports the idea of teens learning adaptive coping skills.

Dumont and Provost (1999) also studied the protective nature of coping strategies. Based on depressive symptoms and daily hassles, 141 eighth graders and 156 eleventh graders were put into four groups characterized as (1) well adjusted, (2) resilient, (3) vulnerable, or (4) non-adjusted. Adolescents were given questionnaires to assess daily hassles, depression, social support, coping strategies, self-esteem, and social activities. The results of the study indicated that there is a connection between self-esteem and coping strategies. Adolescents who have higher levels of self-esteem are less likely to utilize avoidant coping skills. These adolescents utilize coping and problem-solving skills because they feel that they are able to interact with the issue and change the situation. This study shows that teens who feel positively about themselves are more likely to feel confident in utilizing coping and problem-solving skills to address life stressors. However, this research considered other factors such as daily hassles, depression, social support, and social activities, which could have an effect on the research outcome. Further research should be conducted to focus on the effect of coping and problem-solving skills utilized in adolescents.

Aebi, Giger, Plattner, Metzke, and Steinhausen (2013) examined how problematic coping skills in adolescents could lead to criminal behavior in young adulthood. This study sample consisted of almost 2,000 students in Switzerland between the ages of 10 and 17 years old. It looked at the student's demographics, how the students conceptualized stress, how they dealt with stress, how their parents reacted to them, whether substances were used, and the role of mental health and criminal records. Fifteen years after collecting this information the researchers looked to see whether these students were involved in criminal activity. They found that adolescents who committed crimes were five times more likely to commit a crime in adulthood. They also found that those who committed crimes later in life had avoidant types of coping skills, increasing their likelihood of using substances and externalizing their own behaviors. This study found that the use of social skills training and problem-solving skills to combat avoidant coping mechanisms may help prevent increased

involvement in crimes. Further research needs to be conducted on this topic. This study supports utilization of teen-focused social, coping, and problem-solving programing to potentially decrease recidivism for teens later in life.

Social Problem-Solving

Ang (2003) examined whether teaching adolescents social problem solving was beneficial in reducing aggressiveness in juvenile offenders. Conducted in Singapore, this study looked to see if teaching juvenile offenders social problem-solving skills through modeling, coaching, and feedback was effective. It used a sample of 105 juvenile offenders (under the age of 16) who were apprehended for minor offenses. The study showed that social problem-solving skills were able to reduce aggressiveness in juvenile offenders involved in the intervention. It demonstrated that social problem-solving skills can be taught to mandated adolescents and may have a positive effect.
of peace and respect among themselves.

Effects of Restorative Justice and Community Service on Adolescents

Laundra, Rodgers, and Zapp (2013) examined the effect of restorative justice on youth who were involved in teen-focused sentencing via teen courts. Restorative justice posits that the offense affects the community and the victim. With the input of the community and the victim, offenders should be held accountable for their actions. This allows the community, the victim, and the offender to be involved in the handling of the crime and the outcome.

The study looked at 38 teens between the ages of 11 and 18 who were involved in teen courts. Teens involved in this study were given questionnaires that focused on whether they learned anything or grew in some way by interacting with the teen court. The study showed that teens did experience some learning/growth from their involvement with the teen court process, specifically in feeling a part of the community and wanting to improve it. From this small sample size, the researchers found that participation within the teen court program reduced the likelihood of recidivism, at least in the short term. This study supports the idea of restorative justice and its potential effect on the teen population. More research needs to be conducted with a larger sample size to support these findings; however, this study does show, with some significance, that restorative justice programs can help teens reflect on their crimes and the effects that they had on the community at large.

A common example of restorative justice is community service. Van Goethem, Van Hoof, Orobio de Castro, Van Aken, and Hart (2014) examined the effect of community service on adolescents. This research was done through a meta-analysis of research published from January 1980 to September 2012 that included adolescents between the ages of 12 and 20. It was found through the meta-analysis that community service was most effective if it involved some type of reflection. It was also found that adolescents who participated frequently in community service were more likely to benefit from it. Adolescents seemed to benefit from participating in community service even if it was required. This study shows the significant positive effect of community service on adolescents and their growth. The findings of the study seem to conclude that, even when community service is required, such service can have a positive effect on adolescents and merits further research.

Social Justice Implications

The social justice implications for this research are significant. To examine these implications, it is important to start with the teens themselves and the circumstances surrounding what may precipitate risky adolescent behaviors. An effective intervention of social, coping, and problem-solving skills for at-risk teens can have an implication on their participation in the greater social system. One example is an intervention that would help teens better cope with stressors within their lives that lead them to commit a crime. Coping drives teens to communicate better with peers and family members. Utilizing these new acquired skills through teen-focused programing could allow teens to better interact within their communities. By being able to communicate better, teens can establish more positive relationships with their families, friends, and other community members. Such positive relationships may serve as a protective factor in preventing at-risk adolescents from committing additional crimes.

Such a program could impact the families of the teen participants. Teens would be able to better communicate and receive supportive parental monitoring. By providing skills for at-risk teens to utilize, such programs may prevent

crimes and make communities safer. At-risk teens who have gone through a teen-focused program are more likely to be beneficial to their communities. Upon receiving support services, teens who were once at risk could potentially serve as mentors, helping to decrease the amount of crime. The effectiveness of this intervention could affect the trajectory of a teen's life. A program that utilizes social, coping, and social problem-solving skills might reduce the number of at-risk teens who commit crimes and continue on this path into adulthood. Social, coping, and social problem-solving skills used together can prevent further interaction with the criminal justice system for at-risk adolescents into adulthood.

The demonstrated effectiveness of social, coping, and social problem-solving skills can support the creation of teen programs that utilize restorative justice principles around the country for at-risk teens. Creation of programs within other communities could help affect how teen offenders are treated for their crimes and possibly prevent recidivism. Such programs could affect how all communities address teen offenses and decrease the number of teens who become involved with the criminal justice system as adolescents and adults.

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Analysis of The National School Lunch Program

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Abstract

The National School Lunch Program, signed into law by President Harry Truman in 1946, is a social welfare policy that provides low-cost nutritious meals to eligible students in public and nonprofit private schools. This policy has evolved over time and has developed some significant areas of weakness. To analyze a social welfare policy such as this, it is important to first examine the problem it is aiming to solve and the current policy provisions. It is then possible to analyze its strengths and weaknesses and to consider possible policy changes and alternative policy approaches.

Keywords: poverty, schools, food, students, children, hunger

The Problem

According to the *Washington Post*, one-third of U.S children live in a household with an income that is 60% below the national median income (Ingraham, 2014). In other words, one in three children in America lives in poverty. In addition, 15.3 million children live in households considered *food insecure* (Feeding America, n.d.-b). To say that child poverty and associated starvation are a problem is an understatement. The United States is one of the wealthiest, most developed countries in our modern world, yet the rate at which children are living in poverty continues to increase. Another important demographic is the racial inequality in food security. According to Feeding America, 26% (one in four) African American households are considered food insecure as compared to only 11% (one in 10) of Caucasian households (Feeding America, n.d.-a) As a result, African Americans are three times more likely than Caucasians to receive charitable food assistance.

The National School Lunch Program (NSLP), part of the National School Lunch Act of 1946, was our nation's attempt to provide whole healthy meals at reduced or no cost to the hungry and poor children of America. Although the food stamp program, now referred to as the Supplemental Nutritional Assistance Program (SNAP), is another social welfare policy aimed at addressing the problem of poverty and hunger, it is insufficient for most families. For example, a family of four (two parents with two children) receives a monthly benefit of $471, or just $16.82 a day, to feed everyone (Center on Budget and Policy Priorities, 2018). According to the U.S Census Bureau, children with some form of food assistance are still arriving at and leaving school hungry. According to Share Our Strength (a nonprofit), 65% of teachers find that "most kids rely on school meals as their primary source of nutrition." This highlights the immense social problem of child hunger in our society and the need for programs that aim to solve this problem.

Alternative Formulations

Two alternative formulations for the cause of poverty and child hunger are individual characteristics and social problems.

Current Policy Provisions

It is important to first understand the purpose of the NSLP and its role in our society. The NSLP has been implemented in more than 100,000 public and nonprofit schools and has "provided over 28 million low-cost or free lunches to children on a typical school day" (U.S. Department of Agriculture [USDA] Food and Nutrition Service, 2018a). The meals that are provided meet new nutritional standards as of 2012, such as "only fat- free or low-fat milk and . . . both fruit and vegetables every day of the week" (USDA Food and Nutrition Service, 2018a). Each school lunch must also meet the nutritional standards of the most recent Dietary Guidelines for Americans. Additionally, the current meal pattern for school lunches "set[s] specific calorie limits to ensure age-appropriate meals for grades K-5, 6-8, and 9-12. (USDA Food and Nutritional Service, 2018b). However, the local school districts and their associated food authorities are responsible for deciding what foods to serve. A sample menu provided by the Food and Nutritional Service lists "whole wheat spaghetti with meat sauce on a wheat roll, green beans, kiwi, low-fat milk, reduced-fat mayonnaise, low-fat ranch dip, cooked corn, and

more." Breakfasts are not included in the NSLP; the National School Breakfast Program (NSBP) is a separate policy that was established in 1975. However, as stated above, not all children are eligible for these benefits.

The NSLP is a universal entitlement benefit program, and students "are entitled to free lunches only if their families' incomes are below 130% of the annual income poverty level" (ATLAS, 2015). Children who live in households that receive SNAP benefits or cash assistance through TANF (Temporary Assistance for Needy Families), as well as children who are homeless, runaway, or migrants, are eligible for free meals. The program also offers reduced price meals. In order to qualify for this subsidy, students' families must have an income below 185% of the poverty level. The price of lunches will then be reduced to around 40 cents. Some children who do not qualify for either free or reduced priced lunch can "purchase slightly subsidized meals, but these lunches are considered paid because the students shoulder most of the cost" (ATLAS, 2015).

In order to be eligible for the NSLP, parents must submit an application that is provided by each individual school district. Alternatively, students can be enrolled through a process called direct certification. As stated above, students whose families are on food stamps or receive benefits through TANF are eligible, and the schools can identify these families. These students are automatically enrolled for free school lunches. This process was established in 2008–2009 to "limit the potential for error . . . rather than relying on parent applications" (ATLAS, 2015).

The benefits offered through the NSLP fall into one category, food. Originally the benefits consisted only of free or reduced price lunches. However, Congress expanded this coverage to reimbursements for snacks for children in after-school educational programs in 1998 (Missouri Department of Elementary & Secondary Education, n.d.).

Delivery of benefits can be a little bit tricky because this policy operates at a government, state, and local level. All public and nonprofit schools can choose to be a part of the NSLP, and these school districts or independent schools "get cash subsidies and USDA foods from the U.S Department of Agriculture for each meal they serve" (USDA Food and Nutritional Service, 2017). However, these participating schools must meet the nutritional standards and serve free or reduced-price lunches to children who receive in-kind benefits. Schools are also reimbursed for any snack foods that they provide. Schools are reimbursed in cash by the state using federal funds based on how many lunches were served on a monthly or quarterly basis (ATLAS, 2015).

According to the Food Research and Action Center (n.d.), the government spent $10.1 billion for the NSLP in FY 2011. In addition to standard reimbursements to the local school districts, if 60% or more of a school's lunches are free or reduced in price, the school will receive an additional $.02 for each lunch (free, reduced price, or fully paid). The reimbursement rate for the average school that participates in NSLP is $3.07 per meal (Food Research and Action Center, n.d.). In addition to these reimbursements, schools will get free bonus shipping from the USDA for each meal served. Also, schools can get bonus foods or commodity foods. Both of these supplements are dependent on agricultural surplus from the area (Physicians' Committee for Responsible Medicine, n.d.).

Strengths and Weaknesses

A social welfare policy that has been around for more than 70 years will produce various supporters and critics. I believe that two major strengths of this policy are the 1998 expansion to provide cash reimbursements for after-school education programs and the 2008–2009 provision for automatic enrollment of eligible students in programs such as food stamps, TANF, and the Food Distribution Program on Indian Reservations.

The Child Nutrition Reauthorization Act of 1998 aimed to better children's nutritional standards across the country "with a special emphasis on older children by authorizing reimbursement for snacks to serve children through age 18" (Missouri Department of Elementary & Secondary Education, n.d.). This means that schools that are eligible for the NSLP will receive reimbursements for their after-school programs. However, these after-school programs must "include education or enrichment activities in organized, structured and supervised environments" (Missouri Department of Elementary & Secondary Education, n.d.). One of the other reasons why this provision was so important for the schools and children involved is because, as long as extracurricular activities, including choir, band, and drama club, meet these requirements, they will receive reimbursements. This provision encourages schools to provide more food for their students and to create consistent after-school care for students. If a child

does not have any food at home and relies on the school for food, having a fun, engaging after-school program that has snacks will be very beneficial to that child. Whether attending a program for food or education, the child is being fed and taught in a safe environment.

The second aspect of the NSLP that is a tremendous strength is the addition, in August 2009, of *categorical eligibility*, meaning that "all children who fall into that category may receive free meals" (Food Research and Action Center, n.d.). This easier government-managed process can eliminate error because parents are not responsible for applying for the NSLP. According to the Food Research and Action Center, every school in the country that participates in the NSLP is required to directly certify students who live in households that receive food stamps. However, these are not the only students who are able to get direct certification; it is also available to children living in foster care, children who are homeless, children in Head Start, or migrant children. In order to analyze the positive impact of these direct certifications, consider the different scenarios in which these children live. For example, a child living in poverty may have a very unstable home life. If the parent(s) cannot or will not apply for NSLP, the child will not receive the benefits. Allowing these children to receive benefits automatically provides a more direct and sufficient form of benefit delivery. Also, it is important to eliminate as much stress as possible for families in poverty, even if this means having one less governmental program for which they must apply.

Although the National School Lunch Program has strengths, it also has tremendous weaknesses. One weakness of the NSLP is its implementation of the updated USDA nutrition guidelines that resulted from the Healthy Hunger-Free Kids Act in 2012. According to the *Washington Times*, 1,086,000 students have stopped buying NSLP program lunches since this change (Harrington, 2014). According to a study conducted by the Rudd Center for Food Policy and Obesity, students are very unhappy with the new menu options, and as a result, they are throwing their food away, leading to a tremendous amount of food waste (Scherer, 2015). Although obesity is an evident problem in America and Michelle Obama's act had good intentions, it has led to an undeniable reduction in the number of children eating the NSLP meals and also in the number of schools that choose to participate. I believe that, if students are rejecting the new meals, then something should be done. According to an article from *TakePart Magazine*, a twitter hashtag #ThanksMichelleObama was created for kids to express their outrage at the new food options (Scherer, 2015). If students are openly throwing out their meals and choosing to get vending machine snacks instead, then something must be done to fix the system.

Two other prevalent weaknesses of the NSLP are its method of delivery and the stigma associated with it. A study conducted in 2010 found that "students may be reluctant to participate due to the stigma associated with a subsidized meal; that is, they may perceive school meals as 'just for poor kids'" (Corcoran et al., 2012). As a result, only about 70% of those who are eligible for free or reduced priced lunches participate. In addition, the same study found that "18.5% of high school students would eat school lunch more often if their friends did" (Corcoran, et al., 2012). These statistics and empirical data show a flaw in the system of delivery for the NSLP because some students would rather go without lunch each day than be labeled as the poor kid or be ridiculed. At Lake Forest High School, the high school that I attended, each student had a lunch account that parents funded. Students who received free lunches through the NSLP would have funds uploaded to their cards as well and would swipe their cards just like the rest of the students. However, everyone still knew who was getting free lunches, and this unfortunately led to whispers in the cafeteria. I believe that this stigma is a big problem for the NSLP because children are easily influenced and fragile. Being made fun of by peers or feeling left out can lead to detrimental consequences, such as depression, anxiety, or self-harm. An alternative policy provision that would help end this stigma is universal free lunches and breakfasts (McSilver Institute for Poverty Policy and Research, 1970).

Alternative Policy Approaches

Any policy implemented on a national level will have inevitable problems. Therefore, a better approach for attacking child hunger in America would be a program operating at a state or local level. For example, the San Diego Hunger Coalition "represents the voice of nearly half a million San Diegoans" (San Diego Hunger Coalition, n.d.) who are living in food deserts or living in hunger. This program works with policy makers and advocates with the goal of "ending hunger in San Diego County" (San Diego Hunger Coalition, n.d.). I believe that programs such as these, which operate at a lower, more personal

level will have a greater impact on their community.

Similar programs are able to pay close attention and conduct research specific to the local community in order to find the best methods for providing food for children. In the Champaign-Urbana community, for example, the Chambana Moms program pairs with the U.S Department of Agriculture to give free meals to any child under the age of 19 during the summer (Youngblood, 2015). Programs like these are amazing because they provide children with the extra care and sense of well-being that they deserve; however, these programs are not available in all areas of the country. Inner-city schools are often left out; this would be an excellent opportunity for a social worker who can work within these lower income communities to establish a permanent child hunger program (i.e., summer meals or summer snacks).

Another possible policy provision could be the combination of the NSLP and the NSBP. Both programs follow the Dietary Guidelines for America, and both are federal programs that are administered by the state (USDA Food and Nutrition Service, 2017). In 2012, over 12.9 million children participated in the NSBP and more than 31.6 million students participated in the NSLP (U.S. Department of Agriculture Food and Nutrition Service, 2017). Combining these two programs into one program, such as a national school food program, could alleviate stress on the families who need to apply to both programs for all their children and also eliminate unnecessary confusion for policy makers about the different provisions of each program. Also, such a combined program might it easier for states to reimburse schools because all of the meals would fall under one program as opposed to two separate ones. Overall, this alternative policy provision is just an idea to simplify a government social welfare policy and to alleviate unneeded stress on already stressed out families. I believe the elimination of possible error or stress is important because children's environment, including interaction with parents and school systems, needs to be as safe and stress free as possible.

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Schizophrenia and Spirituality: A Paradigm Shift

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Abstract

A holistic approach toward the treatment of mental illness, illustrated by the introduction of religiosity or spirituality to the biopsychosocial model, may elicit new prospects for the mental health field. In addition to the pathological perspective, this article will explore the treatment of schizophrenia viewed through the lens of spirituality. Current empirical research on the efficacy of integrating spirituality as a treatment modality for mental illness is limited. The author proposes a paradigm shift for the treatment of schizophrenia and a call for further research to fuse spirituality into the healing and transformation of the client.

Keywords: schizophrenia, spirituality, treatment

Introduction

As mythologist and author Joseph Campbell said, “The psychotic drowns in the same waters in which the mystic swims with delight.” Schizophrenia is a chronic mental illness that occurs cross-culturally, affecting about 0.3% to 0.7% of the world’s population (*Diagnostic and Statistical Manual of Mental Disorders*, fifth edition; *DSM-5*; American Psychiatric Association, 2013). Specific criteria must be met over a specified duration and length of time for an individual to be diagnosed with schizophrenia. What is not definite and precise is the treatment for schizophrenia, as well as the subjective experience of the individual. According to Gabbard (2014), “There is no such thing as the treatment of schizophrenia.” Due to the multitude of symptoms and fluctuation in symptom expression, effective treatment varies and must meet clients where they are to elicit healing. Therefore, there is a need to shift from the biopsychosocial model of viewing schizophrenia as a pathology to a model that considers the entirety of the human condition.

There is currently minimal research on incorporating spiritual- or religious-based interventions for treating mental illness, especially schizophrenia. Expanding the biopsychosocial treatment model to include spirituality may enable struggling individuals to heal by viewing their symptoms as an opportunity for transformation rather than a chronic disease. Shifting the perspective of religion/spirituality, from being symptomatic in schizophrenia to being an opportunity for insight and self-discovery, may reduce the symptoms of schizophrenia. Restructuring of the Western world’s primary medical model to encompass spiritual well-being may allow clinicians to gain a more complete understanding of their clients. With the high value of religion and spirituality cross-culturally, educating and training clinicians in religion and spirituality may elicit greater opportunity for mental health research, treatment, and interventions.

Diagnostic Criteria

Schizophrenia is a chronic mental illness in which the individual experiences at least two of the following *positive* symptoms: hallucinations, delusions, and disorganized speech. In addition, the two-symptom criterion may be met by *negative symptoms*: disorganized behavior, diminished emotional expression, odd behavior, and unusual perceptions. These symptoms must last for at least six months to meet diagnostic criteria. Positive symptoms, such as hallucinations, typically develop over a short period, often presented through psychotic episodes lasting at least one month. Hallucinations may include audio, such as command hallucinations, or visual effects. A period of remission from the positive symptoms may transition to negative symptom display; this period is known as the prodromal period, in which symptoms are expressed through an absence of functioning. This period may present as disruptions with occupational functioning, withdrawal from relationships, inappropriate expression of aggression and sexuality, lack of empathy, and lack of self-care. Typically, the prodromal period precedes the active phase (psychotic phase).

A unique feature of the schizophrenia diagnosis is the presence and remission of positive and negative symptoms throughout the client’s life span. Furthermore, a recovery phase may last for months to years, in which resistance

toward treatment, lack of awareness of the disorder, and depression and anxiety leave the patient in a vulnerable position. A chronic phase may ensue as well, in which persistent negative symptoms are present and psychotic symptoms go into remission or increase. Therefore, treatment for clients is shaped around the stage they are in; however, the goal is to reduce psychosis severity and duration with continuation of care and treatment (Gabbard, 2014).

Theory

The most common modalities of treatment of schizophrenia in the developed world are from a biopsychosocial approach. These treatments include pharmacotherapy, individual psychotherapy, psychosocial skill training, electroconvulsive therapy, and hospitalization. However, to many, the human experience comprises more than our biological, mental, and physical selves; some may view themselves through a holistic lens. Through a holistic integrative approach, the human condition may include spirituality as a component of functioning and flourishing. With spirituality and religion being a major component in the lives of many individuals across cultures, it is concerning that mental health does not typically incorporate spiritual therapeutic interventions for individuals with schizophrenia.

Religion and spirituality are often present in patients with schizophrenia through delusions and hallucinations that may be positive or negative. Yet there is significant need for more research on the effects and understanding of religion and spirituality in schizophrenia. My clinical judgment, based on research, is that, to fully treat the individual, one must not only look at how to manage the symptoms, but also how to provide empathy and be culturally respectful of each client's religion and search for transcendence. Shifting the paradigm of how we view schizophrenia, to encompass not only the physical and mental but also the spiritual, may initiate alternative ways to promote human flourishing within the client.

Modern Treatments

Through the medical model, medication is typically the initial and primary treatment intervention for schizophrenia. Current Food and Drug Administration approved medications for schizophrenia address positive symptoms, but tend not to help with negative symptoms (Gohil & Carramusa, 2014). The typical medications are antipsychotics, such as clozapine, haloperidol, and quetiapine. In a longitudinal study by Vanasse and colleagues (2016), patients diagnosed with schizophrenia were prescribed antipsychotics. The study determined that of the 9,502 individuals studied, 50% had a mental health event, 114 died from suicide, 35% had a hospitalization, and 46% had an emergency room visit for mental health symptoms. In addition, patients who were using quetiapine, an antipsychotic, were at an increased risk of mental health crises compared to non-medicated patients. Another consideration with using medications as a primary form of treatment is the risk of discontinuation. Discontinuation of medications increases the risk of relapse in a psychotic episode and reduces human flourishing. Therefore, frequent monitoring by medical professionals, consistent appointments, and the client's own ability for self-care are all important in reducing relapses. However, due to the severity of this chronic illness, socioeconomic limitations, and doctor availability, medication as a primary treatment may not be enough for people with schizophrenia and may cause more harm than good (Vanasse et al., 2016).

Therapy complements medication for treatment and alleviation of symptoms for those living with a mental health diagnosis. Cognitive behavioral therapy (CBT), which is commonly used, aims to normalize the individual's psychotic experiences and reduce distress and negative functioning through reformatting and challenging current thought processes and beliefs. In a study of 2,467 participants in outpatient and inpatient treatment from the United States, United Kingdom, Canada, Australia, Netherlands, and Germany, a meta-analysis was conducted on the effect of therapeutic interventions for individuals who have schizophrenia (Sarin, Wallen, & Wilderlöv, 2011). The study concluded that an average of 20 sessions of CBT had a positive outcome on positive, negative, and general symptoms, as well as on functioning. However, the analysis also concluded that positive outcomes were not immediate; rather, progress appeared at a three-month follow-up instead of immediately following CBT intervention. Furthermore, the study focused on the psychosocial component of the biopsychosocial model. This included the therapeutic relationship between the clinician and patient, as well as integration into group therapies. The analysis also concluded that there is a delay in improvement of symptoms with drug treatment, with an average duration of improvement of around three to six months, as

well as increased risk of symptom worsening, medical health problems, and dosage increase. Relapse from CBT is minimal compared to medication interventions. Through CBT, the goal is to treat the patient's symptoms to elicit improvement so that dosage of medications may be reduced, thus placing emphasis on the autonomy and resilience of the client. Through this meta-analysis, CBT is concluded to benefit the individual's long-term management of schizophrenia (Sarin, Wallen, & Wilderlöv, 2011, pp.165–172).

Religion and Culture

The foundations of social work incorporate spirituality into treatment, the mission of social work being the enhancement of human well-being and helping individuals fulfill their basic needs to sustain well-being (National Association of Social Workers, 1996). Most treatment modalities are fixated on the traditional biopsychosocial model. In Western culture, previous studies of medication, psychotherapy, and psychosocial interventions concluded that the psychotherapy and psychosocial interventions have the greatest impact on schizophrenia (Chien, Leung, Yeung, & Wong, 2013). This assumption may be attributed to the *DSM-5*, which currently remains the primary resource for psychiatric intervention. The *DSM-5* briefly notes that culture-related diagnostic issues (such as hallucinations) may present as psychoses to one culture but may be normative for another. No further evidence, treatment options, or cultural education is provided. This is where research, education, and client-provider collaboration are needed.

Spirituality is broadly defined as the individual focus on the human spirit or soul, whereas religion is defined as a belief and worship of an almighty force, typically a god or gods. Religion follows a dogmatic practice, and the foundation is often based upon spirituality. The World Health Organization considers religion and spirituality to be substantial factors in evaluating the quality of life among people. According to the Pew Research Center, as of 2012, 84% of the global population identified with a religion or spirituality. It has been estimated that, as of 2010, the world's population included about 2.2 billion Christians (32%), 1.6 billion Muslims (23%), 1 billion Hindus (15%), nearly 500 million Buddhists (7%), and 14 million Jews (0.2%). In addition, more than 400 million people (6%) practiced various folk or traditional religions, including African traditional religions, Chinese folk religions, Native American religions, and Australian aboriginal religions (Pew Research Center, 2012). Therefore, it suffices to say that religion compromises a major component of individuals' lives around the world, making it a factor in holistic health. We are not just physical bodies; cultures have for centuries focused on spirituality, religion, and transcendence. And cultural differences exist in terms of how spiritual practices are viewed and used in coping with schizophrenia. Practitioners must be prepared to consider such cultural differences with all clients through research, cultural education, and cultural sensitivity.

Religion and Spirituality in Schizophrenia

Religion is commonly expressed among patients with schizophrenia through delusions and grandiose thinking, such as ideas of being a god (Mohr, Brandt, Boras, Gillieron, & Huguluete, 2006). In this way, religiosity may become a manifestation of psychosis and place the client and others in danger. However, to some cultures, these symptoms may be viewed as a shift in the self and movement toward transformation.

According to Mohr and Huguluete (2004), professionals in developed nations, such as the United States, are less likely to incorporate spirituality into psychiatric care due to lack of cultural competence, as well as fixation on the pathology of schizophrenia rather than the individual as a complex being. Research focused on religiosity and spiritual coping mechanisms among people with schizophrenia, as well as cultural comparisons of how delusions and hallucinations are viewed, determined that undeveloped countries often view them as a ritual of spiritual growth. For example, according to Krippner (2002), shamanistic communities view individuals who experience delusions and hallucinations to be of "privileged status." Shamanism also incorporates people with schizophrenia into the community, as seen in ceremonies that provide bonding, allowing the perceived schizophrenic to avoid isolation. This collectivism promotes functionality for the individual with schizophrenia, which is often a struggle in the United States (Krippner, 2002, p. 963).

Spiritism is a religion in Latin American that is being integrated into mental health care. Puerto Rican Spiritists challenge the view of

hallucinations and delusions as being pathological and instead view these symptoms as valued experiences (Moreira-Almeida & Koss-Chioino, 2009). Alternative treatment modalities being conducted in Brazilian psychiatric hospitals combine conventional psychiatric treatments with alternative spiritual interventions. At these hospitals, interventions such as fluidotherapy, medium interventions, and prayer, supplemented with medication, are being used as treatment interventions for those diagnosed with schizophrenia Through patient self-reports and clinicians' observations, spiritual healers elicit positive outcomes for individuals displaying psychotic symptoms through the reduction of symptoms and improved functioning (Lucchetti et al., 2011). These alternative interventions seem to mitigate the severity of symptoms for those struggling with schizophrenia; however, scientific research into spiritual and religious interventions is lacking across the globe.

In a research review of schizophrenia studies conducted around the world, Kulhura (2009) reported that the developing countries of Sri Lanka, India, and Nigeria, which have increased levels of religiosity, had better outcomes, including integration into society and less time hospitalized. This review stated that, based upon a two to five year follow up of 50-60% of developing nations' schizophrenia outcome, a large proportion had a good outcome compared to developed nations. In these countries, individuals with schizophrenia were not viewed as being dangerous and therefore were not avoided by others in the community. When schizophrenia is not perceived with a stigma, individuals with schizophrenia can remain integrated into the community, thus diminishing isolation and increasing social support (Kulhara, Shah, & Grover, 2009). These findings may illuminate the connection between religiosity and social support as influential factors in improving treatment outcomes for individuals diagnosed with schizophrenia.

Viewing individuals who have schizophrenia from a holistic perspective may have significant benefits for their flourishing. Rather than viewing symptoms through a pathological lens, incorporating culture and religion into therapeutic interventions may lead to remission of symptoms. Since religion is unique to the individual, not simply his or her culture, an empathetic and mindful approach by clinicians is required to treat the whole person. In a study of 115 outpatients who suffered from schizophrenia, religion elicited hope, purpose, and meaning in about 70% of the participants' lives, while religious integration negatively impaired 14%. Religion was found to reduce psychotic symptoms as well as increase social integration. Through this, we find that there is a significant relationship between religion and schizophrenia (Mohr, Brandt, Boras, Gillieron, & Huguluete, 2006).

Current State of Research

Research throughout the years has concluded that there is a connection between religion and schizophrenia. However, minimal studies have focused on spiritual or religious interventions in mental health. The lack of research on integrative therapies stifles the evolution of mental health. Developing countries can expand upon current research that incorporates spiritual or religious interventions into the treatment of schizophrenia. This shift in therapeutic approaches can view people with schizophrenia more holistically and elicit change in the medically dominated mental health field. Respecting and implementing conventional treatments, along with these alternative perspectives and interventions, may elicit greater self-awareness and autonomy in suffering patients, allowing them to thrive.

In one study, "Religious and Spiritual Interventions in Mental Health Care," researchers found that therapy, meditation, and audiovisuals (e.g., tapes of prayer, guided meditations, and self-help dialogue) had positive outcomes in Catholic, Jewish, and Muslim patients struggling with mental illness. Through previous studies, the meta-analysis found that these spiritual interventions increased individuals' medication adherence and social functioning, as well as the likelihood of their discussing spirituality with their mental health professionals (Goncalves, Luchetti, Menezes, & Valada, 2015).

In addition, Hook, Worthington, Davis, Jennings, and Gartner (2010) integrated spiritual interventions for schizophrenia with certain religious practices. Muslim CBT was used with participants who identified as Muslim. This form of CBT consisted of prayers from the Koran, audiocassettes of Islamic guidance, and understanding the voices through Islamic doctrine. A post-study assessment concluded that, compared to the control sample, those who received treatment had decreased frequency of auditory hallucinations (Hooket al., 2010). Furthermore, in a study of 406 participants who had chronic mental illness, 80% reported using

religious coping skills, such as prayer or meditation, to remedy mental health symptoms. Thirty percent of participants reported that their religious beliefs kept them going (Tepper, Rogers, Coleman, & Malony, 2001).

A patient with schizophrenia reported that "the Buddhist monk teaches how to meditate to distance myself from the hallucinations" (Mohr & Hugulet, 2004, p.1955). A study conducted by Chadwick and colleagues (2016) used the first group person-based cognitive therapy, which is the integration of CBT and mindfulness. The study was conducted with a population of 108 individuals who had a diagnosis of schizophrenia. The group engaged in half-hour sessions for 12 weeks. The initial sessions consisted of guided meditations that referenced the psychotic experience through attention to the body and breathing. These early stages drew out participants' auditory delusions and discussed how to view and cope with them. Following sessions pertained to weakening the voices and enhancing autonomy, while the final sessions focused on identifying and distancing from negative perceptions of schizophrenic symptoms, as well as positive recognition such as viewing the self as complex and changing. These interventions were supplemented by participants' engagement in daily mindfulness at home, expressed through 10-minute recordings and homework to work on voices and reframing of the self. The study concluded that the intensity of voice distress, the power of the voices, and the controllability of the voices significantly improved post-treatment though CBT mindfulness, supplemented with medications (Chadwick et al., 2016).

Limited research has been done and is continuing on mindfulness-based interventions for psychosis. Mindfulness, stemming from Buddhism, is described as a state of nonjudgmental and open acceptance of present-moment experiences (Chadwick et al., 2016). As indicated in an article by Shonin, Gordon, and Griffiths (2014), through mindfulness-based therapies, such as guided meditation and anchoring techniques (deep breathing), the individual may have the capacity to "allow unpleasant psychotic experiences to come into awareness, avert a conflict-inducing response, and accept both the psychotic experience and oneself" (Chadwick et al., 2009 as cited in Shonin et al., 2013, p. 127). Therefore, more research is necessary to further investigate the benefits of alternative therapies for schizophrenia.

Concluding Thoughts

Spirituality and religion have been shown to be significant in cross-cultural healing of symptoms in schizophrenics. This is seen through research on developing coping skills through implementation of religious or spiritual practices, such as prayer and meditation. Religion may be perceived as producing a negative effect on schizophrenia due to a commonality of grandiose religious and spiritual hallucinations and delusions. However, with cultural sensitivity and religious/spiritual education for clinicians, the integration of religious/spiritual therapeutic interventions into the biopsychosocial model of treatment may be a pathway to further understanding the individual. These types of interventions, supplemented with traditional therapies and keeping the safety of the client in mind, may evolve our current treatment modalities for schizophrenia. Such interventions would be shaped around the subjective experience of patients, depending on their spiritual needs and religious affiliation. For those who do not identify as religious/spiritual, secular meditation, self-help dialogues, and mindfulness are potential treatment methodologies to treat the individual holistically.

A multicultural perspective and awareness can elicit the understanding of spirituality's impact on schizophrenia. Through being mindful of clients' "religious identity, beliefs, values, senses of meaning, sense of peace, and sense of connectedness with society" (Ho, Wan, & Chan, 2016, pp. 269–275), we can explore the ways to implement religious/spiritual therapeutic treatments for schizophrenia.

It is the job of professionals to keep an open mind and to be aware of their own biases while trying to understand where the client is coming from. As indicated by the research described above, there are benefits for certain religious treatments for schizophrenia, more so than for medication and traditional therapy alone. However, more research is necessary to determine objective spiritual and religious interventions that can be implemented for people with schizophrenia across the globe, as well as incorporating spirituality as a form of well-being for those who do not identify as religious/spiritual. With cultural awareness, education on religious/spiritual acts, and empathetic clinicians, the current model of mental health treatment can shift to a model that views people in their entirety. If people with

schizophrenia are viewed holistically, have the support and empathy of the clinician, and work on achieving autonomy over their lives and thoughts, they have the potential to manage their illness. Viewing schizophrenia through the lens of spirituality may enable treatment to be based on growth rather than disease. Therefore, the strengthening of the biopsychosocial-spiritual model should be integrated into a wider range of mental health treatment to explore the human condition, challenge the medical model, and evoke transformation in the vulnerable.

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Community Violence and its Impact Upon Development of PTSD

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Abstract

It can be ascertained that community violence has harmful effects on social-emotional development of children and adolescents. Even in the case of solid familial support systems, simply the act of witnessing the violence that occurs daily in cities such as my hometown, Chicago, makes the child a victim of community violence just as much as those who have been directly impacted by the violence itself. Thus, the child becomes susceptible to the development of disorders such as PTSD at a very young age. This exposure to violence within the community can have lasting affects into adulthood depending upon the effectiveness of the child's coping mechanism and support systems. This paper provides an in-depth exploration of the relationship between community violence and PTSD.

Keywords: PTSD, trauma, disorder, violence

History of Posttraumatic Stress Disorder

Sadock, Kaplan, and Sadock (2007) described the history of posttraumatic stress disorder (PTSD) dating back to the U.S. Civil War. During this time period, cardiac symptoms similar to PTSD were referred to as *soldier's heart*. In World War I, the term *shell shock* derived from soldiers being exposed to trauma from exploding shells. The symptomology of PTSD has evolved over the last half century based on research on survivors of other traumatic events. Survivors of a fire in a crowded night club, World War II veterans, and survivors of war all presented with symptoms of increased nervousness, fatigue, and nightmares in response to these traumatic events. The observed psychiatric illnesses of Vietnam War veterans brought into fruition the idea of PTSD, which was officially introduced as a psychiatric diagnosis in the 1980s. The associated symptoms include the following;

> recurrent, involuntary, and intrusive distressing memories of the traumatic event. . . Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s) . . . dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were occurring . . . intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s) . . . marked physiological reactions to reminders of the traumatic event(s) (American Psychiatric Association, 2013, Diagnostic Criteria).

Epidemiology

The number of new cases of PTSD within a single year is estimated to be 9% to 15% of the total population. The number of existing cases within a population is estimated to be 8% of the population (Sadock et al., 2007). Within high-risk populations, 5% to 75% of the population have been diagnosed with PTSD at some point in their lives. The lifetime prevalence among women is 10% to 12% percent and among men it is 5% to 6%. Posttraumatic stress disorder is most prevalent in young adults due to increased exposure to causal events. Men and women differ in their likelihood of developing PTSD because of the different types of trauma to which they are exposed. The lifetime prevalence is exponentially higher for women, and a higher number of women experience PTSD. Historically, men usually experience trauma as a result of combat and women usually experience trauma as a result of physical and sexual assault. According to Sadock and colleagues (2007), the disorder has the highest likelihood of occurrence as a result of stressors associated with being divorced, single, widowed, having low socioeconomic standing, and being socially withdrawn.

The *Diagnostic and Statistical Manual of Metal Disorders*, fifth edition (*DSM-5*; American Psychiatric Association, 2013) states that the estimated lifetime risk for PTSD at 75 years of age is 8.7%. The number of existing cases within a 12-month period among adults from the United States is estimated to be 3.5%. European and most Asian, African, and Latin American

countries have a lower estimated lifetime risk of developing PTSD symptoms (0.5%–1.0%). Vocation also influences rates of PTSD, particularly for veterans and those engaged in other stressful occupations such as police, fire, and other medical first responders. The highest rates of PTSD occur in survivors of rape, war, captivity, ethnic and political internment, or genocide. Development is also a factor that impacts the prevalence of PTSD. Children and adolescents generally present with a lower prevalence of PTSD following exposure to significant trauma, which may be contributed to previous criterion lacking sufficient evidence supporting development.

Subthreshold PTSD has been narrowly defined. Weiss and colleagues (1992) defined it as a dysfunction that is equivalent to full PTSD, in addition to meeting criteria within two of three symptom clusters (avoidance, reexperiencing, or hyperarousal) or meeting most of the criteria in each diagnostic category. Stein, Walker, Hazen, & Forde and colleagues (1997) defined partial PTSD as presenting with at least one symptom within each category of *Diagnostic and Statistical Manual of Mental Disorders*, version 4 (*DSM-IV*) criteria. Franklin, Chambliss, Walton, and Maieritsch (2018) devised a "model DSM-5" definition for subthreshold PTSD using DSM-IV criteria: "one re-experiencing, one avoidance (DSM-IV C1 or C2), one other DSM-IV criterion C, and one arousal symptom" (p 257). The prevalence of full-threshold PTSD presents as lower among older adults in comparison to the general population, and subthreshold presentations are more common than full PTSD in later stages of life. These symptoms have been associated with significant clinical impairment. Posttraumatic stress disorder rates are higher among U.S. Latinos, African Americans, and American Indians; lower rates are found in Asian Americans (American Psychiatric Association, 2013).

Protective and Risk Factors

Sadock and colleagues (2007) identified severity, duration, and proximity of exposure to the trauma as the most significant risk factors for the development of PTSD. They also identified familial patterns, such as being the first-degree biological relative of persons with a history of depression, as risk factors. They asserted that childhood risk factors include the following:

> demographic factors (e.g., age, sex, socioeconomic status, other life events (positive and negative), social and cultural cognitions, psychiatric comorbidity, and inherent coping strategies. Family factors (e.g., parental psychopathology and functioning, marital status, and education) play key roles in determining symptoms of a child. Parents' responses to traumatic events particularly influence young children who may not completely understand the nature of the trauma or its inherent danger (p. 617).

In the *DSM-5*, environmental and temperamental risk and protective factors for PTSD are classified as pretraumatic, peritraumatic, and posttraumatic (American Psychiatric Association, 2013). Pretraumatic factors include emotional problems that develop by six years of age and any other previous mental disorders such as panic disorder, depressive disorder, and obsessive-compulsive disorder. Environmental factors include lower socioeconomic status, lower levels of education, and exposure to previous trauma, specifically during childhood.

Patton, Miller, Garbarino, Gale, and Kornfeld (2016) asserted that community violence is the leading cause of death for African American males ages 15 to 25, with a murder rate 49 times greater than that of their white male counterparts. African American males residing in Chicago are also the most likely victims of violence and perpetrators of violence. Some of the risk factors associated with this population include being reared in single-parent households and poverty. The consequence of exposure to community violence within this population includes "anxiety, suicidal ideation, posttraumatic stress disorder, depression, and low academic achievement" (Patton et al., 2016, p. 639).

Other risk factors include childhood adversity in the form of lack of economic resources, separation or death of parents, and general family dysfunction. Additional risk factors specific to cultures include self-blaming as a coping strategy and minority racial or ethnic standing. Family psychiatric history is a risk factor, while social support preceding the exposure to trauma is a protective factor. Specific genotypes may be protective or risk factors. Female gender and younger age at the time of exposure to the trauma within adults are also risk factors. Peritraumatic environmental factors identified as risk factors include the severity of the trauma (American Psychiatric Association, 2013). With greater degree of trauma, the likelihood of

developing PTSD increases. Experiences of violence or perceived threats of injury or death, in addition to interpersonal violence at the hands of a caregiver are risk factors, as are children witnessing threats of violence to caregivers and persistent dissociation occurring during the trauma. Posttraumatic temperamental and environmental factors include negative judgements, inapt coping skills, and development of acute stress disorder (American Psychiatric Association, 2013). Successive exposure to the trauma, related triggers, or reminders of the event may impact the development and severity of PTSD. High-stress environments, including financial instability or community violence, also increase the likelihood and development of PTSD. Again, social support, specifically in the form of family stability for children, is a protective factor that regulates client outcomes post trauma.

Stratta and colleagues (2015) identified resilience as a protective factor and explained the complex relationship between the styles of coping, resiliency, and development of post-traumatic stress spectrum symptoms:

> The emotional coping shows an impact on the outcome, leading to an increase of clinical or subclinical stress spectrum symptoms. Instead, when its impact is mediated by resilience, interacting with a positive coping, a decrease in stress symptoms is predicted with resilience becoming a key factor to explain the relations between coping styles and stress spectrum symptoms (p. 59).

These authors also asserted that, if resilience is not engaged, it becomes impossible for positive coping to manage trauma exposure. Resilience "buffers" the stressors and works to reduce the risk of associated stress-related symptoms.

Etiology Across Heuristics

Sadock and colleagues (2007) defined the term *stressor* as

> the prime causative factor in the development of PTSD. Not everyone experiences the disorder after a traumatic event, however. The stressor alone does not suffice to cause the disorder. The response . . . must involve intense fear . . . (with consideration of) individual preexisting biological and psychosocial factors and events that happened before and after the trauma (p. 613).

They described contributing factors across several models. Psychoanalytic models for the onset of PTSD assert that exposure to the trauma has reactivated a prior unresolved psychological conflict. The reemergence of the childhood trauma results in the use of defense mechanisms such as repression, reaction formation, undoing, and denial. In the case of sexual trauma in childhood, a splitting of consciousness emerges. Through this experience, the ego relives and tries to manage the anxiety.

The cognitive model of PTSD states that the individual is unable to process or provide a rationale for the trauma that led to the disorder. As a result, the individual continues to experience stress, exhibit avoidant behaviors, and experience ambivalence in acknowledging and blocking the trauma. The behavioral model of PTSD examines two phases: exposure to the trauma and conditioning of the fear response, which is independent of the initial unconditioned stimulus. Individuals then develop a pattern of avoiding both conditioned and unconditioned stimuli with sometimes positive reinforcement from outside parties such as increased attention or sympathetic responses. Biological theories of PTSD suggest that, through data analyses, "noradrenergic and endogenous opiate systems, as well as the HPA axis, are hyperactive in at least some patients with PTSD" (Sadock et al., 2007, p. 614). Other contributing biological factors include increased responses of the autonomic nervous system, such as elevated blood pressure, heart rate, and abnormal sleep patterns. Within these findings, researchers have found similarities between PTSD and major depressive and panic disorders.

Researchers have recently shown a greater interest in the impact of exposure to community violence on the development of PTSD in urban youth. Eboni Morris (2009) of the National Urban League Policy Institute stated that community violence has been found to be more closely associated with PTSD than any other violence exposure. In fact, the National Survey of Adolescents conducted by McCart and colleagues (2007) asserted that 55% of adolescents reported exposure to community violence and 6% met the diagnostic criteria for PTSD. Adolescents who were African American reported higher levels of community violence and symptoms associated with PTSD. Children growing up in urban environments also had increased levels of PTSD, delinquent behavior, and exposure to violence.

Morris (2009) also highlighted the factor of race. Due to exposure to greater amounts of stress associated with lower socioeconomic status and an overall lack of resources to address mental health needs, African Americans have been shown to experience PTSD at a greater frequency than European Americans. Within a study conducted by Norris and Beutler (1992), the impact of 10 traumatic events were examined within a sample of 1,000 adults consisting of half black, half white, half male, and half female participants. The events that occurred most often included tragic death, sexual assault, and motor vehicle crashes. Norris and Beutler (1992) concluded that, although European Americans reported a greater occurrence of traumatic events, the impact and nature of the trauma for African Americans is compounded by a lack of financial and psychosocial resources in addition to racism and neglect of African American communities: "Whether the event under study is traumatic or more ordinary, there is substantial evidence that social status buffers the impact of life events. . . . Minorities may (also) confront hostility, prejudice, and neglect, which serve to the effects of a crisis" (p. 417). Morris (2009) echoed this by stating that environmental factors such as high crime rates, a population of individuals living below the poverty line, and the lack of mental health services additionally serve as precursors of community violence.

Blizzard, Kemppainen, and Taylor (2008) spoke of the pathology of PTSD from a nursing perspective. These authors believed that the frequent occurrence of community violence in urban and rural areas can create a desensitization of the trauma for the general population. These tragedies, such as becoming a victim of criminal activities, being a victim of natural disasters, witnessing a violent accident or crime, or experiencing physical or sexual abuse, have become so commonplace within community settings that the general public is barely moved by them until those who are important to their individual lives become victims of community violence.

Posttraumatic stress disorder has historically been related to military contact, but more recent studies highlight community violence and natural disasters in hopes of identifying the prevalence rates of this disorder in such communities. Blizzard and colleagues (2008) cited a study in which 372 college students between the ages of 18 and 22 completed self-report measures assessing their exposure to community violence, trauma, perceived social supports, coping styles, and PTSD symptom severity. Findings revealed that 80.5% of participants identified themselves as victims of violence within their community with family support as the most significant protective factor.

Hickman and colleagues (2013) highlighted the concept of *polyvictimization* in violence experienced by children, which is exposure to multiple forms of violence as opposed to multiple incidents of the same type of violence. This study was conducted to gain a more comprehensive representation of children's experiences with violence and the varied predictors of psychological distress in disorders such as PTSD. Caregiver reports indicated that the children in the sample were exposed to an average of 15 incidents of violence over their lifetime. This included assault, neglect, witnessing violence against caregivers, sexual assault, family abduction, and household burglary. The average age of the child was just under five and 75% were younger than 6.5 years old at first occurrence. Witnessing violence was the most commonly experienced category. Fifty-six percent of the sample were exposed to more than one category of violence in their lifetime.

Controversies

According to the American Psychiatric Association (2013), peritraumatic environmental factors that are identified as risk factors include the severity of the trauma. With greater degree of trauma, the likelihood of developing PTSD increases. Additionally, witnessing threats of violence to caregivers and persistent dissociation occurring during the trauma during childhood are risk factors. Marshall, Schell, and Baker (2002) set out to examine the relationship between PTSD symptoms and recollections of peritraumatic dissociative experiences in survivors of community violence who had been hospitalized as a result of their sustained injuries.

Various theoretical accounts describe dissociation as a protective mechanism. It inhibits the occurrence of intensely aversive emotions that may occur during or immediately after a traumatic event. Thus, diversions in consciousness such as detachment from oneself, perception of unreal surroundings, and altered perceptions of pain all work to avoid threatening feelings of vulnerability and intense fear. Peritraumatic dissociation is believed to offer important insights into the etiology of PTSD and indicators of increased risk for posttraumatic maladjustment. The results of the case study by Marshall and colleagues (2002)

suggest that researchers should use caution in interpreting information gathered months or years post trauma because recalled dissociation varies over time. In fact, measuring peritraumatic dissociation using temporally proximal measures provides no significant indication as to the prediction of subsequent PTSD severity. Marshal and colleagues assert that the best indicator for the future occurrence of PTSD symptoms and their severity is the initial symptomatic distress. Findings from this study provide practical application for how measures of peritraumatic dissociation should be utilized.

It should be noted that the sample used for this study consisted largely of male survivors of community violence. Marshall and colleagues (2002) acknowledged the need for additional research with female survivors of community violence. This study shows that individuals often have varied styles of coping and that no single coping mechanism has been identified as being most widely effective at reducing the likelihood for PTSD development. It highlights the importance of emphasizing the individual response to the trauma at the time of the event and the effect of those initial symptoms on the day to day functioning of the individual.

The American Psychiatric Association (2013) states that the prevalence for development of PTSD is greater among females than males across the life span. Females within the general population also experience PTSD for a longer duration than males. The increased risk for development of PTSD in females can be attributed to some extent to a greater chance of exposure to trauma, such as rape and interpersonal violence. Within the population of individuals exposed to the aforementioned traumas such as rape and interpersonal violence, both male and female survivors were equally at risk for PTSD development.

Differential Diagnosis and Comorbidity

In patients with PTSD, comorbidity rates are high, with two-thirds of patients having at least two other diagnoses. The most common include depressive disorders, other anxiety disorders, bipolar disorders, and substance-related disorders. Comorbidity makes the client more susceptible to the onset of PTSD (Sadock et al., 2007). The American Psychiatric Association (2013) states that those with PTSD are 80% more likely to meet the diagnostic criteria for at least one other mental disorder, such as depressive, bipolar, anxiety, or substance abuse disorder. Young children also have at least one other diagnosis, including oppositional defiant disorder and separation anxiety disorder predominant. There is significant comorbidity between PTSD and major neurocognitive disorder and some overlap between symptoms of these disorders. For example, reexperiencing and avoidance are symptoms of PTSD and not the effects of traumatic brain injury (TBI) while persistent disorientation and confusion are symptoms more specific to TBI than to PTSD (American Psychiatric Association, 2013). Overall, the implication for misdiagnosis in both adolescents and adults is that the trauma existing at the core of symptomology goes unidentified and untreated.

According to the American Psychiatric Association (2013), there are several disorders that meet criteria similar to PTSD, with one or two exclusionary factors that provide the contrast to PTSD. An adjustment disorder is diagnosed when the response to a stressor does not meet criterion A of PTSD, which is exposure to actual or threatened death or serious injury or sexual violence. Other PTSD disorders and conditions are qualified as PTSD only if the exposure to the trauma precedes the onset of symptoms.

If the symptom response patterns meet criteria for another mental disorder, these diagnoses should be given in addition to or instead of PTSD. Acute stress disorder differs from PTSD in that the symptom pattern is restricted to a duration of three days to one month following exposure to trauma. For anxiety and obsessive-compulsive disorders, the intrusive thoughts are not trauma related and compulsions are usually present while other features of PTSD are absent. Major depressive disorder does not include PTSD B, C, and symptoms of D and E. These include presence of intrusion symptoms associated with traumatic events, persistent avoidance of stimuli associated with trauma, negative alterations in cognition and mood associated with the trauma, and alterations in arousal and reactivity associated with traumatic events. Personality disorders include symptoms associated with interpersonal difficulties that would be expected independently of a traumatic event. Dissociative disorders may not have co-occurring PTSD symptoms and may or may not be exceeded by exposure to trauma.

New somatic symptoms found in conversion disorders within the context of PTSD might be an indicator of PTSD rather than conversion disorder. In psychotic disorders, flashbacks in PTSD must be distinguished from

symptoms such as illusions, perceptual disturbances associated with schizophrenia, and hallucinations due to another medical condition. With TBI, post-concussive symptoms can occur in individuals with brain injury and individuals with PTSD. The rate of co-occurrence of PTSD and mild TBI is 48% among U.S. military personnel and combat veterans who have been recently deployed to Afghanistan and Iraq. Because these symptoms can overlap, differential diagnosis must be based on the presence of symptoms distinctive to each individual. It is noted that reexperiencing and avoidance are symptoms of PTSD and not TBI, whereas persistent disorientation and confusion are more specific to TBI than PTSD.

Conclusion

From this body of research, it can be ascertained that community violence has harmful effects on social-emotional development of children and adolescents. Even in the case of solid familial support systems, simply the act of witnessing the violence that occurs daily in cities such as my hometown, Chicago, makes the child a victim of community violence just as much as those who have been directly impacted by the violence itself. Thus, the child becomes susceptible to the development of disorders such as PTSD at a very young age. This exposure to violence within the community can have lasting affects into adulthood depending upon the effectiveness of the child's coping mechanism and support systems. Such trauma can shape the child's life so that he or she begins to fear unconditioned stimuli, which can serve as a trigger for the resurgence of or reliving of the traumatic event much later in life.

It is my personal belief that the social ills and environmental factors mentioned by Morris (2009) only intensify the biological and psychological predisposition to the development of PTSD. Biological and psychological factors are often difficult to control, but the social and environmental factors are much more amenable to change. As this body of research indicates, it is a conglomerate of lack of access to socioeconomic resources, lack of tethered family structures, neglect of black and brown communities, and racism that becomes the major catalyst for community violence. For individuals in communities stricken with poverty and violence, such as the south and west sides of Chicago, government officials and health care professionals must accept the charge to work with community members and develop initiatives that will once and for all subdue the acts of violence that have plagued urban communities and ultimately claimed lives for so many years. This change is paramount in the effort to control the onset of PTSD and other stress-related mental disorders in young children in underserved and often forgotten communities.

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An Alternative View of Borderline Personality Disorder

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Abstract

This article will discuss borderline personality disorder and its etiology, including both biological and environmental factors, with the aim of providing further understanding of these clients and targeting stigmatic views surrounding the diagnosis. Current perceptions of this disorder within the mental health community will be presented and the presence of stigma surrounding clients with this disorder discussed. Current treatment options will be highlighted and alternative names for the disorder will be introduced. This article is to intended to challenge the diagnosis and the surrounding stigma that often keep clients with the disorder from getting much needed treatment.

Keywords: disorder, borderline, therapy

Introduction

The term *borderline* was first used in the 1930s to describe individuals whose symptoms were not exclusively neurotic or psychotic, but fell somewhere in between the two. Although the term was used to describe patients, it was not used as a diagnosis until 1980 and did not become known as borderline personality disorder (BPD) until the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-3*; American Psychiatric Association, 2013). In this edition BPD was listed alongside cluster B narcissistic, antisocial, and histrionic personality disorders (Al-Alem & Omar, 2008).

Characterized by extreme emotional dysregulation and unstable interpersonal relationships, BPD involves mood swings that are unlike those that signal mood disorders. Instead of the distinct mood episodes that we see in a diagnosis such as bipolar disorder, those with BPD may have mood swings throughout the day, and these mood swings can dissipate as quickly as they appear (Gabbard, 2005). Among the issues these individuals struggle with is a poor sense of self; they sometimes assume the identity of others. They also struggle with an extreme fear of abandonment. These clients wish to merge with their attachment figures to protect themselves against this fear; however, they are afraid of losing themselves in the process. This type of behavior often leads to chaos in their relationships, including their therapeutic relationships (Gabbard, 2005). Their vulnerability to impulsivity may cause them to seek out drugs or alcohol or to engage in other self-destructive behaviors such as self-injury. Clients with BPD also often struggle with eating disorders as well as suicidal ideation and sometimes suicide attempts (Gabbard, 2005).

Because these clients often struggle with interpersonal relationships, emotional regulation, and other severe symptoms, they have long been labeled difficult and consequently stigmatized by the mental health profession. Although much time has passed since BPD was first identified, a pervasive misunderstanding of the disorder and those who have it persists, and some clinicians refuse to work with this population or do not have the proper training to do so effectively (Hancock, 2017). This article will examine the etiology of the disorder, critique the usefulness of its current terminology, and offer an alternative perspective on how reframing the clinician's view of those with BPD may enhance success in treating these clients.

Etiology

There is no exclusive factor that leads to the development of BPD. However, traumatic experiences such as sexual or physical abuse are believed to be a contributing factor to its development. Other factors, such as a dysfunctional family dynamic, a chaotic environment, and/or the absence of emotional validation or love from caregivers augment the chance that BPD will manifest in one's lifetime. It is important to note that, although many clients report abuse, not all clients do. Furthermore, there are other types of trauma experienced by people with BPD besides abuse. In the end, how an experience is perceived and how it affects the individual are what determines whether that experience is traumatic (Al-Alem and Omar, 2008). According to Gabbard (2005), any

disruption of normal psychological development during childhood may cause the development of BPD symptoms later in life.

Biological and genetic factors have also been found to cause this disorder. Various abnormalities in hormones and neurotransmitters including dopamine, serotonin, acetylcholine, monoamine oxidase, hypothalamic pituitary axis hormones, or thyrotrophic releasing hormone have been found in the brains of those with personality disorders, including those with BPD, suggesting a biological basis for this disorder (Al-Alem and Omar, 2008). Other studies have shown that some parts of the brain, specifically the amygdala and hippocampus, are smaller in those with BPD than in the general population; this size difference may account for the emotional fragility of these individuals. However, many studies have also shown that the presence of trauma can cause structural changes in the brain. Despite the contribution of biological factors to the etiology of the disorder, these factors alone cannot cause BPD, but instead must be combined with environmental factors for borderline pathology to arise (Gabbard, 2005). For example, a study on sexual and physical abuse in patients with BPD found that, when genetic and environmental issues were combined, individuals were at a higher risk of developing BPD (Bradley, Jenei, & Westen, 2005).

Current Perceptions

Despite the availability of extensive research and new treatment methods for this population, some mental health professionals still have negative biases concerning individuals with this disorder. In one study, psychologists who had positive attitudes toward clients with personality disorders had more patients with BPD on their caseload than those who viewed this population negatively (Egan, Haley, & Rees, 2014). In another study, nursing staff and mental health workers at an inpatient mental health facility considered borderline patients more dangerous than those with schizophrenia or depression and would socially distance themselves from them during their treatment (Markham, 2003). Therapists who have worked with clients with BPD have used the words *difficult* and *draining* to describe their work with these patients. Because of this, some clinicians do not work with patients with BPD, and although some views of this population have become more positive, negative ideas surrounding the diagnosis still prevail.

As an example, consider the following. One website that can easily be found by searching Google for *borderline personality disorder* is that of the Zur Institute. This agency serves mental health professionals by providing continuing education courses and other resources. This website includes, as one of the first choices for someone researching BPD, an article on BPD titled "You Are One Borderline Client Away from Losing Your License" (Zur Institute, n.d.). This title emphasizes something that therapists fear—losing their licenses—and if a therapist happened to be confused and struggling with a borderline client, the title might deter him or her from continued work with that client or others with the same diagnosis.

It is no surprise then that some treatment professionals also tend to believe the myth that those with BPD are not treatable. However, recent research has shown the opposite. A new treatment called dialectical behavioral therapy (DBT) was developed by Marsha Linehan specifically for those suffering from BPD. Although this treatment has now been adapted to help with other diagnoses, DBT has been shown to improve treatment outcomes for clients with BPD (Linehan, 2016). This treatment modality teaches clients mindfulness skills, distress tolerance, interpersonal effectiveness, and emotion regulation. Clients are also supported by a skills training group, individual therapy, phone consultations with a therapist, and a treatment consultation team that keeps track of their progress (Behavioral Tech, n.d.). A 2015 study found that clients who received DBT skills training versus individual therapy reduced suicidal ideation, severity and frequency of suicide attempts, and number of crises (Linehan, 2016). This suggests that skills clients learn in DBT programs are useful and effective in coping with borderline symptoms.

Stigma and Terminology

Unfortunately, although research surrounding BPD is more plentiful now than in the past, therapists still shy away from working with these individuals. Therefore, many people who seek treatment are turned away or do not get adequate treatment for their condition. It seems, however, that most of these therapists' aversion stems from a misunderstanding of the disorder. Various factors contribute to this aversion, such as the disorder's stigmatizing reputation and terminology as well a general misunderstanding

of the traumatic histories of clients and how client history contributes to current perceptions, expressions, and behavioral manifestations.

The disorder's terminology is long overdue for a change. The term *borderline personality disorder* is outdated and highly stigmatizing, especially considering the knowledge uncovered since the diagnosis was first defined. When the term *borderline* was coined to describe these clients, there was minimal awareness of the symptoms themselves. Neurosis and psychosis were the main diagnoses for many individuals and were therefore the frame of reference used to understand this disorder. However, this is inappropriate since we now know that the disorder develops as a response to traumatic early experiences related to attachment figures and adverse environmental conditions. Further, the second part of the term, *personality disorder*, suggests that the problem lies within a person's personality and that there is something inherently wrong with who that person is. These connotations can instill hopelessness in a person, adversely affecting self-image, success in treatment, how he or she makes sense of the diagnosis, or whether he or she believes positive change is attainable.

Clinicians can also be misled by the term, as it can lead to a person-blame perspective of clients and their struggles. Clients, families, and clinicians alike have been holding discussions about alternative terminology for some time now. Marsha Linehan, who created DBT, has referred to the disorder as *emotional regulation disorder* instead of BPD (Linehan, 2016). Although this term is preferred by clinicians, patients have favored another term, *emotional intensity disorder*. Both these new terms identify the high intensity of emotions experienced by people with BPD. Regardless of which term is chosen, a name change is clearly warranted and needed to reflect the reality of the disorder.

Reframing Diagnosis and Treatment

A better understanding of the etiology of the disorder by therapists is especially important. Psychotherapy has long been shown to be an integral part of the treatment of people with BPD. Although medications were and are sometimes still used to manage symptoms, the presence of a therapeutic relationship has long been proven to alleviate the suffering of these individuals (Gabbard, 2005). However, despite the need for therapists to work with this population, clients struggle with many behaviors that deter therapists from working with them. Some clients may frequently appear angry and/or combative and may wrongly accuse the therapist. Both therapists and clients need to understand the reasons behind these presenting behaviors in order to understand how to move beyond them.

One reason why these behaviors manifest is that a critical developmental milestone is disrupted early in the client's life. During childhood, the sense of self is internalized by caregiver reflections of what they see in the child. Instead of receiving a positive reflection of themselves in childhood, those with BPD may have internalized a "bad" self, which stemmed from having a frightened or frightening caregiver who communicated negativity to him or her. During therapy, the client will then feel the need to externalize the bad self and project it onto the therapist. In sum, the client will try to recreate the past relationship with the therapist. Although it was not ideal nor comforting to the client, the relationship is at least familiar (Gabbard, 2005).

For therapists, it can be difficult to experience these projections as they can produce various emotions, such as sadness, anger, or hurt, and they may also elicit difficult countertransference reactions. Those with BPD may present with self-injury and suicidal behaviors, which are other attempts to externalize their bad selves (Gabbard, 2005). Any therapist can become upset or overwhelmed, but those who are trained to work with this disorder can respond more positively to the client than those who are unaware of the client's process. This is why a reframing process must occur. Although clients may project a bad self onto the therapist by using abusive or hurtful language, their motivation to do so lies in the reason why they are in therapy. Although understandably difficult, this process is essential to successfully treat clients. If a therapist leaves during this phase of the therapeutic process, the client may become re-traumatized, blaming himself or herself for the end of the therapeutic relationship. Without going through the therapeutic process and understanding how BPD manifests in his or her own life, a client will never understand how to move beyond these behaviors. There is a current need for therapists who understand this disorder so that clients can obtain more treatment opportunities. Therapists need adequate education so that clients are not blamed for behaviors that result from an early tumultuous relationship with caregivers rather than from their own conscious choices.

With all this in mind, therapists also need to be in contact with other clinicians whom they can consult should the need arise. An isolated therapist, especially one with little to no experience with this population, may do more harm than good. Furthermore, therapists must remain compassionate during the therapeutic process, even during difficult times. The complexity of these clients' traumatic pasts is often difficult to understand not just for the therapist, but especially for the client.

It is also important to examine the role of mindfulness-based interventions in treating BPD. To be mindful is to be present in the current moment without judgment, and meditation is its formal practice. Interventions such as mindfulness-based stress reduction, mindfulness-based cognitive therapy, acceptance and commitment therapy, and DBT contain mindfulness and meditation components and have been shown to alleviate the symptoms of BPD (Chafos & Economou, 2014). By fostering a nonjudgmental awareness of their emotional experience, therapists give clients the space needed to "unstick" themselves from their emotions and to observe their behaviors and emotions in a new way. This provides the opportunity for increased insight and growth. Mindfulness meditation in particular has been shown to help emotional dysregulation issues within BPD by stimulating parts of the brain responsible for regulating emotions. It has also been shown to lower suicidal and self-injurious behaviors, and many clients who adopt a daily meditation practice no longer meet criteria for BPD (Chafos & Economou, 2014).

Mindfulness is useful for not just for clients, but also for therapists. Mindfulness helps therapists be more aware of their own emotions, including negative ones (Bien, 2006). This is especially helpful for therapists who work with borderline clients. As mentioned previously, the struggles these clients bring into sessions can be difficult, especially if the therapist becomes a target of the client's negative self-object. Consequently, the therapist may experience difficult emotions and countertransference reactions. Just as mindfulness allows a client to learn to observe his or her emotions and not be overtaken by them, it also serves as a useful tool for therapists as they encounter their own emotional reactions while working with clients. In addition, a therapist who is mindful of his or her emotions gives clients a model for how to effectively deal with emotions (Bien, 2006). Modeling this behavior is extremely helpful for clients with BPD since most are learning how to deal with overwhelming emotions that cause much suffering in their lives.

Bien (2006) also posited that clients need a therapist who is fully present within the therapeutic relationship, exhibited by consistent reflective listening and understanding. Clients come to therapy in order to alleviate suffering and make changes in their lives. A mindful presence when working with clients allows the therapist to be more relatable to the client rather than distant. This helps the therapist develop a better understanding of the client's inner world. If a therapist is too busy analyzing or diagnosing a client, he or she may subsequently appear distracted, rigid, cold, or distant (Bien, 2006). This can make it difficult for the client to trust the therapist, perhaps feeling that the therapist regards him or her as an object rather than someone with immense suffering. In work with those who have BPD, this trust issue is likely to occur as these clients are often analyzing the therapist extremely closely (Gabbard, 2005).

Conclusions

The mental health community has long held negative biases about BPD. Despite new research that explains their behaviors, these clients are still often labeled as difficult, and many therapists still refuse to work with them. There are three main factors that contribute to this stigma. First, the name of the disorder is no longer appropriate, as it was chosen in the 1930s when knowledge about this disorder was minimal. Secondly, the term *personality disorder* suggests that those with this disorder somehow caused it and are at fault for their suffering. Finally, there is a general misunderstanding among clinicians surrounding the etiology of this disorder. A better understanding of the reasons why difficult behaviors may arise in borderline clients is necessary to work with them effectively.

A more widespread awareness of the clinical implications of mindfulness and its benefits for both client and therapist is crucial. Recent studies have shown the effectiveness of many mindfulness-based therapeutic interventions, such as DBT, acceptance and commitment therapy, mindfulness-based stress reduction, and mindfulness-based cognitive therapy. Mindfulness and meditation have been effective in alleviating many troublesome behaviors such as self-injury and suicidal

ideation, and they have been shown to increase emotional regulation in clients. The psychotherapy relationship has also benefited from mindfulness on the part of the clinician, as it allows him or her to relate more effectively to emotional reactions elicited by the client. This, in turn, models a healthier way to deal with emotions for the client, who may then be positively influenced to adopt the practice.

Although the stigma surrounding BPD persists, these three components can be applied to help educate, enlighten, and reframe negative perspectives of this disorder. Those suffering from BPD have had tumultuous pasts, and their healing depends on clinicians who are willing and able to meet them on their journey to better mental health. Borderline personality disorder is treatable, and while many therapists have updated their perspectives, there are still some who have not. Continued collaborative effort is needed among mental health professionals, students, and those with BPD to help foster awareness around this disorder so that treatment is no longer an exception but is instead the rule for this vulnerable population.

Antoinette Senjanovich is a MSW Candidate at Loyola University Chicago with a concentration in mental health. Antoinette's interests include working with trauma survivors and she has developed a strong interest in working with clients with borderline personality disorder. She wrote this paper to address the current stigma surrounding the diagnosis and to offer an alternative perspective of the disorder. Antoinette employs a strengths-based perspective in her work with all clients and utilizes mindfulness-based interventions and dialectical behavior therapy in her role as a clinical intern at Foundations Recovery Network Chicago where she works with patients who are dually diagnosed and are in an intensive outpatient/partial hospitalization program setting. Antoinette plans to continue working with trauma survivors with severe mental illnesses in the future following her graduation in May 2019.

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