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Editorial

"Scientific knowledge, like language, is intrinsically the common property of a group or else nothing at all. To understand it we shall need to know the special characteristics of the groups that create and use it."

~Thomas S. Kuhn, The Structure of Scientific Revolutions, 1996 (p. 210)

When we created this journal four years ago, we chose the name *Praxis: Where Reflection & Practice Meet* because we felt it captured an important characteristic of the process of knowledge generation that occurs in our profession. The word "praxis" comes from the Greek "practice," and it connotes *practice that is inextricably entwined with theory.* If we look at the history of the development of theories in social work, we can see that our profession has a whole heritage of praxis. Social work theory has always developed through a process of dialogue between empirical data from practice, and generalizing from that to thinking about a theory of practice. We can see this dynamic interplay between practice and theory whether we think about Jane Addams and the settlement house movement, Mary Richmond and Jesse Taft and their respective diagnostic and functionalist approaches to casework, or Helen Perlman's attempt to bridge these two paradigms by developing a variant of ego psychology that was more problem-solving in its orientation. Although the empirical basis of social work practice has at times been pejoratively and inaccurately described as "practice wisdom," Mary Woods and Florence Hollis clarify:

> The term "practice wisdom"… does not sufficiently convey the continuous study process through which practice is observed and examined, both case by case and in groups of cases. As in any other healthy profession, practice theory was built up on widely debated premises derived from *scrutiny by practicing social workers of actual experience.* (Woods & Hollis, 1990, p. 16)

Thomas Kuhn's significant contribution to our understanding of the process of scientific discovery is that he placed this process within a social context. The hallmark of scientific knowledge, according to Kuhn, is that it occurs within a community; as Woods and Hollis describe, social work, like any other field, has developed its knowledge base within a scientific community of practicing social workers. For a community to nurture the development of scientific knowledge, however, it must possess certain characteristics – one of these being praxis. In other words, the professional community has to be connected to the everyday life of the people it serves. Jane Addams and her fellow Hull-House settlers were quintessential in this regard. By immersing themselves in the day-to-day lives of their neighbors, the settlers became intimately familiar with the deleterious effects of socio-economic oppression on the well-being of their immigrant neighbors. Juxtaposed against the prevailing view of the time that poverty was the product of individual deviation, this data from practice inspired the settlers to advocate for profound social reform. Similarly, in her pivotal book, *Social Diagnosis (1917),* Mary Richmond set forth an alternative view of the etiology of poverty. Using her casework method, she emphasized the impact that the social environment has on an individual's psychosocial functioning.

The body of knowledge created by these social work pioneers is a wonderful illustration of how new theories are often inspired by a dissatisfaction with the fit between prevailing theories and observations from practice. Harry Stack Sullivan's interpersonal theory (1953) and Heinz Kohut's self psychology (1971) were also the result of perceived discrepancies between tenets of dominant theories and what they saw in practice. More recently, the strengths perspective in social work was inspired by a concern with the mismatch between pathology- and deficit-focused clinical theories and social work's value of nurturing client strengths (Saleebey, 1992). Responding to similar concerns that traditional practice theories can disconnect clients from their capabilities, postmodern, constructivist theories, such as narrative theories, conceptualize the therapeutic relationship as a collaborative partnership where the client is viewed as an author and an expert of his own experience (e.g., White & Epston, 1990). In Jane Addams, Mary Richmond, Harry Stack Sullivan, Heinz Kohut and Dennis Saleebey, we have a series of people who developed their ideas because their contact with clients led them to be dissatisfied with prevailing conceptual frameworks. In response, they changed the conceptual framework. Praxis has always been a part of social work tradition, and this gives us a tremendous advantage in the generation of scientific knowledge.

Along with praxis, another important characteristic of a scientific community is that the community has to be open to people disagreeing with prevailing conceptual frameworks. Kuhn (1996) makes this point with his list of ingredients for "extraordinary research":

The Adolescent Self & Therapeutic Communication: An Integrated Approach for Treatment

by Marielle Mershart

Abstract

This article presents an exploration of the connections between theories of the self and communication in psychotherapy with adolescents. The author attempts to integrate John Bowlby's work on attachment and loss (Bowlby, 1973, Stoebe, 2002; Wilson, 2001), Daniel Stern's domains of the sense of self (Stern, 2000; Mitchell & Black, 1995), Lev Vygotsky's sociohistorical psychology, specifically the role of speech and the "zone of proximal development" (Vygotsky, 1978, Van Der Veer & Valsiner, 1994; Wertsch, 1985), and D. W. Winnicott's understanding of the transitional experience and the holding environment (Goldman, 1993; Mitchell & Black, 1995). Through the course of this article, key aspects of each theoretical perspective are outlined in an effort to build toward an integrated view as a "building block" to a clinical approach that seems to have particular relevance to work with adolescents in the midst of a challenging developmental period of ego consolidation, cognitive expansion and identity differentiation. Further, this approach has been derived out of work with adolescents who have experienced trauma and loss and whose affective presentation is an attempt to adaptively cope with early attunement failures. Case material is offered to support and sustain the author's theoretical assertions and as a means to explore implications for future study of psychotherapy with adolescents.

Ambitions and Explorations

In the preface to his seminal three-volume work *Attachment and Loss,* John Bowlby (1973) felt compelled to explain that his central frame of reference was and continued to be psychoanalysis, despite its limitations and the less than nuancial revisions to classical theory he proposed. In challenging the field to integrate into its view additional ways of clinically assessing and understanding patients, Bowlby wrote:

> Not infrequently…doubts are expressed whether the psychological processes [of attachment] are in reality related so intimately to personality disturbances of later life. Pending much further evidence, these are legitimate doubts. Nevertheless, reasons for holding to the thesis are strong. One is

that data from many sources can be arranged and organized into a pattern that is internally consistent and consistent also with current biological theory. Another is that many clinicians and social workers find the resulting schema enables them to understand better the problems with which they are grappling and so to help their patients or clients more effectively. (p. 5)

Since the time this passage was written, further research has resulted in the evidence Bowlby was hoping for that supports his thesis, as well as its utility for clinicians (Fonagy, et al. 2002; Lyons-Ruth, 2003). Efforts here are attempts at mirroring Bowlby's and other's ambitions to rethink and rework data from many sources that will have some consistency with what is known and better explain what is yet to be uncovered in the treatment process.

With those lofty goals in mind, this paper begins the exploration of the connections between theories of the self and communication, which I will argue are extremely useful in understanding aspects of the adolescent experience and treatment. Case material will be applied to support and sustain theoretical assertions and explore further implications for research and treatment. The areas of interest are Bowlby's study of attachment and loss (Bowlby, 1973, Stoebe, 2002; Wilson, 2001), Daniel Stern's domains of the sense of self (Stern, 2000; Mitchell & Black, 1995), Lev Vygotsky's sociohistorical psychology, specifically the role of speech and the "zone of proximal development" (Vygotsky, 1978; Van Der Veer & Valsiner,1994; Wertsch, 1985), and D. W. Winnicott's understanding of the transitional experience and the holding environment (Goldman, 1993; Mitchell & Black, 1995).

Each theoretical perspective referenced above is offered as a "building block" to a clinical approach that seems to have particular relevance to work with adolescents in the midst of a challenging developmental period of ego consolidation, cognitive expansion and identity differentiation. Contextually, the approach may resonate with adolescents who have experienced trauma and loss and whose affective presentation is an attempt to adaptively cope with early attunement failures.

Bridging the cognitive and the psychodynamic, this article will argue that attachment theory and Stern's hypothesis of co-constructed domains of self connect with Vygotsky's contributions regarding the emergence and function of "psychological tools," specifically speech and its role as a mediator of psychological content. Further, it is the author's view that Vygotsky's concept of the zone of proximal development is an avenue for social learning and attainment of higher psychological functioning, whereas Winnicott's holding environment provides an avenue for affective safety in the presence of unresolved loss and transitional requirements. When conceptually coupled as a dialectical stance, a powerful therapeutic surround may be created. Through the course of this article, key aspects of each theoretical perspective will be outlined and will begin to build toward an integrated view.

Why Integration?

My clinical work as a second year social work graduate student has been centered at an outpatient adolescent treatment program in a hospital based community mental health center. At this clinic, treatment comes in the form of individual, family and group psychotherapy, as well as medication management. Primarily my experience has been as an individual therapist for adolescent boys and girls whose ages range from 12 to 17 years old. Demographically, this urban adolescent outpatient program has an overrepresentation of clients who are African American and Latino. Most clients are funded either on a sliding scale, through Medicaid or with private insurance.

In examining the complexities and characteristics of my adolescent clinical caseload, certain themes surfaced with relative frequency, such as the experience of early trauma in the form of parental loss (death or abandonment) or abuse at the hand of a caregiver. This traumatic history seemed to result in tenuous (or attenuated) attachments to adult caregivers. Externalizing behaviors, particularly explosive anger, defiance and irritability, tended to be common symptoms and often the reason the adolescent was brought in for treatment. As I attempted to understand the developmental and psychodynamic underpinnings of my clients' experiences, I looked often to psychodynamic and object relations theories as a guide. However, the current trends toward outcome-based interventions and the realities imposed on clinicians by a field more and more dominated by brief treatment modalities

compelled me to adapt to and often adopt other treatment perspectives.

More importantly, the clients themselves compelled me to rethink and rework some of the assumptions I had brought with me. Many adolescent clients who came to the outpatient clinic presented with multiple diagnoses, impaired executive functioning, and highly disorganized families, along with early experiences of profound trauma and loss. Frequently, a crisis brought them to treatment—a suicide attempt, academic failure, or severe drug or alcohol abuse. As the assigned clinician, I became acutely aware that intensity of the crisis came with the pressure for outcomes within a time-limited framework. I began searching for any and all therapeutic tools to enhance my understanding of the presenting issues, and aid the treatment process.

The complexities of the needs of the adolescent in the here-and-now seemed to demand an effort of similar complexity in determining treatment strategies. In time, I began to seek ways to find congruence between, and perhaps integration of, psychodynamic approaches and developmental psychology, as well as cognitive and behavioral techniques as a way to inform and amplify treatment interventions. But eclecticism did not seem the way to go. My hope was and is to find a theoretically sound and consistent approach which is flexible and applicable to a range of young clients and which also provides a way of understanding their past as it relates to the present and in turn to the future—that is, treatment that is reflective of the conundrum and challenges of adolescence.

The Relational Underpinnings of Cognition and Communication

As my clinical experience with adolescents in treatment progressed, I found issues related to communication a common theme. Whether in the treatment relationship or in their overall symptomology, modes and methods of expression—or impediments to it—seemed to surface with some regularity, particularly among those presenting with more severe functional impairments like those described earlier. Among those that fit this category, diagnoses ranged from phonological disorder to non-verbal learning disability. In addition to learning or communication disorders, these adolescents generally presented with externalized behaviors characterized by socially unacceptable acting-out and angry outbursts. Often such symptoms were captured in diagnoses such as oppositional defiant or conduct disorder, depending on the targets of the

behavior and the environment in which they were exhibited, as well as within the attention deficit/hyperactivity spectrum. As mentioned earlier, traumatic abuse, abandonment or death of a parent prior to the onset of pubescence was a common theme within their developmental history.

In presenting this anecdotal evidence, I do not mean to imply causality between one or more of the variables cited above. I do wish to put forward a hypothesis that the mix of a history of traumatic loss, and neurological or physiological vulnerabilities to difficulties with learning, communication and impulsivity may, with the passage into adolescence, present particular challenges to these adolescents in navigating this developmental period. I further speculate that internal working models of attachment and the progression of the development of the self may provide clues to the capacities for coping with loss and adaptation to their environment. Further, that the expression of loss and subsequent modes of maladaptive functioning may be observed and worked through in a therapeutic relationship which can provide a transitional passage necessary for healthier coping and emotional growth.

With this background, I offer that the universality of the form and function of communication as a therapeutic informant and tool is relevant to this discussion. This aspect of the treatment experience may be looked at as a central tenet of therapy that carries significance equal to and separate from transference and countertransference processes.

The Facility and Limitations of "Building Blocks"

In her discussion on the social character of thinking, Cavell (2002) explores the construct that knowledge or meaning (or specifically judgment as a type of thinking where the "about-ness" of the world is entertained and intention is conceptualized) is experienced by the mind through the association of one bit of sensory data (and later an idea) built upon another in a search for causality or explanation. She ultimately dismisses this formulation as lacking in explanatory power. Her argument is that the mind does not perceive in discrete, distinct units, therefore, the conceptualization of discrete blocks of perception, one built upon the other, is a contrivance with the aim of simplification. The process engaged in here has all the limitations she cautions against. Cavell's critique and ultimate answer, however, supports the general theme of this effort—that from the start human thinking is

not an inward, differentiated, isolated or individuated process but rather one that is ultimately grounded in the context of relationships or as she calls it "interpersonal activity." Therefore, I will run the risk of simplification and perhaps even reductionism in an effort at illuminating the essential character of therapy, the therapeutic relationship, and an aspect of the "activity" of that relationship, therapeutic communication.

The Adolescent Context

The crisis of adolescence, according to Erikson's view, is the psychosocial struggle between identity consolidation and role confusion (Austrian, 2002). Erikson's dialectical vision of development has great utility for understanding the context of the powerful forces at play in an adolescent's emerging capacity to look within and observe the external world, and make judgments on the about-ness of things in relation to her. The reworking of the self is central to the experience of the adolescent. This reworking comes whether the adolescent is prepared or not. Biologically, this begins with pubescence. The rate of physical growth is second only to that of infants (Austrian, 2002). Adolescents have to engage in the dance between childhood and adulthood without ever having had a lesson. The growth of a sense of differentiation from family, neighborhood, even society, and the establishment of personalized ways of being characterize this time. Also, the cognitive expansion which occurs during adolescence, positions them as thinking beings, and flows from the earliest experiences.

Vygotsky argued that adolescents, during this period of sexual maturation, make leaps in intellectual maturation, that thinking evolves from "complexes to…concepts" (Van Der Veer & Valsiner, 1994, p. 259). Vygotsky felt this change represented a new form of intellectual activity. Out of the child's activity of grouping like concrete ideas, he or she begins to form associations about them. The words a child uses are attempts to generally represent these associations. As the child begins to utilize judgment, discerning the about-ness and relationships between himself, others and things, he begins to articulate increasingly complex meanings, eventually through words, derived from increasingly complex associations. The adolescent is able to arrive at concept-formation that becomes a part of a maturing system of intellectual functions.

Vygotsky also had something to say about imagination and creativity in adolescents. He postulated that

"imagination and creativity are linked to a reworking of various elements of experience, freely combined, and which…require a level of inner freedom of thought, action and cognizing which only he who has mastered thinking in concepts can achieve" (Van Der Veer & Valsiner, 1994, p. 269). Imagination develops out of reworking concrete sensory images with emergent capacities for abstraction, a "rapproachment between fantasy and thinking" (p. 275). Fantasy and imagination function for the adolescent the way play functions for the child; it is a tool of the adolescent to test and explore reality and his place in it—an avenue for creativity. Dialectically speaking, Vygotsky saw as part of the task of adolescent thinking the moving from the concrete through the abstract to the "construction of a new form of concrete image" (Van Der Veer & Valsiner, 1994, p. 283). This conceptualization frees one to view therapy with adolescents in new ways. By granting the adolescent and the clinician the freedom to explore fantasy and creativity of experience as a developmental task, a developmentally appropriate position within the therapeutic process is assumed, one that utilizes the concrete-to-abstract-to-concrete continuum of the reworking of experience and relationship.

Self and Attachment

The idea that "other creatures have minds with points of view different from one's own" (Cavell, 2002, p. 807) develops from experiencing the world through modes of communication, at times imposed from without but often mutually derived. From infancy, the external world comes to the individual and compels the negotiation of meaning. Through this process, intentionality and shared meaning are constructed. Cavell (2002) argues for the final break from the view of early development as

> …exclusively internal, subjective, private…[r]ather: first there is the baby with its pains and pleasures, its early affects, and all its native talents for attachment. This baby is not yet a creature with thoughts. Then come, right away, communications with other persons about objects in a public world, mutual recognition that becomes more and more articulated, and out of this public affair, the slow advent of the subject with an inner world, of a 'self.' (pp. 812-813)

Interpretations of signs and signals occur for both the infant and her caregivers. However, the interac-

tions with the external world primarily propel the infant toward understanding a pre-established set of meanings. The argument that the external world provides the impetus and imposition of thinking that stimulates a later development of secondary process thinking, of questioning the intentions of others will be explored further. Each theorist featured here, I believe, presents ideas that are compatible with this philosophic framework. Theirs are attempts at refining and applying this general argument towards an operationalized psychology of interpersonal development and learning respectively.

Stern's view of the development of the self is rooted in an understanding of adaptive human development that oscillates between "points of connection and points of disconnection throughout life" (Mitchell & Black, 1995, p. 165). Stern focused on qualities of relating consistent with attachment theory that arise out of the developing domains of the sense of self. Stern argues for an organization of the self that develops through layers of experience, successively emerging, dynamically facilitating and interactive. This development is biologically and socially derived and guided by an infant's objective and subjective attempts at making sense of the world and its inhabitants. Stern posits that the self and other are differentiating from birth and cannot be disentangled from a process of increasing relatedness as opposed to individuation.

Stern's domains of self—emergent, core, intersubjective, verbal and narrative—are concerned with pre-verbal, non-verbal and verbal processes of personal meaning making. Stern challenges psychotherapists to engage with smaller behavioral and interactive patterns that become generalized into "ways of being with" as opposed to object internalizations. Within the construction of the intersubjective, verbal and narrative selves, the child is developing capacities for attunement of mind-states with others, sharable meanings through symbols and storytelling (Stern, 2000).

Bowlby conceptualized attachment as "an intense and enduring" biologically based, but subjectively experienced protection from danger and gratification of needs which structuralize into an overall style of relating. These early experiences develop for the infant an internal working model that remains consistent throughout the lifespan, "later influencing interpersonal perceptions, attitudes and expectations" (Wilson, 2001, p. 39).

Caregiver attunement and good enough attachment figures are key. Attachment theory argues that

despair is a resulting affect born out of neurophysio-logical dysregulation—a protracted experience of sep-aration and/or ongoing out-of-attuned caregiving—leading to neuronal organizational deficits and impaired capacity to self regulate. Ainsworth and others postulated that attachment experiences could be generalized into identifiable patterns—*insecure/avoidant, secure, insecure/resistant and disorganized/disoriented*—that were observable and predictive of later patterns of relationships (Wilson, 2001). These patterns of attachment and internal working models tend toward stability over time, operating outside awareness, thus making them change resistant (Fonagy, et al., 2002). Understanding the link between the person's attachment style as an internal working model and way of letting go following an irrevocable loss may help clarify an individual's bereavement process, and facilitate a way of distinguishing between adaptive coping and potential complications in griev-ing loss (Stroebe, 2002).

Longitudinal studies have derived further classifi-cations of histories of childhood attachment relationships: *secure/autonomous, insecure/dismiss-ing, insecure/preoccupied* or *unresolved* (Fonagy, et. al, 2002). While these categories generalize what is in effect the unique experience of the individual, they have facility when the aim is to gain clarity around how an adolescent may be struggling with relating in the present as past trauma continues to be worked out. Of particular interest to this discussion, narratives of the child who has experienced trauma or loss are characterized by "significant disorganization in attach-ment-relationship representation in semantic or syntactic confusions" (Fonagy, et al., 2002, p. 39). The *unresolved* attachment style is a kind of structuralized grief deriving from interruptions and/or prolonged failures of the establishment of the self in relation to a significant other. The concrete loss becomes abstract-ed into self-other-affect triad, or internal working model (Fonagy, et. al, 2002).

Stern's "ways of being with" and Bowlby's "internal working models" present bookends to a conceptualiza-tion of the complexities of the internal and external self in relation to others, that becomes established over time with repetition and reinforcement. The question then surfaces: what does one do with this conceptualization of the client's self in treatment? I assert Vygotsky and Winnicott provide a harmonious client-centered therapeutic approach that allows for the exercising of fantasy, creativity and thinking, which can recon-ceptualize for the adolescent ways of being that acknowledges loss and allow for emotional growth.

Zone of Proximal Development and the Holding Environment

Vygotsky argued that speech is a psychological tool that has several functions that are developmental, biological and social. Language development and cognition flow from thought, action and intersubjec-tive experience, which are meaning-seeking. Of the types of linguistic communication, egocentric speech is engaged in as a normative manifestation of deter-mining self in relation to the external world. Egocentric speech has a problem-solving character, and eventually becomes internalized over time although never disappears. The movement of ego-centric speech from the external to the internal and the resulting pre-eminence of social communica-tion—speech directed to others—build neatly into the progression and co-construction of Stern's verbal and narrative selves. Language serves as an interactive agent for the development of higher psychological functioning in that it symbolically represents a mean-ing beyond immediate self-directed desires (i.e., lower mental functioning). The shift in meaning occurs due to the presence of and interaction with a caretak-er and with the application of language (Northcut, 1992; Vygotsky, 1978).

The experience of a shift in meaning can also be facilitated via the zone of proximal development (ZPD). This is a social construct that represents the potential for development through collaboration with an adult or "capable peer" (Vygotsky, 1978, p. 86). The relevance of this dialectical and facilitating relational concept when applied to the therapeutic alliance is extraordinarily useful, particularly in light of the devel-opmental tasks of adolescence touched on earlier.

Winnicott's transitional experience was envisioned as facilitating a necessary transition between a child's sense of omnipotence and his objective reality. The process allows for the child to experience the limits and potentialities of both. According to Mitchell and Black (1995), Winnicott also argued that children do not transition from dependence to independence but "between two different modes of organizing experi-ence, two different patterns of positioning the self in relation to others" (p. 128). This transitional space was for Winnicott "a protected realm within which the creative self could operate and play," where the objective and subjective interact and transform the self (p. 128). In light of Vygotsky, Stern, and theories of working models of attachment, Winnicott's intrapsychic relational interplay takes on an amplified dialectical and developmental character.

Winnicott's therapeutic holding environment—the creation of a good-enough environment with minimal impingements necessary for the consolidation and emergence of true self—when combined with ZPD, creates a powerful mix of opportunities for the regeneration of personal subjectivity and scaffolding of interpersonal and developmental tasks which can create higher levels of psychological functioning and growth of the self.

A cautionary caveat given by Stern: in the therapeutic process, a clinician's developmental theories are generally kept "well in the background" (Stern, 1985, p. 257). Stern suggests that what the clinician and client are engaging in is a search for a "narrative point of origin," but rarely does one ever get back to an "actual point of origin." He also confesses that one works with "whatever metaphor offers the most force and explanatory power about the patient's life" (p. 257). Finally, and consistent with his vision, the actuality of developmental life events have less meaning to the client (and it should follow, to the clinician) than the sense of self-experience within the realm of development. Thus, Stern grants clinicians the necessary space when working with adolescents who may have a disorganized narrative resulting from trauma and an unresolved attachment style, to create a holding environment from the start in order to find the space and time for entry into the narrative origin of their experience.

The Case of Sam[1]

Sam is a 15-year-old male client who I saw individually throughout the course of my internship. Sam had been diagnosed with a non-verbal learning disability as well as AD/HD, combined type, and a mood disorder. His parents brought him in for treatment due to his failing school performance and his increasingly erratic behavior both at home and at school. Sam presents as socially isolated, depressed and anxious. His acting out is characterized by expressions of anger, grimacing, tics, tapping, and inappropriately knocking or throwing objects. What stands out diagnostically is Sam's particularly unique way of communicating, characterized by being conversationally out-of-sync, elliptical and at times disorganized and incongruent.

His parents divorced when he was four years old. His mother, whom he lives with, presents as overwhelmed and out of tune with the realities of Sam's current limitations. His father is remarried with an infant child. Sam has only sporadic contact with his father. This relationship is a source of distress for

Sam. When Sam's difficulties at school began to become more pronounced upon entering seventh grade, Sam's father attempted to intervene after a long period of detachment and distance. Sam's mother reports that his father began to take an authoritarian stance with Sam, insisting that Sam was being defiant and difficult. Although Sam has attempted to reach out to his father and his new family, his father regularly limits contact with Sam as a consequence of his erratic behavior and poor school functioning. Since the birth of his infant half-brother, his father has restricted Sam's access to both him and his half-sibling to an even greater degree.

Sam and his mother both indicate that the current state of his relationship with his father is part of an ongoing history of rejection and verbal and emotional abuse by the father toward Sam from the time Sam was a toddler. Always a behaviorally challenging and idiosyncratic child, verbal outbursts or hyperactivity by Sam were intolerable to his father. Not surprisingly, Sam, his mother and his teachers report that Sam has experienced peer rejection at school, due in large part to his impaired capacity to effectively express himself. He has few contacts with adolescents his own age outside of his family. Sam often expresses despair and anxiety over his problematic relationships with peers.

The origin of Sam's disordered and disorganized linguistic style is unclear—psychological testing to date has found no physiological or neurobiological impairments. In the context of social isolation and parental rejection, Sam is experiencing ongoing, unresolved loss, academic and social failures and a sense of communicative disconnection from the world.

Due to his unique use of language and the history of language functioning as an instrument of abuse, the role of communication is particularly relevant and challenging in establishing a therapeutic alliance and engaging clinically. For Sam, being understood while being emotionally safe has been crucial to our treatment relationship. We have metaphorically walked back through his memories of words used abusively by his father, the school, and institutions, spending long periods of time holding his confusion. Following Stern's hypothesis of a layering effect in the development of the domains of self, his sense of verbal self in relation to another seems to be the point of origin for Sam's difficulties that has impaired the later development of the intersubjective and narrative selves. Thus, our narrative point of origin seems to be around Sam's ability to express himself in the presence of another and to be understood.

As his clinician, I oriented to Sam around this need

[1]This client's identity has been altered to protect his confidentiality.

to be understood. His unresolved attachment style, characterized in part by his use of language, both verbal and non-verbal, may reflect the grief and loss at being chronically out of attunement with the external world from early childhood on. He talks of being "bewildered." He also talks about attempting to be "creative" when trying to connect to peers. When labeling his feelings he says "I feel emotional distraught" [sic] and "I've been tainted." He says his father has "defiant disorder" and his mother never understands him even though he tries and tries to explain his thoughts to her. Through reflective listening, we worked together to shift the meaning of his experience of the abusive relationship with his father and his struggles within a social context away from the splitting and projective mechanisms that are represented in his speech, toward a more forgiving and reality based view of himself. Our relationship—that of an adolescent male and a female adult therapist—provides an example for Sam of an adult-adolescent dyad that is more often than not successful, satisfying and emotionally safe where he is free to test out ideas and be creative in his use of language. For Sam, success in the realm of expression and shared meaning between himself and another is crucial to his treatment and ultimately for emotional growth.

Conclusions

The end result of mixing theories may be that the nature of their original meaning becomes diluted or even lost. The explanatory power of each of these models, however, compelled me to seek their synthesis. By no means complete, the presentation of this integrated theoretical approach is meant to elicit ways of seeing and gaining clinical understanding of the developmental underpinnings of the adolescent's experience. Further, it is an attempt at a method for therapeutic attunement to the particular and personal language which symbolizes and flows out of that experience. By integrating concepts of self and communication, the clinician will be better able to provide an avenue for the patient to process ongoing loss and its affective expression and a way of fostering psychological growth within the transition from childhood to adulthood—adolescence.

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What's Different about Working with Stepfamilies?

by Anita Bechtold

Abstract

This article explores the problem of adjustment to stepfamily life, and emphasizes ways in which treatment may need to differ for stepfamily members, as compared to interventions with birth families. The difficulties faced by family members, from subjective, gender-related, structural and life cycle perspectives are considered, and suggestions for clinical intervention are discussed. A list of books, websites, and support groups to use with stepfamily clients is included.

Introduction

Stepfamilies have become a familiar family form. One in three Americans is now a stepparent, stepchild, stepsibling, or some other member of a stepfamily (Larson, 1992). It is a family form in which adults, as well as children, may experience significant adjustment problems. For example, remarried couples with children are more than twice as likely to re-divorce as remarried couples without children (White & Booth, 1985), and adolescents in stepfamilies achieve academically no better than children in single parent families and significantly worse than children in first-marriage families (Jeynes, 1999). In addition, being in a stepfamily more than doubles the risk of juvenile delinquent behavior, compared to the risk for children residing with both biological parents (Pasley, 2000).

Many stepfamilies seek family therapy to deal with these adjustment problems. Both client and therapist need to be aware that the issues faced by stepfamilies are often distinct from those faced by traditional families. McGoldrick and Carter (1989) state, "Most people, including therapists, fail to recognize the need for an entirely new paradigm of family at remarriage to allow for the extremely complex new relationships and roles" (p. 399). Burt and Burt (1996) note, "To work successfully with stepfamilies, clinicians must have enough knowledge about how they differ from first-marriage families to validate these differences rather than view them as pathological" (p. 56). This paper will discuss the subjective experience of being in a stepfamily and the structural factors that characterize stepfamilies. It will then consider some principles and strategies for clinical intervention. Though the discussion will be limited in scope, it is intended to give clinicians ideas on authors, resources, and techniques for further investigation.

Persons-in-the-Stepfamily-Environment
The Subjective Experience

For many adults and children, the experience of being in a stepfamily is one in which basic social and emotional needs are not met, and fundamental expectations about family life are violated. Perhaps the most important reason this occurs is that people enter the stepfamily experience with expectations based on the first-marriage, traditional, nuclear-family model. Couples forming stepfamilies, experiencing the same euphoria as most couples at the time of their marriage, see themselves as able to swim any ocean, climb any mountain, or melt any hesitant stepchild's cold demeanor. Consequently, it is unusual for them to seek premarital counseling at this time. Parents generally do not talk to their own children about the changes occurring in their family, much less arrange for the children to receive guidance from someone with a larger perspective on stepfamily realities. A graduate degree in social work, psychology, or counseling does not immunize one against these difficulties. John and Emily Visher (1982) and Roger and Mala Burt (1996), among them, a psychiatrist and two Ph.D. clinical psychologists at the times they formed their stepfamilies, all describe being unprepared to deal with the intensity of the challenges they faced in their remarried family lives.

David Jacobson (1995), an anthropologist, describes the process of stepfamily formation in terms of family cultures. He describes the way a newly married couple carries out the task of establishing a family culture which reflects their mutual influence, and the way in which that culture becomes the definition of "normal" for children born into their household. In fact, a couple's marital world is strengthened and clarified through the process of parenting their children. By choosing what shared values and priorities

to demonstrate in their interactions within and outside of their home, they and their children gain a clearer sense of what their family is about.

A remarried couple has the same task of creating a marital and family culture as the first-marriage couple does, but the process is more complex, as it requires the individuals to "disassemble the microculture of their first marriage…" (Furstenberg & Spanier, 1984, in Jacobson, 1995). Jacobson describes this process as a cognitive and emotional reorganization. Independently and together, husband and wife reevaluate habits, attitudes, and activities typical of their earlier marriages, often discarding them in favor of new patterns and approaches that seem to fit the evolving new marriage. Jacobson also suggests that a new worldview or household culture may be developed between marriages, which then must be relinquished or transformed in the new marriage.

Goldner (in Jacobson, 1995) describes the merging of family cultures in remarriage as characterized by stress and resistance, and as "an inherently disorganizing experience that involves the total transformation of the individual's intimate world." Jacobson sees the marital couple, working on the construction of a marital world, as inclined to exclude others in the process of defining its boundaries. While during the early phase of a first marriage this frequently takes the form of excluding family and friends, in the remarried couple the most notably excluded persons may be the children (Berger, 1998). Alternatively, it may be the stepparent who is excluded, as the biological parent and children continue to live in their already-established household culture. Such a situation may undercut the successful establishment of the new marriage. The exclusion of children may occur not only because the couple is focusing on the marital relationship, but also because the children may be seen as representatives from an old and now rejected marital world. They are unwelcome ties to a different family culture (Jacobson, 1995).

As a result of this experience of "culture shock," stepfamily members may have the experience of not being "at home" in their home. American culture offers us a cultural ideal for what a "home" should be. This ideal suggests that a "home" should be a place where one can relax and in which one is confident that one belongs. A "home" should have a flavor to it. It is the place a person knows the best. There should be a sense of belonging, a sense that, for better or for worse, it is center of the universe.

In the midst of stepfamily adjustment, a family member may not feel this sense of being "at home" anywhere. The need to have a sense of belonging to a family group is powerful and fundamental, but it is rarely met in the early stages of stepfamily formation (Papernow, 1993). A stepmother said:

> It isn't that you feel uncomfortable for three hours on Monday, are rejected by a colleague at work on Wednesday, and feel as though you don't belong in the group at the party on Saturday. It's all those things at once, each day when you get up and go to breakfast with the kids and their dad, when you hear the phone ring only for your spouse, when you greet your stepchildren after school with no response from them, and spend the evening wishing you'd be welcome to help with homework or to play a game. *You don't go home to recover from the slights of the world; you feel slighted when you do go home* [Italics added]. (Visher & Visher, 1996, pp. 29-30)

It is the author's experience that stepfamily members are rarely able to gain the perspective to describe their experience as "culture shock." They know only that they are terribly uncomfortable, and often look for someone to blame. Children, having only experienced one family culture up to this point, have no way of articulating what is happening to them. Even therapists, without the "family culture" perspective, may be alarmed by the intensity with which the family members are reacting to the changes (Burt & Burt, 1996).

Unrealistic expectations are a major cause of difficulty for these families (Berger, 1998; Burt & Burt, 1996; Papernow, 1993; Visher & Visher, 1996). Stepparents may expect themselves to love their stepchildren, or to be loved by them, from the start. Biological parents may expect the same thing of the stepparents and of their children. Both husband and wife may expect a sense of *family* to be established quickly. Both may expect that their stepfamily will soon feel, act, and look like a first-marriage family. Adults blending families may expect that the children will get along well after only a short adjustment period. Husband and wife may both expect that a non-custodial parent will "back off" and allow them to act as though they are the child's only family. One spouse may expect the other to understand financial

obligations to first-marriage children. The other may expect that financial obligations to the new family will come first. Some family members may expect step-grandparents and stepgrandchildren to accept each other easily. Often, and most unrealistically, family members expect that what seem like trivial details to them (how the towels are folded, who gets to throw "junk mail" away, whether people say "good morning" to each other routinely or not) will seem trivial to the others as well, and what seem like important issues to them will seem important to others as well.

Gender Role Issues

The expectation is that women will take responsibility for the emotional and relational life of the family. It is ubiquitous, culture-wide, and indeed, multicultural (Carter & McGoldrick, 1989). This traditional expectation may be particularly unrealistic with regard to stepfamilies. It may prompt the wife to attempt to control relationships between her husband and his children or her children, or between siblings or stepsiblings. She may end up vying for this control with her husband's ex-wife, or an older daughter or stepdaughter. This struggle may give rise to triangles that would not exist in a first-marriage family, and may serve as an irritant for relationships already difficult to establish or maintain, such as those between stepmother and stepdaughter, or between biological mother and stepmother. This taking of responsibility on the part of the wife may also prompt her husband to step back from his relationships at a time when his own children have a strong need to connect with their father. Experienced therapists in this area recommend that the nurturing role and the disciplining role are best maintained by the biological parent of a given child, regardless of the parent's gender (Kelly, 1995; McGoldrick & Carter, 1989).

Gender role issues such as these, the reliance on the first-marriage family model, and a lack of other models, can all contribute to an experience of considerable role ambiguity for stepparents. In addition, a lack of cultural norms related to names, definitions, and relational expectations can give rise to significant stress and confusion over how to be a good stepparent (Berger, 1998).

Children: The 3 Ls

While the stepparents are trying to figure out just what a good stepparent is or does, the children in remarriage are experiencing what Visher and Visher (1996) refer to as the "three Ls": loss, loyalty conflicts, and lack of control (p.150). All three concerns are important for stepchildren in general. Issues of loss may be primary for the youngest, while pre-adolescents often experience intense loyalty conflicts, and adolescents find their lack of control over the changes in their lives the most difficult.

Loyalty conflicts may be present in all stepfamilies, even when the absent parent is deceased. A child may experience a sense of disloyalty to the remarried parent if he does not easily connect with the stepparent. On the other hand, it may seem disloyal to him to accept or develop affection for the stepparent; some children feel so much guilt and anxiety over their developing affection for a stepparent that they act rejecting toward that stepparent as a defense. This may create an unsettling situation in which the more effective the stepparent is in connecting with the child, the more rejecting behavior the child displays. It is important, also, to recognize that both children and adults bring to the stepfamily-formation process an experience of loss in family relationships that are often both profound and fresh. Children are almost always carrying some unresolved grief over their parents' divorce (Kirk & Herman, in Visher & Visher, 1979). Other losses by family members may include loss of a spouse or a marriage, of a dream of a lasting future together, of a family unit, of the daily presence of a loved parent, of a particular home, a daily routine, a neighborhood, a school, or a group of friends. For a child who lives with a single parent for an extended period after her parents separate, a time some refer to as the "foxhole" period (Browning, 1994), remarriage may mean a loss of the "you and me against the world" bond that developed during that time.

An individual in a step family, then, may be characterized as dealing with unresolved grief, culture shock, possible loyalty conflicts, and his own and others' unrealistic expectations. In this context, satisfying normal human needs for a sense of belonging, of being loved and cared about, and of having some personal autonomy and sense of control can be very difficult (Visher & Visher, 1996):

> The many interpersonal differences that surface every day can seem inconsequential to outsiders. However, until negotiation of

these differences and the passage of time lead to a sense of familiarity, all the family members are likely to feel unappreciated, out of control, and as though they do not belong. (p. 28)

The stresses associated with a failure to meet these needs can result in symptomatic behaviors for one, most or all members of the family. Given that intense feelings are a normal response to extreme stress, therapists are encouraged to view the sometimes intensely emotional behaviors exhibited by these families as normal (Burt & Burt, 1996).

Structural Issues

In addition to the subjective experiences of stepfamily members described above, structural factors inherent in stepfamilies strain the newly-forming family system. Browning says that while therapists in first-marriage families generally assume that child distress is a signal of marital distress, this assumption is unwarranted in stepfamilies. It may be due simply to stepfamilies' unique structural factors (1994).

A major structural factor relates to the ambiguous and permeable boundaries of the stepfamily. In a first-marriage family, all members would likely describe their family as having the same list of individuals. This congruence in their perception of family membership strengthens the family boundaries. However, in a stepfamily, the children often have dual family membership. In fact, there may be two or three subsets of children, all with a different list of family members. In addition, at least one biological parent, even if deceased, exists outside the family structure but remains important to a child in the family. Frequently this person has some relationship with, some responsibility for, and some rights concerning one or more of the children. As a result of this incongruence in family membership lists and the potential role of biological parents, the boundaries of the family are often experienced as weak, inconsistent, or unclear (Visher & Visher, 1979).

One boy, living with his mother and stepfather, was told that a family party was planned. He asked if his father would be invited. They said, "No, it is just for our family." He replied, "But Dad is part of my family!" (Burt & Burt, 1996, p. 40). Both children and adults may find it painful to deal with these ambiguities.

The fact that one or more parent-child relationship predates the couple relationship, which has not had time to develop without children, is another potentially problematic structural feature. This gives the parent-child relationship a strength and a history that the marital dyad will not have, at least for some time. In a first-marriage family, the marital dyad creates a context for the rest of the family relationships. It occupies a position of primacy. In stepfamilies, the marital dyad may be experienced as existing on the same level as a sibling relationship. It may be just another dyad fighting for time and other resources within the family unit. As a result, the adults may feel they have to decide which comes first: the marriage or the parenting relationship. Often, a remarried biological parent has the sense that "since the kids were here first and, after all, they're kids--they're dependent and vulnerable," the parent-child relationship has a higher priority than the marital one. A stepparent, accustomed to a more traditional family model, may see it differently and assume that the marital relationship will be the axis around which the family revolves. The establishment of a strong couple bond under these circumstances is challenging (Visher & Visher, 1979).

When individual, dyadic, or group boundaries are ill-defined, triangles are likely to form. McGoldrick and Carter (1989) state that in addition to the standard triangles that form in first-marriage families (parent-parent-child; parent-parent-grandparent), they have encountered additional triangle types that may form in stepfamilies. These include the marital couple plus the ex-spouse; the pseudomutual remarried couple (acting as a unit in the triangle); one ex-spouse, and a child or the children as a group; husband, wife, and a child of one spouse; the pseudomutual remarried couple, his children, and her children; and finally, a parent, the natural children, and the stepchildren. The sheer number of people, along with the number of types of relationships, can create a level of complexity that is challenging for many stepfamilies to handle.

One consequence of these problematic structural features is the possibility that financial or legal issues may arise in a stepfamily that would be unlikely to surface in first-marriage families. These issues can add significant complexity to expectations and decision-making within the stepfamily unit. Legal obligations to a former spouse or children of the first marriage may give rise to resentments on the part of either spouse (Visher & Visher, 1979; Burt & Burt, 1996; Kelly, 1996). Successful stepfamilies inter-

viewed about their experiences stated that negotiating over family finances was a key achievement (Kelley, 1996). Legal issues, particularly adoption (Visher & Visher, 1996), insurance, pensions, and wills (Burt & Burt, 1996) can be quite stressful for stepfamilies.

Family-Life-Cycle Issues

In addition to the individual and structural issues facing the stepfamily, concerns around the family-life-cycle stage may be significant. In a stepfamily, individual-, relational- and family-life-cycle stages may be highly incongruent (McGoldrick & Carter, 1989). For example:

- A man with children in the "launch" stage may marry a woman with younger children in the "family building" stage. This difference in their family-life-cycle stages may create conflicts around priorities, and an unusually long list of family concerns to which the parents need to attend.
- A stepfamily in the process of forming needs time together to get to know each other and establish effective new rituals and procedures. If some of the children in this family are adolescents, with a developmental need to separate from family, it may be difficult to arrange sufficient family time for this formation process.
- The marital dyad may need a strong dose of "couple alone time" in its early phase, which may conflict with a need for whole-family time on the part of one or more of the children.

Implications for Treatment

Therapists who work with this population suggest that clinicians need to resist ascribing pathology to these often intensely emotional clients (Visher & Visher, 1996). In working with a client who is grieving the recent death of a spouse, clinicians would not describe an intense emotional response as a sign of pathology within the client, but would see it as a normal and appropriate response to a difficult situation. Working with stepfamilies requires a similar mindset:

> If a therapist does not assume that the family reactions he or she is seeing are normal, it is easy to diagnose a borderline personality, a neurotic process, or character disorders. In fact, we view mild reactive depression and anxiety as normal reactions to how out-of-control stepfamilies often feel. (Burt & Burt, 1996, p. 19)

Given this high level of affect, the question of who should be seen in therapy takes on great importance. The term "suprafamily" connotes a group of people all of whom might be considered "part of my family" by anyone in a household. This might include, for a given child, the parent and stepparent he lives with, any siblings and stepsiblings, a nonresidential parent and stepparent, if any, and even potentially grandparents or stepgrandparents (Visher & Visher, 1996). In the early years of family therapy with stepfamilies, some therapists brought in all members of a suprafamily for sessions (Burt & Burt, 1996). While there might be specialized situations in which this strategy is appropriate, the level of anxiety produced in such a gathering can make it difficult for anything useful to be accomplished, and Burt and Burt (1996) advise against this approach as a general rule. However, looking at a family through the lens of family therapy is not so much a technique as it is a mindset and a theoretical framework. Looking for systemic aspects of problem maintenance rather than only intrapsychic aspects is useful and, as Bowen insisted, can be done even with only one member of the family (Nichols & Schwartz, 2001).

Family members who may be seen in therapy include one or both of the adults, adults with one or more children, or any subsystem of the family. A therapist may mix types of sessions, seeing the couple twice, then perhaps a child alone, then a parent/child dyad, and so on. Seeing a subsystem in therapy is one way to strengthen the boundaries of that subsystem, and some family subsystems will need their boundaries strengthened more than others. Often in the early stage of stepfamily formation, the marital dyad will need to be strengthened. The marriage has begun without the luxury of a "couple only" phase as first-marriage couples do, and is coping with numerous extra stresses in its early years. It needs support to weather this period (Visher & Visher, 1979; Burt & Burt, 1996). As Booth and White's (1995) study suggests, many marriages do not last through this adjustment phase.

Children who were previously quite open with their biological parent might be hesitant to open up in the new family culture, in which the rules

are not yet well established. Therapy with children alone may be necessary to get a child's concerns on the table, and follow-up therapy with the biological parent or the marital dyad may enable the child to express concerns directly to the adults (Herman, in Visher & Visher, 1979).

Laying the Groundwork

As suggested above, it is reasonable to expect that members of the family may feel unappreciated, out of their element, and out of control. It is difficult for anyone in this situation to begin extending empathy toward other family members until she feels heard and validated herself. Giving each member of the family the opportunity to describe the family situation as he or she sees it, without allowing discussion by other family members at this point, can be a good starting point. It can give the therapist an opportunity to model empathy, enable family members to feel heard, and crack open the rigid view of the family situation that members may hold as individuals (Papernow, 1993). Bowen advises limiting the conversation during family sessions to interactions between the therapist and individual family members, so as to keep the anxiety at a low level (Nichols & Schwartz, 2001). The larger the group, and the more subsystems that are represented, the greater the potential anxiety and the greater the need for crosstalk to be controlled.

Using genograms is also an excellent tool with stepfamilies. A genogram is a tool that is less emotionally charged than a stepfamily's conversation in therapy might be. It allows family members a visual experience of the complexity of their situation, and as such may help them to recognize just how big the task of adjustment is, which may help them establish more realistic expectations. It also facilitates discussions of family history in families with a low tolerance for discussing the past (Visher & Visher, 1996). In addition, many troubled stepfamilies have a tendency to focus their attention solely on an "identified patient" (Visher & Visher, 1979). Because of this, it might not occur to them to share important family information, because they see it as irrelevant: "We KNOW what the problem is; it's Johnny!" Burt and Burt (1996) strongly recommend using genograms with stepfamilies. Genograms may highlight this type of important but omitted data.

Developing Empathy, Problem-Solving Skills, and a Tolerance for Ambiguity

After the data gathering involved in making a genogram and some initial work allowing family members to voice their own views about the family situation, the therapist may be able to make progress in helping family members to share their feelings and experiences with each other. While empathizing with one's step-relatives or spouse may be challenging for many clients, it can be done, particularly in a context of empathy on the part of the therapist. Therapists may coach clients in specific behaviors, such as the "rote empathy" technique, designed to elicit overt empathic behavior. Once a step in the direction of empathy has been made, the family's problem-solving efforts will be much more fruitful (Papernow, 1993).

One pertinent clinical goal of a more psychodynamic nature may be facilitating the client's tolerance of ambiguity. Younger children, in particular, may have a difficult time with the idea that things done differently in their two households are not "right" in one house and "wrong" in the other, but simply different:

> I find the children concerned about which set of parents … is telling the truth or is "right," even in families where there is a minimum of conscious or unconscious parental manipulation of children. I find this has more to do with the child's ability to tolerate ambiguity than it has to do with conflict between the two sets of parents. There is almost always some anxiety reduction in the child when he comes to understand there may be two points of view and that both points of view may be valid. (Kirk, in Visher & Visher, 1979, p. 182)

Stepparents who are trying to be patient while their stepchildren warm up to them may have difficulty with the ambiguity of their "not an insider, not an outsider" role (Papernow, 1993). If ambiguity is more easily tolerated, a significant source of anxiety will be eliminated. To do this, the author contends that parents and children both need to decrease black-and-white thinking; an appropriate goal is to see multiple options, shades of gray, and degrees of acceptability.

Psychoeducation

Another important element of the work is psychoeducation, a feature described by stepfamilies as one of the most useful elements of their therapy (Burt & Burt, 1996; Pasley, Rhoden, Visher & Visher, 1996). Therapists can highlight the unique challenges stepfamilies face, and the need to readjust their expectations of instant love and closeness. Discussion of role ambiguity and permeable family boundaries can help normalize stepfamily stresses. The psychoeducation component may also include communication, negotiation, and conflict resolution skills, such as teaching parents how to conduct family meetings. Burt and Burt (1996) report great success with teaching remarried couples to do "triage," dividing their concerns into three categories: things that will probably get better even if they do nothing, things that will get better with attention, and things that probably will not get better no matter what they do. Once this is done, couples can see where to place their energies.

Some stepfamilies have a very difficult time supporting the relationship between the children and their other parent, and may even try to cut this relationship off. While this is not as common today as it was in the past, the issue still arises, and may even be part of an adult's barely-conscious agenda. For these families, an essential aspect of psychoeducation is sharing the results of several studies suggesting that children function far better if they continue to have consistent contact with both of their biological parents (McGoldrick & Carter, 1989).

Seven Phases of Stepfamily Development

Papernow (1993) has designed a comprehensive schema describing seven phases of normal stepfamily development which can be useful in therapy with clients. Identifying where their family is in the process can guide adults, particularly those who are not naturally reflective, to begin to get some perspective on their situation. It can serve powerfully to establish more realistic expectations.

Papernow (1993) describes the "Early Stages" (Getting Started vs. Getting Stuck) as including Fantasy, Immersion and Awareness. Then the family moves to the "Middle Stages" (Restructuring the Family), which includes Mobilization and Action. The "Later Stages" (Solidifying the Stepfamily) include Contact and Resolution. When couples learn that the name of the first phase is "Fantasy," it underlines the idea that not only were their initial expectations of stepfamily life probably unrealistic, but that this is a normal starting point for most stepfamilies.

Papernow (1993) states that most families take at least five years to work through these stages. Some take much longer, however, and many never make it to the "Resolution" phase. Papernow tells stepparents that when they arrive at the "Resolution" phase, they will have finally reached the goal of becoming an "intimate outsider." While this is not seen as welcome news by many stepparents, Papernow tells them that "intimate outsiders" can often serve helpful functions that parents cannot.

Papernow's (1993) seven phases may also serve as a useful outline for the psychoeducational process. Papernow has identified tasks associated with each phase, as well as therapeutic interventions that are most effective at various phases, so a therapist may gain insight into the family issues and appropriate interventions by using the seven phases as an assessment tool.

Discipline

Discipline is often a difficult issue for stepfamilies. The consensus, not just among clinicians (Burt & Burt, 1996), but among healthy stepfamilies who were asked what advice they would give to newly-forming stepfamilies (Kelly, 1995), is that the family will function better if the biological parent takes responsibility for the discipline of his/her own children. When children respond well to discipline, it is more a result of the strong, healthy relationship they have with the disciplining parent than because a consequence was especially well chosen or timely. Without the establishment of a solid personal bond, efforts at discipline on the part of the stepparent will range from ineffective to disastrous. The stepparent needs to wait until such a bond has formed, which will probably take two years or more (Papernow, 1993).

Stepparents may be frustrated at the suggestion that they wait two years to share in the discipline of their stepchildren. To cope in the interim, some biological parents establish a clear set of rules with their children, and then "deputize" the stepparent to enforce them if the need arises in the parent's absence. The idea is that the stepparent is not making decisions about discipline but

merely carrying out the biological parent's decisions. This is more likely to be accepted by the children. Also, parent, stepparent, and all children may express their feelings, ideas, and needs at family meetings, which enable stepparents to feel as though they have some input into the rules of the house (Kelly, 1995).

A New Family Identity

In addition to supporting individual and marital dyad boundaries, the stepfamily as a group also needs support in developing a clearer sense of its identity, its family culture. A new stepfamily needs to create a sense of its boundaries – but boundaries in stepfamilies are dynamic and ambiguous (Berger, 1998). The ideal stepfamily boundaries are permeable to allow children to move in and out without threatening the family identity by doing so (Visher & Visher, 1996). One important task for the therapist is to assist the family in defining new traditions and rituals that fit their unique situation (Berger, 1998). These can be related to special events such as holidays or birthdays, but they can also be more related to the everyday. Obviously, it takes time for stepfamily members to get to know each other enough to know what will work as a family tradition, and adults who try to impose new traditions on other family members while they are still feeling like "strangers in a strange land" will not succeed. Some of the best traditions emerge spontaneously, but someone needs to notice that they are emerging and insure that they stay in place. The author contends that if the therapist helps the adults to be aware of the importance these new traditions can play, they are more likely to follow through. As time passes and more familiarity develops, traditions are not as difficult to identify or establish.

A therapist can also assist the stepfamily in helping the children to integrate the reality of their "dual family membership" into their individual identities, strengthening individual boundaries in the new context. For example, in one family with whom the author is acquainted, a "Book about Me" was made for a preschooler, including photos of both homes, both addresses and phone numbers, all parents, stepparents, siblings, stepsiblings, grandparents, and stepgrandparents, as well as the child's daycare center, pets, and playmates.

Persons-in-the-Stepfamily-Environment

In summary, stepfamily members often feel hopeless, helpless, alienated, and "stuck" during the early phases of their development, and often much longer. The implications of this distress can be far-reaching. Clinical social workers who are knowledgeable about the subjective experiences of stepfamily members and the structural challenges their families face have an opportunity to provide these families with support in profound ways. They can do this by assisting stepfamily members in relinquishing their unrealistic expectations, coming to know and accept the new reality of their family life, and crafting new relationships for which they have few models. Creative problem-solving is an essential strength of a good clinician and a powerful antidote against the "stuck" experience of many stepfamilies. Connecting families with support groups and other resources can be a lifeline. The help clinicians can provide, if they are knowledgeable about these issues, can be of immeasurable value for all members of stepfamilies, and for the society around them.

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Resources to Share with Clients

1. Stepfamily Association of America, support groups, website: www.saafamilies.org/, and their short publication designed for stepfamilies, entitled *Stepfamilies Stepping Ahead* (Burt, M., Ed., 1989).

2. Stepfamily Foundation website: www.stepfamily.org

3. *Developing Healthy Stepfamilies,* by Patricia Kelley (1995) based on interviews with 20 well-functioning stepfamilies; not written for stepfamilies, but sharing excerpts with clients may be helpful.

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On Roses and Rationing: The Economics of Health Care Access

by Susan E. Sheehan

Abstract

Health care in the United States has always been rationed. Such rationing is both an economic reality and a social responsibility. This paper argues that while the concept is typically renamed in order to make managed care somewhat more palatable, rationing remains a fundamental tenet of the U.S. health care system. An analysis of literature in the fields of managed care and social work ethics is used as the basis for a discussion of this rationing and of social workers' role in its wake. Health care rationing – and its current iteration, managed care – are shown to be neither good nor bad, but rather tools to be managed carefully by social workers. Simple suggestions are offered for social workers' effective intervention in the health care delivery system.

Introduction

Health care in the United States has always been rationed. Rationing implies a controlled limitation of what is needed for survival that most people are loathe to consider as a component of the health care delivery system. It sounds so terribly un-American. This article will argue that social workers have historically participated in seeking more equitable rationing of scarce resources within a capitalist system (Specht & Courtney, 1994), and in securing the best possible outcomes for both individual clients and the communities of which they are a part. In most regards, health care resources are not conceptually different; medical interventions are scarce and choices regarding their allocation will be made by patients and the health care system itself at myriad points. The difference lies in the fact that when health care is being rationed it is effectively implied that some American lives are deemed more expendable than others. Social workers must be actively involved in identifying the issues, in defining the variables, and supporting their clients – here also patients – in navigating a complex system of care.

Certainly, rationing's pejorative connotation has necessitated its being renamed. But like the proverbial rose, rationing is rationing regardless of what it is called. And rationing has been called many things. To explore the notion of rationing it is instructive to consider some of those things by which the American public has come to accept what they might believe they would never condone: the "rationing" of health care. Of the roughly 120 terms in the glossary found in one U.S. health care system text, 75% could easily be redefined using the word "rationing," although that word is nowhere to be found (Jonas, 2003). Some of the more obvious and often used euphemisms include the following:

- *Gatekeeping* refers to any operation that monitors (and restricts) access to care (Jonas, 2001, p. 70; Mechanic, 2001).
- *Utilization* reviews are economic analyses of health care choices (Davidson & Davidson, 1998).
- *Diagnosis-Related Groups* (DRGs) are 468 Reagan-era formulas to determine at what level medical care is reimbursed (Moniz & Gorin, 2003).
- *Managed Care* by virtually all definitions is at its core rationing (Allbrecht, 2001; Eastman & Eastman, 1997; Jonas, 2003; Kapp, 2001; Rosenberg, 1998; Vandivort-Warren, 1998).

Rationing can be conceptualized as an economic reality or a social responsibility. When the discussion is of health care rationing, the two intersect. In other words, it is useful for the purposes of this discussion to review "Economics 101" as well as "Social Work 101."

On Economics 101

Americans have a reputation for trying to live life without limits. Cars are big. Homes are big. Business is big. Health care is both big business and a big social and economic problem. This problem emanates from basic economic principles of supply and demand and limited resources. In terms of health care on both macro levels (national policy where social workers might serve as lobbyists, advisors and expert witnesses) and micro levels (management practice and individual choice where social workers most routinely find themselves in agency and health care casework), the principles of supply and demand

assert that in a free market the quantity of a commodity depends upon the demand for that commodity. Here the commodity is health care. This would be simply a descriptive formula if it were not for the intervening reality of limited resources. Most of the U.S. health care system operates in a free market economy where profit is the primary motive driving the industry. In this free market economy, the price of a commodity (health care) will rise until the demand for that commodity is sated. Where the commodity is a luxury item like designer shoes or a substitutable item like a tastier loaf of bread, this again would be simply a descriptive formula. But when the commodity is health care and, therefore, effectively means human lives, the discussion must move beyond description. Given the reality that *everyone* eventually experiences a health care need, eventually the resources of the system *will* be allocated according to formulae explicit or implicit. This allocation is rationing.

Even in this land of big and plenty there will *never* be enough health care to stave off illness and death. Technology has limits. One of those limits is dollar cost (Abraham, 1993). With pharmaceutical companies advertising that they will be able to cure all ills (Lown, 1999; National Association of Pharmaceutical Companies, 2003) and physicians untrained to confront death (Kapp, 2001), the American public is naturally loathe to accept that some things cannot be cured and that death is inevitable. Some suggest that there *should* be limits on certain radically expensive interventions of limited efficacy (Abraham, 1993; Callahan, 1999). Yet most admit that if the patient in question were dear to them they would feel otherwise. Given limited resources, all parties within the national health care system must make choices about how to allocate the health care resources that they control.

Decision makers include the federal government whose allowance of extraordinary spending has not proven to increase the quality of U.S. health care (Bottles, 2000; Reay, 1999). There are currently 281 million Americans (Jonas, 2003), almost 50 million of whom are uninsured and another roughly equal number are underinsured (Karger & Stoesz, 2002). There are some 1,000 managed care organizations whose benefit plans effectively serve as health care proxies (Agrawal, 1998; Mechanic, 1999). The employers who contract for their services are also economic decision makers. Hospitals and physicians - who some argue are the ones to render the ultimate

decisions (Agrawal, 1998) - and consumer groups which include social workers, complete the cast of characters within the health care system (Keigher, 1997). Some believe that the best option is interdisciplinary collaboration (Abrahamson & Mizrahi, 1996; Keigher, 1997). Others conclude that the solution is to entrust more decision-making to those receiving care – to the patient (Havas, 1998; McBride, 1997). Of course, there remain millions who are not privileged to make those decisions by virtue of living without health insurance in this country.

If the complexities of the national health care system could ever be reduced to a single notion, that notion would be *access*. Access can be understood in myriad ways. The two broadest conceptualizations are access to a particular facet of medical care and access of a particular population to any care at all. For reasons stemming from the basic elements of economics discussed earlier, access by any definition is as it has always been - limited. Even quality of care cannot be logically considered absent access to that care. Of what use is a state-of-the-art imaging center to a population whose managed care plan severely restricts use of that technology? And what impact will a public aid clinic boast if it is located far from public transportation routes within its catchment area? Ultimately every combination and permutation of resource allocation is made for the purpose of rendering health care accessible. It is rationed. It always has been. It always will be.

Havas (1998) identifies managed care as "what happens on the way to not providing a national health care policy" (p.75), and others would certainly agree that the reactive quilting that constitutes what we refer to as the U.S. health care system is far from systematic (Albrecht, 2001; Kohn, Hasty & Henderson, 2002; Lown, 1999). Many point out that managed care is simply a new name for an old reality. Now, however, an ever-increasing proportion of middle class Americans are confronting the limitations of health care for the first time and politicizing widespread discontent (Friedman, 1997; Havas, 1998; Lown, 1999; Mechanic, 1999). Still, in a free market economy, "one person's rationing is another person's income" (Friedman, 1997). This, after all, is in part why managed care companies came to exist. And given their existence, Siskind (1998) describes managed care organizations as an "insurmountable opportunity" that we might do well to learn to work within. Others argue eloquently that managed care is

ethically flawed (Davidson & Davidson, 1996; Galambos, 1999). Buchanan (1998) asserts that rationing is not conducted according to principles of justice despite his conviction that the notion of rationing itself is tenable. Rosenthal and Newhouse (2002) concur. To others, rationing is construed as beyond tenable and the reasonable basis for what is conceived as "sustainable health care" (Callahan, 2001; Jameton & Pierce, 2001). One enlightened physician points out that "[w]hen death is the inevitable result of a chronic and incurable disease, it is often kinder not to impede it with heroic measures but to manage its approach with common sense and compassion" (Lown, 1999).

On Social Work 101

The World Health Organization (1946) definition of health is oft-quoted perhaps because of the eloquence of its charge: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p.100). Whatever health is understood to include as "well-being," it is certainly the absence of disease or infirmity. But it is naïve to think that *anyone* privileged to live very long will escape disease or infirmity. As sure as birth and death, these are part of the human experience. It is the role of social workers to support people as they manage *all* of life.

On a personal economic level, health management impacts social workers in terms of their remuneration. That means that there is some new attention being given to the mechanics of social workers competing in the health care marketplace (Gibelman & Whiting, 1999). On a broad level, the NASW Code of Ethics charges social workers to minister to the disenfranchised (NASW, 1996). In this country, the disenfranchised are invariably either without health insurance or without adequate health insurance. More specifically, the tenets of managed care impact social work ethics in terms of confidentiality, informed consent, self-determination, fiduciary responsibility, and the primacy of the individual over the system such that they coalesce to resemble a Venn diagram on steroids (Davidon, Davidson & Keigher, 1999; Eastman & Eastman, 1997; Galambos, 1999; NASW, 1996; Schneider, Hyer & Luptak, 2001). Each social worker must frame their professional practice and allocate their finite resources within that practice. This is yet another illustration of how health care

rationing impacts the social work community.

When the NASW Code of Ethics (NASW, 1996) addresses cultural competence, it is understood to refer to the ability to understand the community which informs clients and in which those clients, in turn, live and move and have their being. But in the same way that rationing has been broadened in this paper, it is useful to expand social workers' concept of culture. Health care is characterized by a unique and increasingly complex culture. The same caveats that the NASW codified regarding communities of heritage might well be extended to include communities of health. We are unlikely to be able to effectively serve clients with meaningful interventions if we are not committed to influencing the policies which impact their communities (Davidson & Davidson, 1998; Reamer, 1998). Social workers are unlikely to be influential policy makers or social advocates if we are not also cultural insiders.

On Managing Care in an Era of Imbalanced Rationing: The Challenge for Medical Social Work

In advocating for individual clients as well as supporting broad policy change, some easily implemented suggestions are offered for social workers working within the health care field, or for those supporting clients in their interface with the health care system. Everything reasonable must be done to secure basic health care for clients. This demands that social workers be familiar with resources available to those who are able to navigate the systems' labyrinth. These resources may include pharmaceutical companies which offer drugs at no cost, medical specialists who provide some pro bono services, entitlement criteria for hospital-based and free-standing clinics, as well as for ancillary services like transportation, meal delivery, and medical supplies. Additionally, social workers must resist the systemic pressure to offer less attention to the medically indigent. In the responsible use of scarce health care resources, clients must be coached in their rights to self-determination and their attendant right to opt for palliation rather than technologically intense medical care. Before a health care crisis emerges – and eventually it will – clients must be encouraged to prepare and appropriately file legal documents, such as Advance Directives and Living Wills, in order to minimize the likelihood that excessive resources will be used in end of life care.

Policy is a standard response to an issue. Here the issue is the tens of millions without health care in the U.S. The policy response may be formalized as law (like the proposed Clinton Health Plan) or embodied in the traditions of an agency (like the routine prioritization of insured patients in hospital ERs, despite the tenants of the Emergency Medical Treatment and Active Labor Act (Pear, 2003)). Programs develop within the framework of policy. Social workers serve clients with interventions in the context of those programs. For this reason alone, it behooves social workers to actively participate in the creation – or *re*-creation – of policy.

There will always be inequities in material wealth. Nonetheless, it is proposed that the fulcrum of rationing that balances managed care be shifted towards meeting the basic needs of the medically disadvantaged. This is not to suggest that there will ever be a *purely* socialized health cared delivery system in this nation so committed to entrepreneurship and the market economy. It is to suggest that it is morally – and economically – untenable to put exorbitantly high dollar values on some American lives while others are effectively deemed expendable (Kapp, 2001; McBride, 1997; Mechanic, 2001). The U.S. Supreme Court and the State Constitutional reviews of every state in the Union have determined that health care is not a basic right (Saltzman & Furman, 1999). But the courts cannot determine what is conscionable for this wealthiest of nations, for any of us who have chosen the profession of social work, nor for how we will function under the U. S. Constitution and the health care system.

In closing, it is worth noting that rationing in health care is both addressed in the press and academic journals by those who are educated, employed and emancipated; the disenfranchised are by definition without access to the most erudite channels of communication. The discussions of rationing – whether by that name or any other – tend to assume that health care is or will be somehow more limited in this era of managed care. Their fear is that a choice of specialists or experimental treatments might be restricted. For the unemployed and oppressed, rationing might look more like immunizations for children and maintenance prescriptions for those with chronic but easily managed conditions. Managed care is neither good nor bad; care, however, can be badly managed. Likewise, rationing is neither good nor bad. Rationing is simply a technique for managing care.

Because there is no national discussion of the rationing of health care, the piecemeal approach effects a rationing without rationale. It might well be a difficult discussion, but the rightful place of rationing in the provision of U.S. healthcare, nonetheless, needs to be had. Until policy makers – be they elected officials, private businesses, managed care organizations, hospitals, agencies, social workers or outspoken individuals – address rationing with integrity, there will never be basic health care for all Americans. Without access to basic health care, the management of care will continue to be both big business and a big problem. Ultimately, that problem will be most keenly felt by the uninsured asking only the most basic of health care. By compassionate extension, social workers will feel it as well. No one will come up smelling like roses.

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Unique Issues in Psychotherapy with Adult Adoptees

by Jennifer Pineda Carizey

Abstract

The experience of being adopted creates unique life cycle issues that have been the subject of recent study. According to the psychodynamic literature, the factor that has the greatest influence on an adoptee's life cycle is the early loss of a primary object. This loss frequently affects an adoptee's ability to form attachments and develop a coherent adult identity. This paper addresses the various intrapsychic responses to early loss that adults who were adopted as children may have, the unique obstacles they face in forming an integrated sense of self due to feelings of "differentness" and divided loyalties, and the impact of the current societal emphasis of biological ties in definitions of kinship. Clinical considerations are discussed using self psychology and object relations frameworks.

Introduction

Traditionally, American culture has communicated to adopted children that aside from the fact that they are "chosen children," their lives and experiences are just like that of those who are raised by their birth parents (Silverstein & Kaplan, 1998; Wegar, 1997). In more recent years, however, theorists, activists, and adoptees themselves have contested this perspective and argued that the experience of being an adopted person is unique and worthy of attention (Brodzinsky, Smith & Brodzinsky, 1998; Rosenberg, 1992; Wegar, 1997). Numerous studies have addressed the implications that adoption has on what has been coined "the adoption circle," the permanent and unavoidable interconnectedness of the child's, birth parents', and adoptive parents' lives (Rosenberg, 1992; Silverstein & Kaplan, 1998). This paper will focus on the experience of adults who are adopted as children, the implications that their modified life cycles may have on selfobject structures and identity formation, and the influences of the larger socio-cultural context on the experience of being an adoptee in America. Clinical issues are discussed in relation to these topics using self psychology and object relations approaches.

Self psychology is particularly applicable to clinical work with adult adoptees because of its emphasis on the repair of injuries resulting from early selfobject failures. According to self psychologists, the healing process in psychotherapy begins with the client using the therapist as a source of soothing selfobject experiences and ends when structures for self soothing have been internalized, and the client has developed the capacity to seek out appropriate selfobjects in her environment (Cooper & Lesser, 2002). Self psychology recognizes three main types of selfobject experiences that every person needs in order to develop a coherent sense of s*elf – twinship selfobjects, mirroring selfobjects,* and *idealized selfobjects.* These concepts will be further described in relation to the identity formation issues with which adoptees often struggle.

Object relations theory is also useful in psychotherapeutic work with this population, especially due to its focus on how the internalization of early selfobject disappointments impacts one's psychic structure. When a person experiences early object failures or loss, object relations theorists argue, he is at risk for internalizing these "bad objects" and developing attachment difficulties. The emphasis of treatment is to create a therapeutic holding environment in which the therapist provides a new, positive object relationship experience for the client (Brandell & Perlman, 1997).

Loss of a Primary Object: The Primal Wound

Although circumstances vary according to the age at which a child is adopted, the holding environment created by the adoptive parents, and the natural temperament of the child, the one universal feature of all adoptions is early loss of a primary object, an experience referred to as the *primal wound* (Lifton, 1990; Rosenberg, 1992). Some researchers argue that attachment begins in utero and that the loss of a birth mother due to adoption is experienced as a real loss of object (Rosenberg, 1992). Others argue that while an adoptee may not have experienced an intense attachment to her birth mother before the adoption and may not, therefore, be consciously aware of this primary loss, one's adopted status, alone, contributes to

feelings of loss, rejection, and abandonment (Kirschner, 1990; Rosenberg, 1992; Silverstein & Kaplan, 1998).

An adoptee's separation from his birth parents may cause difficulties in subsequent relationships in terms of attachment. Some adoptees form attachments to others in an almost immediate and indiscriminate manner (Samuel, 2003). In other cases, they may respond to the loss of a primary object by developing avoidant defenses that serve to protect them from future losses or rejection, a pattern that is especially common among persons who are adopted at an older age, due to multiple placements or abuse (Silverstein & Kaplan, 1998). The following narrative from an adult adoptee illustrates the low intimacy tolerance experienced by many adoptee clients, regardless of their age at the time of adoption:

> I think we Adoptees have trouble making and sustaining relationships. We share a vulnerability to the stresses and strains of everyday interactions, have real difficulty forming ties and connections. We need security and dependency, but try to escape from it. We seem to need freedom. We don't trust people. (Lifton, 1979, p. 65)

Filling in the Gaps: The Creation of Fantasy Objects

Some adoptees who have limited or no information about their biological background may experience their birth parents as significant but elusive so that they feel compelled to make conjectures about which characteristics they have inherited from these biological sources (Rosenberg, 1992). The adoptee may have considerable difficulty coming to terms with the loss of her primary object, and create fantasies in an attempt to repair the unmet selfobject needs that result from the primal wound (Freeman & Freund, 1998; Lifton, 1990). For example, an adoptee who is athletic and grows up in a family of artistic intellectuals may imagine that his birth parents share his physical talents, thus creating a feeling of connectedness to his fantasized birth parents.

Fantasy objects may manifest themselves in a splitting process in which an adoptee attributes positive characteristics to one set of parents and negative characteristics to the other set (Kirschner, 1990). Often, adoptees will create a fantasy involving idealized birth parents and seek to differentiate between themselves and their adoptive parents (Silverstein & Kaplan, 1998). On the other hand, adoptees may also experience their birth parents as disavowed, abandoning objects and attribute the positive characteristics to their adoptive parents. This splitting between parental sets may impact adoptees' formations of self and influence them to disavow these parts of themselves that they imagine to have inherited from the "bad" set of parents (Kirschner, 1990; Rosenberg, 1992). For example, an adoptee who imagines her birth mother to be a sexually promiscuous and irresponsible woman may deny her own sexuality or punish herself for healthy sexual urges (Rosenberg, 1992).

Existence of a Hole-Object: When the Gap Remains

Sometimes the objects that adoptees create to organize their primary loss experiences are vague due to the lack of internal representations of their birth parents. In such cases, the created objects may be beyond conscious awareness so that they are experienced as missing objects or *hole-objects* (Freeman & Freund, 1998). Clients who present with this hole-object phenomenon may appear to have a lack of interpersonal attachment. They often treat significant people in their lives as if they do not exist or may respond to the loss of an intimate partner or death of a family member with little to no reaction (Freeman & Freund, 1998). This phenomenon clearly impacts the adoptee's ability to sustain meaningful interpersonal relationships.

Attachment to Adoptive Parents

The quality of the attachment that develops between the adoptee and the adoptive parents is a critical factor in the repair of the primary loss (Brodzinsky, et. al, 1998; Rosenberg, 1992). This attachment varies according to the unique characteristics of both the child and the parents who have elected to adopt him. The decision to adopt usually occurs following a certain loss on the part of the prospective adoptive parents, in that most people choose to adopt as a result of their being unable to conceive or carry a biological child to term (Brodzinsky, et al., 1998; Kupecky & Anderson, 1998; Silverstein & Kaplan, 1998; Rosenberg, 1992). Therefore, the degree to which the adoptive parents are able to accept and work through this loss has a strong influence on their

ability to create a healthy holding environment for their adopted child. Adoptive parents who maintain fantasies about their idealized biological child may inadvertently create an environment in which an adopted child experiences rejection due to her inability to meet the idealized expectations (Silverstein & Kaplan, 1998), as illustrated in the following comment from a woman with two adopted children:

> I love my two children very much, but I have an inner fantasy I would never admit to other adoptive parents…I would like to see the face and body of the biological child I couldn't have. We have gorgeous people in our family, and bright people with brilliant minds. I'm sure it would have been a wonderful child. (Lifton, 1979, p. 187)

Identity Formation

Identity formation is an issue that is often addressed in discussions of the adoption experience, especially that of the adoptee entering the transition to adulthood. Early adulthood is regarded as the life cycle stage in which people evaluate the characteristics and values they have inherited from their families of origin and decide which aspects to maintain and which to discard (Urdang, 2002). This can be a unique struggle for an adoptee.

One issue that is thought to interfere with an adoptee's development of a coherent sense of self is the lack of others with similar physical characteristics (Lifton, 1979). The capacity to understand one's growth into an individuated person is thought to rely, to a certain degree, on the existence of role models and *twinship selfobjects* to whom one can relate. Twinship is a self psychology concept which refers to selfobjects that provide a person with a sense of belonging and sameness, confirming her place in the world (Cooper & Lesser, 2002; Brandell & Perlman, 1997). Basch (1992) contends that the twinship experience is, in essence, the experience of "being like" the other and is the most important of the selfobject experiences.

Therefore, the inability of an adoptee to look to an older adult with whom he may share some physical sameness may impede the process of identity formation. This is especially prevalent in cases of interracial or interethnic adoptions, as illustrated by the following example of an adult adoptee that was born in Seoul, South Korea, but grew up in an Italian American family:

> Finding my way through this background—Korean-Italian-American adoptee—has been like swinging on a pendulum. At different stages of my life the pendulum has swung from my identification with my Italian American roots over to my Korean birth and then back again. (Groza, Houlihan & Rosenberg, 2001, p. 198)

The confusion that results from an adoptee's feeling of "differentness" has been coined "genealogical bewilderment" and refers not only to a physical dissimilarity but also to a sense of not being with "one's own kind" (Lifton, 1979, p. 47). The lack of "being like" experiences among adult adoptees is demonstrated in the following narrative from an adult adoptee:

> I never thought I had much in common with anybody. I had no mother, no father, no roots, no biological similarities called sisters and brothers…I wanted to go my own way. That's all I think I ever wanted… (Lifton, 1979, p. 67)

When little information is known about one's birth family, the biological component of one's identity is missing so that a person effectively borrows the identity of the adoptive family (Silverstein & Kaplan, 1998). However, adoptees sometimes have difficulty developing an integrated sense of self without information about their biological history (Rosenberg, 1998). This "need to know" often leads adoptees to search for their birth families during early adulthood. One adult adoptee who searched and received non-identifying information about her biological family described the impact of her first experience with twinship:

> For the first time in my life, I felt physically attached to someone. The information I received told me that I look like both my birth father and birth mother, suffer with her allergies, and now I understand why I have such an interest in music. (Schooler, 2001)

In closed adoption cases, adoptees frequently remain cut off from their heritage and intergenerational line,

potentially resulting in a sense of disconnect and alienation from self (Brodzinsky, et al., 1998).

The development of an integrated sense of self can also be a challenge in the case of open adoptions or when a search for one's birth family results in increased medical, genetic, or ethno-cultural background information. Because early adulthood is marked by the complex process of embracing, modifying, and discarding certain aspects inherited from one's family of origin, this process is further complicated when a person must contend with two families of origin – a birth family and an adoptive family. An adoptee may feel that her life narrative is fragmented (Lifton, 1990), and is faced with the difficult task of either disregarding the identity inherited from one family altogether or integrating the characteristics of both the birth family and the adoptive family. As a result, adoptees may feel divided by two identities that cannot be merged (Partridge, 1991).

When the task of developing an integrated sense of self is complicated by either a missing frame of reference or by the existence of two competing backgrounds, a person's identity may become fragmented, resulting in the formation of an *adopted self* (Lifton, 1990). Adoptees are often implicitly encouraged, either by the biases conveyed through the closed adoption system or by the unspoken pressures created by their adoptive parents' insecurities, to deny the part of themselves that comes from their birth family. This results in a kind of splitting of the self into two other selves: the *false self* and the *forbidden self*. The *false self* is the part that pretends to have been born into the adoptive family and rejects the importance of a birth heritage. The *forbidden self* is that part that still longs for the truth in its quest for an authentic consolidation of identity (Lifton, 1990).

The Created Meaning of Adoption: Good Adoptee versus Bad Adoptee

Much of the adoption literature and research that is available focuses on the way that this population differs from the general public in terms of mental health, social adjustment, and life cycle transitions. In fact, some adoption experts have gone so far as to label these identified differences in behavior and personality traits as pathological, coining this phenomenon the *adopted child syndrome* (Kirschner, 1990; Wegar, 1997). To date, the available literature lends very little attention to the ways in which current cultural values

and the social stigmatization of adoption may affect the ongoing experience of the adoptee.

The life experience of an adoptee raised in America is complicated by the competing socio-cultural values that exist regarding the standards of familial loyalty and the meaning of kinship. A thorough examination of the adoptee, like the exploration of any human experience, must be predicated on a person-in-environment approach. In the case of the adoptee, the existence of the adoption circle should be recognized. That is, the interconnectedness of the adoptee's, birth parents' and adoptive parents' lives must be acknowledged. However, even the adoption circle can be understood only in the context of the socially constructed meaning of the adoption experience. American culture traditionally emphasizes the importance of blood ties in the definition of kinship and, therefore, pathologizes the adoptee experience as "different" (Rosenberg, 1992). A common argument in the literature is that "… genealogical knowledge is necessary for the development of normal identity" (Wegar, 1997, p. 68). Indeed, the discussion of identity formation in this very paper has, as its foundation, the premise that an adopted person's struggle for selfhood is markedly distinct from that of a person for whom blood kinship is a given.

Central to a discussion about the meaning of adoptee identity are the competing definitions of the "good" adoptee and the "bad" adoptee which are largely based on the debate between the adoptee's "need to know" and the birth parents' "right to privacy" (Rosenberg, 1992). These definitions are not absolute, but nonetheless have an intense impact on the way in which an adoptee approaches the task of identity formation and creates meaning out of his life experience.

Most adopted adults who are currently seeking psychotherapeutic treatment were adopted in the closed adoption system, which is marked by a lack of disclosure about the adoptee's birth family (Lifton, 1979; Wegar, 1997). This system implicitly argues that the "good" adoptee is one who does not question adoptive ties and "… is sensitive to his [adoptive] parents' needs to make believe he wasn't adopted" (Lifton, 1979, p. 54). Under this definition, "good" adoptees are grateful for having been saved from orphanhood and may believe that they do not have the right to feel dissatisfied in any way simply because they are alive and have been adopted by people who love them (Lifton, 1979). Unrestrained curiosity about one's

biological background is not in keeping with the image of the "good" adoptee. The "bad" adoptee, in contrast, openly communicates his/her interest in genealogical information. Lifton (1979) argues that adoptive parents often experience this curiosity as a betrayal or rejection, due to their unresolved infertility issues.

On the other side of the debate is the "search movement" currently underway in America that emphasizes the importance of biological ties in the formation of kinship (Lifton, 1979; Rosenberg, 1992; Wegar, 1997). Search activists argue that in order to develop a coherent sense of self, adoptees must search for and be given genealogical information, thus appealing to the American value that kinship is biologically based. Adoptees that lack genealogical continuity are defined as "other" and those who do not wish to search for biological kinship are thought to be even more "different" (Lifton, 1979). Therefore, there is a belief among American non-adoptees that those adoptees who choose to search for their birth families are "more like us" in that they share the "normal" desire for human connectedness with their own kind (Wegar, 1997, p. 13).

This definition of the "normal" adoptee as one who is curious is in direct contrast with the definition of the "good" adoptee who has no interest in the identity or background of his/her birth family. As a result of these conflicting standards, adoptees often have divided loyalties. They are told by American society that they do not have true kinship in their lives and are simultaneously discouraged from seeking such kinship. These competing values may create ambivalence in adoptees regarding their "need to know."

Implications for Practice
Beginning Phase of Treatment

Early object loss can affect the treatment process by influencing the development of a relationship between the adult adoptee client and the clinician. The intimacy avoidant ego-defense that can result from this loss may impede the psychotherapeutic process because developing trust with the therapist and forming an effective therapeutic relationship may be more of a challenge. On the other hand, as previously discussed, some clients have a tendency to attach to others quickly and indiscriminately. This is likely due, in part, to their lack of a *mirroring selfobject* during their early years. According to self

psychology, mirroring selfobjects are those which respond to a person and confirm her innate sense of capableness, greatness, and perfection (Brandell & Perlman, 1997; Cooper & Lesser, 2002).

An adult adoptee who has been deprived of a mirroring selfobject or who continues to suffer from the primal wound may respond to the therapist's empathic ear with an instant *idealizing transference.* That is, the client may experience the therapist as "a powerful and reassuring presence…to whom [she] can look up [to]" (Brandell & Perlman, 1997, p. 71). Ideally, a person will later merge with this idealized selfobject in order to achieve an internal sense of calm (Brandell & Perlman, 1997). When a person develops an idealizing transference to her therapist early on in the treatment, it can be very diagnostic in regard to a possible lack of these experiences prior to the therapeutic relationship.

Adoptees' early object loss may also be a factor in this population's widespread tendency to transferentially experience the therapist as their lost birth parent or other long-lost relative (Bertocci & Schechter, 1991; Kirschner, 1990). This can result in the client experiencing considerable ambivalence about the psychotherapeutic process due to their simultaneously occurring desire for attachment and fear of abandonment.

Middle Phase

The middle phase of treatment with adult adoptees is often marked by issues of transference and countertransference, splitting in identity formation, and an ambivalence about addressing adoption issues within the psychotherapeutic process. Transference issues often arise in relation to the client's formation of fantasy objects. Fantasy objects impact the psychotherapeutic process when the client transfers them onto the therapist, thereby experiencing the therapist as the "good," idealized birth mother, for example. A transference that idealizes the therapist, however, can quickly change to a negative transference of the rejecting, abandoning birth parent when the therapist is unable to meet the high expectations that have been created by the adoptee's fantasized objects (Rosenberg, 1992). The transference of fantasy objects onto the therapist often triggers countertransferential responses. At times, therapists who are faced with clients who want them to be good birth mothers find that this transfer-

ence appeals to their "desire to provide them with something good" (Samuel, 2003, p. 214), and creates pressure to satisfy the needs left unfulfilled by the lost object.

Transference issues may also arise in regard to clients who present with a hole-object, or a sense of a missing object. Since hole-objects lack concreteness, they can manifest in the psychotherapeutic transference as the client treating the therapist as if he does not exist; this way of being related to can be experienced by the therapist as a sense of unreality, confusion, or a general feeling of disconnect during interactions with these adoptees (Freeman & Freund, 1998). This, too, can be an obstruction to the maintenance of the therapeutic alliance and can stunt treatment progress.

When an adoptee develops an *adopted self,* which is split into a *false self* and a *forbidden self,* the challenging process of identity formation is further complicated. A theoretical approach using object relations may be effective in psychotherapeutic work with adoptees who experience this kind of splitting, as this school of thought holds as one of its primary goals the modification of intrapsychic splits, including that which involves the false self (Cooper & Lesser, 2002). By providing new object experiences in a therapeutic holding environment, the therapist can assist the client in building new internal objects to create a more authentic self.

The process of splitting between the birth parents and the adoptive parents, often observed among adult adoptees, can lead to a splitting mechanism in the psychotherapeutic process as well. This pattern is referred to as *double transference,* and occurs when the client splits the therapist, experiencing her as "all good" or "all bad," just as he might experience the exaggerated demarcation of the parental sets (Brodzinsky, et al., 1998; Samuel, 2003).

Adoptees that present with identity formation difficulties due to a fragmented life narrative or divided loyalties may be helped with a self psychology approach. A common goal of self psychology treatment is the development of self cohesion (Pessein & Young, 1993). Providing empathic attunement to an adoptee's selfobject needs may be an effective intervention in offering a reparative experience in the face of an adoptee's early object loss and the subsequent disintegration of identity (Pessein & Young, 1993). However, when information on biological origins is lacking, adoptees may experience obstacles in their efforts to develop self-cohesion without gaining access to historical information or actual interaction with their birth families (Lifton, 1979; Wegar, 1997).

The contradicting societal messages that adult adoptees receive about the nature of kinship and the definitions of the "good" adoptee and "bad" adoptee can create substantial ambivalence regarding the degree to which their adoption status will be addressed in the therapy room. This ambivalence can be dealt with in the therapeutic process by acknowledging that one's adoption status is an important aspect of one's experience without defining it as "a pathologically scarring event" (Rosenberg, 1992, p. 148). The unique developmental tasks of adoption can be normalized for clients without offering a narrow definition of "normal" (Rosenberg, 1992). For some adult adoptees, a search for birth parents may be a necessary step in healing. Other adoptees will be completely uninterested in gaining knowledge about their biological background.

When an adoptee client presents his adoption as a "non-issue," special challenges are created for the therapist. Sometimes "good" adoptee clients maintain that being adopted has caused no discomfort or confusion in their lives. They may express a lack of interest in even discussing their adoption status in psychotherapy sessions. This presentation may stem from the development of coping skills that minimize the importance of the adoption in an effort to protect their adoptive parents from "awareness of wishes and feelings about the birth parent" (Freeman & Freund, 1998, p. 27). Therapists may choose to "start where the client is," therefore respecting the assertion that their adoption status is of no consequence. On the other hand, therapists may feel obligated to emphasize, to some degree, the importance of their clients' response to the adoption experience, thus risking the creation of divergent goals.

Traditionally, therapists have erred on the side of minimizing the impact of adoption on their clients (Lifton, 1990; Rosenberg, 1992), which has resulted in their colluding in avoidance and risking repetition of the empathic failure these clients may have experienced with their adoptive parents. In a recent empirical study examining adult adoptees' and birth parents' experiences in psychotherapy, therapists who addressed adoption as an important clinical issue were perceived as significantly more helpful compared to those therapists who did not address the adoption experience (Sass & Henderson, 2002).

Therapists working with adult adoptees must be aware of the countertransferential reactions that may be experienced due to their beliefs about kinship, adoption, and the "need to know." The literature is filled with examples of adult adoptee clients who have received psychotherapeutic treatment from therapists who failed to initiate explorations of the meaning the client has given to the adoption experience (Brodzinsky, et. al, 1998; Freeman & Freund, 1998; Lifton, 1990; Rosenberg, 1992; Sass & Henderson, 2002). For example, Freeman and Freund (1998) describe the therapeutic work that was done with Kathy, a woman who had been in therapy twice before and whose prior therapists had completely avoided discussion of her adoption. The third therapist, however, acknowledged Kathy's distinct experience as an adoptee and eventually helped her to address ongoing issues of insecure attachments, identity confusion, and fear of abandonment. Through the course of treatment, Kathy and her therapist learned that these issues each stemmed, in some way, from Kathy's personal narrative about being an adoptee. Had Kathy's therapist not been aware of the adult adoptee's unique struggle with loss and the impact it has on subsequent identity formation, Kathy may not have had the opportunity to integrate her adoption narrative into a coherent sense of self.

Therapists' common reluctance to discuss the impact of adoption may be indicative of their discomfort with this issue or a lack of knowledge on how to address the characteristic concerns and developmental tasks of an adult adoptee. It may be necessary for clinicians to seek more training about the unique life cycle of the adoptee in order to better serve this population.

Termination

The primary loss experienced by adoptees may impact the termination process in psychotherapy. As is the case with many clients who have a pattern of difficult separations, there is a risk that adoptees will experience the ending of a therapeutic relationship as another rejection or abandonment (Rosenberg, 1992). Psychotherapists must be aware that while the termination process may be complicated due to adoptee clients' proclivity to experience the therapist as an abandoning object (Siebold, 1991), it simultaneously creates a unique opportunity to rework the client's experience of separation and loss in a safe, empathic environment.

Conclusion

The issues of loss, attachment, and identity formation are common themes that arise in psychotherapeutic practice. Adult adoptees typically present with these intrapsychic themes that can be effectively addressed in the course of therapy. Additionally, the psychotherapeutic process can serve as a safe environment in which to explore the meaning that has been attributed to being an adoptee in America, an issue that seems to have been largely neglected in existing literature and current practice. Through an awareness of the common reactions to loss among this population, as well as a thorough understanding of the socio-cultural forces that impact the adoptee experience, psychotherapists can assist adult adoptees in modifying internalized object structures and healing the primal wound.

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Racial Perceptions of Homelessness:
A Chicago-based Study Investigating Racial Bias

by Tana K. Bliss, Courtney M. Blum, Jeffrey Bulanda and Annie M. Cella

Abstract

The relationship between homelessness and racism has not been clearly explored in the research to date. The present study seeks to understand how the race of the homeless individual affects the perception of that individual by others. White and African-American participants were selected at random and asked to fill out a questionnaire based on a case vignette that described either a white or black homeless male. The data was compared in regard to social distance, perceived dangerousness, support for economic aid and blame across racial groups. The only relationship yielding a significant result was the relationship between race and economic aid. African Americans had an increased propensity to support economic aid across all racial categories of homeless individuals.

Introduction

Homelessness has been a fact of American life throughout this country's history, and a problem of epidemic proportions for decades. Over the years, however, the perception of homelessness has changed. From the moralistic view of the "worthy" versus the "unworthy" poor, to the romanticized "tramp" representation of the homeless, to skid row, both the population of people that are homeless and the way they are perceived by society as a whole has changed according to prevailing societal trends (Hopper & Baumohl, 1996). During the 1980's, the problem of homelessness became popularized through media coverage. Currently, Americans perceive the homeless as consisting primarily of non-white males (Link, Phelan, Stueve, Moore, Bresnahan, & Struening, 1996). Indeed, the population of homeless individuals has grown to include a disproportionate number of African Americans (Hopper & Milburn, 1996).

Researchers have insisted for years that homelessness has to be seen as a social circumstance in addition to a personal characteristic (Erikson, 1995; Link, et al., 1996). Therefore, when studying homelessness it is important to include questions about prevailing socioeconomic tides rather than about the personalities of the people caught in these tides (Erikson, 1996). Erikson (1996) describes the homeless as being "swept away from the settled shore by a cruel and unrelenting undertow"(p. vii). He uses this metaphor as a means of asking two questions: What is the nature of homelessness? What can be done to reverse it?

This study aims to continue this trend of examining homelessness as a social phenomenon by exploring the role of racism in homelessness. We will specifically be focusing on how individuals feel about a homeless person of their own and of a different racial category. We hope to discover some of the contributing factors to the public's perceptions of homelessness, which can lead us to begin to answer the first question Erikson posits about the nature of homelessness.

Despite the fact that homelessness is recognized as a significant problem in America, it is interesting to note that few studies have been devoted to homelessness among ethnic groups (Julia & Hartnett, 1999). In fact, while attempting to collect articles for this study's literature review, it was difficult to find studies dedicated specifically to the relationship between race and homelessness. The fact that there are a disproportionate number of homeless African Americans, however, leads us to think that one contributing factor to the social phenomenon of homelessness is socialized, or institutionalized racism. For this reason, we hope to shed light on the extent to which institutionalized racism, as a social circumstance, affects public attitudes towards the population of homeless people today.

Public attitudes toward homelessness are important to study because they may have dire consequences for the homeless. The public's understanding about homelessness shapes the public response to the problem on both an individual and collective basis. For example, if people believe that people who are homeless are lazy and do not want to work, then they are going to be less likely to volunteer and give donations to a homeless shelter. Further, public attitudes about homeless people have important policy implications in that attitudes shape the way individuals vote and public policies are made (Link, et al., 1996). If the public has negative opinions about the homeless, then

they may be less likely to support policies that can positively effect the homeless. By examining the public's understanding of homelessness and extrapolating whether racial differences shape this understanding, we can begin to pinpoint the policy implications derived from the public's attitudes. In addition, through examining the nature of the relationship between homelessness and racism, we can begin to answer Erikson's (1996) second question: What can be done to reverse it?

The Public Perception of Homelessness

The public perception of the homeless has changed over the years. Feagin (1975) found that when respondents in his 1970's studies evaluated the causes of homelessness and poverty, they blamed the person's behavioral characteristics (such as a lack of thrift and proper money management, and a lack of effort on the homeless person's part to change his/her situation) more than they blamed economic and social factors such as low wages, scarcity of jobs, poor schools and racial discrimination. This perceptual bias continued into the middle of the 1980's. Kluegal and Smith (1986) performed a study in which the results almost identically replicated Faegin's study. Their research found that people thought that it was the homeless persons' fault that they were in their current situation.

Research from the early 1990's reveals a changing public perception of the homeless. People's perceptions were still not uniformly positive, but the level of compassion expressed was quite high and the likelihood of people blaming the homeless person for his or her situation was surprisingly low (Phelan, Link, Moore, & Stueve, 1997). Lee, Jones, and Lewis (1990) found that three-fifths of their respondents attributed homelessness to structural forces rather than personal choice. It seemed that the public began to see homelessness as something that occurred because of an outside source, rather than because of something that the homeless person did. In 1995, The Gallup Organization conducted a survey regarding American's understanding of, and attitudes toward, the homeless. It was found that three-fourths of the people surveyed thought that unemployment was a characteristic of homelessness. A majority of the respondents also thought that job loss and lack of affordable housing were the major causes of homelessness. Similar results were also found by Link and his colleagues (1996). They discovered that people

believed structural factors concerning housing, the economic system, and a lack of government aid were major causes of homelessness.

Still, both studies found that a large majority of the people surveyed felt that drug and alcohol abuse were problems that contributed to homelessness (Gallup Organization, 1990; Link et al., 1996). In addition, 35.1% of respondents in the Gallup Organization survey (1995) believed that the homeless were mentally ill. The Gallup Organization (1995) also found that the "average" homeless person was characterized as an unmarried male between the ages of 18 to 55. Further, when asked about minority groups the public viewed the problem as affecting racial minorities (Link et al., 1996). These results suggest that the American public believes that the causes of homelessness are complex and due to a combination of both structural forces and individual factors.

Since it seems there is a widespread public perception that people are homeless at least in part because of external and structural factors, how does the public feel toward the homeless? In the 1996 study done by Link and his colleagues, a vast majority of the people surveyed expressed feelings of sadness and compassion for homeless people (85.8%). They said that they felt angry that so many people were homeless in a country as rich as America. But the research also suggested that despite their compassion for the homeless, people still had a hard time experiencing empathy for them. Sixty-two percent of those surveyed said that it was hard to imagine what homeless people do with all of their free time, and thirty-seven percent said that they thought homelessness frees a person from worries that other people have about jobs and families. This suggests that people's feelings toward homelessness are very complex. People may say that they are compassionate, but may still have a lack of empathy. One reason people said that they have a hard time being empathetic towards homeless people is because they feel repelled when they see homeless people in such destitute and disorderly conditions (Link, et al., 1996).

Homeless people are stigmatized more severely than other poor people (Link et al., 1996). This is due, in part, to the fact that many homeless people live in public spaces, which makes homelessness more visible and the homeless more disruptive than other citizens. Homeless people may have difficul-

ties involving cleaning and grooming themselves. As a result, they may be aesthetically unappealing (Phelan et al., 1997). In addition, people associate the homeless with alcohol and drug abuse (Link et al., 1996). When the media portrays the homeless on TV or in newspapers, they portray them in ways that reinforce these stereotypes. People's perceptions of homelessness may be influenced by a small group of homeless people or by the media, so they may overgeneralize their views of homelessness to all persons that are homeless. They may also overestimate the prevalence of certain characteristics such as dirtiness, dangerousness, and alcoholism to the entire homeless population.

Racism and Homelessness

Statistics describing the racial composition of the homeless demonstrate that African Americans are substantially over-represented when compared to their white counterparts. Nationally, African Americans make up approximately 50% of the homeless population (U.S. Conference of Mayors, 2000), yet they only make up 12.3% of the United States population (U.S. Census Bureau, 2000). In the city of Chicago, approximately 79% of the homeless population is comprised of African Americans (U.S. Conference of Mayors, 2000), though African Americans comprise only 36.8% of the city's total population.

African Americans differ from white Americans in their increased likelihood of facing homelessness. They differ in other significant ways as well. Sumerlin and Privette (1993) found that African American and white homeless men differed significantly in a number of categories, including self-actualization, willingness to use services, subjective health ratings, and history of being homeless. In reflecting on the significant differences between African American men and white homeless men, the authors suggest that, "it is possible that the factors contributing to the etiology and continuance of homelessness for black and white men are different" (Sumerlin & Privette, 1993, p. 1046).

Given such differences, it is important to consider the role that race plays in homelessness. Several authors have stated that racial exclusion, inner city isolation, and limited educational and occupational resources may account for the overrepresentation of African Americans among the poverty-stricken and,

in turn, the homeless (Belcher, 1992; Feagin & Feagin, 1999; Hopper & Milburn, 1995). African Americans are predominantly concentrated in cities where many job opportunities have disappeared over the past two decades (Feagin & Feagin, 1999; Hopper & Milburn, 1995). Hopper & Milburn (1995) also point out that inner city neighborhoods face concentrated poverty in addition to commercial investment decline, social service cut backs, and dilapidated sectors of the physical landscape.

Race issues in American society are so deep-seated that it has become almost second nature to some Americans to assume that race determines an individual's abilities and makes a member of one race intrinsically superior to a member of another race. Whites have historically been perceived to be the superior race in the United States, a fact that has produced profoundly different individual and institutional responses to people of color and whites, and harmed those of color by judgments and actions that are directly or indirectly racist.

D'Souza (1995) argues that, in the absence of substantial information about a person's individual attributes, people often use race as "base rate" information from which to make impressions about any given group member. In an attempt to address this issue, as well as the issue of racism, this study will compare how individuals feel about a homeless person of their own and of a different racial category along four axes: blame, willingness to offer economic support, perceived dangerousness, and social distance (Phelan, et al., 1997). Consistent with D'Souza's argument, it is our hypothesis that individuals will be more likely to see the homeless person of their own racial category as an individual, and thus be more compassionate towards him. Similarly, we hypothesize that participants will be more likely to view a homeless person of a different race as part of a homogenous group, and thus be less likely to be compassionate towards him. We anticipate that responses will differ depending upon the person's race, and the race of the homeless person he or she is asked to consider. We hypothesize that individuals will exhibit more social distance from members of a different racial category, will be more likely to blame individuals of a different racial category for their homelessness, will perceive members of another racial category as being more dangerous, and will be less willing to offer economic support to members of a different racial category.

Methodology

This is a descriptive study that explores whether attitudes regarding homeless individuals are influenced by racial differences or similarities. We specifically examined the differences between how white and African American residents of Chicago viewed homeless individuals of their own racial group versus a different racial group. Attitudes towards the homeless were measured according to scales measuring social distance, perceived dangerousness, support for economic aid, and blame as adapted from Phelan, et al. (1997). We received approval for the study from Loyola University Chicago's Institutional Review Board (IRB).

Sample

Seventy-seven people who were selected at random from persons attending events in the City of Chicago were given a questionnaire regarding their attitudes toward the homeless. To recruit participants, we went to various public areas, such as Grant Park concerts, public transportation stations, Daley Plaza, and outdoor events (i.e. races and festivals). To randomly select participants, our research team members approached every seventh person we perceived to be white (of European/Caucasian ancestry) who was sitting down, and every third person we perceived to be African-American. This method was used to attempt to obtain an equal representation of white and African-American participants in view of the fact that there are a greater number of white people in Chicago as a whole (U.S. Conference of Mayors, 2000), as well as at the events we attended. Interviewers later confirmed their perception of the race of potential participants through inviting them to identify their race on the questionnaire.

Forty of the participants identified themselves as African American and thirty-seven of the participants indicated they were white. Each participant was given the same questionnaire, except that half of the questionnaires were about a white homeless person and the other half were about an African-American homeless person. In total, four groups were compared. The first group consisted of African-American participants who answered a questionnaire based on a vignette regarding a white homeless person (N=20). The second group consisted of African-American participants who answered a questionnaire based on a vignette regarding a black person (N=20). The third group consisted of white participants who answered a questionnaire based on a vignette about a white homeless person (N=18), and the last group consisted of white participants who answered a questionnaire based on a vignette regarding a black homeless person (N=19).

The inclusion/exclusion criteria for our study were as follows. The participants had to be between the ages of 18 and 65. Individuals that were neither African American nor self-identified as "white" were excluded. If the participant stated that they were half white and half African American, we decided to exclude the participant based on their potential inability to closely identify with either race. Individuals who self-identified as Hispanic were also excluded due to the potential confounding variable of Hispanic cultural attitudes towards both race and homelessness. Finally, individuals who had been homeless themselves were excluded.

The Instrument

In understanding the role that race plays in a person's perception of and compassion towards homelessness, we employed a vignette experiment. Two vignettes were adapted from a study by Phelan et al. (1997). They varied only in the specified race of the subject that was used:

> James is a 35-year-old, single, black/white man. He is currently homeless and lives in shelters for homeless people. He grew up in a predominantly low-income black/white neighborhood. He quit school before finishing high school in order to get a job at a fast-food restaurant. Since then he has held a number of low paying jobs, but has been unemployed for over a year.

Since 30 to 40 year old men make up the highest percentage of homeless individuals, a 35-year-old man was illustrated in the vignette. About half of the participants received a vignette describing a white man and half received a vignette of a black homeless man. By maintaining consistency in all personal characteristics except race, we were able to attribute any difference in perception exclusively to race. Furthermore, because African Amerian and white participants were randomly assigned vignettes, it was determined that differing responses were the result of

variations in stimulus rather than variations in the respondents' race.

As in the Phelan et al. (1997) study, a set of questions about the homeless individual was used, addressing issues of social distance, perceived dangerousness, support for public assistance, and causal attributions for his condition. There were four questions concerning social distance (Alpha=.85), two questions concerning perceived dangerousness (Alpha=.56), three questions concerning support for economic aid (Alpha=.79), and one question concerning blame.

These included such questions as:

- "How willing would you be to hire James to do odd jobs for you?"
- "Do you think James would be dangerous to be around?"
- "Do you think James deserves help from society?"
- "Do you think that James is to blame for his current situation?"

Respondents were asked to rate their responses on a four-point Likert scale, with one being "definitely willing/definitely yes," and four being, "definitely unwilling/definitely no."

These four measures allowed us to obtain a picture of social rejection and compassion towards the homeless. An understanding of social distance allowed us to see how close people were willing to get to homeless persons, in particular to homeless individuals of a different race. Perceived dangerousness was also integral to our study, as we felt African Americans would generally be seen as more violent than whites. Support for public assistance allowed us to consider whether people were actually willing to use money and tax dollars to assist the homeless. It was hypothesized that the participants would be more willing to support homeless individuals of their own race. The level of blame people placed on the homeless was also measured, which gave an indication of the degree to which surveyed individuals felt the homeless were responsible for their own situations. All of these areas were assessed in relation to the variable of race. Finally, the questionnaire included demographic questions on the respondent's age, gender, race, income level, zip code, and experience with the homeless.

Research Procedures

When collecting data, research team members took turns explaining the project and asking each potential respondent to participate in the study. The first respondent in either racial group on each data collection day was given the vignette describing the white homeless man. The vignettes were then alternated in an effort to ensure that equal numbers of each variation of the vignette were given. Data was collected until a total of 77 completed surveys were obtained from all data groups. According to our exclusion criteria, we expected that 10 surveys would need to be thrown out. In fact, only 5 surveys were not used.

Each research team member was briefed on exactly what to say to each potential participant to ensure consistency. Upon approaching a potential respondent, the research-team member explained the topic of the study and explained that participation included a one-time-only commitment of approximately 10 minutes. Potential respondents were told that the study concerned people's perceptions of homelessness. Race as a subject of inquiry was not mentioned. Each participant was asked to read a consent form separate from the survey. Participants were not asked to give their name on the actual survey. Completed surveys were not examined until the data collection was complete. Confidentiality was ensured by not including the participants name on the survey. Loyola University Chicago School of Social Work pens were given to each participant as a token of our appreciation.

Data Analysis

We broke our sample into four groups according to their race and whether or not they filled out a vignette describing a black or white homeless person. Descriptive statistics were calculated for all demographic variables. We then recoded each scale to compare those who said "definitely willing/definitely yes" to all other response choices. We hypothesized that this subgroup would prove to be significantly different than the respondents as a whole and that they would be more likely to be compassionate. Using Chi square tests we compared across all four scales (social distance, dangerousness, support for economic aid and blame). The groups where then combined by race so we could look at all white respondents versus all African-American respondents. Chi square tests were run again using the

recoded scales on these combined groups. We also divided the sample across race to compare respondents' experience with homelessness so that those that had either volunteered or worked at a homeless shelter or known someone that was homeless, were compared to those that had little or no experience with homelessness. Chi square tests were then run using each of the four scales to compare the experience of each of these groups. Chi square tests were also run for each of the four scales dividing the sample across race so that we compared those with the greatest incomes (in excess of $75,000) to those with the least income (less than $18,000).

Results

There were 77 participants in this study. The age range of participants was 18 to 65 years old. The average age of the whole sample was 39 years old. The modal income range was $35,000-50,000. Females made up 46 of the participants, while 31 were male. There were 40 African-American participants and 37 white participants. The average age of the African-American participants was 45 years old. The modal income range for African Americans was $35,000-50,000. The average age of the white participants was 33 years old, and the modal income range for this group was $25,001-35,000.

None of the Chi square tests comparing the four groups or four scales had statistically significant results, nor did any of the Chi square tests based on income or participants' experiences with homeless people. The only tests that obtained statistically significant results were the Chi square tests comparing all African American and white respondents, regardless of vignette. From those results, the scale that was statistically significant involved three questions around the category of "willingness to provide economic aid." In this case, African Americans were more willing than whites to say "definitely yes" to the question of whether James deserves help from society (Chi square = 4.94, df = 1, Fisher's Exact Test p = .037), whether he should be given government assistance to pay for food, clothing, and housing (Chi square = 5.653, df = 1, Fisher's Exact Test p = .031), and whether he should be given government assistance for medical care (Chi square = 5.635, df = 1, Fisher's Exact Test p = .023).

Discussion

The one correlation that proved to be statistically significant was that African-Americans as a group supported economic aid for the homeless individual in the vignette, regardless of race. Other research supports the fact that African-Americans, as a group and regardless of socioeconomic differences, fight against economic disparities. There were no significant differences regarding white respondents' feelings for or against economic aid with regard to either race, suggesting an ambivalence on the part of white Americans regarding economic aid. The difference between the two racial groups may be due to African Americans' historic difficulties in achieving the economic status that most white Americans have achieved. We would argue that they have been more likely to experience economic discrimination from a capitalist system that has created and maintained a stratified economic system, and thus they may feel that all individuals put at a disadvantage by such a system deserve a helping hand in the form of economic aid.

America's historical approach toward public assistance has been based on the deservingness of the poor rather than a general commitment to "assisting the economically disadvantaged" (Rosenheck, Bassuk & Solomon, 2001, p. 20). According to the Chicago Coalition of Homelessness (2001), African American single men make up the highest percentage of the homeless population in Chicago. The high percentage of African American males is consistent with the trend toward targeted funding to specific groups of homeless who are considered the "deserving" poor, for example, children, women, and families (Rosenheck, Bassuk, & Solomon, 2001). The risk and disadvantage to identifying specific subgroups is that programs intended for a special population may "blur awareness of the structural causes of homelessness and may lead policymakers to erroneously explain homelessness as a result of personal or subgroup failings" (Rosenheck et al., 2001, p. 1). The disproportionate number of homeless African American males in Chicago reflects policy efforts made toward specific populations that may have an effect on the public's perception of homelessness in two ways. First, if the tendency towards racial bias in homelessness is accurate, then mainstreamed whites (with no familial history of poverty or discrimination) may be more like-

ly to disregard homeless African Americans as having been the cause of their predicament. Second, as referred to earlier, African Americans with a cultural history of social unrest may be more likely to identify with and empathize with the oppressed.

Public policy is integral to the shifting of these extremes. Policy makers hold an important role in changing American's attitudes towards the homeless and bringing white and black citizens to a position of awareness and action. One suggestion is for the implementation of programs and legislation that address the needs of specific groups, such as African-Americans. Importantly, however, this emphasis on subgroups should be aligned with a goal to improve the conditions of the homeless as a whole.

As previously stated, the remainder of our comparisons of the scales that measured blame, social distance, and perceived dangerousness, were statistically insignificant whether we used mean scores or compared those endorsing the most extreme response to all others. As we were expecting significant differences, it is interesting to consider why we may not have found those results. First, socioeconomic status may be more of a factor in discrimination than race. It may not have mattered whether the individual was African-American or white, and the respondent may simply have categorized all homeless individuals into one group—not differentiating between homeless people based on race. Thus, the distinguishing feature of the race of the homeless man in the vignette may have been overlooked in the respondent's answers to the various scales. This suggests that homelessness itself is a source of fear and blame, regardless of race.

Limitations of the Research

In conducting this study, various threats to internal and external validity were identified. The sample was not "random" in the sense that we could only interview people who agreed to participate. Our selection criteria made it difficult to generalize to the entire Chicago population. Because race was the only controlled variable, there may have been other confounding variables that contributed to the participants' response, such as gender, education level and age.

This research would have a stronger basis if a larger sample size was used. Twenty individuals in each of the four groupings may not have provided a large enough sample to produce significant results. A more random sample would have also strengthened the validity of our results. While all participants were found in public places, it may have been limiting to only recruit at public functions in downtown Chicago. The sample could have been more diverse if the participants were recruited from a variety of culturally and socio-economically diverse neighborhoods.

There were also some limitations in the instrument used and the method of collecting data. The instrument only had a four-point scale, which minimized the possibility of obtaining significant results, especially when considering the relatively small sample size. The instrument would have been more sensitive if the scale was expanded to include a ten-point range. In addition, the race of the homeless individual in the vignette may not have been apparent to the respondent. As we wanted to ensure that the respondents were unaware of the racial hypotheses involved in this study, we made the racial factor as subtle as possible, simply mentioning it twice as a descriptor in the vignette. However, the respondent may have read over that description and focused more on his/her own conception of what a homeless individual is instead of an image of a white or African-American homeless individual that we intended to be evoked by the vignette.

Since much of this study focused on racial issues, there may have been bias in the fact that all interviewers were white. The race of the researchers may have influenced the responses of the study subjects. To control for this, African-American researchers could have approached the African-American respondents and white-American researchers could have approached the white respondents.

Another factor that must be considered is social desirability. In conducting research on such emotionally and politically charged topics as race and homelessness, it is important to consider that the respondents may have responded based on what they believed was "politically correct," even if the survey was confidential. Thus, what they put on paper may not have accurately reflected what they felt about homelessness. Stating they support economic aid for homelessness, for example, is different than actually being willing to give economic aid.

Despite these limitations, there are some applicable findings that could have implications for policy-making regarding homelessness. Our research suggests

that whites are less inclined to support economic aid for the homeless than are blacks. African-American participants felt more strongly that homeless individuals, in general, should receive economic support, while white Americans were more ambivalent. Additional research could help clarify the relationship between the fact that the majority of policymakers are white Americans and the reality of the current dearth of resources available to the homeless in general. This may be a factor in the answer to Erikson's (1997) second question: "What can be done to reverse homelessness?"

The study of the correlation between race and perceptions of the homeless is an important area of study. However, the researchers found that few studies have addressed this topic. Thus, further research could be conducted using the basic premises of this experiment, and addressing the limitations that have been listed. Further research could include a study with a larger sample and revision of the research instrument to include a greater scale and also more items or questions to deepen the understanding of people's perceptions.

This area of study is particularly important to the field of social work due to the profession's ethical responsibility to be aware of social phenomena and contribute towards reducing the disparities that exist between racial and economic groups. With such knowledge, social workers will be better armed to advocate for perhaps the most disenfranchised population in our nation.

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Case History: Mining Adler and Buie for Insight regarding the Assessment and Treatment of Borderline Personality Disorder

by John Baker

Abstract

A client with symptoms of depression and an underlying personality disorder is described. Her presentation is examined in light of theoretical conceptions of borderline personality disorder developed by Gerald Adler and Daniel Buie. The examination proceeds to a general discussion of the treatment implications of the theory, and then concludes with specific insights and treatment applications for the individual client under discussion.

Introduction

Janice, a 37-year old Caucasian woman with a diagnosis of major depression, presented at the mental health clinic where I was interning. She entered into her first therapeutic relationship with me. As I came to know her better, it was clear that she was indeed battling chronic, disabling depression. I became increasingly aware of the fact that she also appeared to show symptoms of what the DSM-IV describes as a Cluster "B" Axis II personality disorder. Upon further consideration, her presentation appeared to fit with at least some definitions of a borderline personality disorder.

Adolf Stern first used the term "borderline" in 1938 to describe clients with an array of psychopathological symptoms (Linehan, 1993). Since that time, numerous authors have defined and redefined the term, using a wide range of theoretical constructs, and widely varying interpretations of symptomology. Currently, the most widely used description for the borderline phenomenon is found in the DSM-IV, which presents it as an Axis II personality disorder (DSM-IV-TR, 2000, p. 706). The DSM takes an essentially descriptive, medically-based approach of identifying pathological conditions on the basis of their most commonly observed symptoms. Linehan (1993) takes this one step further and organizes the DSM's diagnostic, symptomological criteria for borderline personality disorder into broad categories including emotional, interpersonal, behavioral, and cognitive dysregulation, as well as self-dysfunction. She identifies more specific symptoms under these categories:

A. Emotional dysregulation (problems with anger; emotional instability)
B. Interpersonal dysregulation (unstable relationships; efforts to avoid loss)
C. Behavioral dysregulation (suicidal ideation)
D. Self-dysfunction (unstable self, self-image; chronic emptiness)

My client appeared to have severe problems in all of these areas. This suggested to me that her symptomatology was at least roughly analogous to Linehan's interpretation of the DSM criteria set for borderline personality disorder.

Viewing my client in terms of a symptom-based diagnosis was useful as an initial hypothesis with which to organize my understanding of Janice, and gave me some sense of where to look for further illumination of the clinical picture she presented. It also provided useful ideas for how I might approach the client in the course of treatment and how that treatment might be expected to progress.

As a beginning social work clinician, I have been initially attracted to ideas contained in the self psychology tradition. I am also intrigued by the explanatory power of object relations theory as a way of understanding early childhood sources of later psychopathology. Gerald Adler, writing both with Daniel Buie and alone, draws heavily on both self psychology and object relations to richly describe the borderline condition, etiology, and treatment. Adler and Buie describe the core borderline condition as "intensely painful aloneness," a feeling state that "often includes a sense of inner emptiness together with increasing panic and despair…over time, these patients develop a concomitant desperate hopelessness that this feeling will ever be alleviated" (Adler & Buie, 1979 p. 83). They attribute their "aloneness" to an inability to hold on to soothing introjects. The borderline individual is one who cannot internalize an affective memory of a caring selfobject. He suffers from a "relative or total inability to maintain positive images or fantasies of sustaining people in his present or past life" (p. 83).

This inability to maintain such internalized images

means that the borderline individual is forever dependent on external selfobjects for a sense of connectedness, a sense of soothing. As these selfobjects inevitably fail to fulfill the borderline's needs, he is thrown into an existential panic in which he experiences again the pain of this fundamental aloneness, and, finding it to be too much to bear, is forced to paroxysms of effort to re-establish a sense of connection (Adler & Buie, 1979).

Adler and Buie (1979) employ an object relations framework to trace the roots of this all-encompassing borderline aloneness to a specific developmental failure arising from problems in the infant/maternal dyad. They identify the failure as occurring at around 18 months, in Piaget's Stage VI, when a child possesses a "sustained mental representation of the object as retaining permanent existence despite the fact it leaves the field of perception" (p. 85). Adler and Buie borrow from Fraiberg (1969) in conceptualizing this ability to evoke the memory of the missing object as "evocative memory." Fraiberg differentiates evocative from "recognition" memory, in which the "object can be recognized when presented, and can be remembered for a few moments, but its image can not be evoked unaided" (p. 86). This capacity corresponds to the cognitive development of Piaget's Stage IV, 12-month-old infant.

It is a fundamental assumption of object relations theory that the maternal/caregiver object is the most critical object in the infant's life. The child with evocative memory has the ability to internalize the soothing, affectively laden image of the caregiver such that the infant can maintain a sense of calm and connectedness in the caregiver's absence. Adler and Buie note that while evocative memory capacity is first achieved in normal development at around 18 months, the infant's ability to call up evocative memory is initially highly fragile and subject to disintegration in the face of a too-prolonged absence of the caregiver or other shocks to the young psyche. As they see it, it requires a year or more beyond its initial achievement for evocative memory to solidify, and even then, the child can be shaken into a regressive, pre-object permanence state by too great a shock to the system.

The authors see problems with evocative memory capacity as the core deficit that is the source of borderline psychopathology: "We believe that adult borderline patients have not achieved solid evocative memory in the area of affective object relationships, and are prone to regress in the area of object relations

to recognition memory, or earlier, when faced with certain stresses" (Adler & Buie, 1979, p. 87).

Adler and Buie argue that failure of the mother to provide an adequately sustaining holding environment is the primary cause for the child's inability to develop evocative memory. The failure of "good-enough mothering" is experienced by the infant as aloneness. "If this aloneness constitutes too much of the infant's experience, he will be unable to negotiate development of libidinal object constancy; i.e. as an adult he will not be able to maintain a sense of soothing contact with sustaining introjections because the introjects will be unstable and subject to loss through a form of structural regression" (Adler & Buie, 1979). The infant, who has not had sufficient experience at an early juncture with the sustaining presence of a nurturing, connected mother, will fail to develop the internal structures with which to self-soothe. They are then, at least potentially, doomed to grow up to the borderline state in which the temporary loss of sustaining introjects brings the same experience of aloneness as did the failures of the holding environment during infancy.

Applying Theory to Janice

Adler and Buie's approach to object relations directed me to look to the client's narrative of her past for evidence to support the hypothesis of an early failure in the mother/infant relationship. Adler, writing alone, clarifies the general theoretical idea of a failure to provide an adequate holding environment and good-enough mothering by identifying childhood neglect and abuse as significant potential factors in the borderline's failure to develop the internal structures associated with evocative memory:

> Their childhood experiences are replete with stories of abandonment, neglect and abuse, always emotional, and often physical and/or sexual. These painful experiences leave them untrusting, as well as vulnerable to re-experiencing the childhood feelings and difficulties in adult relationships. As part of these experiences, they were left developmentally vulnerable because their environments failed to provide the necessary safety, both to internalize interactions with loving reliable parental figures and to interdigitate them with the biological unfolding of their evolving cognitive and affective structures.

(Adler, 1993, p. 195)

Janice's history seemed to resonate strongly with this depiction of early developmental rupture. Nowhere in our explorations of her childhood memories was there an indication of a loving, supportive relationship. Janice stated that from her earliest memory up to and beyond her college years, she was regularly subjected to severe physical abuse, primarily at the hands of her mother. The abuse was intense, terrifying, and entirely unpredictable. Janice was unable to identify any pattern or obvious triggers for what would set her mother off. Janice indicated that she was also regularly subjected to beatings and other violent physical abuse at the hands of her father. She stated that neither parent would protect her from the other, and that in fact they often openly collaborated with each other in her abuse. She also hinted at possible sexual abuse at the hands of her father.

Current Presentation

Janice's descriptions of her life experience were suggestive of the sort of early developmental failure Adler presents as central to the development of a borderline personality disorder. There also appeared to be resonance between Janice's current presentation and the characteristics identified by Adler as common with the disorder.

Two factors seem to stand out in Adler's formulation of the borderline personality organization. They are the intensity of the individual's experience of aloneness and the intensity of his/her reaction to that aloneness. Adler and Buie (1979) present persons with borderline personalities as "people with a relatively unstable personality organization who are particularly vulnerable to feelings of abandonment and aloneness which are precipitated in the context of dyadic relationships. In order to alleviate or prevent aloneness, intense needs to be held, fed, touched and ultimately to be merged together, are mobilized in these patients within a dyadic relationship. When these felt needs are not fulfilled, intense rage ensues" (p. 84).

Adler suggests that in addition to specific problems around issues of aloneness, the borderline disorder is characterized by problems with the "need-fear dilemma" and with "primitive guilt" (Adler 1985, 1989, 1993). He notes that people with psychotic disorders fear relationships because they are unable to maintain the boundary between self and other within themselves. He maintains that individuals with borderline

personality disorder also fear this experience of fusion, though in fact it rarely happens. "But it is the fear of the loss of this separateness that is the essence of the borderlines' need-fear dilemma. They act or flee from relationships because of this fear, which in turn increases their feelings of neediness and aloneness" (Adler, 1993, p. 197).

Adler defines a borderline's guilt as "primitive" based on its intensity, the ease with which it is projected, and its absolute "all or nothing quality" (p. 197). He ties this sense of guilt to the intensity of their self-hatred, which can be projected out towards a selfobject at one moment and turned against themselves in the next. He adds, "the result of all these factors is an instability in their relationships, which readily become unrealistic, intense, demanding, chaotic and terrifying."

I was most struck by the central place the fear of being alone held for Janice. The experience of having been alone, and the fear of returning to it, was the predominant theme to emerge from our sessions together. It appeared to be the organizing principle around which all of her relationship and life decisions were being made at the time.

Janice presented herself as a woman without a single friend, and stated that those whom she had known in the past had always betrayed her. Now well into her 30s, she indicated that though she had had some superficial involvements with men in her life, she had never been truly attracted to, or emotionally involved with a man until she met her lover slightly more than two years prior to the beginning of her therapy with me. The object of Janice's affection was a cross-addicted drug abuser (I will call him Bill) with whom she lived. Janice was involved in a highly charged, chaotic relationship with Bill. She stated that he was the only man who ever truly loved her. The intensity of the experience of believing that she was "truly loved" was the most important fact in her life, and she appeared willing to do almost anything to maintain access to its source. Bill's frequent absences were a continuing theme in their relationship. He would disappear for hours or days or weeks at a time, precipitating a crisis state in her in which she experienced a profound sense of sadness and disintegration, followed by equally intense rage. From her descriptions of these rages, they sounded all-encompassing, as if all rational restraint or cognitive balance was lost in an overwhelming flood of pain and anger.

It did not appear, however, that Bill's presence was

any more reassuring than his absence. In what may have been evidence of her experiencing Adler's need-fear dilemma, she seemed to want nothing more than the experience of intense intimacy with him, but appeared unable to tolerate it when it did occur. Janice described, with apparent bewilderment, feelings of intense closeness to Bill that also appeared to precipitate intense, raging behavior in which she picked fights with him for not being more available, closer, or more attentive. She then experienced an overwhelming guilt that appeared to resonate with Adler's definition of "primitive guilt." When experiencing this reactive guilt she perceived herself as worthless, crazy, stupid and weak. She raged at herself for being in such a relationship, for being unable to better control herself in it, and for being unable to leave it.

Adler follows Kernberg in seeing persons with borderline personalities as having problems with splitting, or the "inability to bring together positive affect and positive self and object representations with negative affect and negative self and object representations" (Adler, 1993, p. 197). Though Janice constantly struggled to do so, she appeared unable to maintain a negative internalized image of her lover. She saw him as a physically beautiful, charismatically attractive man whose charm earned him the affection of the very people he lied to, stole from and otherwise betrayed. She seemed cognitively aware of his failings but did not appear to be able to affectively hold him responsible for them. Rather than accept the negative light in which these failings might cast him, she turned her disappointment inward, and found in them evidence of her own lack of self worth. She was able, for example, to confirm her long-standing suspicion that he lied to her concerning his whereabouts when he was not present. Initially, she was appropriately angry at this fundamental violation of her trust. By the time she came in to see me a few days later though, her anger had turned inward. Bill was no longer responsible. Instead, her question was "What's wrong with me that someone who says they love me would lie to me?"

Treatment Implications

Adler's therapeutic approach to the client with borderline personality disorder, consistent with self psychology and much of psychodynamic therapy in general, puts the therapeutic relationship itself at the center of the treatment. The therapy revolves around what Adler refers to as "selfobject transferences" in which "the therapist performs certain functions for the patient that are absent in the patient. The therapist's performance of these functions is necessary for the patient to feel whole and complete, while experiencing these therapist functions as part of himself" (Adler, 1985, p. 100).

Adler envisions a three-phase treatment approach (Adler 1985, 1989, 1993). As will be discussed in more detail later, only the initial phase of treatment deals with the client's borderline pathology:

> The primary aim of first-phase treatment is establishing and maintaining a relationship in which the therapist can be steadily used over time by the patient as a holding selfobject. Once established, this situation makes it possible for the patient not only to develop insight into the nature and basis of his aloneness but also to acquire a solid evocative memory of the therapist as sustaining holder, which in turn serves as a substrate out of which can be formed adequate holding introjects. That is, developmental processes that were at one time arrested are now set in motion to correct the original failure. (Adler, 1985, pp.49-50)

Of course, things are not quite that simple. The central fact of the borderline condition—aloneness and the client's inability to tolerate it—is also the central complication in the treatment. Adler (1985, 1989, 1993) argues that it is inevitable that aloneness issues will surface as the therapeutic relationship successfully develops. The client senses that the therapist is soothing and sustaining. He begins to relax his defenses in response and to use the relationship to satisfy his need for soothing. But the very experience of being soothed then triggers an awareness of the enormity of his felt need and his vulnerability to feeling abandoned. This snowballs into "a sense of intense, unsatisfied longing," a feeling of emptiness when not in the presence of the therapist. The client responds to this feeling of emptiness with characteristic rage. The rage in turn engenders an "annihilatory panic" in which whatever fragile soothing introjects the patient may have are overwhelmed, leaving him in the throes of the core sense of aloneness that is at the heart of the borderline condition. "The patient may become increasingly needy, desperate, suicidal,

feel totally alone, and have the experience that no one is there or that all positive, internal images have been destroyed (Adler 1993, p. 198).

Thus, the transference within the therapeutic relationship duplicates the patterns and experiences that make up the borderline condition. The therapist's role here is to create a safe container, a holding environment in which therapist and client can both address and interpret these feeling states and survive the rage associated with them. In Adler's words (1993):

> The essence of the treatment approach is the establishment of a holding environment that both requires an interpretive approach and ultimately allows interpretation as the cornerstone of the resolution of the borderline problems. The elaboration of fantasies and helping the patient bear painful affects are crucial ingredients of the therapy. Of particular importance is the borderline patient's inability to tolerate feelings of sadness and anger. Helping the patient acknowledge such feelings when present, and elaborating bodily feelings and fantasies that accompany these feelings, comprise much of the therapeutic work. The therapist's exploration of the patient's fantasies about their relationship and the patient's conviction of personal badness and worthlessness as well as distrust ultimately assist in the development of a safe treatment situation. (pp. 199-200)

Helping the patient to negotiate the intensity of their affects—including both their sense of aloneness and rage—is a central component of the work in this phase. Adler warns the therapist to be particularly mindful of his own countertransference in the face of the client's intense affects. He suggests that the very fact of surviving the projected rage can have a highly therapeutic effect. In part, this is because the client benefits from the model of a new and different experience than any he has had in the past. Adler suggests though that the therapeutic benefit derives largely from the mechanisms associated with a projective identification properly contained. The projection of rage onto an object is seen as one of the primary defenses used by a borderline. The therapist must accept the projection, contain it, and through interpretation and analysis, give it back to the client in a modified form, which the client can then accept and internalize (Adler, 1985, 1993).

This interaction is a core component in the therapy, and one of the primary means used for the client to build his own internal structures for holding and soothing introjects. "Although most containment experiences are only relatively successful… there is an incremental experience over time in successful therapy that can allow the patient to re-internalize modified projections. These ultimately become the holding and soothing introjects that heal the patient's aloneness difficulties" (Adler, 1993, p. 199).

Adler (1985) also warns that the very nature of the client's deficit—the lack of holding-soothing introjects requires that the therapist be prepared to extend himself far beyond the normal bounds of the client-therapist relationship. Borderline clients, by definition, are not able to call upon evocative memory to sooth themselves in the absence of the actual presence of the therapist. They may be able to remember what the therapist looks like (recognition memory), but the therapist has ceased to affectively exist. As the therapy proceeds, and before the client has established sufficiently resilient internalized holding-soothing introjects, Adler suggests that they may need to make heavy use of transitional objects, which may include the sound of the therapist's voice in a phone call, a postcard, or some other object that evokes the affective experience. Lacking these, the threat of regressive rage in response to such perceived empathic breaks as the therapist's vacations (or even simple non-presence between sessions) is ever present.

Adler (1993) presents a view of increasing mental health as the client gradually establishes holding-soothing introjects and the capacity for evocative memory. As this capacity strengthens, the rage response weakens. With successful completion of phase one treatment, the client has achieved a relatively stable capacity for evocative memory, which signals that he has progressed to more normal ranges of neurosis and narcissistic character disorders. Adler's second and third phases of treatment are designed to treat these disorders and are modeled closely on Kohut's use of mirroring and idealizing transferences in the therapeutic relationship (Adler, 1985, 1993).

Application to Janice

I found myself uncomfortable with placing the interpretation of the transference at the center of

the therapy. This is the classical psychoanalytic idea, that the transference embodies the unconscious patterns and fault lines that lie at the core of the pathology. This material is revealed in the course of therapy to be analyzed and interpreted. The resulting insight is seen as having enormous corrective, therapeutic value for the client. Part of my discomfort was practical. One of Adler's clinical examples concerns treatment of a male patient for a period of 10 years, five times a week (Adler, 1989). Another (Adler, 1985) involves a patient seen twice a week for four years. While such an intensive, long-term interaction could perhaps produce the transference relationship Adler describes, this was clearly not going to happen in my brief relationship with Janice, which lasted only six months.

I remain unclear whether or not a therapeutic process that emphasizes the creation of a holding environment and the containment of projected rage can indeed kick-start arrested development as promised. In fact, my relationship with Janice never progressed to the point that she directed her rage at me. I did find, however, that Adler's presentation of the basic Kohutian idea of transmuting internalization as a therapeutic mechanism provided me with an appealing structure for organizing my sense of my role in the relationship with her.

Janice made a variety of references to the importance of her experience in having someone (me) who really listened to her. She indicated this was the first time she had this experience. She also expressed her fear that no one, including me, could truly understand her, and her fear that for me to do so would "burden me" with the weight of her negativity. Initially, I had been reluctant to explore these statements with her, in part because my sense was that it was not our relationship at issue in the therapy. But I found Adler's description of the uses of selfobject transference to be a green light for proceeding in this area.

By adopting the stance that an exploration of the relationship we were developing was in itself a potentially therapeutic undertaking, I was able to be more open to engaging in the discussion of Janice's hopes and fears regarding me. This allowed our relationship to more fully develop and, I believe, provided her with a model for a positive, genuine, empathic, relationship unlike any she had described experiencing in the past. She learned that I remained open to her no matter how depressed or self-deprecating she became.

While I could not fully understand her, neither was her negativity an intolerable burden for me. She did not have to remain alone with it. I could remain with her through her anger and hopelessness and, in so doing, perhaps assist her in beginning to form an "evocative memory of the therapist as a sustaining holder," as envisioned by Adler in his outline of the goals and processes of first-phase treatment (Adler, 1985, pp. 49-50).

I found the concept of evocative memory and the insight it provided into Janice's world to be particularly helpful. I can identify for myself the experience of evocative memory, and recognize how important a place it plays in maintaining a soothing balance in my own internal landscape. Attempting to imagine a consciousness devoid of such memory may be the most useful insight to have arisen from this inquiry as it gave me the opportunity for new and more empathic understanding of what profound aloneness means to those who experience it.

Looking back on my work with Janice, it seems to me that the application of the borderline label itself was far less important than the fact that it led me to a formulation that provided a more cohesive framework for understanding and responding to Janice's concerns as she sat across from me. Understanding Adler's explanation of the mechanism through which the real relationship that was developing between us could promote positive change was enormously useful in freeing me up to more fully engage Janice.

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The Phenomena of Phantom Illness:
A Discussion of Munchausen Syndrome by Proxy

by Devon Rocha

Abstract

Munchausen syndrome by proxy refers to a pattern of behavior in which a caregiver either makes his or her child sick or lies about symptoms the child is experiencing in order to present the child to physicians. Unnecessary medical tests and procedures are then undertaken in order to determine the cause of the illness. This becomes a cycle that sometimes results in the death of the child victim. Debates exist over whether Munchausen syndrome is a diagnosable mental health disorder of the perpetrator or if it should signify a type of child abuse that is being perpetrated. There is also substantial debate on the appropriateness of the term "Munchausen syndrome by proxy." These discussions are informative, but provide limited guidance to social work, child welfare, and medical professionals as to how to recognize that this pattern of behavior may put a child in danger. This article argues for the inclusion of Munchausen syndrome by proxy in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders as a diagnosis under the factitious disorder category. This inclusion would stimulate research into uncovering a concrete etiology, as well as the development of treatment approaches. Some of the current treatment ideas for recognizing and dealing with these cases are explored.

Introduction

Munchausen syndrome by proxy (MSBP) is a controversial topic, but one of which all social workers, child welfare professionals, and mental health practitioners should be aware. Much of the literature about MSBP attempts to solidify its definition. There is an ongoing debate by the social work, medical, legal, and law enforcement professions about what the term should encompass. Questions have surfaced as to whether Munchausen syndrome by proxy should be characterized as a psychiatric diagnosis or as a form of child abuse. Tied in with this discussion is a debate about what this phenomena should be called, as "Munchausen syndrome by proxy" is not a universally accepted term. It is the purpose of this article to bring out the major points in each of these debates, and to offer a central, defining view of the topic.

Statistical information about known cases is cited to present a more complete picture of the dangers of MSBP. Some theoretical considerations are then explored in an effort to generate views on how to deal with cases involving MSBP in the most appropriate and therapeutic manner.

Munchausen Syndrome by Proxy Defined

"Munchausen syndrome by proxy" refers to a pattern of behaviors in which a parent fabricates an illness in his or her child, either by lying about symptoms the child is experiencing or physically inducing the symptoms. The parent repeatedly presents the child to doctors, who in turn attempt to find the source of the child's "illness." Some speculations on why people would do this include the need to be the sick person by proxy, the desire to attract a spouse's attention, or the need to be in the spotlight. In MSBP, the child is harmed both by the parent, who manipulates the child's health to make it appear as if the child were sick, and by the doctor(s), who perform often invasive and painful procedures to determine the nature of the illness.

MSBP is an elusive cause of abuse to children because it is difficult to spot, at least in part because it is difficult for people to suspect parents of child abuse when they present as vigilant and knowledgeable about their child's health. It is also difficult to prove, and therefore, it may not get reported, investigated, or substantiated. Chiczewski and Kelly (2003) point out that the Illinois Department of Children and Family Services (DCFS) receives very few allegations of MSBP because most suspected cases are not reported to (or accepted by) the Illinois Child Abuse Hotline due to insufficient evidence. Harm to victims can carry on for years if the doctors are not suspicious or if they do not report their suspicions to the authorities, sometimes culminating in the death of the child.

MSBP is included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2000) as a condition under consideration for inclusion in a future edition of the DSM. It is grouped under the factitious disorder umbrella, wherein a person feigns illness in him- or herself. The four features, as listed for factitious disorder by proxy

in Appendix B, Criteria Sets and Axes Provided for Further Study in DSM IV-TR, are:

A. Intentional production of symptoms in another person who is under the individual's care;
B. The motivation for the perpetrator is to assume the sick role by proxy;
C. Lack of external incentives;
D. An inability to account for the behavior by another mental disorder. (p. 783)

As Rogers (2000) points out, this definition is open to more than the parent-child by proxy fabrication. This is important because it opens up the diagnosis to any person who might manipulate someone's health in this manner. For example, a person with this disorder could act similarly with an ailing parent or a person with a disability in their care (Meadow, 1995). The overarching pattern seems to be the manipulation of a weaker person in hopes of manipulating a more powerful person to satisfy pathological needs (Schreier, 2002a).

If the DSM were to include this as a full-fledged diagnosis, it might make sense to expand some of the criteria. The motivation of the perpetrator, instead of just to be sick by proxy, could possibly be opened up to include large-scale attention-seeking (Meadow, 1995). For example, when one woman who was eventually convicted of MSBP abuse became bogged down with hospital bills that insurance would not cover, she actually lobbied for healthcare reform, and ended up on a local news station with Hillary Clinton (Schreier, 2002a). Another DSM-IV-TR criterion that could be expanded is the fourth, "an inability to account for the behavior by another mental disorder." It seems possible that a contributing factor to MSBP in some people might be a personality disorder, such as Dependent Personality Disorder or Paranoid Personality Disorder, but the presence of another mental illness should not preclude an MSBP diagnosis if the defined patterns of behaviors exist. Donald and Jureidini (1996) stress the importance of including the medical professions' involvement in the abuse that occurs. A criterion to account for this could be simply, "Repetitive presentation of fabricated symptoms to medical personnel."

Data and Prevalence

Numerous case studies featuring MSBP have been published. Sheridan (2003) conducted a meta-analysis of 450 cases covered in 154 articles and generated statistics regarding MSBP. Most significantly, she found that 76.5% of the perpetrators were the biological mothers of the victims, and most had training in a health-related field. Victims were 52% male and 48% female. Most victims were 4 years of age or younger. Death of the victims occurred in 6% of the cases, 25% of the victims' siblings were known to be dead, and 61% of the siblings had illnesses similar to those of the current victims. Nearly one quarter of the perpetrators were described as having another psychiatric disorder, most often depression or a personality disorder. In 57% of cases, the perpetrators actively produced the symptoms, most often via suffocation, giving drugs to the victim, or poisoning. The most commonly reported medical problems of the victims of MSBP were apnea, anorexia, diarrhea, and seizures.

Prevalence rates are difficult to ascertain because the degree of awareness of MSBP among medical professionals is unknown. It could be that doctors are aware of the potential reality of MSBP, but are just not seeing it in their clients, or it could be that the doctors are simply unaware of the possibility that MSBP exists. As Eminson and Jureidini (2003) point out, MSBP can actually thrive in modern medical practice because contemporary medicine is investigation-oriented and also extremely litigious. Thus, there might be a tendency to over-test patients to guard against possible malpractice litigation due to not having run all diagnostic tests, and possibly missing the detection of something. Additionally, doctors (in hospital settings especially) are trained to investigate the origin of symptoms through various tests and procedures, and not to take social histories. Donald and Jureidini (1996), in analyzing the physicians' roles in cases of MSBP, note that incomplete or poor history taking is "central to its etiology."

Despite many case studies and detailed statistics regarding this phenomenon, there are some who attempt to refute the existence of MSBP. For example, Allison and Roberts (1998) liken MSBP to the social construction of witchcraft and then later, hysteria, as conditions afflicting women. An organization called Mothers Against Munchausen Syndrome by Proxy Allegations (M.A.M.A.) describes MSBP as a convenient way for doctors to avoid malpractice lawsuits or "rid themselves of a troublesome mom when unable to diagnose a child's condition" (www.msbp.com, para. 3). However, these analogies and explanations

are arguably a little too simplistic to account for the numerous MSBP cases found around the world. It may be that they feed off the lack of consensus regarding the classification of MSBP.

The Name Game

There are many terms used in the literature to describe this pathological phenomenon. These include "Munchausen syndrome by proxy," "Munchausen by proxy syndrome," "Factitious illness by proxy," and "Factitious disorder by proxy." One of the reasons this debate over semantics persists is because of the disagreement on how to classify it. While all are very similar, the fact that there is not consensus on what to call this condition becomes a weapon in the argument made by those who do not believe it actually exists. Additionally, some argue that MSBP and its derived names should be dropped altogether and, instead, a qualifier should be added to the child's presenting condition to designate it as fabricated.

The phrase "Munchausen syndrome by proxy" was first used by Roy Meadow because it seemed to be an offshoot of the preexisting condition known as Munchausen syndrome, in which a person feigns illness in him or herself (Bools, 1996). The 'by proxy' designation was added to signify that the person used someone else to feign the illness. "Munchausen by proxy syndrome" came into favor because the term differentiated it from Munchausen syndrome. As stated previously, MSBP is included in the research section of the DSM IV-TR as factitious disorder by proxy. Fisher and Mitchell (1995) see this as the DSM following a trend against the use of eponyms. Rogers (2004) believes that 'feigning disorder by proxy' is an appropriate diagnostic label, and could be sub-categorized in the DSM in a manner similar to the way in which factitious disorder is categorized with psychological signs and symptoms by proxy and medical signs by proxy. Fisher and Mitchell (1995) are proponents of eliminating the label altogether, and simply diagnosing the child with a 'factitious' or 'fabricated' qualifier.

"Munchausen syndrome by proxy," while possibly the most used, is probably not the most appropriate terminology. This is especially so given that there is no evidence that its namesake, Baron von Munchausen, known for his tall tales and adventurous stories, ever sought unnecessary medical

treatment or even tried to deceive people (Zide & Gray, 2001). Since the DSM has already preliminarily included it as factitious disorder by proxy, this would seem to be an appropriate label. This is truly an interdisciplinary issue, affecting medical, social work, psychiatric, and legal professions that warrants more research and attention than semantic debates. Indeed, the focus of attention needs to shift to understanding how to protect the child victims and how to help them with the traumatic effects of MSBP. The first step in helping victims is learning to recognize when children are being abused by their parents in the disguise of medical care.

A Psychiatric Condition

There is much debate surrounding the classification of Munchausen syndrome by proxy. Should it be classified as a psychiatric diagnosis, or should it be considered a form of child abuse? To think of this solely as a form of child abuse would be to discount the unique manner in which the perpetrators use the medical profession to carry out at least some of the abuse. Donald and Jureidini (1996) cite three ways that MSBP has been regarded as different from child abuse. First, MSBP seems to be symptomatic of some "specific psychiatric disturbance in the perpetrator" (para. 3). The fact that this syndrome is seen around the world makes it a cross-cultural phenomena, and would seem to hint at some sort of common etiology. This type of psychopathology could be the need to be the sick person by proxy, or it could point to a pathological attention-seeking fixation. Neither phenomenon is associated with the common understanding of child abuse. Higher reported mortality rates and the observation that MSBP abuse seems to be premeditated, rather than motivated by frustration or rage toward the child, are also cited by Donald and Jureidini as characteristics of the condition that differentiates it from classic child abuse. Lastly, consistent with the point made above, the authors weigh heavily the involvement of the medical profession as a differentiating factor.

There is an advantage to formally naming MSBP as a psychiatric condition. Most importantly, it would stimulate the mental health profession in devising treatment approaches for these perpetrators and their victims. Currently, a preponderance of the research and published writing is devoted to the classification of MSBP, instead of its etiology or treatment.

Moving beyond classification would be productive in helping to recognize and stop the abuse, and in treating the perpetrators and victims.

Many professionals oppose classification of MSBP as a psychiatric disorder, however. Their arguments reflect broader concerns that accrue to the diagnosis of mental disorders in general and the specific system used for diagnoses found in the DSM. Chiczewski and Kelly (2003), for example, state that law enforcement personnel should treat MSBP as a form of child abuse and not as a psychiatric diagnosis. The classification of MSBP as child abuse by this profession is arguably an appropriate position because it is the duty of law enforcement personnel to protect society from criminal behavior regardless of its underlying cause. For example, if someone with bipolar disorder shoplifts, that person will be treated as a thief by law enforcement personnel, and only secondarily as a person with bipolar disorder. But this does not mean that other professions should not regard MSBP as a psychiatric condition. This just demonstrates the importance of knowing the implications of various psychiatric disorders. For MSBP, a major implication is child abuse, and that needs to be dealt with appropriately and in its own right.

From a psychiatric perspective, Eminson and Jureidini (2003) also state that MSBP should not be considered a diagnosis, in part because there is not a single or specific causal explanation for the behavior. They give an example of meningococcal bacteria as a specific cause for many different illnesses and diagnoses, all of which can be related back to that bacteria, and thus, can be reliably thought of as diagnoses. This analogy and argument overlook the fact that there can be several different contributing factors to the development of many psychiatric disorders. These factors may even differ for two people with the same psychiatric diagnosis.

Fisher and Mitchell (1995) also state that it is not appropriate to say that someone 'has' MSBP. Their reasoning is that neither the perpetrators, nor their victims, have a specific set of symptoms. Perhaps all perpetrators do not engage in the same harmful behaviors with their victims (one parent might suffocate a child, one parent might use poison, for example), but the pattern is essentially the same. Whether or not these behaviors can be referred to as "symptoms" relate to Rosenberg's point of view. Rosenberg (2003) contends that MSBP should not be considered a diagnosis because it represents a collec-

tion of acts and not just the "predisposing state of mind" (p. 423). However, the diagnosis of conduct disorder, for example, is based largely on acting out behaviors as the symptom picture. Rosenberg also states that only observable criteria can be used in a diagnosis, and that the intent of the perpetrator, perhaps to garner attention or assume the sick role by proxy, cannot be observed. However, in the diagnosis of antisocial personality disorder, the individual's lack of guilt regarding his or her crimes is not directly observable either. Thus, some arguments against MSBP as a diagnosis do not hold up when compared with the nature of other currently accepted psychiatric disorders.

There is also concern that utilizing MSBP as a diagnosis of the perpetrator may result in diminished responsibility for the abuse that ensues. Rand and Feldman (1999) state that psychiatric diagnoses should have limited use in the court for this reason. However, it should be noted that an explanation of MSBP might actually convince a judge or jury to convict a parent of child abuse, even though they may not have hit, neglected, nor sexually abused their child. In cases where hospital surveillance tapes depicting a parent tampering with tests or with their child's health are not available, but other evidence for MSBP exists, the perpetrator could rightfully be held accountable.

Donald and Jureidini (1996) see MSBP as a label not for a diagnosis nor for a form of child abuse, but to describe a "complex transaction" among a parent, a child, and the doctor consulted by the parent in regards to the child's illness (How should MSBP be defined section, para. 6). Fisher and Mitchell (1995) advocate that MSBP not be "diagnosed" at all, and that pediatricians who observe fabricated illness in a child describe it as just that, for example, as factitious or induced apnea. This would presumably help guard against using a diagnosis such as MSBP to reduce blame for the perpetrator if prosecuted (as in, arguing that a person is not guilty of child abuse because he or she is mentally ill with MSBP), but it would also shift attention away from working to uncover the psychopathology of this condition. This is too important and dangerous an issue to ignore or minimize. It is the author's contention that MSBP should be recognized as a need for attention at the expense of a child's physical health and emotional well-being, and dealt with actively by child welfare professionals, therapists, law enforcement, and medical personnel.

Smith-Alnimer and Papas-Kavalis (2003) wrote about MSBP as both a psychological diagnosis and as a form of child abuse. This position is consistent with The American Professional Society on the Abuse of Children's (APSAC) two-element definition of MSBP: 1) A pediatric condition falsification evident in the child, and 2) A caretaker who has a diagnosis of factitious disorder by proxy, because he or she harms the child for self-serving psychological needs (Schreier, 2002a & 2002b). This definition seems to effectively connect the pediatric condition and psychiatric disorder labels into one definition. It also indicates the appropriateness of giving a psychiatric diagnosis to the perpetrator.

Theories of Etiology and Treatment

Scheper-Hughes (2002) weighs in on the existence of MSBP by detailing some of her anthropological studies undertaken in an economically disadvantaged region of Brazil. She observed mothers repeatedly taking their babies to doctors and receiving medications and food, but not administering them, effectively keeping the child sick, and necessitating further medical attention. She asserts that MSBP exists as an extreme pole along a continuum of maladaptive maternal behaviors that arise in response to prior unmet emotional and environmental needs of the mother. She conceptualized this behavior as the poor mothers' needing to feel connected to the social world, and using the child as an object of primary or secondary gain, which serves the mother's (and even the doctor's) narcissistic needs. This goes back to the idea of the parent's motivation being an attempt to maintain a relationship with "powerful" medical personnel. Scheper-Hughes also observed that the perpetrator could feel excited at having "tricked" doctors and hospitals. On the other side of the coin, the doctors might see the child victim as a frustrating, yet unique "challenge" to his practice.

Szajnberg and Moilanen (1996) discuss MSBP perpetrators as presenting a convincing "false self" to clinicians. This conceptualization came from the observations of clinicians who treated MSBP-perpetrating parents. Despite evidence to the contrary, these therapists described having an "uncanny, ego-dystonic, and uncomfortable sense of disbelief" that the parent had actually induced the child's sickness (para. 6). The idea of the false self is derived from Winnicott's view of object relations. In addition to

the mother, it can also be applied to the child victim in these cases. According to Winnicott, the true self develops in the child out of a genuine and flexible attachment (presumably with the mother) (Berzoff, Flanagan, & Hertz, 2002). But when the child is brought up in a holding environment exclusively focused on the needs of the mother, an overly compliant false self will develop in the place of the true self (Berzoff, et al., 2002). In MSBP cases, it is out of his or her own needs that the parent seeks medical attention for the child. Accordingly, it is not only the physical and medical abuse that harms the child, but if he or she survives, he or she will likely continue in a pattern of being overly compliant, putting his or her needs last, if attending to them at all (Berzoff, et al, 2002).

Hotchkiss (1997) writes about the idea of the child as a fetishistic object. In referring to mothers, she notes that "in projecting her own woundedness onto her child and then becoming the agent of the child's healing, she could heal herself over and over again" (p. 321). The idea of MSBP behavior as a form of fetishistic ritual is an interesting idea which may illuminate some obsessional and compulsive features of this disorder. Haddad, et al. (2002) notes that often the mother has had a personal history of symptoms similar to the ones she induces or reports in the child. This is a more literal interpretation of the notion of the mother 'healing' herself, but it could be an interesting point of therapeutic exploration with the MSBP perpetrator.

Szajnberg and Moilanen (1996) indicate that MSBP perpetrators exhibit a disturbance in the capacity for valuing intimacy and emotional proximity. This points to individual psychotherapy as a recommended form of treatment. However, the literature that does touch on treating those with MSBP is inconclusive about success in working with this population. Additionally, there is not much literature regarding specific treatment approaches.

Along with concepts from object relations theory, self psychological concepts could be useful in understanding treatment with a client with MSBP because self psychology also speaks to the existence of a false self and a true self (Cooper & Lesser, 2002). From a self-psychological viewpoint, perhaps the mother uses her child as a selfobject. Through the fabrication of symptoms or inducing illness, her child mirrors her own feelings of being sick and requiring care.

While empathy in the therapeutic relationship is central to a self-psychology model of treatment (Cooper & Lesser, 2002), the therapist should keep in mind that it may be difficult to garner empathy for the MSBP client, given his or her actions and likely refusal of responsibility toward hurting his or her child. Lastly, cognitive therapy techniques might be explored with these clients by focusing on the cognitive distortions the patient may cling to that result in such abusive behavior toward their child.

The role of the medical profession in the treatment of MSBP is pivotal, since doctors themselves can unknowingly carry out much of the abuse of these children on behalf of the parent through various examinations and treatments. Donald and Jureidini (1996) offer several factors in particular that should raise physicians' suspicions about MSBP abuse, including medical problems that do not respond to treatment, implausible lab findings, and similar unexplained illnesses in siblings. There is discussion about the actions that doctors should take when suspicious of abuse. For example, Bryk and Seigel (1997) suggest getting more specific details about the patient's history, obtaining records from other hospitals, and restricting hospital visitation or having someone else present during visits with a suspicious parent. However, there is no research that examines the ability or likelihood of doctors to recognize these signs (or what signs they will actually respond to), and what will lead them to take action to protect the child

Summary

Munchausen syndrome by proxy is a frightening child welfare phenomenon that presents itself in the medical arena. The existing literature is informative, albeit preoccupied with how the disorder should be defined and what it should be called. Many disagree about the value of regarding MSBP as a psychiatric diagnosis of the perpetrating parent, and instead opt to think of it solely as a form of child abuse. This line of thinking seems to trivialize the unique nature in which these parents harm their children. Additionally, MSBP differs from what we conceptualize as child abuse in many ways. Classification of MSBP as a psychiatric diagnosis could help bring professionals together on the issue. Reaching such a consensus would allow us to focus on understanding the dynamics of the problem and how to effectually treat both the MSBP-diagnosed person and the victim.

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Mental Health Parity: Past, Present and Future

by Brittany Boden, Berklee Cochand, Caroline Nelson and Renee Potter

Abstract

This article addresses the development of the Mental Health Parity Act of 1996, created to respond to the need for adequate insurance coverage for those that suffer from mental illness. Due to the problematic tendency to keep costs low, managed care organizations and insurance companies in the United States have limited the amount of mental health benefits that one may receive. This has resulted in the creation of a distinct disparity between mental health and medical benefits affecting many people today. In-depth examination of positive and negative aspects of the Mental Health Parity Act of 1996 are discussed, as well as the recently proposed Mental Health Equitable Treatment Act of 2003.

Introduction

Carla Hochalter was hospitalized with debilitating symptoms of depression after her daughter, Anne Marie, was paralyzed in the Columbine school shooting of 1999. In spite of the severity of her illness, her behavioral healthcare manager determined after 30 days of inpatient treatment that hospitalization was no longer medically necessary, forcing her into partial, outpatient treatment. One week after her release, she went to a gun shop, asked to see a pistol, loaded it, and fatally shot herself (Perina, 2002). Such an extreme story exemplifies the consequences of a savings-driven mental healthcare system that is fostered by a cultural denial of mental illness. The Mental Health Parity Act of 1996 represented a milestone piece of legislation for mental healthcare. While the act was limited in scope and application, it brought about the advent of the concept of medical parity: the spirit of equal regard and equal treatment for physical and mental illness.

The Problem

In America, the surface problem that has created a need for legislation for mental health parity is the simple fact that many people either have no insurance coverage for mental health problems, or their mental health insurance benefits are minimal in comparison to health coverage for other illnesses. Individuals who are fortunate enough to have some kind of mental health coverage are likely to have higher co-pays for these services, limits on the number of visits, limits on amounts of reimbursement for services, and lower lifetime caps as compared with those for other medical problems. All of these factors result in benefits that can run out quickly, forcing many individuals to turn to the public sector for care. Taxpayers ultimately end up footing the bill for the difference between the needed and available benefits (Hughes, 1996). Each year, the total of direct and indirect costs of mental illness is approximately $113 billion (Chordas, 2003). Therefore, people who are not utilizing mental health services may end up paying for those who can no longer afford to finance the cost of their own mental health services. It can easily be argued that providing mental health parity would ultimately benefit U.S. taxpayers (Hughes, 1996).

When conceptualizing the problem of mental health insurance disparity, one must consider the reason why mental health coverage has been separated and distinguished from medical coverage. The presence of legislation to establish parity in health insurance coverage indicates that mental illness has achieved a level of significance in the array of social problems facing our country today. A resistance to parity indicates that mental illness is viewed differently than medical illness in this country. The question arises of whether or not mental disorders are medically legitimate (Woolfolk & Doris, 2002). A lack of clarity has surrounded mental disorders for hundreds of years, and erroneous beliefs about the nature of these disorders have long existed. In the late seventeenth century, Cotton Mather, a well-known Boston minister, was known to have preached that those who were "mad" had the devil in them, yet similar statements were not made about the physically ill. Evidence suggests that the stigma which has accompanied mental illness since the colonial times, still remains today. Survey results from public opinion polls have indicated that many people feel that mental difficulties are caused by emotional weakness, and many also feel that mentally ill people choose to be ill (Fraser, 1994). It appears that mental illness is often viewed as a private trouble rather than a public issue.

Stereotypes about mental illnesses are accompamied by societal stigma associated with these problems. Some people develop stereotypes about mental illness based on one encounter with an individual exhibiting erratic behaviors or psychotic symptoms. Stereotyping of the mentally ill can also be attributed to the media. Accounts of criminals with mental illness often appear in newspapers, television and motion pictures (Hughes, 1996). One study looked at six different U.S. newspapers in the year 1999, and examined hundreds of articles that presented "mental illness" as the key subject (Wahl, Wood, & Richards, 2002). In these articles, "dangerousness" was the most common theme, and twice as many of these articles were negative as opposed to positive in nature. These articles tended to omit the names of specific psychiatric disorders, leave out descriptions of the symptoms of the disorders that they did name, and exclude the perspectives of individuals who utilize mental health services. This lack of accurate representation promotes a lack of understanding of mental illness (Wahl, Wood, & Richards, 2002). A report by the World Health Organization said that the social stigma linked to mental illness has led to insufficient attention, as well as insufficient resources, being allocated to mental health care (Woolfolk & Doris, 2002). In short, as Hughes (1996) states, "people with mental illness are some of the most underrepresented and misunderstood in our society" (p. 35).

The problem of mental health disparity affects many Americans in a variety of ways. It is important to understand that mental health consumers are diverse in age, gender, class, and income (Hughes, 1996). In one year, about 30% of adult Americans will suffer from symptoms related to a diagnosable mental disorder, and about 20% of American children will exhibit symptoms of diagnosable mental disorders (Daw Holloway, 2003). One statistic indicates that in any one month, nearly 8 million people face symptoms of depression (Abrahamson, Steele, & Abrahamson, 2003). In other words, many people may need mental health services at some point in their lives, but those who have little or no mental health coverage may be deterred from seeking help. Indeed, it is estimated that almost one half of those who suffer from a mental disorder will not seek treatment (SAMHSA, 2003). For those who do seek professional help, limitations on mental health benefits can place mental health professionals in the unfortunate position of having to tell them that their difficulties are not considered serious enough to receive coverage from their insurance company (Abrahamson, Steele, & Abrahamson, 2003) Disparity of mental health benefits can have the effect of discouraging service utilization and can also have a negative effect on the therapeutic alliance when mental health professionals become de facto representatives of the managed care system.

The problem of mental health parity exists because managed care organizations and insurance companies put restrictions on mental health benefits in order to keep costs low and to make a profit. Employers and insurers have thus managed to create a problem that impacts individuals with a mental illness. In Congress, insurance companies and managed care organizations carry heavy influence over legislators. These interests may have just as much influence, if not more, than the interests of the people who are actually affected by changes in mental health insurance coverage.

History of Mental Health Parity Policy

Mental Health Parity legislation emerged in many different incarnations throughout the 1990s. In response to a family member's serious mental illness, Senator Pete Domenici introduced the Equitable Health Care for Severe Mental Illness Act of 1993 (Geller, 2000). This was the first act directly relating to the concern of equity in mental health coverage. While great attention was paid to Clinton's 1993 Health Security Act, little progress was made to pass Domenici's act. The 1993 Health Security Act provided hope that mental health would be recognized on the same level as physical health (Geller, 2000). Unfortunately, when the Act was introduced to the public, there was no parity between mental and physical health. When the Act was taken to Congress in 1994, the Financial Committee made an enormous step forward by including parity in the discussion of what the benefits board must provide (Geller, 2000). In addition to the Health Security Act of 1993, Senator Robert Dole introduced the Dole Bill in 1994 to Congress. This bill stated that the Secretary of Health and Human Services should give priority to providing coverage for mental health and substance abuse services that is equivalent to coverage for medical services in terms of duration of treatment and cost (Gellar, 2003). After this bill was introduced, two other separate senate bills, the Mitchell Bill of August

12, 1994 and the Mainstream Proposal of 1994, also recognized the idea of true parity in regards to mental health coverage. Despite attempts at recognizing parity at the federal level, however, parity failed to be passed into actual legislation (Gellar, 2003).

Similarly, in 1995 Senator Nancy Kassebaum introduced The Health Insurance Reform Act that revisited the issue of parity in mental health coverage. Aimed at addressing issues of access to coverage, the act was amended in 1996 to include a parity provision. When the act was passed as a bill in 1996, it unfortunately failed to include parity. Senators Domenici and Paul Wellstone were determined to include parity at the federal level and introduced the Mental Health Parity Act of 1996. This act prohibited insurance companies from setting restrictions on annual/lifetime benefits for mental illness coverage (NAMI, 1999). Signed into law by President Clinton on September 26, 1996, it was then implemented in 1998.

Although this act addresses an important aspect in regards to insurance coverage, major historical social welfare issues remain. While healthcare in general has evolved over the years to be more accessible to the public, the availability of mental health parity to the public is a persisting problem. Reflected in the passage of the Mental Health Parity Act of 1996 is the notion that attitudes toward mental health are starting to change. In previous years, the stigma that mental illness carried prevented many individuals from seeking treatment and identifying their issue as a mental disorder. Today, in some circles, mental illness is beginning to be characterized as a brain disorder, which can be easily diagnosed and seen as a biologically based medical problem (Flynn, 1998). With the development of managed care, more people are seeking treatment for their illnesses and more attention is being directed toward members of this population and their needs. In 1999, almost 177 million Americans with health insurance (72 %) were enrolled in managed behavioral health organizations (Satcher, 1999). Parity at the federal level is gaining more recognition as countless attempts to establish mental health equalities have persisted. With the introduction of the Paul Wellstone Mental Health Equitable Treatment Act of 2003, various measures are being implemented at the federal level to eliminate problematic issues that exist in the Mental Health Parity Act of 1996. As a result of parity legislation, equality between medical and mental health is

finally on the way to becoming a public issue.

The Policy

The Mental Health Parity Act (MHPA) of 1996 was intended to regulate discriminatory insurance practices that limit mental health coverage. The act went into effect on January 1, 1998 and it was due to sunset December 31, 2003, although the act was later extended to December 31, 2004. Employees and their dependents are the beneficiaries of this act, which prohibits employers from imposing lifetime or annual limitations on coverage for mental health benefits that have not been applied to medical benefits. This act only affects group health plans that already have mental health benefits; those that do not remain unaffected by the act. The act only applies to employers with more than 50 employees and if the cost of implementation is more than 1% of the total health plans cost, then the employer can apply for an exemption. The MHPA also allows group health plans to limit mental health services within a vague definition of what is deemed "medically necessary" (The Forums Institute, 1997).

The original amendment for the MHPA of 1996 was much broader in scope and was significantly watered down via bureaucratic compromise that originated with lobbying from the business community (Forums Institute, 1997). U.S. Senators Wellstone (D-MN) and Domenici (R-NJ), in addition to Representatives Roukema (R-NJ) and Kennedy (D-RI), continued to seek full mental health parity for the working people of this country and their dependents. However, current practices are not in the spirit of parity and maintain discriminatory access to treatment for mental illness (Killeen, 2002).

A new piece of parity legislation was introduced in 2003 - The Paul Wellstone Mental Health Equitable Treatment Act of 2003 - named in honor of the late Senator Paul Wellstone. This act will strengthen the original MHPA of 1996, as it expands upon the existing MHPA by requiring parity for the majority of illnesses found in the Diagnostic Statistical Manual, including the following mental health diagnoses: schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and severe anxiety disorders (Killeen, 2002). This act also prevents group health plans from imposing treatment limitations or financial requirements on the mental health coverage unless the same limitations and requirements are imposed

on medical benefits. The act defines treatment limitations as limits on the frequency of treatment, the number of visits, the number of covered hospital days or any other limits placed on the scope and duration of treatment, and it defines financial requirements to include deductibles, coinsurance, co-payments and catastrophic maximums (NAMI, 2003).

A downfall of this new act is that treatment for substance abuse is still not included. Considering that 50% of people with severe mental illness are affected by substance abuse, and 37% of alcohol abusers and 53% of drug abusers have at least one serious mental illness, how can treatment that does not address substance abuse be considered fair and equitable (NAMI, 2003)? Moreover, this omission is costly, given that approximately 73% of people with substance abuse disorders are employed, and $140 billion per year is spent on lost productivity (NMHA, 1999).

The funding mechanisms for the MHPA of 1996 are embedded within insurance plans. As such, the cost of the increased coverage for mental health benefits would have to either be paid by the insurance carriers or by whomever would pay for the insurance premiums: either employers alone in employer-sponsored health care plans, or a combination of employers and employees. Presumably, insurance carriers will not opt to absorb the costs of increased benefit coverage and so the burden of financing the benefits would fall to employers and employees. This has been one of the main arguments against parity by its opponents, along with the concern that the financial burden would result in employers dropping coverage for mental health benefits altogether or implementing other cost saving measures that would pose other limits to mental health benefits. Since the implementation of the 1996 MHPA, however, a majority of employer-sponsored plans that made MHPA-related changes did not compensate by increasing limits on other medical benefits because they expected increases in cost to be very minimal (SAMHSA, 1998).

Administration of the policy falls to the private sector via group policy changes between employers and their insurance brokerage companies or insurance carriers. These changes are then disseminated to members and beneficiaries covered by the group plan in accordance with the Employee Retirement Income Security Act (ERISA)'s Workers' Right to Health Plan Information (U.S. DOL, 2002). The MHPA of 1996 is actually an amendment to the Public Health Service

Act (PHSA) and the ERISA of 1974. The Internal Revenue Code of 1986 under the Taxpayer Relief Act of 1997 was also amended by MHPA. As a result, jurisdiction over the policy's administration is shared between the Secretary of the Treasury (overseer of the Internal Revenue Code), the Secretary of Labor (overseer of ERISA) and the Secretary of Health and Human Services (overseer of the PHS Act). If someone fails to comply with the policy, they can be charged an excise tax or other civil money penalties. What these bodies actually do to enforce the laws and how severe the penalties can be is unclear. The National Partnership for Reinventing Government and others have issued criticisms of the Department of Labor's enforcement procedures and penalty structure, citing that, "[w]eak or absent penalties undermine compliance by communicating to the public (and to others in the justice system, such as U.S. Attorneys who decide which cases to prosecute) that a violation is not very serious" (NPR, 2003, para.19). The Department of Labor does, however, offer "compliance assistance guidelines" for employers and group health plans to comply with recent health care law changes (U. S. DOL, 2002).

As the policy is enacted under the umbrellas of the Department of Health and Human Services, the Department of Labor and the Department of the Treasury, it is subject to evaluation based on Executive Order 12866. This order requires government agencies to assess the economic and regulatory impacts of new legislation when the Office of Management and Budget (OMB) determines such impacts will be 'significant.' The Departments of Labor and Health and Human Services conducted an economic impact analysis on the MHPA of 1996 that was submitted to the General Accounting Office for review in 1998 (GAO, 1998). The newly introduced Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, also known as HR-953 and S-486, provides for a similar evaluation to be conducted by the GAO within two years of the act's passage into law (Bazelon, 2003).

Social workers have contributed to the grassroots campaign to support the legislation for Mental Health Parity through involvement and education by the National Association of Social Workers. The knowledge base of the MHPA of 1996 comes from the work of other national mental healthcare advocates like the National Association of Mental Illness, the National Mental Health Association (NMHA) and the Bazelon

Center for Mental Health Law. The federal government was brought into the discussion about the fractured mental healthcare system via the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH). They collaborated to produce the Report of the Surgeon General on Mental Health in 1999, a document that legitimized and federalized the effort to revamp the mental healthcare system (Satcher, 1999).

Analysis

From a social and economic viewpoint, the goals of the Mental Health Parity Act of 1996 are just and fair but remain limited. Who is covered under this act remains too narrow in scope and the act does not adequately provide benefits to those suffering from chronic or less severe forms of mental illness or chemical dependency. However, people who have access to the benefits provided by their employer as a result of the MHPA of 1996 will be able to experience more equitable treatment in mental health care coverage. From an economic perspective, the goals of working towards equality in mental health coverage compared to medical health coverage seem to be fair. While many insurance companies are fearful of the rise in cost they will encounter, it has been proven that parity is indeed affordable. For example, studies done in North Carolina, Texas, and Maryland, states that have activated parity laws, reveal that costs actually declined after parity was introduced. Also, in general, the number of users for managed care increased, with lower average expenditures per user indicating that parity can be an effective policy (Satcher, 1999).

For people with mental health issues, the goals do contribute to a better way of life for those who have access to health coverage. The ability to seek treatment in a way that does not contain discriminatory limitations allows people greater access to treatment and to knowledge about the kinds of treatment available. As more people begin to view their illness as something that can be treated, this act can contribute to restoring healthy functioning and gaining participation in the work force. A slight decrease in the stigma that has in previous generations been highly associated with mental illness, should also allow for improved access to treatment.

In addition to contributing to a better way of life for its target group, individuals afflicted with mental illness, the MHPA of 1996 is also consistent with social work values. Equality and social justice for people suffering with mental illness is something the act is strongly moving towards. Ending discrimination in terms of prohibiting annual lifetime limits reflects the growing recognition of mental illness coverage as a social problem, and strives to increase services to this population. The Mental Health Parity Act of 1996 attempts to reduce the gap between mental and physical illness that is still prominent, and shift the perspective of viewing them as two separate issues to viewing them as united. Also inherent in this act is the increasing attention directed towards self-dignity and self-worth of people who suffer from various mental illnesses. The target populations are gaining the opportunity to address their own needs and make notable changes in their lifestyles with the passage of this act.

Political Feasibility

There appears to be significant support for the new Paul Wellstone Mental Health Equitable Treatment Act of 2003. According to the National Mental Health Association, nine out of ten Americans believe that health insurance companies should provide benefits for mental illness that is more than or equal to benefits provided for physical illness or injury (NMHA, 1999). In June of 2002, more than 2,000 supporters of mental health parity assembled in Washington D.C. to urge Congress to act and end insurance discrimination against individuals with mental illness and their families. Over 1,800 members of the National Association of Mental Illness (NAMI) have called upon Congress to pass federal parity legislation. Senator Domenici has asserted that, "…illnesses of the brain are just like illnesses affecting any other organ of the body and their treatment should be covered the same way" (NAMI, 2002, para. 2).

The Paul Wellstone Mental Health Equitable Treatment Act of 2003 will be met with strong Republican opposition because it includes coverage for more than 200 mental illnesses; Republicans believe that such broad coverage would drive up the cost of employers' health coverage (Arias, 2002). Senators Pete Domenici and Edward Kennedy are diligently working to get this act passed. On November 6, 2003 they announced that the Senate would not act on the bill before Congress adjourned for 2003, saying that the Senate Majority Leader Bill Frist had assured them that this bill is a priority for 2004.

Senator Frist's assurance was able to ward off an initiative by Senator Kennedy to offer the Paul Wellstone Mental Health Equitable Treatment Act of 2003 as an amendment to the next continuing resolution. Congress has made use of continuing resolutions to allow the government to continue to function since the 2004 fiscal year started on October 1, 2003. By placing this act as an amendment on the continuing resolution, it would force the issue and keep the bill alive. Senator Kennedy may renew this initiative if the Senate does not act on the bill before the fall of 2004. Congress enacted another one-year extension of current mental health parity requirements before adjourning at the end of 2003 (Washington Bulletin, 2003). Mental health advocacy organizations are mobilizing support since the commitment to move the bill to the Senate floor early in 2004 has, as of this writing, not happened. According to the Mental Health Liaison Group, "With a shorter session this year, the Senate must act on parity soon or it will not pass in 2004" (Bazelon, 2004, Background section, para. 2).

Senate Majority Leader Bill Frist (R-TN) holds a great deal of power when it comes to passing the Paul Wellstone Mental Health Equitable Treatment Act of 2003. He has been suspected of having a hidden agenda because during his career in the Senate he has consistently championed the interests of the health care industry with its bottom-line interests conflicting with public health (Paine, 2002). Considering Frist's medical background, one cannot be surprised that doctors and other health professionals are at the top of his political contributors' list, with nearly $594,000 in contributions since 1997 (Weiss, 2002). Moreover, Frist has significant personal and financial ties to the health care industry; his father and brother founded Hospital Corporation of America (HCA), the nation's largest for-profit hospital chain. HCA's political action committee contributed more than $175,000 to federal candidates in 2002. Frist has resisted pressure to abstain from voting on legislation that could impact HCA's bottom line, claiming his investments are now in a blind trust (Weiss, 2002).

Economic Feasibility

The economic feasibility of the MHPA of 1996 and future incarnations of mental health parity legislation is substantiated by findings after several years under parity law (Levin, 1998; NMHA, 2003). Parity has been found to be feasible both by the low increase in premiums as well as the money saved by expanded access to mental health services. Parity ends up saving employers in increased productivity, reduced absenteeism and, in some cases, decreased premiums. Estimations on how much parity would increase premiums ranged from less than 1% to 1.6%, a relatively low cost, even at the highest. Some studies have shown that employers have rarely chosen to change health plan benefits in order to recoup the costs of increased parity (NMHA, 2003), but a major study by the General Accounting Office shows that a high percentage of employers have restricted mental health benefits in some other way to curtail the cost of parity benefits (Karger & Stoesz, 2002).

Studies also indicate that there is a direct correlation between medical costs and mental health care coverage. For example, psychiatric long term disability (LTD) claims are seen to increase for health plans in which access to mental health services are restricted (Salkever, 2000). A large Connecticut corporation saw a 37% increase in the use of medical care and sick leave when it cut its mental health services by 30% (Rosenheck, 1999). Whereas, when corporations increase access to mental health services, a large savings can be realized. For example, when the Kennecott Copper Corporation provided mental health counseling for its employees, the company's hospital, medical, and surgical costs decreased by a striking 48.9% (NMHA, 2003). In Minnesota, where a comprehensive state parity law has been enacted, Blue Cross/Blue Shield was able to, after one year under the law, make a 5 to 6% reduction on its insurance premiums (Levin, 1998). Therefore, future funding considerations for even more comprehensive federal parity legislation should be fully realized.

Administrative Feasibility

After the MHPA of 1996 went into effect, an evaluation conducted by the General Accounting Office revealed that 86% of employers were in compliance with the policy; however, 87% of the employers had altered their employee benefits making mental health benefits more restrictive. While some benefit plans were altered, none of the employers eliminated mental health coverage as a whole (Karger & Stoesz, 2002). Based on these results, it appears that the act has to some degree accomplished what it was intended to do

because the majority of employers are in compliance with the act. The problem is that benefits for individuals with a mental illness were reduced in an effort to offset the increased annual and lifetime caps (Satel & Humphreys, 2003). Therefore, those with a mental illness are not actually receiving coverage comparable to coverage for those with a physical illness at this time. The new act being proposed in Congress, the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, has much broader goals that would theoretically do away with this problem. However, it must be remembered that in the end, the bottom line is always cost. With this in mind, it is questionable whether the bill can truly achieve its goals.

The criticism of the proposed legislation is that full parity will result in a situation where people seeking long-term psychotherapy for marginal distress will cause inflation in the cost of mental health benefits for employers and, as a result, employers will cut back coverage across the board. If cost inflation begins occurring for employers, then managed care will likely be used to control the situation by constantly evaluating whether a minimally acceptable amount of care has been delivered and ending benefits for treatment as soon as this point is reached. As a result, the combination of managed care with full parity may actually allow for total mental health costs to go down (Satel & Humphreys, 2003). However, a consequence of this care management is that individuals with severe mental illness are treated quicker and at a minimal level in order to reduce costs, but this treatment may not truly be sufficient and they may be sent home from hospitals in poor condition. The patients may then need to be readmitted and often this will be to a state mental hospital (Satel & Humphreys, 2003). Therefore, the pairing of full parity and managed care could result in another social problem being created in which individuals with a severe mental illness do not receive the treatment that parity had intended for them to receive.

However, other views indicate that full parity would overall be beneficial to individuals and employers because full access to mental health services would cause fewer other medical services to be used and some costly medical problems could also be prevented. Research has indicated that between 50% and 70% of doctor's regular caseloads are comprised of patients whose medical problems are significantly related to psychological problems. In addition, increased availability and usage of mental health services has been associated with lower hospital and medical spending, because people receiving counseling or psychotherapy have had shorter hospital stays and less physician office visits (Abrahamson, Steele, & Abrahamson, 2003). The fact that mental health service usage may decrease the incidence of other medical problems means that money can be saved in the long run. Therefore, any increases in premiums that may occur as a result of parity will be offset.

It is possible that an alternative policy could be more effective than the policy proposed in the bill before Congress at this time. In general, a single-payer system in which mental health coverage is universal would be beneficial to everyone and would eliminate problems created by managed care involvement in mental health (Hughes, 1996). However, it is unlikely that universal mental health coverage would be instituted without general universal health care insurance in this country. Another possible way to dissolve some of the problems that managed care could create with mental health parity would be to identify and distinguish the more severe mental illnesses and guarantee parity for them (Satel & Humphreys, 2003). This would ensure that severe mental illness would receive coverage on par with medical illnesses, yet it would not benefit those with less severe, yet still disabling psychological troubles. Creating a policy that only recognizes severe mental illness would certainly not ensure equal consideration for psychological symptoms and physical symptoms, and thus would in many ways defeat the purpose of parity. A policy that provides an overall solution is difficult to attain.

In addition, there are several barriers that exist to attaining full implementation of the parity legislation. Reinforcement of this act by the federal government must be given significant importance. If the act is not strictly enforced, it is likely that employers and insurance companies will not be motivated to change their own policies. It is also necessary to consider the fact that the 1996 act is a federal law and that states have some leeway in the interpretation of this act. However, the new Paul Wellstone Act of 2003, if passed, is more specific and therefore would provide more structure in terms of state legislation. Another obstacle to the full implementation of this act is the fact that the act cannot have the effect of eliminating

the stigma that is still associated with mental illness. The public, as well as employers, need to accept mental illness as a medical problem or a problem that is not self-induced.

Despite its limitations, the MHPA of 1996 marked a significant moment in the fight for the legitimization of mental health and well-being. The stigma and denial surrounding mental illness will persist for a long time, as we even see evidence of extensive discrimination against physical ailments, such as disabilities, in our country today. Still, the stigma appears to be dissipating. It has taken the diligent work of lobbyists, educators and mental health professionals to push for the string of mental health legislation we have seen over the last decade. It was also the life experiences of Senators Peter Domenici and Paul Wellstone that carried the concept of parity into focus. Pete Domenici's daughter spiraled into symptoms of a diagnosis of schizophrenia in the late 1980s, and Paul Wellstone's older brother also suffers with symptoms of schizophrenia. Each man watched in despair as their families had to drain all of their resources to provide care for their loved ones. Though the MHPA is a watered down version of what it was originally, it is significant that it was not only extended but that the Paul Wellstone Equitable Mental Health Treatment Act of 2003 has since been introduced. The new legislation does not cover treatment for people struggling with substance abuse and it still leaves enormous segments of the population to stumble through the broken public mental healthcare system. However, parity legislation is managing to bring mental health issues up to the same level of awareness as physical health issues in incremental steps.

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The authors of this article have completed their first year in the MSW program. Brittany Boden's first-year placement was at St. Joseph Carondelet Child Care Center. Her second year placement will be with Community Counseling Centers of Chicago. Berklee Cochand completed her first-year field placement at Lincoln Park Hospital on the Physical Rehabilitation and Skilled Nursing Units. Her second-year placement will be with Metropolitan Family Services. Caroline Nelson's first-year field placement was at Youth Services of Glenview, and Renee Potter did her first-year placement at the Counseling Center of Lakeview.

Dissertation Abstracts

Influences of Childhood/Adolescence Paternal Relationships on African American Women's Expectation and Needs for Adult Emotional (Heterosexual) Intimacy
Kimberly Rene Adams, Ph.D.

This study examined the influence of childhood/adolescence father/daughter relationships on African American women's expectations and needs for adult emotional (heterosexual) intimate relationships. A qualitative case study research method was used as the framework for this study. Sixteen African American women completed qualitative survey questionnaires, providing rich data on their relationships with their fathers. Four major themes emerged from this study: (a) endless search for lost father; (b) building defense mechanisms against intimacy; (c) reframing negative childhood/adolescent father/daughter experiences and processing these experiences to serve functional purposes in women's lives; and (d) experiencing emotionally healthy, nurturing childhood/adolescence father/daughter relationships while maintaining healthy, satisfying adult emotional (heterosexual) intimacy.

What was learned from this study included that a father's presence during childhood/adolescence does not guarantee outcomes for a woman's adult emotional (heterosexual) intimacy. Social workers can benefit from this research by understanding that some assumptions from family research literature are not supported by this study. Additional research can extend findings of this multiple case study to a larger group of women, and incorporate a broader continuum in terms of age, socioeconomic status, educational level, and geographic location.

Tell Me Where it Hurts: An Exploratory Study of Abuse, Somatoform Disorder, and the Elaboration of Meaning
Margaret Arnd-Caddigan, Ph.D.

Tell Me Where it Hurts . . . is a qualitative study in which eight adult female survivors of childhood abuse who have a somatoform disorder discussed their experiences of abuse and their experiences around the issue of their somatic symptoms. The research question was whether or not significant deficits in meaning attached to their abuse and/or somatic symptoms would be apparent. Specifically, the researcher was looking for deficits in meaning on the interpersonal, individual, and/or cultural levels.

While there was some evidence of deficits in meaning on the interpersonal and individual levels for both abuse and somatic symptoms, conflicts in meaning between levels arose as the more prominent phenomenon. Of perhaps even greater interest is the degree to which conflicts in meaning elaborated around the issue of somatic symptoms mirrored the conflicts in meaning elaborated in relation to the subjects' abuse. This finding has implications for the treatment of adult survivors of abuse who have a somatoform disorder.

Snips and Snails and Puppy Dog Tails: An Exploration Into the Factors Impacting the Awareness of Male Sexual Victimization

Gina Yellin Bogan, Ph.D.

Although research studies vary on the prevalence of the victimization of men, various research studies all report considerable numbers of men who have been victims of sexual aggression. Young men in high school and college are the group most at risk for being sexually assaulted outside of a prison system (Isely, 1998). This study was designed to explore whether public high school social workers are aware of male student victims of sexual aggression, and if the social worker feels confident that they can meet these students' therapeutic needs. Respondents' age, gender, race/ethnicity, experience, and personal knowledge of victims were examined to see if they were related to awareness level, confidence in working with victims, and assessment practices when working with male students. Quantitative methodology using a research survey design was used. The research sample consisted of all public high school social workers in Illinois. The results of the research indicated that the main factor in awareness of sexual victimization is the number of male victims the social worker has worked with. Work with male victims increases awareness of male victimization and female victimization; however, work with female victims does not increase awareness of male victimization. Respondents were more confident working with female than male victims and more likely to ask females than males about sexual victimization during an assessment.

Involuntary Clients in Groups: An Examination of Factors that Influence Engagement

Kay Goler Levin, Ph.D.

This exploratory case study examined the factors which influence the engagement of involuntary clients in groups from the perspectives of group leaders, as well as group members. This study introduced the practice wisdom of seasoned group leaders, and provided amplification of the voice of an often marginalized population - individuals involuntarily mandated into group treatment. The methodology used in this study involved the triangulation of three data points in order to understand the engagement process: the individual group leader's perception of the actual engagement of the group members, the group member's perception of the factors which fostered his/her engagement with the group, and an objective measure, the Group Engagement Measure (Macgowan, 1997).

This study applied individual relational theories to understand the research question. These theories include: affect attunement (Stern, 1985), the holding environment (Winnicott, 1965), and the zone of proximal development (Vygotsky, 1978). Results indicate that there existed a relationship between the perceptions of both group leaders and group members. There was a concordance between group leaders' purposeful behaviors in group, and group members' attribution of meaning to those behaviors.

Non-Standard Dialectical Behavior Therapy:
Effects on Hospital Measures of Symptom Severity

Daniel Grohens, Ph.D.

This study investigates the effects of extensions of the standard model of Dialectical Behavioral Therapy (DBT) under three conditions (Waves) of its application within a public psychiatric hospital. As part of a State Department of Mental Health initiative, select State Hospitals and community clinics were trained in DBT and programs were developed at these sites. This study examines the relative effectiveness of DBT for hospitalized borderline patients on hospital measures of symptom severity: Total Admissions, Total Days of Stay, Days of Seclusion and Restraint, comparisons of Self Injury, and a combined measure of Observational Intensity. The Waves include varying treatment components of DBT and treatment-as-usual. It was hypothesized that patients with more treatment components of DBT would have better outcomes than would patients with less. The aim of the study was to measure the effectiveness of treatments for this clinically challenging patient group, especially the use of an extension of a standard model in a "real world," State Hospital application.

Results did not significantly differ from the treatment-as-usual groups. Various findings of significant effect were attenuated by failure to identify significant variances among groups in post hoc analyses for unequal groups. Results tended to indicate the inverse of the hypotheses for Total Admissions and Total Days of Stay, such that the Waves with more DBT had worse or equivalent but not better outcomes. Extensions of DBT for inpatient treatment may require more of the complex of elements of the standard version if they are to be significantly better than other inpatient treatments-as-usual for patients with borderline personality disorder. The research reports the beneficial influence of the DBT model on the clinical thinking among staff and upon therapeutic communications with patients with BPD. Both staff and patients appreciated having the set of DBT concepts and skills with which to engage in the work of therapy. Having commonly understood clinical tools and skills to use, teach, reference and practice, enriched the clinical quality of treatment.

Use of Identity Complexity and Evaluative Narrative Endpoints
to Understand the Meaning Systems of Individuals Receiving
Atypical Neuroleptic Medication for Schizophrenia

Marie Opatrny, Ph.D.

Individuals receiving atypical neuroleptic medication for schizophrenia often experience a reduction in negative symptoms. This qualitative study explored the needs of this rapidly growing population through a framework of Identity Complexity and evaluative narrative endpoints. Such a framework provides flexibility for understanding individual needs, and considers the meaning of actions within the context of a situation and the individual's environment. It is also consistent with the perspective of personal identity as a continual, evolving process. Information contained in narrative responses to the researcher's open-ended questions revealed the presence of positive indicators for identity complexity in many of the interviews. A number of the individuals interviewed were able to create coherent narratives, however, they often experienced difficulty maintaining the narrative cohesion. Research findings are discussed, and the use of Identity Complexity and narrative evaluations for psychotherapeutic interventions with individuals receiving atypical neuroleptic medications are examined. Recommendations for possible future studies with additional populations are suggested.