

# THE *Family Psychologist*

**BULLETIN OF THE DIVISION OF FAMILY PSYCHOLOGY (43)**

Spring 2005

Celebrating the Diversity of All Couples and Families

Volume 21, No.2

**THEME: ATTACHMENT IN THE FAMILY: THEORY INFORMING PRACTICE**

## **From the President:** Attachment Theory and Division 43

*Mark Stanton, PhD, ABPP*

The conceptualization of attachment, as described in the theme articles in this issue, is an omnidirectional, complex model of interaction that actively incorporates concepts from family psychology, couple and family therapy, and systems theory.

When I first learned attachment theory, it was presented with a primary focus on the unidirectional, dyadic relationship between a mother and her child. Individualistic psychology seemed to suggest that the mother either provided sufficient or insufficient care for the development of secure attachment. Today it is much clearer that attachment is the result of reciprocal relationships driven by the needs of all involved to provide and receive nurture and safety.

The focus in this issue on clinical interventions based upon attachment theory is crucial. Theory apart from therapy does not change relationships. The models presented here are interesting, clinically relevant approaches to the enhancement of attachment in couples and families. This is a theme quite appropriate to Division 43. We appreciate the leadership of Guy

Diamond as Guest Editor for the feature articles and The Final Word in this issue.

### **2005 Goals for the Division**

At the recent Division 43 Board meeting in Alexandria, Virginia, I outlined six goals that I believe are important for our division in 2005.

#### *1) Increase meaningful involvement in the division*

There are many aspects of Family Psychology that are significant to our members and we hope to involve more members in Division 43 Committees and Special Interest Groups (SIGs) that provide networking, support, projects, and programs to address these issues. We hope that you will consider the list of committees and SIGs on the inside back cover of this issue of TFP (and the invitation to join a SIG in this issue). The Division is strongest when it meets the real-life needs of its members. We want to provide venues for connection with other division members who share your interests so that you can collaborate for mutual benefit. For instance, we recently started a SIG for family psychologists who practice in medical settings or educate and train medical residents in family psychology. Clark Campbell, the chair of this SIG, put a notice on the division listserv and quickly received indica-

tions of interest from about 15 members who want to discuss issues of mutual interest. These groups will interact throughout the year on an email listserv. Commit-

tees and SIGs will conduct meetings in the Division 43 Hospitality Suite in Washington DC in August in order for participants to become acquainted face-to-face and to plan projects and meetings that will advance the field of family psychology and meet the needs of members. We hope that committees and SIGs will develop posters, papers, and symposia proposals for future APA Conventions. The key idea is meaningful involvement that meets real needs.

#### *2) Strengthen student participation and membership*

We are fortunate to have many excellent student members who share the values and orientation of our division. We want to provide opportunities for students to interact with each other and with experienced family psychologists. Our Student Representative to the Division 43 Board, Bethany Tavegia, is developing a Student Committee composed of representatives of programs that have an emphasis or track in Family Psychology. The Student



*Mark Stanton, PhD, ABPP*

**Division 43 Officer  
Candidate Statements  
in This Issue!**

*continued on p.6*

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### Editorial Policy

The *Family Psychologist* is a quarterly publication devoted to news and issues in the delivery of services to individuals and families. Articles pertaining to family psychology and policy are invited.

Unless otherwise stated, opinions expressed are those of the authors and do not represent the official position of Division 43.

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The current issue of *The Family Psychologist* and an archive of past issues are available in Adobe Acrobat on the Division 43 web site: <http://www.apa.org/divisions/div43/mag.html>

### Submission Deadlines for *The Family Psychologist*

Deadline	Issue	Pub. Date
November 15	Winter	January
February 15	Spring	April
May 15	Summer	August
August 15	Fall	October

# From the Guest Editor

Guy Diamond, PhD  
University of Pennsylvania



Guy Diamond, PhD

In the past decade, numerous clinical researchers and theoreticians have turned to attachment theory as a theoretical framework to help understand the processes occurring within family therapy and to help sharpen the focus of treatment on the most fundamental human conflicts and needs. Many developmental psychologists began applying attachment theory to clinical work in the late 1980's (Belsky & Nezworski, 1988). Since then, many family therapists have made similar explorations (see Byng Hall, Nadine Kaslow, Robert Marvin,

Howard Liddle, Beatrice Wood, and Sue Johnson to name a few). This progression of ideas has recently culminated in several edited volumes that explore the inter play between attachment theory and clinical practice (see Erdman & Caffery, 2003; Johnson & Wiffering, 2004; and Wood, 2002).

The appeal of attachment theory is multifaceted. In contrast to the biological framework of general systems theory or the mechanical model of cybernetics theory, attachment theory views the natural biologically wired-in capacity for caregiving (parents) and need for attachment (children) as the motivational force of family relationships. In such a theory, concepts such as safety, trust, nurturance, and emotional needs become the core concepts that motivate people's behavior and can organize clinical intervention. As the papers in this special issue suggest, attachment fo-

cused couples or family therapies target these core human needs as the initial, if not primary focus, of therapy. Once these fundamental needs are addressed, working out the behavioral or organizational aspects of interpersonal life becomes easier.

Attachment theory also offers an interesting framework for understanding how one works though attachment failures that leave many patients feeling wounded or traumatized for life. The adult attachment interview (AAI; a research tool to assess adults attachment style, Main & Goldwyn, 1988) assesses the discourse strategies one uses to describe family relational bonds and experiences as a child. Adults with secure attachment styles are able to openly express a need for emotional support, show a more balanced and compassionate view of self and others, recall and reflect a wide range of emotional states, and are able to contain, rather than be overwhelmed by, negative, painful memories. This capacity for affect tolerance/regulation, integrative insight, and flexible emotional possessing is a discourse strategy, referred to as coherence, indicative of a secure attachment style.

As one reads the attachment informed clinical models described in this special issue, it is apparent that these psychotherapies specifically seek to help patients develop processing skills that will help them "earn" back a more secure attachment style. Earned security (Main & Goldwyn, 1988) refers to the capacity to work through past attachment failures so that they do not overly determine or control one's current relational capacity or flexibility. In individual therapy, earning security occurs through dialogue between patient and therapist. In family therapy, this process is intensified by working through trauma with the actual people who partially contributed to these experiences. This adds existential meaning to the process.

Finally, the integration of family therapy and attachment theory offers a meaning full opportunity for dialogue between clinical and developmental psychology. Developmental psychologists have greatly advanced our understanding of deleterious and resilient family functioning, yet this information rarely informs clinical practice. Given its relevance to development and treatment, attachment theory may help reunite these separated siblings. Family psychology and Division 43 seem like a perfect context for this kind of collaboration.

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# Attachment-Based Family Therapy for Depression: Theory and Case Study

Guy Diamond, PhD

Our application of attachment theory has led to the development of attachment based family therapy (ABFT; Diamond et al., 2002). This model integrates the theory of change (e.g., enactment) from structural family therapy, the comprehensive conceptual and clinical framework from multidimensional family therapy (Liddle, 1999), the focus on trust and fairness from contextual family therapy (Boszormenyi-Nagy, & Spark, 1973), and the use of emotions to facilitate change from Emotional-focused therapy (Greenberg & Johnson, 1988). The model is designed as a brief intervention (6 to 12 sessions) and has begun to garner empirical support for its efficacy and proposed mechanisms of change (Diamond, Siqueland, & Diamond, 2003). Most of the research thus far has been with inner-city African American youth. But ABFT is used in our depression clinic in psychiatry with a general outpatient population.

The core assumption of ABFT is that depressed adolescents lack a secure emotional base from which they can resolve the traumagenic issues that have activated their depression. Often growing from a biological predisposition, depression gets activated by core traumatic experiences such as abandonment, neglect, or abuse, or less dramatic but more chronic conditions of marital conflict, harsh criticism, or over controlling or disengaged parenting. Depression reinforces feelings of isolation, mistrust of others, and low entitlement, thereby handicapping the adolescent's ability to address or at best weather these interpersonal injustices. The depression also undermines even the best parents' attempts to reach out and protect the adolescent. Yet many parents of depressed youth struggle with their own psychiatric problems, the use of negative parenting skills, and/or have a history of attachment failures, all of which compro-

mise their ability to provide a secure base to the adolescent.

Given this framework, ABFT therapists initially focus therapy on the adolescent's experience of core interpersonal conflicts that have damaged trust between the adolescent and the parent. To identify, discuss, and resolve, or at least come to terms with, these traumas is believed to help repair the fabric of trust between adolescents and their parents. Whether the issues actually get resolved or not, the experience of entering into dialogue with parents about these core interpersonal failures create a "learning moment" that can help adolescents practice new interpersonal problem solving skills (e.g., conflict resolution, affect regulation). Simultaneously, parents exercise new affect sensitive parenting skills that convey support and protection. In this regard, the conversation becomes a corrective attachment experience.

Accomplishing this interpersonal event is achieved in a fairly structured manner. Treatment is conceptualized as five intervention tasks. Tasks are discreet treatment processes and goals that can focus each treatment session. The *Relational Reframe Task* aims to shift the focus of therapy from fixing the adolescent or the depression, to repairing the relational ruptures that have damaged trust in the family. The pivotal question in this task is "when you are feeling so depressed and suicidal, why don't you turn to your parents for help?" This focus does not blame the parents, but rather builds them as a curative resource. The *Alliance Building Task with the Adolescent* focuses on strengthening treatment engagement and building hope for change. With the adolescent alone, the session focuses on strengthening patient-therapist trust, identifying core family dynamics that fuel

family conflict, and encouraging the patient to discuss these issues with his or her parents. The *Alliance Building Task with the Parent* focuses on reducing parental distress and improving parenting practices. This begins with a supportive exploration of stressors affecting the parent (e.g., psychiatric distress, marital problems, or their own childhood history of neglect). When parents experience empathy for their own vulnerabilities, they become more empathic about their adolescent's struggles. In this softened state, they become more receptive to learning parenting skills that focus on affective attunement and emotional facilitation. In many ways, this session applies Gottman's (Gottman, Katz, & Hooven, 1996) meta-emotion framework to clinical practice. That is, we identify parents' emotional philosophy, explore how their history contributes to that point of view, and then teach parents emotional coaching skills.

The *Reattachment Task*, which culminates the work of the previous sessions, targets the disengagement and isolation that characterizes most depressed adolescents. The session begins with the adolescent disclosing past and present family conflicts that have violated the attachment bond and damaged trust. As parents respond empathetically, adolescents are more forthcoming. Parents often apologize for these attachment failures, which often promotes forgiveness of the parent by the adolescent. Ideally, both the adolescent and parents experience a renewed mutual interest in repairing the relationship. Most importantly, this task diffuses family tension and generates a shared commitment to future respect and communication. The *Competency Promoting Task* focuses on building self-esteem by promoting autonomy (i.e., improving school performance/attendance,

finding a job, developing or returning to social activities, etc.). Success builds a sense of competency, which can buffer against further depression. With parental trust/attachment on the mend, the family can serve as a secure base from which an adolescent can explore his or her autonomy and competency. The case example below provides a brief overview of the course of treatment.

Karla was a 16-year-old African American girl, living with her mother and three young siblings. She was doing poorly in the 11th grade, but did hold a job at McDonald's. Mother was unemployed but in a job training program. Karla came to our program with a severe episode of major depression triggered by the mother's naive announcement that the father would be returning home to live with them. Father had been in jail for four years for drug charges, but Karla still remembered the years of marital conflict and physical abuse he had brought to the family.

In the first session, Karla remained quite and reticent to talk. The mother told of Karla's depression and school problems over the years and her own struggles with work and being a single mother. She talked about the father's return home, but minimized the impact of his drug use and violence. This made Karla visibly angry. The therapists tried to explore these feelings, but Karla resisted these questions, even though Karla's concerns about the father's return were becoming apparent. But rather than pursue this topic, the therapist used the relational reframe to address a bigger issue. "Why is it Karla, that when you have strong feelings like this, you can not share them with your mother?" Karla's limited responses indicated that she believed she could take care of herself ("I have done it all my life") and that mom had enough to worry about with all the kids and no work. The therapist then turned to the mother and said, "It seems that your daughter is very protective of you, but unfortunately it leaves her feeling isolated and leaves you feeling left out of her life. Would you like to change this and become a better resource or even friend to your daughter?" The mother

wholeheartedly agreed to this goal, but Karla remained skeptical. The therapist respected this resistance and just invited Kara to come alone next week to discuss her concerns.

The alliance session alone with Karla began with some general conversation about friends, school, and her job, which her mother had taken away until her schoolwork improved. The heart of the session focused on understanding Karla's concerns about her father's return and her unwillingness to discuss this, and other things, with her mother. Karla reported quite a long history of parentification, where she took care of her drug using father or protected the younger children during the parent's arguments. She had also witnessed several physically abusive episodes. Karla's concerns about her mother's health, emotional stability and stress, only strengthened her belief that her own problems would burden her mother. We empathized with her protectiveness and her loneliness, but we challenged her low entitlement to address serious problems with her father. "Why don't you deserve to express yourself, to have a voice? We think your mother is desperate to know you better and would welcome your concerns. We can start to help her with some of these other burdens (We had begun some case management activities). After an hour of empathy and challenge, respect and encouragement, Karla still resisted the idea of a discussion with her mother. She did however agree to attend the next family session to hear what the mother might have to say after we spoke with her.

In the meeting alone with the mother, we developed a better understanding of her marital history. Her high school sweetheart who had all the promise in the world became a drug user and wife abuser. Still, the mother felt that he had many good qualities and she was glad to be a two-parent family for these kids. She also assumed that what conflicts did appear, happened behind closed doors away from the kids. As she told the story, she began to see how naïve she had been and that as hard as this was for her, it must have been terrifying for the kids. She asked if this was why Karla was

depressed. Balancing confidentiality with setting up dialogue, we agreed that this was an important topic to address in the future conjoint session. The session then turned to preparing the mother with a few listening skills (emotional coaching) that would reduce Karla's barriers to expressing her feelings. We also suggested that since Karla was a bit reluctant to speak up, that maybe mom could start out talking about her thoughts and memories about those early days.

In the fourth session, we brought Karla and her mother back together. The therapist opened the session with the following statement: "Clearly this family has many strengths and a lot of love for each other. But you have gone through some hard times that have never been discussed together. But every one has agreed to begin this conversation today." The therapist then turned to the mother to begin, but Karla spoke up and talked for the next twenty minutes about her father. She described how he had taken her out of school to watch the younger children while he went out, or how she had sheltered the children in her room while dad beat mom in the other room. Mom listened with sadness, shame, and anger. But, she did not let these feelings overwhelm her. Instead she focused on her daughter, asking questions, showing curiosity, and expressing empathy.

Once Karla had finished an uninterrupted story, the mother described how depressed and powerless she had felt back then. This was not done as an excuse or to burden Karla, but to help Karla understand her mother's own struggles. Then the mother said, "But whatever I was going through, I am so sorry for not protecting you more. I never want to do that again." Both mother and daughter began to cry and continued to talk about the past and the future.

In the following sessions, mother and daughter came to therapy like giggling girlfriends. Karla had been coming to mom's room each night for long talks in bed. Mom wrote to the father about him living somewhere else when he returned. Mom became an advocate for Karla at school and helped

her change some classes and get extra tutoring. Karla was also more direct about the importance of working, so mother found other ways to motivate Karla's schoolwork. Karla's depression diminished, but she still had bouts of moodiness and irritability. At a 6-month follow up, she reported no depression.

Not all cases go as well as Karla's. Some adolescents never try to trust again. Some parents are too disturbed or too fed up to empathically embrace their adolescent's pain. Other cases land somewhere in the middle. Still the therapist's ability to orchestrate non blaming, reflective, and empathic conversations about core family conflicts helps the adolescent and parent work through, or come to terms with, attachment failures that have damaged the natural instinct of trust (adolescent) and commitment (parent). This process can help to rebuild the family as a safe and secure base.

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## President's Message

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Committee will help organize and host student activities and the APA Convention in Washington DC, including a Social Hour that provides an opportunity for students to network with division members and a program in the Hospitality Suite entitled "How to Have Your Poster Accepted by Division 43 for the 2006 APA Convention." Many students would like to present at the convention, but are unsure about proposal protocols or the process of submission. This session will encourage student submissions for next year's program. The Student Research Award is being reconfigured to focus on student posters submitted for the APA Convention, so this session may be beneficial for any student who wants to enter that contest in 2006. Finally, a Student Column is being reactivated in *The Family Psychologist* and the Reference Corner in *TFP* is encouraging student book review submissions.

### 3) Organize graduate education programs in family psychology

The goal this year is to identify and organize doctoral psychology programs that have an emphasis (strong inclusion in the curriculum) or track (3-4 courses) in family psychology. The program directors or faculty who are directly responsible for the emphasis or track will be invited to participate in the Family Psychology Graduate Education SIG. This SIG will meet at APA in Washington DC in the Hospitality Suite to consider issues and develop strategies to enhance family psychology in graduate education in clinical, counseling, and school psychology programs. Graduate educators can learn from each other how to enhance their family psychology emphasis or track. In addition, we hope to finalize and approve the Recommendations for Graduate Education in Family Psychology that have been developed by Michele Harway and myself as part of the foundation for submission of our renewal application for specialty status with the Council for the Recognition of Specialties in Professional Psychology (CRSPP).

### 4) Continue the 2004 theme of the integration of science and practice

Important steps were taken within the division last year under the leadership of Jay Lebow to bridge research and clinical practice in family psychology. Kristina Gordon, VP for Science, is chairing a task force on evidence-based couples and family treatments. Another task force is being created to focus on relational diagnosis and classification. The theme issues of *The Family Psychologist* have featured research-based articles on key areas of importance for family psychology research and practice, including an excellent Science Column edited by Steve Beach. The division will support these efforts and other efforts to continue to address the needs of researchers and clinicians in our division.

### 5) Develop 1-3 membership strategies for the division

Membership in APA and almost all APA divisions has decreased in recent years. The Division 43 Board is considering a few ways to effectively communicate the nature, purpose, and vision of our division to psychologists so that those who identify themselves as family (or systems) psychologists will recognize the division as a key place for professional identity and function.

### 6) Maintain and increase our Division voice in APA governance

We were successful in our recent efforts to regain our second seat on the APA Council of Representatives, so we will once again have two seats in 2006. However, the apportionment of seats is an annual process that requires diligence in order to maintain a strong voice in APA decisions. We will encourage our members again this year to submit their votes on the apportionment ballot (many members do not vote, so simply increasing the number of members who vote makes a huge difference) and to dedicate as many of the 10 votes allowed to each member as possible to our division. In addition, we are making efforts to nominate members of Division 43 to APA councils and committees so that the perspective of family psychology may be included in the dialog and determination of issues.

# Attachment and Family Systems Therapy

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This is a wonderful time to be a clinician who works with couple and families. We are on the edge of a whole new world. Science is, at last, beginning to address the mysteries of close human relationships. Clinicians, who are attempting to enhance and repair such relationships, can now turn to a body of scientific observation to understand the key elements in these relationships and how they evolve—for better or for worse. For example, as a result of the work of John Gottman, couple therapists can look for, articulate and better address negative cycles of interactions that lead to alienation and divorce, such as criticize/demand followed by defend/distance. This scientific observation also seems, for the most part, to fit with the insights of family systems theory, first articulated by Bertalanfy (1968), that focuses on feedback loops and the power of circular self-reinforcing patterns of interaction to determine inner and outer realities. It would be wonderful indeed if we were also able to find a coherent, profound relational theory that fit with a systemic interpersonal perspective, was based in creative research and observation and gave us a language, a map and an explanatory frame for close relationships. We would then have a new clarity about the factors that define the nature of the relationships we work with, what to target in therapy and what differences will truly make a difference. Attachment theory offers us just such a theory.

More specifically, attachment theory offers systems therapists a compelling focus for intervention. Systemic interventions that deal with recurring distress in key relationships have to take account of multiple realities and how those realities mesh together. This is a complex task and the opportunities for getting lost—focusing on a thousand peripheral issues are numerous.

Couple interventions, for example, have focused on problem solving content issues such as money management, offering insight into family of origin patterns—or changing the metaphors people use to describe their relationships, without knowing whether these are key defining elements in relationships. The attachment perspective, supported by a myriad of empirical studies (Johnson & Whiffen, 1999), directs the therapist to focus on issues of safe emotional connection, security and trust. This perspective sees the creation of a safe haven and a secure base in key relationships with a few significant others as THE most fundamental human survival mechanism—a mechanism wired in by millions of years of evolution. Secure dependency on others is then a vital part of human nature—not a developmental weakness to be overcome. Whether a therapist is working with a couple, or a mother and a depressed adolescent, the focus will be on how these two partners can exit from interactions that keep both insecure and wary and build safe, soothing interactions characterized by a felt emotional bond that confirms the value of each person to the other.

In the past, systems therapists seemed to focus more on power and power imbalances than on nurturance and the creation of the kind of proximity that “tranquillizes the nervous system” (Schore, 1994). More recently, once a safe emotional connection is established, clinicians have found that problem solving and communication skills, no longer distorted by anxiety, improve radically. The key problem—in attachment terms—is always seen as the blocks to safe emotional connection and the resulting isolation and sense of vulnerability. Isolation is traumatizing, while connection is a source of resilience. A spouse or an adolescent who is “acting out” will then be viewed as attempting to get a response (and any response is better than none here) from the attachment figure, rather than seeking power or demonstrating personal deficits. So, many years ago when a child cried or

when a partner complained excessively therapists informed clients that to comfort the child or partner at these times trained them to be dependent and reinforced problem behavior. The child was then left to cry so he could find out that it was not possible to influence or control the parent, and the partner was told she needed to be more independent. An attachment oriented therapist, in contrast, helps the child or partner to express needs for safe caring contact clearly and supports the other to respond. Secure connection then reduces distress and the need for protest and complaint.

Attachment not only focuses the therapists interventions, it provides a language for the therapist. In a transcript of a therapy session in Emotionally Focused Couples Therapy (EFT: Johnson, 2004), an empirically validated intervention that uses an attachment frame, words such as safety, aloneness, abandonment, and fears of unworthiness or inadequacy will come up continually. The basic needs and fears that cue and organize responses in close relationships are mapped out and referred to. This language is also cross-cultural. Just as there are six or seven emotions that all peoples on this planet can recognize in each others faces, attachment needs—to be held, to be comforted, to be able to depend on another to be there when needed—and attachment fears are universal. EFT therapists, for example, can work effectively with the educated and uneducated, western and oriental cultures, gay and heterosexual relationships.

Once the therapist has a clear template for close relationships, core relationship problems become finite and predictable. For example, research tells us that most unhappy marriages are characterized negative cycles of demand—withdraw patterns of interaction. Attachment theory tells us that indeed there are only so many ways to deal with lack of secure connection with a person you depend on. In general, there are two, critical pursuit and demandingness

where attachment needs and fears are hyper-activated, or defensive withdrawal and numbing where such needs and fears are deactivated. Attachment not only explains this pattern, described in observational research on marital distress, it helps us see beyond basic patterns to the emotional and cognitive responses that fuel them. This perspective on problems also normalizes the occurrence of depression and anxiety that often accompanies relationship distress (Whisman, 1999). In this light, it is not surprising that systems therapies are being used more and used to effectively address “individual” problems such as depression and anxiety. Aloneness, helplessness and a lack of confirmation of worth from another are natural precursors for these problems. Attachment enables the integration of a systems and an individual perspective in general. The nature of connection to others and definition of self are two sides of the same coin. Those who are securely attached tend to have a more elaborated, coherent and positive sense of self (Mikulincer, 1995).

Attachment theory tells us what the defining moments in a relationship are, and so it also outlines the in-session tasks and change events the systems therapist wishes to create. Change events that can provide an antidote to previous negative experiences and can create emotional security will, according to attachment theory, be characterized by the clear expression of attachment needs and by emotional accessibility and responsiveness. In the second stage of therapy in EFT a key change event is called a softening. This is where a previously blaming spouse is able to express attachment needs and fears from a position of vulnerability and in a way that enables the other partner to respond. This event is one where specific kinds of enactments are created. Enactments have been identified as a general intervention that is found in most systems approaches. In this intervention both participants interact with each other in a way directed by the therapist. Such new enactments are deemed necessary to change a relationship. However, attachment theory tells the therapist specifi-

cally what kinds of enactments will transform a key relationship. This specificity then promotes the study of the process of change. In EFT, softening events are associated with positive outcome and recent research specifies the optimal interventions used by therapists in such events, such as evocative questions that help clients to expand their emotional responses, and so expedites therapy (Bradley & Furrow, 2004).

A clear theory about the nature of relationships also helps to define pivotal impasses and how to move through them. An example of this is attachment injuries, an impasse in couples therapy that has been observed, articulated and for which change steps have now been specified. These impasses arise at moments of risk, in couple and family therapy, where one person is about to put themselves in the hands of the other. Old injuries, usually betrayals and abandonments at moments of need then arise and block trusting responses (Johnson, 2004). These impasses also arise in family therapy where, for example, a child refuses to reach for a parent and then discloses a deep traumatic injury resulting from the absence of the parent when the child was sick and scared. The attachment perspective here elucidates the whole area of forgiveness and reconciliation—a key one in systems therapies.

The systems therapist has to integrate many different aspects of a relationship to help client’s create a new whole. Any useful theory has then to be broad, able to integrate, for example, sex and caretaking with attachment responses in adult love relationships and past experience with present responses. Attachment theory is able to do this. It is also able to offer very specific direction to a therapist. For example, it tells the couple therapist that the essential negative element in an avoidant withdrawal response is when it occurs. Partners in distressed relationships who shut the other out and withdraw usually do so exactly when they or the other is vulnerable – that is when attachment needs come up. This is hard to tolerate since it undermines the security of the bond between partners.

All of the above contributions of attachment theory result in a new ability to define the tasks and transforming moments in a systems therapy. This then results in a more systematic and effective intervention. We know from research that secure attached adult partners and parents and children are more able to be open and self-disclose. They are more able to reflect on the process of communication and meta-communicate. They are more cognitively flexible under stress and more open to new evidence. They are better at regulating strong emotions and are more assertive about their needs. All these would imply that creating more secure attachment will have a wide reaching and powerful impact on distressed relationships. But we do not even need to engage in this kind of inference, there is clear evidence that attachment oriented interventions change close relationships in ways that matter. In couple therapy, the best example of this is EFT. In a meta-analysis of EFT studies 70 to 73% of clients recovered from distress and 90% significantly improved (Johnson et al., 1999). Results, even with high risk couples, also appear to be stable; there are also very few drop-outs in EFT studies and clients report that interventions get to the heart of relationship issues. In family therapy there are positive results for EFT with families with bulimic adolescents, for depressed adolescents and their parents (Diamond & Stern, 2003) and for troubled mother-infant relationships (Cohen et al., 2003). There are also studies in process that capitalize on the ability of secure attachment with partners to help individuals deal with and heal from traumatic stress and to face traumas such as cancer with resilience and courage. When relationship health and dysfunction is clearly articulated and refined by a body of empirical research, then interventions are able to be more ‘on target’ and so more effective.

In Bowlby’s first volume of his trilogy on attachment (1969) he gives wonderfully intricate descriptions of the “dance” between a parent and child and how this dance changes on a minute to minute ba-



sis. Once we understand the dance, its underlying organizing principles and the pivotal moments when it shifts direction we can effectively change it. This is attachment theory's contribution to systems interventions. With the advent of attachment theory we can at last marry empirical research on the nature of close relationships and how those relationships move and change with systematic clinically relevant interventions. Carol Anderson's comment at the 2000 AAMFT conference, that systems therapists have "set out on a vast and troubled ocean in a very small theoretical boat" is no longer true. For me, as a clinician and a researcher, this theory provides a guide to every couple and family I see and offers me a clear pathway to shaping significant change for these couples and families. At-

tachment theory is then one of the main pathways into a whole new world that is opening up for systems therapies.

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## Teaching the Psychology of Men: A Continuing Education Program To Be Offered During APA Washington Convention

Teaching the psychology of men will be a Continuing Education Program during the APA Convention in Washington. Issues related to the psychology of men and masculinity are increasingly identified as important areas in psychology including boy's and men's development across the life-span, issues of multiculturalism and sexual orientation, violence against women, homophobia, fathering, men's health and others. Therefore, the teaching of the psychology of men is central to psychology, yet one of the least developed areas in psychology.

The purpose of this introductory workshop is to assist psychologists in developing course work on the psychology of men using the theoretical and empirical literature on men and masculinity. Participants will learn basic knowledge on how to create a psychology of men course or how to infuse this content into existing courses on gender or the psychology of women. Each presenter will share their syllabi, reading materials, class manuals, evaluation processes, and other resources. The workshop will discuss pedagogical processes such as traditional lecturing, psychoeducational techniques, group discussion approaches, use of video media, student assessment techniques, managing classroom problems, and the infusion of diversity and multiculturalism as critical content.

The goals of the workshop are to help psychologists: 1) Design a psychology of men course or incorporate the psychology of men into existing courses; 2) Locate syllabi, core concepts, readings, media, self assessments, and other resources to teach the psychology of men; 3) Utilize multiple teaching methods when teaching the psychology of men including psychoeducational and multicultural approaches; and 4) Enumerate the critical problems/dilemmas and solutions when teaching the psychology of men.

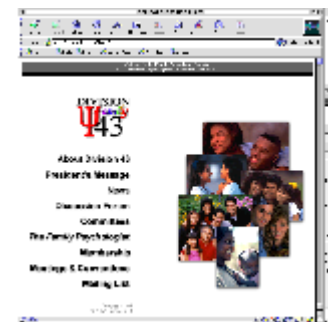
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## Attachment and Family Therapy: Theory Informing Practice

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The interface between clinical and developmental processes has been a subject of considerable interest within the scientific and treatment communities (Rutter, 1997). Developmental theory and research have informed clinical practice, and new treatments systematically target developmental processes (see Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Liddle et al., 2001). These therapies use knowledge about research-established risk and protective factors to inform assessment and intervention. Although exemplars exist about how to use research findings in clinical theory, model development, and practice (e.g., Liddle, Rowe, Dakof, & Lyke, 1998; Liddle et al., 2000), more of this translational work needs to be done (Cicchetti & Toth, 1995; Shirk, Talmi, & Olds, 2000). As new findings emerge, and as specialties of research synthesize available empirical knowledge, new opportunities to mine the clinical implications of this work materialize. In this article we discuss the clinical implications of attachment research and discuss them within multidimensional family therapy, an established treatment designed to incorporate developmental research findings.

It is reasonable to expect that attachment research holds promise as a source of clinical influence. The empirically established connection of solid attachment relations to developmental outcomes is widely known (Henry et al., 1993; Tarter et al., 1999). Attachment offers a systemic conceptual

framework about human development and dysfunction. Its tradition and content are in harmony with family therapy's sensibilities. For instance, attachment theory and research have respected, understood, and exploited the interplay between individual and interpersonal/transactional functioning. The transgenerational perspective of attachment theory and research is another aspect of attachment and family therapy compatibility (Doane, Hill, & Diamond, 1991). Attachment theory and research on development-enhancing attachment relationships have been used to create prevention interventions for teen problem behaviors. Studies conducted by Allen and colleagues, for instance, demonstrate how key aspects of attachment can serve as organizers for adolescent problem prevention programs (Allen, Philliber, Herrling, & Kuperminc, 1997). Other clinical applications of attachment research in clinical work are underway as well (e.g., Johnson, Maddeaux, & Blouin, 1998; Luthar & Cicchetti, 2000; Sexson, Glanville, & Kaslow, 2001).

Broadly defined, attachment reflects one's degree of confidence that significant others, usually family members, will provide support and protection and will remain within emotional proximity (Biringen, 1994; Bowlby, 1979). The quality of the family attachment system is largely a function of the attachment relationships among family members. This means that more organized, flexible, and cohesive families tend to be characterized by secure attachment among their members, while more distant and conflicted families tend to be characterized by avoidant and insecure attachment (Cobb, 1996). Attachment relations in adolescence is a time of transformation where adolescents need to remain connected to their parents while at the same

time, increasing their autonomy from their families and deepening their connection to peers of both sexes. Secure attachment in the adolescent years is strongly related to trusting and warm relationships with one's parent(s) (Tacón & Caldera, 2001). Insecure adolescent attachment is associated with ambivalence and distance between the adolescent and one or both parents (Maio, Fincham, & Lycett, 2000). Parents' attachment security matters a great deal as well. Mothers who were poorly attached to their own parents as teenagers tend to have detached and chaotic relationships with their children (Newcomb & Loeb, 1999). Generally speaking, it is the network of attachment relationships within the family, more than any single relationship, which determines the overall health or dysfunction of the family environment (Sroufe, 1988). Family therapy targets the family attachment system – the nexus of relationships within the family (Biringen, 1994).<sup>1</sup> Treatment shifts the family's attachment system away from dismissiveness (i.e., distance in and lack of concern for interpersonal relationships) and toward greater security. The *dismissive* form of attachment is highly predictive of a host of negative outcomes, including drug abuse, delinquency, and other forms of socially destructive behavior in adolescence and adulthood (e.g., Rosenstein & Horowitz, 1996). The shift away from the *dismissive* form of attachment is accomplished by creating a secure base within the family that facilitates both connectedness to the family and exploration (e.g., social relationships) outside the family (Byng-Hall, 1999).

### Therapeutic Intervention for Dismissive Attachment

*Building Attachment Relationships.* In our clinical model, Multidimensional Family

Therapy (MDFT; Liddle, 2002), treatment's initial phase is characterized by the establishment of several working alliances inside and outside the family simultaneously. Clinical research has found that productive family discussions are unlikely to occur until both the parents and the adolescent have come to trust the clinician and to believe that they can benefit from treatment (e.g., Diamond, Liddle, Hogue, & Dakof, 1999). In attachment terms, family members must become securely attached to the therapist (Akister, 1998). To build a relationship with the adolescent, MDFT uses Adolescent Engagement Interventions (AEI). AEI's communicate basic attachment-related messages to teens, including that (a) there is something for them to gain from therapy, (b) they have a right to feel as they do, (c) the relational goals that they develop (e.g., being able to tell their parents how they feel) can be accomplished during the course of treatment, and (d) their participation is instrumental to treatment's success. These messages all reflect secure attachment relationships, in the form of genuine interest, validation, desire for partnership, and acknowledgment of the adolescent's crucial role in the therapeutic process (Allen & Hauser, 1996; Allen & Land, 1999; Woodward, Fergusson, & Belsky, 2000). Engaging parents into treatment is accomplished through Parental Reconnection Interventions (PRI). The PRI, a module based on research (as is the AEI), structures therapy—provides a generic therapeutic objective (something important to do with every case) and a corresponding set of behaviors to facilitate the objective's achievement. Parents in *dismissive* and conflicted families are frustrated by their inability to communicate with or control their adolescents, and in some cases are giving up entirely (Brown, 1993; Liddle et al., 1998). Therefore, reestablishing parental feelings of love toward, commitment to, and influence over their adolescents is essential in securing parents' active participation in therapy and fostering improved adolescent-parent attachment (Allen, Hauser, & Borman-Spurrell, 1996; Tacón & Caldera, 2001). Building these important attachment relationships between the

therapist, adolescent, and parent systems is the first step in clinical work.

*Encouraging Autonomous Relatedness.* The next step in building a secure family attachment system involves facilitating autonomous relatedness within the family (cf. Allen, Hauser, Bell, & O'Connor, 1994). Families with *dismissive* interactional process styles have been characterized as having an oversupply of independence and insufficient relatedness (Allen, Hauser, & Borman-Spurrell, 1996). Facilitating communication among family members, while continuing to support each person's autonomy (e.g., gently reminding the parents that the adolescent is increasingly capable of participating in family decisions, and encouraging them to talk to the adolescent about their non-parenting adult lives) promotes movement toward autonomous relatedness. Helping families to process negative emotions, and using them to craft guiding themes for therapeutic work, is another way in which we facilitate closeness and relatedness (Liddle, 1994).

*Changing Internalized Attachment Representations.* MDFT attempts to re-weave the fabric of parent-adolescent attachment. A hallmark of the *dismissive* and conflicted family is negative emotion that quickly escalates out of control (Dishion & Patterson, 1997; Liddle, 1994). Persistent negativity is associated with a weak parent-adolescent attachment bond (Allen, Hauser, O'Connor, Bell, & Eickholt, 1996). In families with traumatic histories, chronic negativity can hide hurts and disappointments and cement emotional distance (Doane & Diamond, 1994). For instance, a teenager whose father abandoned him emotionally or physically is understandably reluctant and possibly afraid to embrace the father in the present, and may push him away with hostility and aggression. Until the fears and hurts have been discussed, chronic negativity will likely continue to impede therapeutic progress (Lindegger & Barry, 1999). MDFT refers to this pattern of spiraling negativity as the *therapeutic impasse* (Diamond & Liddle, 1999). In-session impasses are often centered on current behavioral

concerns such as household chores, parental supervision, and peer associations. In joint sessions, arguments over these sorts of issues would begin and would dominate the session. If the impasse is not addressed and resolved, the session tends to break down and therapeutic progress stops. Successful impasse resolution is achieved by a *shift intervention*. Shift interventions are utilized to access the "softer" and at first inaccessible feelings associated with parent-adolescent conflict and disconnection.

The interactional characteristics (including therapist behaviors) associated with impasse resolution via shift intervention were determined in one of our MDFT process studies. Compared to cases of unsuccessful in-session impasse resolution, cases of successful resolution were characterized by significantly less parental power assertiveness and greater levels of openness, collaborative negotiation, and assumption of responsibility (Diamond & Liddle, 1999). When the shift intervention was successful, parents and adolescents initially engaged in intense conflict were now working together, respecting one another, open to suggestions from one another and from the therapist, and willing to claim responsibility for their respective roles in creating the impasse. In attachment terms, the parents and adolescent were displaying autonomous relatedness and were behaving in ways characteristic of securely attached families (cf. Allen & Hauser, 1996). Warmth, trust, and concern between parents and adolescents, all significant correlates of attachment security (Allen, Moore, Kuperminc, & Bell, 1998), were increasingly present in families who had successfully navigated the impasse.

### Summary and Conclusion

The divide separating research and clinical work is narrowing. The ability of developmental research findings to inform clinical practice relies on therapists' knowledge about normative and nonnormative processes in adolescence and their capacity to apply that knowledge. Specifically, if therapists understand how attachment relationships unravel or stay healthy, their inter-

ventions can target specific mechanisms linked to positive and negative developmental outcomes. The furor in the field about the non-interaction of research and practice has subsided. One sign of progress on this front is in the realm addressed in this article – changes in clinical practice brought about by the incorporation of knowledge about normative and non-normative developmental transitions.

<sup>1</sup>In Multidimensional Family Therapy, attachment relations within the family are targeted, as are relations between family members and other social institutions that have developmental influence (Liddle, 2001). A parent's and or adolescent's relationships with school or juvenile justice systems are routinely assessed and targeted for change. This article focuses mostly on intrafamilial attachment relations, however.

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## So Now We Know What Love Is—It's All About Attachment

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It is hard to look after our relationships if we do not understand what love is all about. Who can deliberately shape, or even repair a dream—a moment of infatuation? If love is an immature illusion or a passing sexual frenzy perhaps we can give up on it and become good friends? But most of us want more than that from our life partner. Couple therapists have been in the dark as well. How to direct people when you do not have a map or even know the destination. We could settle for helping folks reduce conflict—the most accepted symptom of a distressed relationship. But is a lack of conflict the real goal most people have when they get married? And are we sure we really know what the fights are all about? These issues are more compelling than ever. In the last decade, we have really started to understand just how important the quality of our love relationships are. They are not the icing on the cake. Happily married folks are physically and mentally healthier, more resilient under stress, more able to deal with the world. All the research suggests that we were not built for self-sufficiency. Isolation is more dangerous to our health than smoking! We are at our best when we know that a few people on this planet will come when we call—that we can reach for them and they will be there for us.

So, it is just as well that love is no longer a mystery. In fact, getting to know what love is all about may just be as crucial for most of us as exploring space or inventing more and more complex technologies. It also opens a whole new world. So—here is a brief low-down on love, courtesy of a man called John Bowlby and researchers and clinicians like myself.

We all need to know that we can depend on a few precious others. We do not grow out of this. Emotional isolation is dangerous for all of us. Our need to matter to those closest to us in a very particular way is wired in by millions of years of evolution. It is the most basic survival strategy to have another who can be counted on to be accessible and responsive to us. We need it at 3, 30, 60, and 90. Attachment theory began with professionals like Bowlby interviewing widows after World War 11 and watching mothers and babies and noting what happened when the mothers left the babies alone in a strange situation. In the 1990's a few of us began to apply what this pioneer had learned to adult relationships. What we learned is that some things do not really change that much from the cradle to the grave. We all need a safe haven we can go to in times of stress, uncertainty and vulnerability. Closeness to a loved one is nature's best tranquillizer. Knowing that we exist and matter in the mind of a loved one makes the world a much less daunting place. Distressed partners in my office often say, "He just isn't there for me—I am alone" or "She says all I want is sex, but that isn't true—it's just my way of getting close. But most of all knowing that she desires me—I feel safe." Not being able to connect emotionally to those we love—not feeling safe with them—brings up strong emotions. Our body knows that this matters—that it could be a matter of life or death, even in our western affluent world. But then—if we

don't understand what these emotions are all about we can end up feeling foolish, ashamed, or disoriented. Emotions are not irrational, they tell us what matters, and emotional connection matters.

Not only do we need a safe haven—a place to take shelter from the world—we need a secure base—a place to go out from and face the world. When we know that we matter to another and can call to and reach that other and bring them close, we can risk and deal with stress and uncertainties. Those Israelis who had a felt emotional sense that their partners were responsive and would be there for them managed scud missile attacks and their aftermath much better than those who doubted this, or denied they needed it. When we know we can come home we can travel far and take great risks. We are better at dealing with emotions and we can communicate better. For example, adolescents who have a safe haven and secure base with their mums are able to see the whole picture in a discussion and see the places they would get stuck in conflicts. People who have this haven also know themselves better and feel better about themselves. All this points to the fact that the essence of love is emotional accessibility and responsiveness. And research on distressed marriages tells us that it is this responsiveness and the ability to soothe each other that predicts relationship distress—not the level of conflict. All this also helps us understand how most conflicts take hold of a relationship. The most usual and dangerous conflict is when one person is *protesting* the lack of connection, but they are not getting through so they begin to blame and criticize and the other tries to keep the peace—to shut down—to not care so much. The couple think they are fighting about money or the kids, but they are nearly always



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caught in a struggle for safety, responsiveness, and connection. Most often one person gets caught in anxiously demanding to create connection while the other gets caught in shutting down to avoid the fight. Both lose out on feeling they have a secure bond.

When we know we can trust another to respond emotionally to us we can assert ourselves—we can confide—we can access all the skills we have and use with other people who are not so important to us. We are better at caregiving then and we feel desired, so we are more able to be lovingly sexual. There are also key times when our needs for the other escalate—times of sickness and fear—times of loss such as miscarriages. When we can come together at these times, it strengthens our bond. When we cannot, it sets fire to the relationship. Sometimes those are the exact times that we don't know how to ask or show our response and the relationship slips into the danger zone.

So if we are beginning to know the heart of love—now we have a language and a map and know where we are going—can we heal distressed marriages? I think so. At least we are getting better at it. How can you heal a body if you don't know what really matters—what really makes the blood flow? But now we can see, with the help of attachment theory, where to go and what to do (Johnson & Whiffen, 2003). We can teach mothers how to respond to their children so as to create a safe haven where the child can grow. We can teach spouses to see through the maze of power struggles and differences to the fact that both are trying to get safe connection—but usually in ways that pull them apart.

In the kind of couple and family therapy I and my colleagues do, we work with people to help them see the dance they get stuck in. The dance that makes each one dangerous for the other. We help them see the attachment longings, needs, and fears in that dance. Then we support them to take risks to find and share their attachment needs in a way that pulls their partner close. The approach is called emotionally focused

therapy or EFT (Johnson, 2004). We find that many couples can change their relationship this way—even if they are living very stressful lives. What we see is that when the couple feel safer with each other, there are key events—predictable times when the relationship moves and changes in ways that really matter. These always involve people taking risks to reach for their partner and making a more secure bond. So a man might say to his wife, “I do want to be with you. I just can't bear the disappointment in your eyes. I know how I disappoint you. So I shut down and shut you out. But I want you to stop testing me and give me a chance. I want to be there for you.” Then a wife is able to say to her husband, “I am too scared to put myself in your hands—I will break apart if I do that and you move away and let me fall. It's easier to tell you what is wrong—to stay in my tank. I can't risk depending on you—but maybe, maybe—I can ask you to hold me?” This is the way relationships move from insecurity to secure bonding, from distance to connection in EFT. Our research suggests that this change lasts and that about 70% of the couples we see can get there (Johnson et al., 1999). This is much bigger than learning to compromise or disagreeing less. It is what love is all about. It is what people mean when they say “I don't just want an orgasm—I want you loving me—responding to me” or “I don't care about your performance—you don't have to do everything right. Just tell me you don't know how to respond—but stay with me—don't turn away.”

Bowlby believed that human attachment was the pinnacle of human evolution. I am with him. For many years psychologists and counselors ignored love—it was too flakey—too difficult to grasp. But this is no longer true—we can understand it and we can use this understanding to help couples and families actively create the loving relationships we all need. Lyn Miles, my favorite singer says in one of her songs that love is a “warm wind—you can't hold it in your hand.” But when I hear this, I think—oh yes—at last—we can.

The website for EFT is [www.eft.ca](http://www.eft.ca). There are many references on this site that link attachment theory and couple and family therapy.

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## Clinical Application of Attachment Theory: Cultural Implications

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Attachment theory has been gaining attention in the field of marital and family therapy in recent decades. The literature on attachment theory proposes that the quality of relationship individuals experienced at an early age holds strong influences over their manner of relating to others later on in life. Studies have shown that children with secure attachment at one year are at an advantage over those with anxious resistant attachment and anxious avoidant attachment in having a better quality relationship with others up through five years (Bowlby, 1988; Gunner & Sroufe, 1991). Variables studied ranged from a child's frustratability, persistence, cooperativeness, and task enthusiasm to social competence, self esteem, empathy and classroom behavior (Nichols & Schwartz, 2004). Others have proposed that this influence lasts into adulthood, affecting adult relationships in couples and families; and that romantic love can be conceptualized as an attachment process (Hazan & Shaver, 1987; Nichols & Schwartz, 2004; Johnson, 2002). Applying attachment theory to clinical practice, a therapist can help couples or families explore their contemporary relationships, and examine how their current relationships may reflect past experiences in attachment (Bowlby, 1988; Nichols & Schwartz, 2004). For example, one can help parents understand that their children's behavioral problems may be a result of the children's anxiety over the parents' lack of availability and responsiveness; or one can help a couple understand that their angry and defensive interactions may be a result of their attachment insecurities (Gottman, 1994; Johnson, 1996; Nichols & Schwartz, 2004).

Attachment theory is a useful tool in marital and family therapy. However, in our increasingly diverse American society, care should be taken in applying it to couples and families from different cultural backgrounds. Mainstream American culture is basically individualistic, while many ethnic minority cultures are familistic or collectivistic. Attachment and its related concepts may manifest themselves differently in different cultures. We will highlight here some of the precautions in applying these concepts to clients from collectivistic cultures.

First, in exploring the quality of attachment in early life, clinicians need to embrace a more flexible approach to the concept of caregivers in culturally diverse communities (Ivey, D'Andrea, Ivey, & Simek-Morgan, 2002; Sue & Sue, 1999). In mainstream American culture, which tends to focus on the nuclear family, the parents are the primary caregivers of the children. In contrast, in collectivistic cultures, care for children may be commonly shared by members of the extended family, such as grandparents, aunts and uncles, or even others who are not blood relatives, such as godparents, neighbors, and close family friends. Children can be well taken care of by these individuals and enjoy secure attachment, even though they may not see their parents as much as children in a mainstream American family. Take for example, this Asian American couple. Because of financial reasons, they have to work long hours during the week. On weekdays, their children are taken care of by their grandmother, who lives nearby and stays at home as a homemaker. When a clinician inter-

views this family, the couple would probably agree that they do not spend much time with their children during the week, and the children would say they spend more time with their grandparents than with their parents. Holding a mainstream American cultural point of view, the clinician may conclude that these children are deprived of parental attention. However, from a collectivistic cultural point of view, it is normal and acceptable for extended family members to chime in to care for the next generation (Hong & Ham, 2001; Lee, 1997). Actually, the quality of care given to the children by conscientious extended family members or individuals within the family/community network may, at times, be superior to that given by parents in a nuclear family with no one to share their childcare responsibilities.

Second, there are diverse childrearing practices across cultures. In mainstream American families, children are taught to be independent when they are very young. For example, it is common for young children to sleep in their own rooms apart from their parents. However, in collectivistic cultures, parents may sleep in the same room as the children until they are much older. Using a mainstream American perspective, a clinician may construe that the parents have an enmeshed or pathological relationship with their child, or maybe something even more sinister, such as sexual abuse. Yet from a collectivistic cultural point of view, sleeping in the same room with children can be a manifestation of the parents' care and closeness to their children, resulting in secure attachment. Conversely, letting children sleep in their own room may be seen as rejecting and cold (Hong & Hong, 1991).



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Third, the concepts of differentiation and enmeshment also need to be interpreted within the different cultural contexts. In mainstream American society, most people would frown to see a 30-year-old adult still living in the same home with his/her parents. A clinician may conclude that this individual is unable to differentiate from the parents, and that there is a pathological dependency, or the family is enmeshed. Nonetheless, it is common for an unmarried Asian American person to live with the parents until the person gets married, because marriage is the normative lifecycle stage for branching out. Furthermore, adult children, whether married or not, tend to have a closer relationship with parents than those in mainstream American families. Culturally, children are expected to reciprocate the care they received from their parents by caring for their aging parents (Hong & Ham, 2001). Again, this relationship must not be mislabeled as enmeshment or dependency.

Finally, when a clinician helps family members explore their upbringing experiences, care must be taken to examine these past events in the proper social, cultural, and historical context (Hong & Ham, 2001). For example, a person who grew up in a rural area in a developing country 40 years ago, in comparing his childhood with contemporary American children, may report he had no toys to play with and no storybooks to read (not to mention television or other modern day amenities). But a closer examination may reveal that he had a happy childhood, well taken care of by extended family members, playing with stones and branches, catching insects or fishing with cousins and other children in the community, and listening to stories told by adults in the evening. If a clinician is not careful, this happy and secure childhood with high quality interpersonal relatedness could be misinterpreted as a chaotic and deprived childhood. Worse still, the client may be misled by an unformed clinician to believe that he really had a miserable childhood, and be induced iatrogenically to develop pathological symptoms.

Overall, while attachment theory has high explanatory and clinical utility, there are some warnings and caveats in applying this theory to culturally diverse populations. Clinicians applying this theory in their work must be sensitive to the cultural practices in their clients' community. They also need to help the clients explore and interpret their early interpersonal relationships in the proper cultural, social, and historical contexts, rather than simplistically comparing them to contemporary mainstream America. It would be expedient for clinicians to bear in mind the tenets of social constructionism when applying this rich and powerful theory to culturally diverse communities, for our knowledge, interpretations, and meanings are all shaped by the socio-cultural contexts in which we live.

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## Join a SIG!

The goal is to identify division members who are interested and active in these areas for networking and collaboration. It is anticipated that each of the SIGs and Committees will convene in the Division 43 Hospitality Suite in Washington DC. If you are interested in participating in one of these groups, please contact the chair indicated.

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## EDUCATION AND TRAINING

A. Rodney Nurse, PhD, ABPP, Editor

### Letter to the Column Editor:

*In the Winter Issue, 2005, I issued an invitation, which I repeat here.*

*"Letters to the Education Column Editor: This (experimental) column section is designed to provide an opportunity for Division 43 members to write brief letters expressing their perspectives related to the subject matter of education and training columns and in response to TFP articles specifically on education topics. I am hopeful that given President Mark Stanton's theme of education for this year, this section will serve as a useful purpose of suggesting a variety of perspectives."*

*"So, when you read a TFP education and/or training article that stimulates your thinking and you wish you could enter into a discussion with the author (or column editor) to provide an additional perspective or thought, pay attention to that impulse and write a letter to me (email or snail mail)!" Note addresses: drrrnurse@aol.com, or PO Box 175, Orinda, CA 94563.*

*I'm very pleased to include an email from Dr. Luciano L'Abate with observations about the three family psychology program description articles in the Winter 2005 issue in the TFP.*

Dear Dr. Nurse:

I am taking you at your word to comment on articles related to education and training in family psychology in the last issue of *The Family Psychologist*.

What impressed me the most about the various programs presented in that issue was the relative absence of two aspects that make us family psychologists (L'Abate, 1992) different from family therapists from other disciplines, namely: evaluation (L'Abate, 1994)

and prevention (L'Abate, 1990).

With the exception of the program at Alliant International University in San Francisco, that did mention "intellectual and psycho-diagnostic assessment," none of the other programs mentioned this aspect of training. Sadly, none of the programs covered in that issue mentioned prevention.

Are we selling out our professional identity as family psychologists to become like all the other disciplines interested in family therapy: namely (1) not stressing family evaluation before and after our interventions and (2) forgetting that for every couple or family that we see in therapy there are many more troubled couples and families that need prevention rather than therapy? How about prevention and therapy?

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Cordially, Lu

Luciano L'Abate, PhD  
(llabate3@bellsouth.net)

### Column Editor Comment:

*Luciano L'Abate makes interesting observations. Some fundamental questions triggered in me: Is the lack of reference to assessment in two of the program articles a*

*reflection of a general downplay of assessment? Is assessment important? If we need assessment in our programs do we build on earlier instruments? (See Nurse, 1999, for building on older "clinical" tests and questionnaires). Do we use direct family related instruments such as described in the Fall 2004 issue of TFP? In considering as-*

*essment instruments, how does family psychology's interpersonal, systemic foundation intersect with intrapersonal approaches? How do we conceptualize the family to be assessed, given changes in the last half century? (See an example below of a naturally occurring self-naming of a segment of relationship in "Wives-In-Law" below).*

### Mark Stanton's response:

*I appreciate Luciano L'Abate's concern for two key issues in education in family psychology. I agree that prevention is not specifically mentioned in the articles in the issue (although I know it is included in some courses in at least one of the programs). He is correct that more attention is warranted to prevention.*

*On the other hand, assessment is more evident than the critique indicates. I would note that the Texas Woman's University article indicated that "One course, Theory and Practice of Family Psychology, covers the wide variety of family intervention theories and contains a laboratory component to model and practice basic family therapy skills. The course teaches students to use system theories as bases for making assessments and conceptualizations and for devising treatment strategies in work with families in clinical settings." Second, the Azusa Pacific University program indicates that it is competency based and that it adopts the seven core competencies identified by the National Council of Schools and*



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*Programs of Professional Psychology: research and evaluation, relationship, assessment, intervention, diversity, consultation, and management and supervision. All APU students complete four assessment courses that provide a foundation in assessment. Later (p.8) it is specified that at APU the assessment competency is increased by the addition of means to conceptualize and measure systemic properties, such as relationship dynamics and family functioning, including instruction in couple and family assessment devices. Finally, an example is provided of an APU course that includes systemic assessment: "second year students take Family Psychology, a course that examines family development, the assessment of family functioning, the intersection of psychopathology and family dynamics, and family psychotherapy. Students learn to administer and interpret family assessment measures." Systemic assessment is an important aspect of education in family psychology and Luciano L'Abate is correct to emphasize it, but it appears that all three programs in the last issue do recognize that need and seek to provide education in elements of assessment.*

**Column Editor: Wives-in-Law?**

No, there is not a typo in the title. I recently learned of two women (neither a patient nor a client) who had coined this term to fit a family relationship for which we have no specific word in the English language as far I know. I think it is a useful word.

Let me describe their relationship. One woman, let's call her Anna, had three children by her husband, let's call him Lee. They had difficulty living together and so they divorced, painfully, but relatively overtly cooperatively. Anna and Lee wisely set up their two homes near each other so that their children could travel back and forth easily and the parents could share parenting without one being labeled "custodian" and the other "visitor." After a time as the pain in the divorce receded, Lee met Bell, who subsequently moved in with him and they married. As the children grew, being two boys and a girl of different ages, they had different activities and

interests...soccer, dance, drums, baseball, drama, basketball, etc., etc., etc. The children liked both of their "moms," one of course a step-mother. As the women became acquainted, assisting each other in transportation and events for the very complicated schedules of these children, they grew to like each other. Both had necessary interchanging parenting relationships with the children (facilitated by their slightly different out-of-the-home work schedules). But they had no term to designate their relationship when they were discussing the children with others. Yet both loved the children, were constantly involved with their activities. After brainstorming for a time, what seemed natural for them was to describe their relationship as that of "wives-in-law," which they have continued to do.

I have no way of knowing just what complex of needs this met for these particular women. I think, however, that in part it likely provided a way to acknowledge their hard working, warm, cooperative parenting relationship as they both, along with Lee, were raising children. Neither "mom" was primary in terms of care taking. And all three adults had active parenting relationships with "their" children. Other cultures, I recall from anthropological studies, often have specific names for kinship relationships. It seems to me that we need new terms to provide a reflection of status, function, and especially relationship. I refer the reader back to Luciano L'Abate's column, The Final Word, in the Fall 2004 issue of *TFP*. Citing changes in family structure as I do in the next paragraph, he states: "I resorted to using the concept of 'intimate relationships,' defined as being 'close, committed, interdependent and prolonged.'"

The model for the definition of family by the Bureau of Census is "one household, two married parents." Going by the last Census only 25 percent of families met this criterion and by 2010 the percentage is projected to be 20 percent (cited in Ahrons, 2004). One implication for me of this shift is that as family psychologists we would do well to keep an eye for kinship related

words that develop naturally in our culture. With this base we would further a natural language for discussions, whether in the classroom, therapy office or study in research lab. In *The Way We Never Were*, by family historian Stephanie Coontz, reference is made to the "tremendous variety of workable childrearing patterns in history," suggesting that "with little effort, we should be able to forge new institutions and values" (2000).

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**The Family Psychologist Archive**

Back issues of *The Family Psychologist* are available for the past three years in an archive on the Division 43 web site. If you are looking for a recent article, you may find it there. Division members may make copies of articles for use in clinical work or educational purposes (course handouts, course reading assignments). Visit [www.apa.org/divisions/div43](http://www.apa.org/divisions/div43) and click on *The Family Psychologist*.

## REFERENCE CORNER

Nancy S. Elman, PhD, Editor

*This issue of The Reference Corner includes two new books on families with disparate challenges, one with serious mental illness, and the other with extramarital affairs. A new and significant contribution to the literature on attachment that links basic research to practice complements the theme of attachment of this issue. In keeping with Editor and Division President Mark Stanton's presidential emphasis on Family Psychology Education and Training, each issue of The Reference Corner this year has at least one review by an advanced graduate student or new professional. If you are a trainer, please consider encouraging a student to write a review (perhaps with you) as an opportunity to contribute to the field. Contact me with suggestions or requests. If you are the author of a new book in family psychology that seems appropriate to review in this column, please make arrangements to have a copy to be considered for review sent as close as possible to the publication date. Send books (or galleys if possible) to Nancy S. Elman, Ph.D., Editor, University of Pittsburgh, 5946 Posvar Hall, Pittsburgh, PA 15260; email: elman@pitt.edu.*

**Atkinson, Leslie, & Goldberg, Susan. (Eds.). (2004). Attachment Issues in Psychopathology and Intervention. Mahwah, NJ: Lawrence Erlbaum Associates. ISBN: 0-8058-3693-4 (hc). (289 pp.) \$45.00.**

*Reviewed by Nancy Elman*

The nearly 4-year-old girl said warmly to her maternal grandmother while wrapped tightly around her neck and hips after a bath and stories, "I'm attached to you, Grammy." The grandmother said to the child, "I'm

attached to you, too, Lindsey," and the child replied with glee: "We're attached to each other!" OK, I'm the grandmother, and this interaction took place fairly recently after a family vacation, touching me with the simple elegance of a moment when attachment can be so beautifully celebrated and making my interest in a work like Atkinson and Goldberg's *Attachment Issues in Psychopathology and Intervention* seem inevitable.

Leslie Atkinson and Susan Goldberg have set out what seems like a fairly simple agenda for their edited collection, *Attachment Issues in Psychopathology and Intervention*: to push forward thinking about the clinical aspects of attachment theory (p. vii) and to focus on applications of attachment that integrate developmental and clinical perspectives. They cite progress toward this goal over the recent past: a 1988 work by Belsky and Nezworski, *Clinical Implications of Attachment*, as a landmark book limited by the fact that there were no clinical data to move from implications to applications. Atkinson and Zucker's 1997 *Attachment and Psychopathology* is seen as the next advance in linking the two strands, although the linkages were still difficult to demonstrate empirically.

This current book came about because editors Atkinson and Goldberg believe that there has been significant progress in areas such as understanding the disorganized attachment style, and applications to empirical to clinical work. They have included writings by some of the most senior and respected experts on attachment. The book is divided neatly in half: the first half dedicated to exploring research on the links between attachment and the development of psychopathology, the second half de-

voted to intervention. In the first half Atkinson and Goldberg succinctly review where the field has been focused: on issues of a) continuity of attachment over time (hence predictability) and b) context, the conditions for different attachment responses. They set as the goal for the book to address the form of psychological difficulty or pathology, at what stage of development, impacted by what applications. Byron Egeland and Elizabeth Carlson follow with a chapter that demonstrates the pathways from attachment to pathology over time (linking the data from the youngest children as far as adolescence), and then showing pathways to particular outcomes such as anxiety disorders,



Nancy S. Elman, PhD

ers, antisocial behavior, depression and dissociation. The patterns are becoming increasingly clearer as empirical research becomes more robust. This data, mostly drawn from the Minnesota Longitudinal Study of Parents and Children, documents the progress. The remainder of this section of the book presents additional empirical evidence for the relationship of attachment to such disorders as failure to thrive, disorganized attachment between parents and young children, and adolescent psychopathology.

The second part, *Intervention*, moves from empirical findings on relationships and risks based on attachment experiences to several models and examples of clinical intervention that, for the most part, readily dovetail with a family systems perspective. Two are about clinical assessment and treatment for parents and children. In the first, Kobak and Esposito present a tripartite Level of Processing (LOP) model for focusing on each individual's (parent and child) attachment style and/or internal working models about relationships, the interpersonal level of reading and sending

signals between parent and child, and the metacognitive level (especially at first for the parent) of reflecting on and evaluating the internal working models about self and other and course-correcting as change is needed. It is a simple enough outline or paradigm with useful implications for clinicians. In a second chapter focused on parent/child intervention, Cicchetti, Toth and Rogosch report on a program utilizing attachment theory to treat depressed mothers and their toddlers.

The remaining chapters address a variety of adult clinical issues, again broadly systemic. Dozier and Bates extrapolate from attachment to approaching the “states of mind” of the therapist, considering how attachment plays out and effects the therapeutic relationship. They describe the treatment relationship, rightly I think, as often an attachment relationship, “directed at modifying the client’s processing of attachment-related information” (p. 167). Drawing on empirical research on states of mind and ways of interacting, Dozier and Bates suggest that one role for the therapist may be to respond to the client in ways that challenge the client’s expectations or working models of attachment. Sue Johnson contributes a chapter on creating secure attachment in couples therapy where one partner of the couple has suffered from a trauma. Johnson’s Emotionally Focused Couples Therapy (EFT) may be the most familiar of anything in this book to family psychologists. In this work she has focused on the importance of key attachment relationships, e.g., partners, in providing a safe haven within which old wounds may be healed, considering how specific attachment styles and behaviors may be addressed in the therapy. Finally, Arietta Slade reports on two individual therapies in which attachment issues of each client in significant family relationships (and in the transference) formed the basis of the work. Drawing on extensive clinical examples, she details the work with two female clients, one with a dismissive and one with a preoccupied attachment style. Her descriptions bring to vivid life these adult attachment patterns of relating.

Atkinson and Goldberg have, it seems, done what they set out to accomplish. *Attachment Issues in Psychopathology and Intervention* takes the next step in moving forward applications of attachment theory and research findings toward clinical relevance within a family systems perspective. The chapters in the Intervention section of the book are enriched with either chunks of transcription of key interchanges or more complete case examples that may help the reader transfer the model directly to what one might say or do or attend to in the therapeutic hour. As well, the relevance of the direct linkage of research about particular attachment styles and interactions is demonstrated, moving the field beyond some of the earlier global fuzziness about attachment categories. Family therapy and family psychology have probably not yet made enough application of attachment theory and research to practice - this book takes another step forward in making it relevant, through the improving research and the elegant examples of the wide range of potential clinical applications.

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**Marley, James A. (2004). Family Involvement in Treating Schizophrenia: Models, Essential Skills and Process. New York: Hawthorn Clinical Practice Press. ISBN 0-7890-1250-2 (pbk). (157 pp.) \$24.95.**

*Reviewed by James E. Dobbins*

There can be no greater test of a psychological theory than how well it informs research or successfully guides practice with difficult-to-treat clients. *Family Involvement in Treating Schizophrenia...* examines the utility of the major family therapy theories when applied to the difficult work of helping families to cope with severe mental illness. James Marley, from Loyola University of Chicago, suggests that clinicians might approach a book on this topic as redundant to what we have heard time and

time again about the difficulties of treating schizophrenia. This is a disorder that we may be comfortable leaving out of the arena of family therapy because medications and case management have done a better job of reducing the negative and positive symptoms associated with this disorder. If these are the places that your thinking goes about a 157- page text on treating this population, you would be all wrong in this case. James Marley has done a superb job of bringing light to a darkened hall in the house of family psychology. First, it is great to have a handy reference on the theories that define the professional roles of the family psychologist. He helps the reader to understand that there is not enough research on the utility of family therapy with families who experience schizophrenia. He also reminds us that without research on schizophrenia some of our major theories and theorists would not be in existence. He weaves the relationships among the various schools together in a tight narrative so that the story is not lost about the characters or the causes that the major theorists tried to champion in their work with schizophrenia. More importantly, he makes compelling statements about the strengths and shortcomings of each theory. He leads readers to the awareness that we are not fully utilizing our creativity and influence to advocate for families who need something more than self-help or wrap-around services.

I greatly appreciated the balance and due concern given to the therapist, client, and systems of care that affect families who deal with schizophrenia. Having taught in this area for the past ten years I feel that I have here a much needed text for the graduate student who needs to understand both theory and application within an integrated format. This book is a good companion to the state of the art text written by Diane Marsh (1992). Her book differs in that it focuses on the diathesis-stress model and offers little about theories of family therapy. If space allowed I would let the book speak for itself, citing theory by theory Marley’s parsimonious and engaging analysis of how theory and associated techniques should or

should not be used. This is where the practitioner may get the most mileage out of the information. He discusses each theory in terms of its principal tenets and techniques, with additional analysis as to what will facilitate or likely block or harm therapeutic process. In general he suggests that although psychodynamic theory has much to offer in terms of the role of listening and a long term approach to care, it suffers from the inability to shed its negative image as a "mother blaming" theory. In an analysis of experiential theories, Marley notes that the personalism of a Carl Whittaker or Virginia Satir can not be duplicated, so for all of the strength of these approaches, they lack the ability to be replicated. Structural and strategic theories offer many positives in terms of how closely they use the language of general systems theory. Structural theory offers a user-friendly language of change, while strategic therapy has moderated its principle weakness of being too directive for a collaborative therapy. Humanistic and narrative (including solution focused) approaches are a good fit for the non-blaming stance that is critical in working with families who have a schizophrenic member, but the use of questions may be a test for the issue of expressed emotions more than other approaches. Multiple family theories are seen as the strongest and best researched approaches to intervention with schizophrenia. This includes the psychoeducational theories at the heart of the extremely successful National Alliance for the Mentally Ill family education programs.

At the end of this book Marley projects future possibilities for the individual family psychologist and the governance of the field as it relates to advocacy and care of families who have members with schizophrenia. He mentions that this domain will likely become the turf of specialized rehabilitation clinicians who use family therapy theory as an adjunct, so he provides a generic five-step approach to institutional development of "family focus" programs and individual professional competence in this mission field. He has guidelines for supervision and ethical guidelines.

I was struck by Marley's statement that "the schism that exists between researcher and therapist did not always exist, at least when it comes to family work with schizophrenia" (p.140). He extends a challenge to family psychologists to see how we can move the next generation of students back into this work. His work suggests that unless we work with the most challenging cases we may not have the authority to say that we have the best tools to work with those who are less challenging.

Given the comprehensiveness of the book, I would call it a pocket reference for those who want to expand their understanding of theory or their efficacy for working with clients who are compromised in their ability to participate in their own recovery.

*James E. Dobbins, PhD, ABPP, is Professor in the School of Professional Psychology at Wright State University. He is Director of the post doctoral training program and currently serves as Vice President for Practice of Division 43.*

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**Allan, G., Duncombe, J., Harrison, K., & Marsden, D. (Eds). (2004.) The State of Affairs: Explorations in Infidelity and Commitment. Mahwah, NJ: Lawrence Erlbaum Associates. ISBN: 0805844570 (pbk). (253 pp.). \$29.95.**

*Reviewed by Sorrenta Stuart*

*The State of Affairs: Explorations in Infidelity and Commitment* is a straightforward representation of research on infidelity in romantic relationships. The editors chose colleagues holding differing theoretical perspectives from the United States and abroad, and their combined contributions give a

cross-national view of affairs. The chapters consist of descriptive research, surveys, large statistical studies, interviews, and case studies. They illustrate both the liberating effects of extra-marital affairs and the detrimental effects they have on society at large and on individuals and families.

It is not news that affairs and infidelity have become more common in the institution of marriage. This book is a useful guide for mental health and social service professionals and students interested in the many factors that lead to and impact infidelity in romantic relationships. Themes of secrecy, lust, and betrayal are common threads, and issues such as jealousy, betrayal, and lies must be addressed in any effort to help couples repair damage to their relationship. Although affairs are often romanticized in popular culture, the experience of a couple suffering from the repercussions of infidelity is usually quite unromantic.

*The State of Affairs* illustrates changing societal attitudes over time concerning infidelity. Traditionally, sexuality was viewed as a matrimonial duty rather than as a pleasure. Today sexuality is perceived more and more as an individual and mutual right and pleasure. Authors Kontula and Haavio-Mannila describe how sexual tolerance has increased in Western societies and how sex itself has become more hedonistic. They report that sexuality has become more recreational and pleasure-oriented, and carefully review the earlier role of reproduction in American sexual life. Sexuality has become a source of thrill and excitement for many individuals. If a person does not derive this sense of pleasure from his or her partner, it has become more common in Western societies to look outside the monogamous partnership.

Broad-based studies are presented in *The State of Affairs* that demonstrate trends in infidelity in the US and internationally, furthering this book's credibility. Although many scholars shy away from issues regarding sexual contact and intimacy, the

editors actively approach and dissect issues surrounding sex and secrecy in romantic relationships. This may be especially useful to clinicians working with diverse populations, and psychotherapists are urged to recall the importance of differing cultural attitudes when working with couples in distress. The work approaches aspects clinicians may not consider, such as the differences between his- and her- affairs, effects on children, and coping strategies.

A chapter by Duncombe and Marsden effectively demonstrates the narrative of an affair. The authors look closely at events before, during, and after an affair, using a sociological perspective to study the story of Sarah, who had an extramarital affair with David. Although the narrative touches on broad themes, such as affairs for sexual pleasure and/or emotional fulfillment, it also emphasizes that each individual story is different. This is a critical aspect when considering the generalizations people tend to make in explaining affairs, such as boredom, curiosity, and "sociological trends." Sarah's story itself is riveting. The narrative instills a feeling of understanding for individuals involved in an affair and offers psychotherapists a more empathic stance toward partners who stray. Sarah's story introduces themes of guilt, secrecy, and jealousy, as well as adventure, lust, and romance. These contrasting themes evoke interest and questions such as "Could her

husband have stopped the affair?" and "Why was she obsessed with the other man?" Sarah's story presents themes of the attractiveness of the unknown and avoidance of the monotony of the mundane, as well as those of gender, power, media images, and egalitarianism. Sarah's suicidal ideation cues psychotherapists to the pain individuals may feel by the ending of romantic relationships. Eventually Sarah's affair reached an impasse. She could no longer continue to emotionally hurt herself and her family, and eventually came clean to her husband only to find out that he too had participated in many sexual affairs.

The reasons that many people engage in extramarital affairs become more apparent through three chapters that describe themes of sex, validation, and love. Several authors discuss communication styles between couples that influence affairs. By reviewing the research literature the authors found that verbal and nonverbal separating between two people often leads to one searching elsewhere for intimacy. Buunk and Dijkstra explore how the incidence of extramarital sex varies between men and women. Women often seek affairs for emotional support while men seek affairs for sexual satisfaction. Family patterns may predispose partners to have or not have an affair, such as having had divorced parents. Also, affairs occur at different stages in a relationship: an affair after childbirth is dif-

ferent than one in the later years of marriage. Affairs may occur for revenge, to restore self-esteem, or to abate feelings of loneliness. Adulterers often experience a powerful change in their identity during and after the affair, and it becomes clear that affairs can lead to not only the demise of the marriage, but to the demise of the individual's prior identity as well. These and other findings are grounded in empirical research, and this may offer insight into the future direction of both study and practice dealing with romantic relationships and the role of affairs.

*The State of Affairs* can aid psychotherapists in working with individuals, couples, and families in the aftermath of the affair. This is an excellent book for therapists and students hoping to gain more knowledge on marriage, partnerships, and affairs to enhance their practice. This book begins to make sense of several issues in relation to affairs, is informative, and an interesting read as well.

*Sorrenta Stuart is a Master's candidate in Marriage and Family Therapy at the University of San Francisco, and is currently a trainee at a middle school in San Francisco.*

# Crisis in Children's Mental Health Care: A Well-Kept Secret

Karen Saywitz, PhD  
Chair, Interdivisional Task Force on Child and Adolescent Mental Health

Laura Nabors, PhD

"Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them." (Report of the Surgeon General's Conference on Children's Mental Health, 2000)

These are the words of former U.S. Surgeon General, David Satcher, who concluded that our system of delivering children's mental health care was in crisis and that a nationwide overhaul was necessary. Recently, President Bush appointed the New Freedom Commission on Mental Health to re-examine the issue. Preliminary reports referred to the situation as a public health crisis. In response, the American Psychological Association (APA) passed a resolution on children's mental health and funded two task forces to outline the role Psychology should play as a leader in a national reform effort. Both task forces concluded that the public, the policy-makers, and many professionals remain unaware of the problem, recommending that increased awareness both inside and outside of Psychology be a top priority.

In short, one in ten children or adolescents have a serious mental health problem, and another 10% have mild to moderate problems. However, less than half of children with mental health problems actually receive treatment or services. Even then, only one in five receive treatment from a professional specifically trained to work with children or teens. Moreover, there are grave disparities in identification and prevention of mental health problems as well as in access to services for families of color, in

poverty, or who have children with special needs. Reform is even more urgent now that research indicates many mental health disorders in children and adolescents are treatable and even preventable.

The costs to our country are staggering. Untreated mental health problems in children can lead to tragic consequences, including suicide, substance abuse, inability to live independently, incarceration, lack of vocational success, and health problems. Not only are families affected but also communities, schools, employers and the nation as a whole.

## What is APA doing?

Eight APA Divisions have joined efforts in an Inter-divisional Task Force on Children's Mental Health Care to promote the conceptualization and realization of a new national model for promoting, preserving and restoring our children's mental health. This model calls for a comprehensive, sustainable, collaborative system. Components include:

- *Promotion* of healthy social and emotional development for all children
- *Prevention* of mental health disorders in children
- *Early screening and identification of indicators of mental health problems* in schools, daycare, health clinics, emergency rooms, and especially high risk settings such as juvenile justice and child welfare programs
- *Early childhood intervention* grounded in emerging research highlighting the role of environmental factors in brain development
- Universal access to a *comprehensive range of treatments and services* for children and families identified with mental health problems *coordinated* across agencies and service systems that are *culturally, linguistically, and developmentally*

*sensitive, individualized, family centered, home-school- and-community based, and evidence-based*

- *Sufficient funding and realignment of funding streams* to create an infrastructure that supports a comprehensive array of services

## What can you do?

Spread the word. The system is broken and needs repair.

- Educate others about the seriousness of mental health problems for children and the stigma that prevents families from seeking treatment
- Inform others that children's mental health and social, emotional, and behavioral well-being are critical for "healthy" development
- Improve awareness of the early signals of mental health problems and the fact that there are effective treatments available
- Inform others about the shortage of mental health professionals trained to work with children, adolescents and their families using evidence-based treatments

## How? Here are resources to help

The Inter-divisional Task Force on Children's Mental Health is developing materials to provide members with the background information necessary to spread the word. We are creating a website to centralize information on children's mental health to be accessed by both the lay public and professionals. We have completed a set of *Talking Points* you can use to advocate for reform found at <http://mirror.apa.org/ppo/issues/tftalkingpoints.html>. We created a *Fact Sheet on Early Signals of Possible Infant, Child, and Adolescent Mental Health Problems* to help educate colleagues in other disciplines. We are organizing congressional briefings by experts and a national

multidisciplinary summit to address child mental health policy.

Visit the website, peruse the links, download fact sheets and talking points. Then....

Educate colleagues, patients, parents, coaches, church, community and PTA members, school administrators, and school boards about this crisis in children's mental health services.

- Talk to a department head at a Psychology program near you. Let the chair know how important it is to train graduate students to work with children and families.
- Educate colleagues in other disciplines. Increase awareness of early warning signs, guideposts for referral, and effective treatments. Volunteer to train new providers — supervise someone who wants to learn. Give an inservice presentation.
- Donate time to help a child in a high-risk group who lacks access to quality mental health services.
- Write and visit your local congressperson. Contact state psychological associations or departments of mental health or write them a letter delineating these needs.

- Contact local mental health boards and advocate on behalf of children or families.
- Encourage pediatricians and nurses you know to take time for a "mental health check up" with the children and families they serve.
- Lobby managed care providers so that they will cover mental health services for all youth, and especially for children and adolescents who are likely to be underserved.
- Advocate for comprehensive mental health care plans for children, with supporting infrastructures.

Bringing these issues to the public will take effort, perseverance, and vigorous lobbying, but the crisis in children's mental health care cannot remain a well-kept secret. With two Presidential commissions recommending historic reforms and the science of Psychology at critical mass, psychologists are poised to make a meaningful difference in the lives of children and families nationwide. There is broad consensus that this is an ideal moment to for us to intensify our effort.

**APA Convention  
August 18–21, 2005  
Washington, DC  
Great Family Psychology Programs  
We'll See You There!**

## Inter-divisional Task Force on Children's Mental Health

### Participating Divisions:

- Developmental Psychology
- Clinical Psychology
- School Psychology
- Child, Youth & Family Services
- Family Psychology
- Society for Community Research & Action
- Society for Pediatric Psychology
- Society of Clinical Child and Adolescent Psychology

### To learn more

See the report of the APA Working Group on Children's Mental Health, 2001, at <http://www.apa.org/pi/cyf/dpnacmh.pdf>

See the report of the Task Force on Psychology's Agenda for Child and Adolescent Mental Health, 2004, [http://www.apa.org/pi/cyf/child\\_adoles\\_mentalhealth\\_report](http://www.apa.org/pi/cyf/child_adoles_mentalhealth_report)

See the Report of the U.S. Surgeon General's Conference on Children's Mental Health, 2000, at <http://www.surgeongeneral.gov/topics/cmh/childreport.htm>.

See Talking Points on Child and Adolescent Mental Health <http://mirror.apa.org/ppo/issues/tftalkingpoints.html>

Inquiries about the Interdivisional Task Force on Child and Adolescent Mental Health can be directed to Karen Saywitz, Chair, at [ksaywitz@ucla.edu](mailto:ksaywitz@ucla.edu).



## STUDENT CORNER

Bethany Tavegia, MA, Editor

### Family Psychology Students

This year, my major function as the student representative will be to lay the groundwork for a more formalized and active student role on the board. I see my primary responsibilities focused in three major areas: creating a national student committee, soliciting student involvement in the Division during the annual convention, and reinstating a student column in *The Family Psychologist*.

In organizing a student committee, I would like to see a student from each graduate program with a family psychology tracks or emphasis serve on the committee. Division board members were asked to give names of students who would be interested in participating. Other members will include the past student representative and the Division's president-elect's choice for student representative the following year. The roles and responsibilities of the student members have not yet been clearly defined and there is room

for input and flexibility as we work to create a cohesive group.

I will be making a concerted effort to include graduate students interested in family psychology at the Division's activities during the annual convention. I will be contacting APAGS to see how I can make our Division more visible to interested students and will be sending out emails through the various listservs to encourage student participation in our social hour at the annual convention. While this year's social hour is student focused, our key Division leaders will be involved as well. This will be an important time for students to network not only with each other, but also with board members and other key figures in family psychology. In addition, in the hospitality suite, we will offer a student session entitled "How to Have Your Poster Accepted by Division 43 for the 2006 APA Convention," coordinated by the Vice-

President for Science, Kristina C. Gordon. My hope is to communicate to our student members that the Division welcomes their participation and involvement. The student committee will convene for the first time during the convention and will begin discussion for future plans.

Finally, the student column in *The Family Psychologist* will once again appear on a regular basis. Students will have the opportunity to submit short (800-900 word) articles related to the theme. We are also interested in publishing student reviews of recent books in the Reference Corner (see Nancy Elman's call for reviews in that column).

I welcome your participation in the Division! Please contact me at [btavegia@apu.edu](mailto:btavegia@apu.edu) to get involved.

### FAMILY PSYCHOLOGIST SOUGHT

for multidisciplinary child and family oriented private practice in Charlottesville, VA.

Experienced child and family psychologist is sought for a full-time position in a practice that includes child psychiatrists, clinical psychologists and master's level clinicians.

The optimal applicant would have at least 3 years experience providing family, couples, and individual psychotherapy services to children, adolescents, and their families. Competence with psychological testing is preferred. Particular theoretical orientation is not as critical as maturity, ability to function effectively as a team member and colleague, and solid communication skills.

For more information about the practice, the website address is [www.pdakids.com](http://www.pdakids.com).

Salary is negotiable depending on experience and potential contribution to the practice. Start date is September, 2005.

Opportunity for partnership in the practice is available as well.

To apply fax cover letter and vita to Maureen Otten, Office Manager, at (434) 220-4687 or e-mail to [motten@pdakids.com](mailto:motten@pdakids.com).

Each month we will have an article in The Family Psychologist focused on a different aspect of Family Forensic Psychology (FFP). Everyone interested in this area of Family Psychology is encouraged to contact Neil Grossman at [neilgrossman@mindspring.com](mailto:neilgrossman@mindspring.com) to become a member of the FFP Special Interest Group.

### Entwined: New Reproductive Technology and Family Forensics Psychology

Lita Linzer Schwartz, PhD, ABPP

Family psychologists who focus on forensic issues have long been involved in child custody evaluations in adoption and divorce conflicts, or in dealing with the adults in these conflicts, seeking to resolve their differences through mediation and/or counseling. In more recent years, these situations have become more complicated as a result of the new reproductive technologies, which may involve a third party in the creation of children, as well as an increase in same-sex partners becoming parents.

#### The Types of Technology

There are basically three types of new reproductive technologies:

1. Surrogacy - with variations within this technology
2. Artificial insemination - by the husband or by a donor.
3. *In vitro* fertilization

The varieties of surrogacy may involve the intended mother's ova or a surrogate's ova, the intended mother as carrier, or a gestational carrier. Where a third party is to participate in the conception, that individual should be screened by a psychologist to reduce the danger of a change of mind when the child is born,

and all parties involved should have counseling before conception, during the pregnancy, and after the birth (Shanley, 2001). In all cases, a contract is signed that states the arrangements to which all parties are agreeing.

The "Baby M" case (Schwartz, 1988) was probably the best-known surrogacy case. It points up the need for family psychologists to be knowledgeable about the practice of surrogacy (where it is allowed) and the risks involved, so that they can be effective in guiding their patients/clients to consider the full situation in which they might become involved. One legal complication, varying by state, is whose name is listed on the birth certificate as mother (Appleton, 1999; Schwartz, 2003).

Artificial insemination (AI) can be by the husband, by a donor if the husband's sperm count is very low or carries a genetic defect, by a donor for lesbian couples or a single female, or by frozen sperm after the death of a husband. Sometimes the donor is anonymous, sometimes known.

Gay partners who wish to have a child are confronted with the obvious problem that neither of them can furnish ova nor carry a fetus. They, therefore, need to find a female willing to supply both, or two females each of whom supplies half the solution. Lesbian partners, on the other hand, need a sperm donor, but can each have a role in the pregnancy - one supplies the egg and the other carries the fertilized ovum. The difficulties come, for all of these same-sexed parents, in who is considered the legal parent and what role the non-biological partner is permitted to play. Most studies suggest that same-sex parents tend to divide family responsibilities equally and that the children have a healthy psychological development (Johnson & O'Connor, 2002).

*In vitro* fertilization is the technique of choice if the woman's fallopian tubes are blocked. This involves fertilization of ova by sperm in

a petri dish and subsequent implantation of the fertilized ova in the mother's womb. There should be no legal complications with this technology.

#### Family Questions

Whether or not children should be told how they were conceived varies both with the technology used and how many people are aware that it was used to create the children. *In vitro* fertilization and artificial insemination by the husband need no explanation. AI by an anonymous donor can be handled much like adoption, i.e., "We wanted a child so much that . . ." In surrogacy, if a family member was involved as egg donor or gestational surrogate, that relative's connection with the child should be worked out beforehand, with the aid of a family psychologist, and certainly may be explained when the child is old enough to understand. Care should be taken, if the child needs therapy later on, that the nature of conception not receive undue emphasis as a cause of the child's problems.

#### Legal Questions

The principal legal question that arises with some of these techniques is "Who is the parent?" As noted, this differs by state and should be considered before conception occurs. A second issue, should there be a custody dispute after the child's birth, is what placement is in the child's best interests? If there is one donor and one biological parent and the couple splits, whether heterosexual or homosexual, who becomes the child's primary caretaker? Who is the legal/biological/psychological parent? This will vary by state especially in the case of homosexual partners.

The family forensic psychologist may become involved in evaluating the role of each partner in caring for the child, and, if the partners separate, what recommendations to make regarding custody and visitation. The forensic evaluator is urged to observe the child interacting with both parents in home visits, so that a decision will rest on what is "least detri-

mental” to him/her (Tye, 2003). If, as is likely, the child has developed an attachment to both parents, then the psychologist should encourage the parties to enable the child to maintain interaction with both of them.

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*Lita Linzer Schwartz, PhD, ABPP (Forensic)* is a Distinguished Professor Emerita of The Pennsylvania State University, and is the author of numerous articles, chapters, and books on the inter-related topics of infertility, alternative reproductive technologies, and adoption.

## Forensic Task Force, Division of Family Psychology

*Neil Grossman, Chair*

We have created a Family Forensic Psychology – Special Interest Group (FFSIG). Membership in this group is open to all members of the Division of Family Psychology (Div 43). The goal of the group is to further learning, training and the dissemination of information about Forensic Family Psychology. The FFSIG will operate under the guidance of the Forensic Task Force of Div 43. A coordinating committee will facilitate the day to day operations of this SIG. Thus far, there are 25 members of the FFSIG, including several people who joined the division to be able to be members of this group.

The FFSIG has a listserv to promote discussions among its members and to make announcements. Members of the FFSIG will be encouraged to join and/or form various study groups. It is hoped that once the study groups are formed much of the business of these groups will take place off the listserv with the work products of these groups being shared on the listserv. One of the goals of the FFSIG is to publish information about Family Forensic Psychology. To further this goal an e-newsletter will be published to disseminate articles and reports of the study groups. It is hoped that this will lead to publication in professional journals, presentation of workshops and will prompt research. There will be a FFP column in each issue of the *Family Psychologist* and one issue will be devoted to this topic in late 2005 or early 2006.

### Plan Ahead!

#### Division 43 Presidential Program at APA Convention

#### Family Psychology Interventions for Substance Use Disorders: Two Evidence-Based Models

Featuring Presentations by  
William Fals-Stewart, PhD, and Thomas Sexton, PhD

Each will present a summary of their most recent research and provide elements of their evidence-based clinical model. This is intended to appeal to both researchers and clinicians, continuing the division theme of bridging science and practice.

In addition, there will be a conversation hour at the Hospitality Suite following the program in order to provide more time for discussion and interaction.

# Council of Representatives Report

James H. Bray, PhD

The Council of Representatives met in Washington, DC from February 17–20, 2005 for the first session of the year. Dr. Ronald Levant, APA President, presided over the meeting. It was a productive and very interesting meeting. A special note is that Dr. Levant is a past president of this division and his skill and sensitivity as a family psychologist was evident throughout.

The finances of the APA are once again very strong. We ended 2004 with a substantial budget surplus of about 1.8 million dollars. This is an excellent turn around from a few years ago when we were experiencing budget deficits.

I am pleased to announce that the Council passed a \$98.5 million budget with a projected \$540,000 surplus for 2005. The budget allows us to continue our many successful programs and replace a number of personnel who resigned after our budget deficits in 2002. The Council voted to donate \$250,000 for relief aid to the Tsunami Victim's Fund. These funds are targeted for mental health services as the survivors struggle to regain their lives.

APA's income comes from an interesting mix of sources. Publication sales contribute 61% of our income. Electronic products substantially exceed print products and are expected to continue to rise. Dues represents **only 14% of income** (down from 16% last year) and the rest comes from a variety of sources, such as grants and contracts. Our net worth climbed 15% in 2004 and we have topped our previous net worth of \$44 million in 2001. Our able CFO, Jack McKay, deserves lots of credit for helping APA regain its financial position.



James Bray, PhD

The following are some of the items passed by the Council that have particular relevance to Division members. The Council provided additional funds for our Membership Recruitment and Retention Fund. While APA membership had a small increase in 2004, the trends are level or downward in the near future as an entire generation of psychologists moves towards retirement.

The Council voted to provide \$60,000 per year to support the Archives of the History of American Psychology. The Council funded several task forces that will need volunteers. Please contact me if you would like to participate. These include the Working Group on Psychoactive Medications for Children and Adolescents, the Task Force on Gender Identity, Gender Variance and Intersex Condi-

tions, and the Task Force on the Sexualization of Girls. The APA passed a resolution to support empirically supported sex education and HIV prevention programs for adolescents. I added several amendments to include family interventions, which are supported by research funded by the National Institute of Mental Health. There was considerable debate about accepting a UN report on the World Conference Against Racism. Dr. Florence Kaslow and others felt that the report had anti-Semitic statements. Dr. Kaslow was instrumental in developing an alternative report that resulted in several resolutions that will make it clear that the APA does not support anti-Semitic discrimination. The Council re-approved the recognition of

clinical geropsychology as a proficiency in professional psychology. After considerable debate the Council did not approve the application for the establishment of a new division, the Society for Human-Animal Studies.

Many small states and divisions are having difficulty sending their council representatives to the meetings. Council members are paying their own travel expenses to do the associations work. I introduced a budget request to help support their travel expenses and it was passed and will start in 2006.

**Washington, DC is on the horizon!!!** Plan to attend the APA Annual Convention in Washington DC, August 18–21, 2005. Dr. Levant has planned an exciting, informative and FUN conference, so come and bring your family.

Please contact me (jbray@bcm.tmc.edu) if you would like further information about the Council's activities.

## Erratum

*The Family Psychologist*, Vol. 21, No. 1, page 30, second column, 3rd article from bottom, should have included Deborah Gorman-Smith as a co-author. The correct citation is as follows:

Henry, D., Tolan, P.H., & Gorman-Smith, D.—Clustering methods in family psychology research.

# Candidate Statements

## President-Elect Candidate

*William H. Watson, PhD*

I am pleased and honored to be nominated for President of Division 43. I have been a family psychologist for over 20 years, and am a strong believer in the mission and promise of Division 43 both within APA and in the wider fields of family psychology and family therapy internationally. I have been involved in the leadership of Division 43 in a variety of capacities over the past 6 years. I have served two terms on the board as division treasurer. I am the division representative to, and chair of, the Family Psychology Specialty Council, co-chair of the Education and Training task force, and chair of the membership committee. I have also served as organizer of the hospitality suite and co-chair of the program committee.



I am currently Associate Professor of Psychiatry (Psychology) and Neurology at the University of Rochester Medical Center. I am a core faculty member of the Primary Care Family Psychology track of our APA-accredited postdoctoral fellowship program. I also teach and supervise in the University of Rochester Family Therapy Training Program's postgraduate and master's degree programs. As the faculty member responsible for the 3-course family therapy sequence taught to our psychiatry residents, I have developed a particular appreciation for what family psychology has to offer the medical field, in both training and practice. During my eighteen years here, I have also provided family therapy training to psychology doctoral students, psychology interns, and fellows, social work interns, medical students and residents in pediatrics, neurology, and adolescent medicine. A significant portion of my time is devoted to providing family psychology consultation to the

Strong Epilepsy Center in the Department of Neurology, where my work centers on mind/body issues in patients and families dealing with intractable seizures, both epileptic and psychogenic.

On the broader professional front, I serve as a site visitor for the AAMFT Commission on Accreditation for Marriage and Family Therapy Education and as a contributing editor for the *Journal of Psychology and Theology*. I am also on the boards of several local and regional professional associations. My publications are in the areas of the individual and family dynamics of somatoform disorders, the initial family interview, and family systems approaches to spirituality.

My abiding professional interests are in education, training, and clinical practice. As an educator, I have a particular concern for postdoctoral training in family psychology, and for the role of family psychology in medical education and in health care. I also highly value family psychology research, which calls us to put our clinical assumptions to the test and allows us to deepen our understanding of the interpersonal processes that underlie family and organizational dynamics. Division 43 has a distinguished record in supporting all three of these areas—education, research, and practice—though there is more to be done. I would like to see the division continue to strengthen its leadership in these areas, both within APA and nationally.

Now that family psychology has been recognized as a specialty by APA, Division 43 is actively participating with others in family psychology to define our specialty in terms of graduate education, postdoctoral training, and clinical practice. As we get these foundational tasks accomplished, I believe the next step will be to craft a strategic vision for family psychology for the next decade. What are the critical issues fac-

ing family psychology? How does the field need to be moved forward in education, clinical practice, research, public policy? I believe the division can provide shape and definition to the future of family psychology by addressing these questions through focused dialogue within our division, with other APA divisions that share similar concerns, and with other organizations concerned with family systems and interpersonal processes.

The average age of the membership of APA has increased by 10 years in the past decade. It is imperative that we find ways to support early career family psychologists if we hope to remain relevant and productive to the field. I would like to see the division continue to develop its outreach to students in order to provide support to developing family psychologists early in their careers, providing students with a “home base” that is experienced as both welcoming and as helpful in specific, pragmatic ways relevant to their needs. Developing our effectiveness with student members will serve both to provide a valuable service to a key constituency and to energize the division with new talent, fresh perspectives, and a growing, vital membership.

We have much to offer other divisions and the rest of APA by our advocacy of the family and promotion of the systemic perspective in practice, in research, in healthcare, and in public policy. I would like to see us continue our work to impact other divisions and APA on behalf of family psychology.

## Vice President for Science Candidates

### *Guy Diamond, PhD*

Building on its current activities, Division 43 has the potential to provide leadership in promoting family intervention science and practice throughout APA and the broader health care system. In the past decade, we have made great strides in gaining recognition for family-based treatments as an empirically supported intervention modality for several disorders. Federal and private funding sources and HMO organizations have begun to see the value of having family treatments as a core component in a continuum of care. Yet this status will only remain or improve if we continue to promote efficacy and effectiveness research. Increasingly, research funding and reimbursement for a treatment modality is dependent on empirical support for its efficacy. For example, treatment dissemination studies funded by the Substance Abuse and Mental Health Services Administration (e.g., CSAT, CMHS) must use empirically supported treatments that have been tested in clinical trials. Unfortunately only a few family-based treatments have earned this distinction (e.g., MDFT, FFT, MST); so much more work is needed.



Psychology is the best discipline poised to carry out this mission and Division 43 should be the APA home to support it. As the VP of Research for the Division, I would seek to pull together researchers, providers, and policy makers within and outside of the Division to create a strategic plan that would help guide our efforts over the next decade. More funding to support family treatment studies, more new investigators to enter this field of research, and more research that is relevant to practice are only a few of the agendas that we need to push forward to build our status in the this health care environment. Below is a brief description of my current work. I hope you will find me a worthy can-

didate of this important position in the Division.

Currently, I am an Associate Professor at the University of Pennsylvania School of Medicine and the Director of the Center for Family Intervention Science (CFIS) at the Children's Hospital of Philadelphia. CFIS is a treatment and services research center focused on developing, testing, and disseminating treatments for adolescence and there families struggling with substance abuse and or mental health problem, particularly depression. Studies at CFIS primarily focus on inner-city African American youth seeking treatment in community mental health or medical settings. Current studies include (a) family based treatment or children of depressed parents, (b) identification and brief family treatment of suicidal adolescents presenting in primary care, (c) identification and referral of depressed adolescents presenting in the emergency room, and (d) a multi-site study of family therapy plus Motivational Interviewing for treating adolescences in primary care who are depressed and smoking. Most of our studies use a mixed model approach integrating qualitative and quantitative methods. We are particularly interested in the participatory action research models where patients and community providers play an active role in contributing to the research design, implementation, and interpretation of results.

### *Kristina Gordon, PhD*

I have been extremely privileged to serve as Vice President for Science for this division during the past two years. This is a very dedicated, hard-working, and impressive Board and it's been a pleasure to be part of it. Part of the reason I agreed to run again when approached is that this has been such a good experience. However, the other half of the reason is that I have begun making progress on the goals I set when I last ran for this position, and I would very much like to have the opportunity to keep nurturing that pro-



cess along. As the VP for Science, I chaired a well-received panel discussion at the APA meeting that allowed researchers and practitioners to talk about treating difficult couples. I also developed a task-force made up of scientist-practitioners to assess the current state of evidence based practice in couple and family therapy in order to make recommendations to researchers about how to improve treatment research to better serve clinicians' needs, as well as create a document and website that will better direct clinicians to existing useful research. This task force continues to evolve in very exciting directions and I think it eventually will produce work that will have significant impact on the creation of empirically rigorous, and perhaps more importantly, clinically useful treatment-outcome research. We will present preliminary findings at the AFTA/IFTA conference in June. In addition, I have also overseen the formation of a committee to evaluate the scientific basis of relational diagnoses; the ultimate goal of this effort is to have couple and family therapies and research recognized as important and necessary in the mental health field. Finally, I have worked to strengthen links between our division and other relevant divisions through active outreach and recruitment of new members to our division and by creating new liaison positions between our division and other similar couple and family groups.

In the future, I'd like to oversee the development of programs designed to nurture our students' research efforts and to help mentor our new psychologists' efforts to establish evidence-based practices and their own research programs. Ultimately, I'd like us to join with other organizations to develop a couples and family therapy practice-research network similar to the program that is being pioneered in Pennsylvania to study treatment processes in individual therapy.

Currently, I am serving as a professor in the University of Tennessee's clinical psychology program, I have worked with the program there to improve the integration of research and clinical practice in our train-

ing program. My own research program also has focused upon combining research and practice. I have published numerous articles on forgiveness in couples and conducted a successful multiple case study trial of an integrative treatment for couples dealing with infidelity. My colleagues and I have conducted many workshops on this treatment and are under contract to write a treatment manual and a self-help book for Guilford based on this work. In addition, my work at the University of Tennessee on forgiveness and family functioning merited Division 43's Randy Gerson Memorial Award. Finally, I have served as an ad hoc reviewer for the *Journal of Family Psychology*, the *Journal of Marriage and the Family*, the *Journal of Marital and Family Therapy*, the *Journal of Consulting and Clinical Psychology*, and *Personal Relationships*.

## Vice President for Practice Candidates

**Deborah L. Cox, PhD**

The concepts that best sum up my professional orientation are *integration* and *connection*. My scholarship is deeply informed by my practice, which in turn is deeply informed by collaborative connections across disciplinary lines. Integration and connection are at the heart of my social justice orientation to family psychology practice.



My relationship with Division 43 became closer about five years ago when I was asked to be a part of the editorial staff of *The Family Psychologist*. In this role, I've brought a diverse set of voices (e.g., school counselors, clergy, clinical psychologists, narrative researchers) to the issues of family psychology practice. The range of topics my colleagues have covered in this section reflect the rich diversity of perspectives and expertise held by those who work with families. This diversity is meaningful to me because I work *both inside and out-*

*side* the traditional lines of distinction around family psychology.

While I identify myself solidly as a family psychologist, I train community and school counselors, a job that forces me to assimilate different points of view about mental health, children, culture, and family development into my working models of growth. Further, while I cherish my practice, I am also passionately devoted to research - - a combination that keeps me making connections between what I learn from families and what I pursue in my processes of inquiry.

I'm an associate professor of counseling and a member of the gender studies faculty at Southwest Missouri State University, where I'm also part of a newly developing, multidisciplinary family institute. I teach multicultural counseling and couples and family therapy and lead student research teams. My approach to the student-centered research team experience has evolved into a shared process of narrative inquiry that teaches me to appreciate the fine line between what is deeply investigative and what is deeply therapeutic. My most central research projects involve the impact of social beauty rules in women's relationships, and family developmental experiences inside conservative religious groups. I'm also part of a new, collaborative group project with several other psychologist-moms whose goal is to refine mothering identity theory.

I have a small clinical practice, where my interests include social empowerment therapy with families of children with learning challenges. Poverty and social oppression are significant family psychology issues in our area. So, to this work, I bring both: (1) experience ranging from therapy in agencies and family violence shelters, to private practice, to school psychology and family therapy for the Dallas (Texas) Public Schools, and (2) grounding in the social justice implications of *connection*. For the last fourteen years, my work with a host of different kinds of professionals—school personnel, social workers, minis-

ters—teaches me the urgency of collaboration and connection between people who work with families. This background shapes my vision for working as Vice President of Practice for Division 43. I see family psychology practice as uniquely poised to initiate important cross-disciplinary learning for the promotion of, not just traditional therapy, but all kinds of efforts to empower families in our communities.

Most central to who I am is my family. I live with my husband and colleague, Dr. Joe Hulgus, and our wonderful four-year-old son, A.J. Most of my work in this discipline of family psychology is devoted, in some way, to them.

**James Dobbins, PhD, ABPP**



I have had the pleasure of serving on the Board of Division 43 this past year and in that service learned that there is much more work to be done in regard to advancing family psychology so that it is better able to

actualize its voice in professional education, training, as well as the practice of psychology. I came to this position having already served as the secretary on the American Board of Professional Psychology. I have also held positions on the boards of three other national organizations, including the Association of black Psychologists, The American Orthopsychiatry Association, and the National Council of Schools of Professional Psychology. For the past twenty-six years, I have taught family psychology as a professor in the Wright State University School of Professional Psychology and seventeen of those years I directed a very successful family intervention program called the Male Responsibility Program. I am currently a full professor and Director of postdoctoral training in which I coordinate training oriented to the generalist, which includes family assessment and interventions in diverse settings. The Male Responsibility Program provides family assessments and primary and secondary in-

tervention to fifty African American families per year. It has been exported to other regions of the United States as we press forward with manuals for the interventions. I am committed to helping the Board to meet the challenges that we face as an organization, i.e. attracting more members, articulating family psychology as a specialty and integrating science, practice and public interest. I hope to provide a clearer voice for practitioners in the Division by the continuance of some of the activities that I began this past year such as regular submissions to *The Family Psychologist* and discussions on the listserv. I also want to use the annual meeting as a place for practitioners to meet in order to more effectively advocate for training, policies and development of best practices. I believe that these efforts will help to expand the roles and influence of the family psychology practitioner in a rapidly changing health care context.

## Secretary Candidates

### *Jaime E. Mendoza, PsyD*

My professional identity is grounded in family psychology. I am pleased and honored to be considered as a nominee for the position of secretary of Division 43. I am currently the hospitality chair for the 2005 APA convention and will be the program chair for the 2006 conference. I became a member of the division as a student and have continued as an active member for nine years.



### **Background and Qualifications**

I am currently an Assistant Professor of Graduate Psychology at Azusa Pacific University, an APA accredited program. Core courses that I teach include: Family Therapy, Family Psychology, and Domestic Violence Interventions to Masters and Doctoral-level students. I received my BA from the University of California, San Diego. I earned an MA in Marriage and Family Therapy and later a PsyD from Azusa Pacific University. My ini-

tial training in psychology began in 1994 as a Family Preservation In-home Counselor. I provided mental health services to at-risk families in their home using a multi-systemic model. My research interests continued on the application of systemic interventions. The primary areas of interest include: school-based mental health, family assessment, training graduate psychology students to apply family psychology interventions, and multicultural issues.

As part of my position at APU, I am also the Director of a training center that addresses the mental health needs of the multi-ethnic community in the Eastern Los Angeles County. The program emphasizes systemic interventions when working with children, adults, and families. The center trains doctoral and masters level students and two Post Doctoral Fellows. Professionally, I serve as a mental health consultant and trainer for the Los Angeles Office of Education and several Head Start programs.

My activity in Division 43 began with a student lead presentation in 1999. Since then, I have been a chairperson for two conferences. The first conference (2000) was the Student Affiliation of Multi-ethnic and Multicultural Mental Health which allowed students to network with professionals and fellow students who were interested in multi-cultural research and issues. The second conference (2004) was sponsored by APA and it focused on teaching professionals and students how to provide effective mental health services from a systemic perspective to monolingual Spanish and monolingual Chinese clients. I contributed articles to *The Family Psychologist* in 2003 and 2005.

I am excited at the possibility of becoming the Secretary of the division. I understand that the role of the secretary is to record minutes of meetings and facilitate communication within the division and I would be honored by this opportunity. One of my goals beyond being the division secretary would be to promote greater student and professional participation within the division.

### *Terry Soo-Hoo, PhD*

I am honored to be nominated for Secretary of Division 43. I bring to the Division of Family Psychology over 25 years of experience both in the clinical field and in the academic arena. Upon the completion of my PhD at the University of California Berkeley I began working in community mental health in San Francisco in the early 1980's. In those developing years of community mental health we were all pioneers and were struggling with developing new and innovative approaches that addressed the special needs of the various ethnic communities of San Francisco. Much of the mental health profession relied on out dated models of mental health and illness and many professionals had difficulty adapting these approaches to meet the diverse needs of the culturally different. I took on the challenge of exploring and incorporating the new concepts that were developing from the expanding field of family psychology and family therapy and adapting these ideas to working with specific ethnic populations. I specifically focused on working with Asian American families. Later I got involved with the Mental Research Institute in Palo Alto and was impressed with their innovative non-pathology model of working with families. However, I was constantly aware of the sparse amount of research or scholarly writing on applications of the various family therapy approaches to specific ethnic populations.



I entered university teaching to guide the development of the next generation of family psychology practitioners. I have published journal articles on working with Asian American families. I have also published on consultation within multicultural settings. In addition, I advocate the development of innovative culturally relevant treatment approaches. Thus I have presented at international conferences on integrating Eastern and Western approaches



to treating children who have experienced trauma.

In 2001 I served as Division 43 Hospitality Suite Chair in the highly successful San Francisco convention, and chaired the Program Committee in 2002.

As secretary I will bring to Division 43 an enthusiasm and energy to expand interest in multicultural issues in family psychology and family therapy. There is much to be done in the field of working with the culturally diverse. I believe that Division 43 should take an active, dynamic leadership role in encouraging and guiding such work, and that I am uniquely positioned to do so. I ask for your support to elect me to become part of the Division leadership team.

## APA Council Representative Candidates

### *Nancy S. Elman, PhD, ABPP*

It is an honor to be nominated to serve as the representative of Division 43 to APA Council. I am very pleased that after having lost one Council seat a year ago, the Division responded vigorously and has regained its 2nd seat. This sends a strong message to those in APA governance about family psychology's strong voice.



APA is the premier voice of professional psychology in this country. It is, however, not without its challenges in the early years of the 21st century. Issues of membership as well as relevance must be addressed. Students and young professionals need a strong voice; governance must be responsive to those changes and not stagnate in tradition. As a first time member of Council, I would hope to bring all my professional and leadership experience to strengthening psychology and serving as an advocate for family psychology as a sig-

nificant specialty. As your representative, I will make every effort to enhance understanding of the role of family psychology in practice, research, training and community applications. My career as both a university-based trainer and a practitioner will enable me to consider the perspectives of both academic and practicing psychologists.

As a long-time member of Division 43, I have held the role as Editor of *The Reference Corner* of *The Family Psychologist* (see column elsewhere in this issue) for 5 years, and have served as Secretary of the Division for two consecutive terms. As Secretary, I have participated as a member of the Executive Committee, handled the usual minutes and reports, coordinated a revision of the Division's Policies and Procedures Manual and Bylaws, and participated on both the Nominating and Awards committees. I have had opportunities to represent Family Psychology's interests within APA and professional psychology, e.g., as the Division's representative for Cluster Programming in planning collaborative sessions for the Toronto Convention (2002), and representing Division 43 at the National Competencies Conference (2002) where I was one of 10 core group leaders. Equally important to my potential to be an effective Council Representative, several leadership roles in psychology governance have given me background and skills to implement action at APA. Most recently, I served two years as Chair of ACCA (Advisory Committee on Colleague Assistance of BPA). This allowed me to grow in understanding APA governance, and to establish an important linkage between APA and ASPPB, the association of state and provincial licensing boards. As a member of the Board of Directors of CCPTP, the training council for Counseling Psychology, I co-chaired a task force that coordinated a major national training conference (Miami, 2000), as well as helped forge linkages with NCSPP and APPIC.

On a personal note, my family consists of two grown and married children and three grandchildren, a 7 and two 4s, whom I

adore unequivocally. They have inspired me more than I could have imagined about the real meaning of this work. I will welcome the opportunity to continue to provide leadership in Division 43 by becoming your Council Representative.

### *Florence W. Kaslow, PhD, ABPP*



From 2001–2004 I had the privilege of serving as one of the Division's two Council Representatives. It is a time-consuming and challenging task, and it takes quite a while to learn the intricacies of navigating and negotiating

through the labyrinth of agenda book items, different constituencies and their priorities, caucuses and task forces, as well as who's who and what's what. During my time on Council I joined several caucuses, and was appointed to Presidential Task Forces by both Presidents Robert Sternberg and Diane Halpern. I am currently still actively involved in the high profile World Congress Against Racism Task Force, and have been promoting the importance of understanding and accepting religious pluralism, in addition to multicultural, ethnic, and racial diversity.

I am a founding member of Division 43 and served as its second President during 1987. During that year the *Journal of Family Psychology* was founded. I initiated and still chair the Division's International Committee, and am *The Family Psychologist's* International Roving Reporter. Several years ago, the Division's *Florence Kaslow International Award* was introduced to honor my work in international family psychology.

I was one of the original authors of what later became the Division's CRSPPP petition for seeking APA recognition of Family Psychology as a specialty. As one of probably a dozen triple-diplomated ABPP specialists, I am a Past-President of the American Board of Family Psychology, and I am currently its representative to the ABPP Board of Trustees. I have written

extensively in the field of family psychology, and am often designated one of the founders of the field.

I have been the Division's recipient of the *Family Psychologist of the Year Award*, as well as APA's *Awards for Distinguished Contribution to Applied Psychology* and *Distinguished Contribution to the International Advancement of Psychology*.

When on Council, I was also selected to represent the Division on the Steering Committee for the Psychology and Law Conference concerning children, and to have at least five members of the Division invited to present. If elected, I will continue to work to have Division members involved on the Boards and Committees and other deliberative bodies.

Because Division 43 and the field of family psychology are so important to me and I think I bring an extensive depth and breadth of knowledge about family systems to Council, as well as valuable prior experience serving on Council and being a respected member of this important body, I believe I am the person most qualified to represent Division 43 at this time, and ask that you please *vote for me*. I won't let you down. Many thanks.

**Jay Lebow, PhD, ABPP**

It has been my pleasure over the past few years to serve as vice-president for science, president-elect, president, and past president of the division. That experience has provided me with both an in-



depth sense of the issues facing the division and of the vital role the division can serve in bringing the issues and concerns of family psychologists to the broader membership of APA. I hope to be able to continue to provide leadership within the division and to represent the division in APA as a Council Representative.

I am a Senior Therapist and Research Consultant at The Family Institute at Northwestern and Associate Clinical Professor at Northwestern University. In this position, I provide therapy to clients, do research and teach in the Family Institute's university programs. This diverse set of activities has helped me appreciate the range of concerns of members of the division. When I am in practice, I am a practitioner; when doing research, a researcher, and when teaching, an educator. I believe each of these sets of concerns needs to be represented within the division and, more broadly, within APA.

My clinical practice has always occupied the majority of time as a family psychologist. I have written a number of articles and book chapters that overview couple and family therapy including chapters for the *Annual Review of Psychology*, *The Psychologists Desk Reference*, and the *Comprehensive Textbook of Psychiatry* and edited three volumes in family psychology. I also participate in research; at present, I am involved in a research project centered on tracking progress in individual, couple, and family therapy.

My interests in family psychology and in couple and family therapy are longstanding. I am a diplomate in Family Psychology of the American Board of Professional Psychology. I serve on the editorial boards of a number of journals including the *Journal of Marital and Family Therapy* and *Family Process*. I have also been active in related organizations, most prominently, the American Family Therapy Academy and the American Board of Family Psychology, where I have served on the Board of Directors.

I am quite excited to be nominated for Council Representative. If elected, one of my goals would be to augment the focus on family and couple and family therapy within APA. We need to build upon the recent recognition of family psychology as an area of specialization within psychology to assure that family psychology achieves its proper place both in APA and the broader world of mental health treatment. My agenda for family psychology also includes working to

assure that third party payers appropriately compensate for couple and family therapy, that training programs include family psychology as a core part of their curricula, and that funding for family psychology research be significantly increased. I also would like to see the Division continue to spear-head efforts to advance and disseminate knowledge about family psychology. And we must continue to work to increase diversity within the field of family psychology.

**Susan H. McDaniel, PhD**



I would be honored to serve Division 43 as Council Representative. I became a member and active in the Division while in graduate school in the late 70s, as a student of Harry Goolishian's. At the time

Harry was Council Rep, where he seemed to have a lifelong term. Harry was a creative, independent thinker, one of the pioneers of family therapy, a man who could be impatient when he did not feel a person, organization, or country was doing the right thing. To my young eyes, he did not seem to be someone who would have the time or the patience to be involved in APA governance. After he and I sat through a particularly long Board meeting (I was a Committee Chair), I asked Harry why he did it. He said, "If we don't do it, who will?"

Since then, I have served the Division in many capacities, among them: Chair of Legislative Affairs, VP for Education, President, and Chair of the Fellows Committee. I worked on the CRSPP petition for Family Psychology, and our Specialty Guidelines. I have served the larger APA on a CAPP Task Force on Primary Care and one on Health Care. I was the first psychologist to represent APA as part of the Department of HHS Primary Care Policy Fellowship. I was honored to be selected as Family Psychologist of the Year in 1995, received the Award for Innovative Contributions to Family Therapy in 2000, and the Award for Distinguished Achievement in

Education in 2004. I have been Chair of the APA Publications and Communications Board, and will complete my 6 years of service on that Board in June 2006. In many ways, representing the Division on Council seems like a natural next step in my service to APA.

I would view my job as Council rep as urging APA to use its considerable influence to advance the cause of systemic and family approaches to health and mental healthcare, and insuring the influence of Division 43 and its members in the organization as a whole.

In my day job, I am Professor of Psychiatry & Family Medicine, Director of the Wynne Center for Family Research, and Associate Chair of Family Medicine at the University of Rochester School of Medicine & Dentistry. My academic interests include family-oriented mental health in primary care. Currently I am working on a book on family dynamics and genetic conditions.

Thank you for your support. I am proud to be a Family Psychologist, and part of a group of people with so much talent and commitment. As Harry Goolishian said, "If we don't do it, who will?"

## The Final Word

*(continued from back cover)*

Another theoretically interesting, albeit sad-denning, feature of Karla's situation is that she is having trouble in school. Bowlby and Ainsworth were initially very interested in the possibility that dysfunctions of what they called the attachment behavioral system interfered with another developmentally crucial behavioral system, exploration. Bowlby and Ainsworth were astute observers of infants and young children; they noticed that children's cognitive and motor learning and their attainment of a sense of self-efficacy depend on their parents' and caregivers' ability and willingness to provide a safe haven and secure base.

Human beings are hard-wired to give priority to safety and security concerns, so it is extremely difficult to pay attention in school or explore the vast and potentially interesting world of knowledge when one's attachment concerns overwhelm one's mind. Thus, as school psychologists know, problems in learning are often secondary to problems in family relationships.

Interestingly, one of the crucial moments in the therapeutic process outlined by Diamond is one in which Karla's mother uses attachment terminology to apologize to her depressed daughter: "But whatever I was going through, I am so sorry for not protecting you more." This heartrending insight and apology precipitates a breakthrough in therapy: Both Karla and her mother burst into tears and find themselves able to converse and share feelings in an atmosphere of mutual sympathy and affection. The mother then begins to take back the maternal role, even gaining the courage to ask her husband to find another place to live. This turning point is very similar to the ones Sue Johnson describes in her article and in her recent book with Valerie Whiffen (Johnson & Whiffen, 2003).

Bowlby theorized that providing loving-kindness and security to another person depends on a third hard-wired behavioral system, which he called the caregiving system. In some of our recent questionnaire survey studies and laboratory experiments (e.g., Gillath, Shaver, & Mikulincer, 2005), we have been testing the idea that attachment insecurity interferes with empathy, compassion, and caregiving just as it interferes with exploration. The results are clear: People with an anxious attachment style are preoccupied with their own needs for attention, love, support, and emotion-regulation, and this gets in the way of empathy and effective helping, especially for people who are in pain or extremely upset (As Karla's mother noticed about herself, what she was "going through" got in the way of protecting her daughter). People with an avoidant attachment style create so much distance between themselves and intimacy, touch, and emotional vulnerability that they

tend to be more cynical than compassionate, more rejecting than accepting and supporting. These two dispositional patterns predispose people to adopt either the "pursuer" or the "withdrawer" positions in marital conflicts, even though particular features of the situations they create for themselves or find themselves in also contribute.

Johnson explains in her article how dysfunctional patterns of marital interaction, such as one partner criticizing or demanding while the other one defends and distances, can be understood in attachment terms. Both stances are impervious to simple requests to relax and communicate, and for good reasons: No one wants to open him- or herself to further rejection or vilification while risking a bid for forgiveness. Johnson has developed several specific and empirically validated procedures for moving members of a dyad toward a "softening" of their defensive stances and creating an opening for dialog, reorganization, and trust. At the heart of many defensive marital standoffs are what Johnson calls "attachment injuries," violations of expectations about support and kindness, betrayals of agreements that make renewed trust almost impossible. These injuries are similar to the ones Karla suffered in the case outlined by Diamond, but the violations in marriage often have to do with sexual infidelity, extreme dishonesty, failure to support a person following a miscarriage, failure to help when help was badly needed, and so on. Many troubled spouses cannot, on their own, find their way back to providing a safe haven and secure base for their angry or well-defended partners. They need to be skillfully led back to the place, familiar to many from the days when their relationship was on a better course, where they can openly express both love and the need for love—emotions associated with caregiving and attachment.

I wish I had a hundred pages to explain how recent attachment research might help therapists formulate their clinical cases and move toward more successful treatments, but I will have to be cryptic. In my own recent work with Mario Mikulincer and our

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## The Final Word

(continued from previous page)

associates (summarized, for example, in Mikulincer & Shaver, 2005, in press; Shaver & Mikulincer, 2004) we have been looking at the effects of subliminal threats and subliminal hints of security on other psychological and behavioral processes. In line with attachment theory, subliminal threats (e.g., the words death, illness, failure, separation) increase a person's mental activation of attachment-related concepts and representations, such as names of attachment figures and words such as love, hug, and support. Interestingly, the more anxiously attached a person is, the more these threats activate not only positive attachment-related concepts but also negative ones (e.g., alone, rejected). The more avoidant a person is, the longer it takes him or her to mentally activate the names and cognitive representations of attachment figures when the subliminal threat word is "separation." In other words, I think we are on the verge of being able to supply better assessment of attachment problems and additional ideas about how to address them. We have also discovered that a variety of security inductions, including subliminal presentation of attachment figures' names, presentation of words such as love, hug, and support, and guided imagery exercises that encourage a person to think about receiving ideal support from another person, have amazing effects: an increase in humane values, heightened willingness to help others in need, reduction of out-group prejudice, greater tendencies toward gratitude and forgiveness, a reduction in PTSD symptoms (in Israel, where many people have been traumatized by terrorism), and a more positive mood. These studies hint, I believe, at processes that could be activated in therapeutic situations, and their documented interactions with measurable attachment-related individual differences may provide new, person-specific ideas for therapeutic interventions.

Although I don't have space here to go into other topics of great interest, such as the importance of helping clients and families construct more coherent narratives of their past attachment-related experiences (as assessed, for example, with the Adult Attachment Interview; Hesse, 1999) and the importance of thinking about meta-cognition or mentalization (Bateman & Fonagy, 2004), psychological defenses (Shaver & Mikulincer, 2004), "core conflictual relationship themes" (Luborsky & Crits-Christoph, 1998), and "object representations" and dysfunctional beliefs in attachment terms, I am happy to report that two clinical colleagues of mine, Joe Obegi and Ety Berant, are currently editing a book that explores interfaces between attachment theory and research and various approaches to therapy in a very concrete and therapist-friendly way, and Jude Cassidy and I are preparing a second edition of our 1999 *Handbook of Attachment*, which will include more than the first edition did about therapeutic applications of attachment theory and research. Thus, the territory boldly entered by Diamond and Johnson in their work and in this issue of *The Family Psychologist* will be further mapped in at least two forthcoming books. I eagerly look forward to watching and helping the field develop further and reach its full potential.

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## The Therapeutic Payoff for Careful Theory and Research on Attachment

*Phillip R. Shaver, PhD*  
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This is an exciting time to be an attachment theorist and researcher, because while we have been laboring hard in our laboratories for a couple of decades, trying to develop measures and probing research procedures to study attachment processes, an increasing number of clinicians, counselors, and therapists have been developing creative and effective ways to apply insights and findings from attachment research. Those applications are represented in the present issue of *The Family Psychologist* by Guy Diamond's use of attachment-based family therapy (ABFT) to treat adolescent depression and Sue Johnson's adaptation of emotion-focused therapy (EFT) to treat couples with severe marital difficulties. I will offer a few comments about each of these articles and then go on to provide a very brief overview of issues in recent attachment research that may contribute further to therapeutic case formulations and treatment strategies. This is obviously a huge topic, so I can hope only to whet readers' appetites and point to recent literature that may be worth further study.



*Phillip R. Shaver, PhD*

Guy Diamond's case study reveals several strengths of an attachment-based approach to therapy. His adolescent client, Karla, has been repeatedly injured emotionally in family interactions, feels she has had to take care of her mother (a position known as "role reversal" in the attachment literature), is having difficulty in school, and now has to cope with the possibility of her abusive father returning from jail to make family life even more dangerous and difficult. Frankly, I get depressed just thinking about this young woman's terrible situation, which is why I am a researcher rather than a clinician. I don't have what it takes to enter the psychological lion's den every day to do battle with people's awful problems.

There are two aspects of Karla's situation that map well onto Bowlby's account of important issues in dysfunctional attachment relationships. First, Karla's parents, including her mother, have failed to protect and nurture her, and in fact have created massive threats from which she needed to be protected but was not. Second, Karla concluded, because of her father's abusive treatment of her mother that she, Karla, had to provide protection for her mother as well as her siblings. Finding that one's only hope of safety and security is to prop up and protect the person who is supposed to provide your own protection has to be one of the worst messages a child can receive. There is no way a child can develop normally under those circumstances.

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