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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.
Authors or publishers may send books for potential review directly to the editors of the Clinical Corner, Research Corner, Reference Corner, and Family Forensic Psychology column.

Unless otherwise stated,
TFP editorial staff is glad to bring you a new series of articles on the family life cycle. These articles examine the unique social, legal, and developmental challenges of later life. George K. Hong, President of the Society for Family Psychology, addresses the topic of aging from a multicultural, systemic and social justice perspective. His column calls attention to the role of family psychologists as social change agents and our duty to promote the welfare of the elderly through research and practice. Are we doing enough to counter the stereotypes and prejudice of an ageist society? Stephen Cheung, Vice-President for Education, proposes to use an integrative approach to family psychology in order to meet the needs of families in later life. He shows how the principles of positive psychology, multicultural psychotherapy and postmodern theory can inform our multisystemic work in ways that enhance the resilience of the elderly and their families. Neil Grossman’s article focuses on the psycho-legal issues that arise in later life, and highlights the importance of collaborating with attorneys in order to resolve family conflict over estate planning and caretaking for example. In this issue, TFP readers will also find articles that address the topic of disruption in the family life cycle (e.g., divorce, remarriage,
Continuing with the theme of the family life cycle for this year’s TFP, the present column will focus on families in later life or families with older members. While other family life cycle stages are typically associated with distinct events indicating a change in status, e.g. marriage or having a child, there is no definitive marker for “later life”. Formal regulations associated with being elderly, such as eligibility for retirement or “senior citizen” benefits, are not definitive markers of this life stage. Being “older” is a state of mind and physical health. It is also dependent on the eyes of the beholder. One person (especially a teenager or a child) may regard being 50 or 60 as old, while another may consider 50 or 60 to be one’s prime, particularly in regards to career or other life achievements. The lifespan literature generally describes the period from around 40-45 to 60-65 as middle adulthood (Santrock, 2011), after which comes late adulthood. So when we talk about families in later life or families with older adults, we need to be aware that the subjective perceptions and experiences of the family members, in addition to chronological age, are crucial features of this stage of the life cycle.

The literature on families in later life calls attention to two major issues: (1) The elderly’s psycho-emotional and physical well-being and (2) younger family members’ relationship with older members and responsibilities towards them. Much has been said in the mass media about the “graying” of America and the costs of social security, Medicare, and other retirement benefits. While medical care and
physical or financial concerns are included in this discussion, less attention is paid to the issue of the psycho-emotional wellbeing of older adults. The U.S. is often described as an ageist and gerophobic society where youth is glorified (Walsh, 2011). For many, aging is a frightening idea; it is seen as a process of deterioration and loss. Age discrimination and negative stereotypes of older persons abound. How do we, as family psychologists, promote a more balanced view of aging? What exactly can we do to help older people achieve happiness and satisfaction? What have we done so far? Part of this relates to our clinical training in working with older adults. The other part relates to our work outside the clinic as community advocates and change agents promoting services and quality of life for the older population. In February 2002, APA’s Council of Representatives passed a resolution on ageism (American Psychological Association, 2002). This resolution highlights the need for psychological research that promotes accurate information about aging and that supports the development of appropriate mental health services for older adults. I want to invite everyone to take a proactive approach to serving the aging population of the U.S., and to examine how we are addressing the challenges of families in later life. In addition to addressing clinical problems, what can family psychologists do to promote the wellness of the older population?

The second important concern of families in later life is younger generations’ relationship with the elderly and specifically the stress associated with caring for older family members. Caring for aging parents puts a strain on adult children’s resources (e.g., time, money, energy). The stress of caring for the elderly is a cross-cultural phenomenon; however, it is particularly severe in familistic cultural groups where the connection between adults and their elderly parents is highly intimate and strong. It is also a significant source of hardship for the sandwich generation who has to care for their dependent children as well as their aging parents or relatives. The clinical manifestations of stress may include feelings of guilt for not doing enough, frustration about not being able to do more, and the need to seek relief. Caring for the elderly may also be a source of family conflict when adult children disagree on what to do and when they do not share equal responsibility for their aging parents. Adult siblings sometimes underestimate the stress experienced by the primary caretaker of aging parents; they may blame their sister or brother for not providing adequate care or for not being considerate enough towards the elderly parent. In turn, the primary caretaker will feel wronged, unappreciated, or angry towards the other siblings. Couples with different levels of allegiance and closeness with their elderly parents may also experience tension in their marital relationship. From a systemic perspective, it is important that family psychologists not only address the stress of caring for the elderly within the family, but also consider what services may be provided at the level of the community and society. Again, we may have to take on the role of change agents to advocate for the allocation of more public resources to the development of services for families with older adults. Are family psychologists doing an adequate job in this regard?

In terms of education and training, is the field of family psychology devoting enough attention, both in research and practice, to families in later life or families with older adults? To what extent is this subject adequately covered in the graduate curriculum? I often hear graduate students and interns talk about their interests in working with children and families with various needs, but very few express an interest in working with the elderly. Does this represent the general sentiment of the field? Working with the elderly would remind a person of one’s own eventual aging and mortality, and might arouse a lot of negative thoughts and emotions. This could be a psychological barrier for many practitioners, especially younger graduate students and interns. Furthermore, while all graduate students and interns have experience with childhood and young adulthood, most have not personally experienced older adulthood. Many of them may be quite far away from this stage. This lack of firsthand experience and relative unfamiliarity may distance them from the subject. Indeed, the very few who have indicated to me an interest in working with older adults were often more mature graduate students or individuals who already had some exposure to this population. Given these considerations, how can we help our graduate students and interns overcome the psychological barriers to serving the older population? How do we prepare future professionals to provide adequate service to the elderly? To what extent should working with older adults and families in later life be given more coverage in the graduate curriculum? These are issues that family psychologists need to consider proactively.
For the psychologist interested in systemic dynamics, the whole arena of remarriage, step parenting and blending families provides a plethora of opportunities for development and professional challenge. With so many first marriages ending in divorce, the number of people in our country who are confronted with reconfiguring family constellations is staggering. It is an excellent niche market for those of you who want to expand your practice. However, effective treatment of such family constellations often requires a higher level of training, more practical knowledge and increased clinical acumen in order to successfully navigate the increasingly complex waters of remarriage and blending families. The family therapist working with such families has to learn about myriad topics such as normal child development, adolescent rebellion (revisited), and the impact of grief and trauma on the individual and the family, as well as state laws about divorce and custody and the legal rights of grandparents and non-custodial parents. But nowadays that may be only the beginning of the process of honing your skill and knowledge to become a more effective stepfamily therapist. The therapist also has to have a very solid grip on themselves as they are likely to be bombard by numerous factions and factors, and introduced to modern and complex definitions of “family” that impact a newly developing unit.

The expression “blended” families is frequently used to describe various permutations and combinations of “yours, mine, and ours.” After 30 years of practice with treating step-families and remarriage, if there is one thing I have learned about blending families, it is that there are many normal issues of differentiation that get triggered and that effectively blending families can take a lot more time and require much greater effort than new couples usually anticipate. I have also been a witness to incredible experiences of bonding and collaboration, and family members becoming empowered by successfully working through thorny issues.

As our society has evolved and become more diversified, and as divorce and remarriage has become

References

more the norm, the various constellations of what constitutes family can boggle the mind of the family therapist. For example, here’s a typical case of a “blending family” that was referred to me:

Teresa and Alex were referred by their local family practice doctor. They were having serious problems with their new “yours, mine and ours household.” Teresa had her first child with her high school sweetheart when she was only 17. She basically raised that child named Susan on her own with only the help of her boyfriend’s parents, although the boyfriend (Chris) was not involved at all. He quickly left the area and was abroad in the service for many years.

She later married a widower named Allan who was older than her and brought his two boys, 11 and 13 years old, into Teresa’s life. Allan died unexpectedly two years later in a tragic work-related accident and Teresa became the only parent to her daughter who was now 10 and her two stepsons, Chase and Jerome. Teresa then met Brad, quickly fell in love with him, and married him within 14 months of Allan’s death.

Brad had previously been married for about thirteen years until his wife (Jessica) fell in love with her female business partner, Anne. Brad and Jessica divorced quickly and relatively amicably. They agreed to have shared custody of their three children, Lisa, Greg, and Petra. Unfortunately, their son Greg was unwilling to have anything to do with Jessica’s lesbian partner and flatly refused to live with his mother and her new partner Anne. Lisa and Petra seemed to be very comfortable with Anne and spent at least half their time at that home. This worked out well for about a year until Jessica and Anne decided to quickly have a child of their own before they were too old to get pregnant. Anne’s brother agreed to provide the donor sperm and Jessica elected to be the one to get pregnant. Petra who is 12 years of age became extremely upset and is currently refusing to stay at her mother’s home now that a new baby is expected in that household. She feels her mother has “now abandoned her twice” and Petra has become quite defiant. She is also terribly confused and anxious about the intensity of her anger.

Meanwhile, Susan’s absentee biological father, Chris, had a change of heart about being a parent after serving two tours in Iraq and losing one leg and returning home to the States. He now sincerely wants to have a father relationship with his daughter Susan. Brad is incensed and adamantly says no but Teresa is torn by her daughter’s desire to have a deeper connection with her biological father. Furthermore, Teresa is also getting a lot of pressure from the paternal grandparents of Susan who are begging Teresa to give their son a chance to have some meaning to his life. Teresa is very connected with those grandparents and also feels a strong responsibility to meet their requests because they supported her when her own parents disowned her for getting pregnant in high school and keeping her child.

Add to the mix that Teresa’s two step sons from Allan are still recovering from the death of their father, are anxious about losing their connection with Teresa since her quick marriage to Brad, and now are supposed to be accepting Brad as a new stepfather along with his three children.

Teresa never anticipated two of Brad’s three children living in Brad and Teresa’s home full time. She feels both Chase and Jerome need more attention from her and Brad right now. She loves Brad and thought their marriage would settle everyone down but now guiltily wonders if she married Brad too quickly. Simultaneously, Brad is really worried about Petra and feels he has to give her extra time and reassure her that she will always have a home with him and Teresa. Teresa finds it too confusing to have one of his children living with her all the time while one lives there part time and now the third one is jockeying to stay with them permanently. The carpooling arrangements alone require a complex computer program!

Teresa and Brad have started arguing frequently and Teresa is experiencing serious stress-related headaches and even hives and fainting spells. Their sexual relationship has dramatically decreased, although it had initially been one of the more delightful aspects of their relationship. This is not what either of them had in mind when they got married.

Dizzy? Having trouble keeping up with who’s who? Some “blending families” are even more complex than this case example and have much less good will between them. As a therapist, you have to remain solidly grounded in these situations. The therapist has to establish a balanced alliance with both clients while maintaining clarity about the most pertinent issues to address in therapy sessions. How do you manage appropriate therapeutic boundaries but also be flexible about the varied and urgent needs of the children and adults in these complex relationships? What’s the most effective use of limited financial resources?

Yes, the possibilities and the responsibility can seem daunting. However, at the same time that remarriage cases can be quite exacting and sometimes
exhausting for the clinician, it’s tremendously intellectually and strategically challenging. It is also incredibly rewarding to experience how many different people’s lives can be positively influenced through effective stepfamily treatment. I am grateful for the opportunity to help people create a family and expand their awareness of themselves in the process.

Here are a few suggestions that can be helpful in working with these cases:

- Successful therapists in this area of expertise must expand their referral sources and develop collaborative relationships with other therapists. Often children or adolescents need individual evaluation and/or therapy and you may need to refer some subsets of the broader family system to other family therapists who will work in conjunction with you. It is important to find colleagues who will not be working at cross-purposes with you. Thus, if you are the first professional to be contacted, be proactive and judicious about referring to other professionals.

- While some therapists will immediately and effectively involve parents and children and stepchildren in family therapy, my preference is almost always to work with the newly formed couple first to help them get to the place that they can be facilitative in family sessions. I do not want children, who are often already traumatized by previous events, to witness their parents and stepparents acting out in family therapy sessions.

- In my experience some of the biggest roadblocks to successful resolution of blending families develop out of unrealistic expectations for stepparents and stepchildren to automatically love each other. Although as family therapists most of us are aware of this issue, it can’t be overestimated how much these expectations lead to guilt, secrecy, disappointment and feelings of inadequacy. These issues need to be explored patiently, openly, and periodically in couples and/or stepfamily therapy.

- Be sure to focus attention to the couple’s sexual issues even when there are difficult step parenting problems. Many couples are dismayed when their previously good sexual relationship quickly falls apart around parenting issues but they put that on the backburner and so do their therapists. This leads to further demoralization (and crankiness!) Enhancing their intimacy and sexual relationship can help provide the respite, the glue, and the close foundation to work through problems with genuine and troubling differences around child-rearing in blended families.

- Patricia Papernow’s classic book, Becoming a stepfamily: Patterns of development in remarried families, was originally written over 15 years ago, but remains very useful not only to therapists but also to parents. She describes three main stages of development (with 7 substages) in stepfamilies and encourages realistic expectations of what it takes for stepfamilies to become more integrated.

- Two more recent books can offer therapists useful information and research about modern family constellations including Susan D. Stewart’s Brave new stepfamilies: Diverse paths toward stepfamily loving. Also, the scholarly but highly readable and excellent work of Abbie E. Goldberg, Ph.D., will help keep you abreast of the research on lesbian and gay parents and their children and stepchildren.

References
Until recently, the study of the elderly had received very little of our professional attention because our society focuses on youth and avoids the reality of aging, death and loss. It is estimated that by 2030, about one in five Americans will be over 65. Thanks to medical advances, more people than ever before are living into their 80s, 90s and even past 100. With the aging of the baby boomer generation, it has become essential for family psychologists to consider the issues of families in later life. In this paper, I use clinical cases to describe the common needs, challenges, resources, and resilience of families in later years. I also discuss some of the treatment strategies for this life stage and conclude with some implications for education in family psychology.

Ann is an 87-year-old Caucasian-American female referred to treatment for mild depression. Her depression appeared to be associated with her medical condition: Pinched nerves on her lower back secondary to a herniated disc on her spinal cord restricted her mobility. In addition, Ann had just learned that she might need more treatment for her colon cancer which had been in remission for 10 years. Until then, Ann had lived an active lifestyle (e.g., serving in her local church, visiting her children and grandchildren often, and making a couple of vacation trips a year). She and her 89-year-old husband, Bill, moved back to southern California about twenty years ago to live closer to their three children and five grandchildren upon retirement from their years of overseas missionary service. Ann’s three adult children were in their sixties, and all had one to two children of their own. Ann was very close to her oldest daughter and youngest son. By contrast, her relationship with her middle daughter had been distant, and her middle daughter perceived that her parents had favored her elder and younger siblings. In the turmoil of taking care of Ann’s health, the family had several discussions about the division of labor that would make the caregiving more manageable for Ann’s children and Bill, who was also a survivor of skin cancer and who had arthritis. These discussions involved strong disagreements that resulted in tension and hurt among and between parents and children.

To help this family, I used a systems approach that integrated family and individual knowledge as well as principles of positive psychology, multicultural psychotherapy and solution-focused brief therapy (SFBT). Ann’s depression was conceptualized as a normal reaction to her excruciating back and leg pains, lack of mobility, and the news of the resurgence of cancer cells in her body. Her husband and children were naturally impacted by the deterioration of her health and were adjusting to the associated stress. In this life stage transition, past sibling rivalry and woundedness had re-surfaced and resulted in hurt and anger. The therapeutic strategies based on life cycle knowledge included validating and normalizing the feelings and coping efforts of Ann and her family; they also involved psychoeducation on the challenges and resources of the very old age period of later life. The therapeutic goals were: (1) Stress reduction; (2) Gathering information about [Ann’s] medical condition, functional abilities, limitations,
and prognosis; (3) Providing concrete guidelines for sustaining care, problem solving, and optimal functioning; and (4) Linking the family to supplementary services to support the family’s coping efforts (Walsh, 2011, p. 268).

Unlike most deficit models of mental health, positive psychology, multicultural psychotherapy, and solution-focused brief therapy (SFBT) emphasize family hope, resources, and resilience. It is for these reasons that I integrated these models into my treatment approach. In addition to providing encouragement and education on stress management and care, I explored the positive values, virtues, and resources of Ann’s family from the viewpoint of positive psychology (Cheung, 2008; Seligman & Csikszentmihalyi, 2000). In accordance with the basic tenets of multicultural psychotherapy, I also emphasized Ann’s diversity and resources (e.g., strength, support, and hope). For example, I affirmed the resources of her faith, and encouraged her to spend time in prayers and Bible mediation and to maintain close contact with her faith community for support. Furthermore, therapeutic work focused on discovering exceptions to Ann’s problems and highlighting her strengths and successes (Cheung, 2009).

Ann’s feelings, efforts, attempted solutions, and outcomes were validated; her challenges were normalized, while her strengths and resources were underscored and used. Although Ann is still fighting her cancer and managing her pain, she feels much more supported, connected and empowered to continue her later life with courage, purpose, meaning, and endurance.

The psychological literature often describes families in later life in terms of poor health, weaknesses, deaths, and losses. This life stage has traditionally been viewed from a deficit perspective with an emphasis on what is missing in the client. As illustrated above, it is important that family psychologists help students develop a balanced view of later life. This can be done by integrating systemic knowledge about the family life cycle with principles of positive psychology and multicultural and postmodern psychotherapy.

References


One of the core initiatives of 2011 APA President Dr. Melba Vasquez is the Task Force on Immigration composed of seven distinguished APA experts on the psychology of immigration under the leadership of Dr. Carola Suárez-Orozco. The Task Force also uses the advice of 15 external experts. I had the privilege of being part of this process as one of the external advisors that contributed to the preparation of the final draft of the report. After the report was submitted for review to the various APA constituencies, I acted as a reviewer representing the Society for Family Psychology. Considering the present political context of immigration policy in the US, the report is timely and provides systematic evidence that will make a meaningful contribution to public discourse on immigration. This report will help to raise awareness about the challenges and opportunities of addressing the dilemmas of immigration in the US. In this column, I summarize the key ideas contained in the report that soon will be available to the whole APA membership and the public.

The report is a comprehensive and rich review of the literature on immigration. The authors draw from research in psychology and other social sciences. A draft of the report was sent to division representatives with an invitation to comment on its content. It consisted of nine sections, an introduction, conclusion, and glossary. A description of the literature review process was missing and I recommended that it be included in an appendix that made clear what literature was excluded and included.

The first section provides a historical and cultural perspective on immigration to the US. It also includes demographic information about the immigrant populations of the US and answers the question of what motivated these communities to immigrate to the US. Two other sections examine how the context of the host country influences the socio-cultural adaptation and integration of immigrants, and discuss key themes of immigration psychology such as assimilation, acculturation, acculturation stress, identity, citizenship and political participation. Section 4 describes the developmental challenges faced by immigrant children and adolescents, young adults, middle-aged individuals, and older adults. Here, I suggested that the Task Force expand their review of the literature to incorporate family psychology research on intercultural couples and families.

The report clearly makes the case for a relational and contextual view of immigrants and their families. For example, it calls for an understanding of immigration that is informed by the context of immigrants’ country of origin, the time when immigration occurred, and identity markers such as gender, age, and race. These issues are addressed in Section 5 which focuses on intersectionality and looks at the different effects of immigration given individuals’ immigration and social status (e.g., documented or undocumented immigrants; migrant farm workers; refugees; asylum seekers; homosexual, disabled immigrants). In my review of the report, I suggested that the Task Force use the word “undocumented” rather than “illegal” or “unauthorized” because the latters are derogatory terms. I also recommended that the Task Force clarify the role of poverty in their discussion of immigrants’
Practice Corner:

Michael G. Conner, Psy.D., Editor

This column is the first part of a series of articles on family crisis intervention. It is intended to fill in a gap in the professional literature. It also is a call for family psychologists to expand our knowledge base and define standards of best practice. Although a number of books have been published on the subject, there are no established guidelines that consider a psychologist’s ethical responsibility to care, prevent and protect their clients from harm. In fact, competent practice as it relates to crisis intervention may conflict with the American Psychological Association’s Ethical Principles and Code of Conduct. As a result, risk management often involves avoiding the risk by using strategies such as delegation and referral that do not exempt a psychologist from the ethical duty of care. Psychologists have the responsibility not only to prevent and protect their clients from harm but also to advocate for their client’s safety on a case-by-case basis. Psychologists use their clinical expertise and judgment to foresee risk and evaluate the degree of harm associated with it. In some circumstances, psychologists may also be required to use their conscience. In this column, I address the fundamental issues pertaining to work with families in crisis, and discuss the principles of foreseeability, duty of care, and the duty to protect and prevent harm to self and others, as it applies to families. I also describe family psychologists’ responsibility regarding crisis intervention and protection of a family client. Case examples and questions are presented to prompt psychologists to reflect on their responsibilities to family clients in light of the ethical and professional standards that limit psychologists’ ability to provide essential services to families in crisis.

experience. Specifically, I asked that they examine how researchers controlled for the effect of poverty in their analysis of the psychological factors related to immigration.

The last four sections of the report focus on psychological assessment, and in particular, describe the challenges of evaluating culturally and linguistically diverse populations in educational and clinical settings. Questions of reliability, validity, insensitivity, and translation are addressed thoroughly. The concept of “immigrant mental health paradox” is discussed using scientific evidence from the field of public health. The last sections also look at the barriers, such as language and lack of insurance, that explain immigrants’ underutilization of mental health services. The report concludes with numerous recommendations for research, education, and practice.

The report constitutes a valuable informational tool for the public, policy makers, clinicians, and researchers. It should be a required reading for all undergraduate and graduate students in psychology and most definitely those preparing to work with immigrants and their family. The report provides a comprehensive and nuanced examination of immigration psychology, with a view to promoting research that advances the field and moves us beyond our current understanding of immigrants’ experience. It was long overdue and will hopefully enhance our systemic understanding of immigration and immigrant families. Immigration is a complex process that involves negotiating one’s identity with the host culture and community in which one lives. In other words, we all contribute to the process of identity making, and being an immigrant is not simply an identity that can be categorized and operationalized into a research variable, immigrant v. US citizen. It is part of the constellation of identity markers that define the psychological and relational experiences of individuals and families. In this report, the Immigration Task Force calls the profession of psychology to adopt an affirmative stance towards immigration and to be accountable for its role in shaping the experience of immigrants.
Crisis intervention may include psychological, counseling and social services in response to problems such as traumatic injury, violence, suicide, self-injury, domestic violence, child abuse, addiction, bereavement and grief, hostage taking, vicarious traumatization, compassion fatigue, changes in life circumstances, dissolution of marriage, and disaster. There are many definitions of crisis but there are common characteristics. Roberts (2000) found a general consensus among clinical social workers and psychologists that the following characterizes people in crisis. (1) They perceive the precipitating event as being meaningful and threatening. (2) They are unable to modify or lessen the impact of stressful events with usual coping methods. (3) They experience increased fear, tension, or confusion. (4) They exhibit a high level of subjective and physiological distress. (5) They enter an active state of physical and psychological instability.

Roberts also outlines the basic tenets of crisis theory. (1) A crisis is episodic. It may be the result of normal lifespan adjustments, or hazardous events that may be catastrophic or a series of stressful events with cumulative effect. (2) The impact disturbs the homeostatic state and creates a vulnerable state in the person. (3) The person then enters a state of disequilibrium when resiliency functions collapse and precipitating factors cannot be resolved, avoided or redefined.

When the presenting problem is a crisis, behavioral emergency or trauma, those affected by it may experience what McEwen (2000) describes as allostatic loading, that is, a heightened neural and neuroendocrine response. This basic biological mechanism will initially mobilize the body’s resources to adapt. Allostatic loading, over time, and with repeated exposures, provides a model to understand the biological impact of a crisis on health, behavior, brain function as well as the neuropsychological collapse professionals see in patients who are overwhelmed with crisis.

James (2008) offers a cogent perspective on crisis intervention in general. He describes six common characteristics. (1) A crisis represents both a danger and opportunity where the person may be overwhelmed, and the distress compels the person to adapt. (2) The symptomatology is often complicated. (3) There are no quick fixes. (4) There is a necessity for choice. (5) The disequilibrium or disorganization can be universal to people and idiosyncratic to a person. Roberts also seems to suggest that (6) crisis intervention can complement therapy but is not synonymous with brief or solution-focused therapy.

A family crisis can occur in a variety of ways. The crisis may involve one or more family members. These members may be biologically or legally related parents, adult children, children or relatives. The etiology of the crisis may be part of an internal dynamic and/or the result of external influences. Family members will be more or less affected. The source of the crisis, as well as support for resolution, may reside within a couple, the family or an expanded relational system. Psychologists and families must decide whether to focus on those family members that are most affected by the crisis, or whether to work with the entire family and draw on stabilizing, supportive and corrective influences within the family.

Crisis Intervention

In reviewing the literature (Callahan, 2008; James, 2008; Roberts, 2005; and Wiger and Harrowski, 2003), I have identified eight elements of crisis intervention. These are (1) informed consent or assent, (2) screening or assessment, (3) developing a plan, (4) risk management, (5) education, (6) counseling, (7) intervention, and (8) support services. Some may disagree with this characterization of crisis intervention. I propose that disagreement may simply illustrate that crisis intervention is not well defined in the literature and across the health professions.

Crisis intervention is a psychological specialty that encompasses research and applied work with people who are experiencing a crisis, behavioral emergency, or traumatic event. Crisis intervention is a service designed to help patients avoid, resolve, and/or redefine destabilizing influences. These
influences may be psychological, social or medical. Crisis interventions draw upon research and applied work from the fields of psychology, counseling and social services.

Psychologist Duty of Care

A psychologist has a broad duty to prevent harm and protect patients. This duty includes patients’ privacy, communication, records, treatment, the patient’s capacity to function, and consideration of the patient’s responsibilities to others who are dependent on them. The Ethical Principles and Code of Conduct (EPCC) of the American Psychological Association (2010) is clear that a psychologist should avoid harming or causing harm to others. However, a psychologist providing crisis intervention services has a “duty of care”, which in tort law is generally understood to be a legal obligation to “be careful” in our practice so that people are not injured by our actions or our failure to act. A duty of care is apparent when a new or existing patient is in crisis. The crisis can present in an individual, family, or organizational context. A psychologist is not held responsible for treating a person who is not a patient. But they do have a duty to respond, and certainly to avoid negligent actions including abandonment of a patient who enters a crisis. For established patients, a psychologist has an ethical responsibility to (1) make clear their commitment to their patients, (2) employ the appropriate elements of crisis intervention, and if necessary, (3) to do what is reasonable and appropriate to intervene, prevent and protect the patient from foreseeable harm. Making decisions about reasonable and appropriate course of actions requires professional judgment with regard to timing, duration and intensity of interventions appropriate within that unfolding and often unique context.

A psychologist working with families will invariably encounter cases where one or more family members will experience a crisis. Aggression, violence, suicidal behavior, self-injury, and a decompensating mental status are typical problems. If any family member experiences these problems, the family psychologist should (1) affirm their commitment to the family, (2) screen and assess the needs of family members collectively or individually as necessary, and (3) support, intervene, refer or delegate the crisis to appropriate clinical or non-clinical professionals.

Duty to Protect and Prevent Harm to Others

Psychologists who provide crisis intervention services understand that they have a duty to the public that can override the duty to their patient if there is a need to “protect” a potential victim of violence or homicidal behavior. As a duty of care, a psychologist may be required to prevent harm or protect others. These duties to prevent and protect derive from Tarasoff v. Regents of the University of California (1974), in which the Supreme Court of California held that mental health professionals have a duty to protect individuals who are threatened with bodily harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court further called for a “duty to protect” the intended victim. The psychologist, in such a case, might discharge that duty in several ways, including notifying the police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual. When a psychologist performs the duty to protect, treatment is not always compromised, but confidentiality may be compromised in favor of the patient’s treatment interests. In the case of dangerousness to others, and when reasonable and appropriate, psychologists may be compelled by state law, ethics, or standards of care, to take preventative or protective actions when their patient is an immediate danger to self or others.

Imagine that your client, a mother and child, have arrived in your office. The mother speaks of despair, is suicidal, visibly under the influence of alcohol and clearly impaired with respect to her ability to drive. She denies being under the influence of alcohol or drugs. The mother arrived by car and expresses the intent to drive away. What is your duty to your client and the public?
Duty to Protect and to Prevent Harm to the Client

A psychologist is expected to adhere to the standard of care when taking any action that could foreseeably harm others. Unfortunately, psychologists may also face situations in which both taking action or not taking action may cause harm to the client or others. For example, reporting suspected child abuse is very likely to cause harm to the suspect and/or others in that suspect’s life. The act of reporting may also cause harm to the client who is the child of the suspect. I believe that in some instances psychologists’ responsibility to protect others is as important as their responsibility to their patient.

What does a psychologist do when a family or a family member is threatened by others? Does it matter if the threat is physical or psychological? Is there a difference between a threat that comes from within the family or a threat that comes from the extended family that is not your client? What can or should a psychologist do when a family or member of the family is faced with a continuous or escalating crisis that the psychologist reasonably expects will not be addressed by making a referral or delegating care to others? What should a psychologist do knowing that a failure to take steps will result in increasing risk of unacceptable harm?

The exact conduct associated with a psychologist’s duty to protect and prevent harm is not clear or universally agreed upon. Clients in crisis experience a wide range of stressors; they also present multiple risks. The consequences of an unmanaged crisis may include death, incarceration, hospitalization, suicidal behavior, physical injury, homicidal behavior, loss of parental rights, psychological injury or chronic impairment. Because crisis events are complex and varied, it is crucial that psychologists apply foreseeability in performing their duty to protect and prevent harm.

Foreseeability

Negligence in psychological practice is generally understood as the failure to perform the professional responsibility of Ordinary Care and Competence (OCC). Responsibility and potential liability pertain to acts in which the potential for harm can be reasonably anticipated. This refers to the principle of foreseeability or psychologists’ ability to evaluate the likelihood and magnitude of potential harm. Risk assessment is the basis of foreseeability, and does not simply involve a bimodal classification of factors that represent a risk or not. It is a process that happens at the same time as client management and that takes into account the dynamic context of crisis situations.

In critical situations, foreseeability calls for practitioners’ awareness of destabilizing influences in the context of the crisis. Because the context – the background and circumstances in which the critical event occurs – is dynamic and thus changing, it is difficult to predict what might happen. In hindsight, the context of a crisis is generally clear. However, in crisis situations, the clinician must often act with limited clarity and foresight. This is why foreseeability is best described as risk assessment (i.e., foreseeability of risk) rather than prediction of specific harm from a specific source (i.e., foreseeability of harm). In other words, foreseeability is based primarily on clinicians’ judgment of relative risks. Psychologists use their judgment to assess “dangerousness”, not to predict harm (Litwack, 2001; Litwack, T. R., Kirschner, S. M., & Wack, R. C., 1993).

Foreseeability entails action in the sense that a psychologist cannot measure foreseeability independent of the harm prevention technique that is being considered. In some situations, a psychologist may choose not to intervene. In other situations, a psychologist may be required to limit intervention to the use of a single technique, or to do everything conceivable to resolve the crisis. The need for preventative action does not only depend on the severity of the crisis and the level of risk, but also on the potential outcome of the crisis. Although the risk level may be low, the outcome may be so harmful that it is essential to take preventative measures.

Integrating Risk Assessment and Management

Crisis prevention requires that assessment and intervention be a continuous and contiguous process that extends beyond the resolution of the crisis. However, the judiciary, law enforcement,
health providers and other human services seldom provide or continue to provide evaluation and care in situations that are not emergent even when those cases involve some level of danger to self or others or some risk of psychological collapse. Typically, services are offered in situations of behavioral emergency such as suicidal or psychotic homicidal behavior or complete inability to care for self and dependent others. Gaps and discontinuity in care call for strategies that are essential to the continuous management of crisis. These strategies include what I refer to as “hardening”, “isolating”, “insulating” and “buffering” the “target” or “victim” from destabilizing influences such as stress, abuse, assault, neglect or trauma. “Hardening” a client involves preparing the client to deal with stressful events by giving them tools and opportunities to use these tools. The client can be “isolated” by removing the client from destabilizing environments. This might include restraining orders, limited communication, and relocation. Insulating a client involves helping the client develop and strengthen strategies for self-care and self-protection. “Buffering” requires that someone serve as an advocate for the client in dealing with other service providers and individuals who represent a stabilizing or destabilizing influence in the life of the client. These include attorneys, social services, family members, significant others and mental health professionals.

Psychologists commonly protect themselves from liability by avoiding risk and terminating services. They do so by declining to provide services, warning potential victims, referring clients, and delegating their responsibility for harm prevention and protection. This is partly because psychologists are fearful of ethics complaints. Unlike law enforcement officials, psychologists are limited in their ability to take actions to protect themselves and others from an immediate threat. In particular, private practitioners do not have the same authority and resources available to state and community human services agencies to protect public safety. In other words, it is difficult for psychologists to effectively protect their clients from others who are a destabilizing influence or represent a danger to their psychological, medical or physical safety. The following example illustrates the complexity of performing the duty to care and protect.

The client is a family consisting of a father, his child and his wife (the stepmother). The child’s biological mother is facing attempted murder charges after firing a gun at the father. In a violent encounter, the stepmother struggled with the child’s mother preventing her from shooting the father. The mother’s eight-year-old child was exposed to the events. The father and the stepmother have many serious symptoms of PTSD. There is substantial evidence indicating that the mother has initiated litigation to gain custody of the child during her prosecution with the support of her family and their vast financial resources. Referral of the child has been impossible due to professional availability and financial constraints. Mental health professionals in your community are telling you that they are unwilling to take on the case because there is a custody battle, the mother may be dangerous, the father cannot arrange payment for services and there is a high risk for an ethics complaint. The local community mental health center has told you that they provide intervention services to patients discharged from psychiatric inpatient treatment, or to those who represent a potential danger to themselves or others. There are no free counseling centers. The father and stepmother are bankrupt and can no longer afford legal representation. They cannot even afford their insurance co-pays. The father has been laid off work. The stepmother is struggling at work. The couple’s mental states are decompensating during and between appointments. The father and stepmother are facing physical and psychological collapse as a result of increasing financial, work, family and legal stress. Medications are not helping. Sleep is extremely disturbed and poor. Both experience nightmares and flashbacks. Their emotions are brittle and their moods are severely anxious and depressed. Thought processes are fear-based, defensive and catastrophizing. The father is indecisive and has difficulty advocating effectively for himself and his family. He recently suffered a disassociative episode. The father and stepmother recently separated because of increasing conflict and the interaction effect of stress and PTSD symptoms. You have consulted with two psychologists and your attorney. You conclude, based on court records, credible collateral sources and consultation, that the mother, her family and their attorneys are having a devastating destabilizing influence on the family - your client. What are your responsibilities to the family? What are your ethical responsibilities to the child’s mother and her family? What are you prepared to do and what are your intervention options? Should you continue to see the family or terminate services?

Let’s consider three illustrative options. (1) You may decide to continue to work with the family
during this crisis. (2) Whether you terminate or not, you may want to provide information about community crisis and emergency services. If so, you will consider the feasibility, appropriateness and helpfulness of those resources. (3) If it is necessary that you intervene, in doing so you might be departing from your role as family therapist. You may intervene by providing advice and directives based on rational analysis and a solution focus. On behalf of your client you might also become the client’s advocate in multiple systems including familial and legal. If necessary, you might also meet with individuals privately to screen, monitor and adjust your treatment and intervention plan.

When a psychologist can reasonably assume that there is a risk, and that the consequences are unacceptable or can be significantly harmful, I argue that it may be permissible for the psychologist to reach out to others on behalf of the client family in order to prevent harm and protect the client or a member of that family. However, to do so, the psychologist must have an advanced understanding of “advocacy” and “boundary crossing”. “Boundary crossing” is different from “boundary violation”. Crossing boundaries to intervene and advocate for a client’s psychological welfare is acceptable under certain circumstances. Advocacy and boundary crossing are complicated by (1) the process of litigation, (2) the law, (3) professional ethics and standards of mental health professionals, (4) the practices of other non-mental-health professionals, and (5) the motivations and rights of clients and other parties. Standards and guidelines for appropriate crisis intervention are necessary to protect the client but also the family psychologist.

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Tarasoff v. Regents of the University of California, 529 P2d 553 (Cal. 1974)
Tarasoff v. Regents of the University of California, 551 P2d 334 (Cal. 1976)
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The conflicts in Iraq and Afghanistan have resulted in the largest deployment of US troops since the Vietnam War. Among these are large numbers of Reserve Component (i.e., National Guard and Reserve; NG/R) ‘citizen’ soldiers. These military personnel are, on average, older than active duty service members, and hence are more likely to be partnered and parenting. Minnesota, which ranks 26th in U.S. population, has the 5th largest National Guard force in the USA with over 13,000 service members, and it is estimated that approximately 40% are parents of dependent children. There have been few studies examining the impact of deployment on the children and families of these soldiers. Below, we briefly review the literature on the impact of deployment on families, and describe the development and evaluation of a web-enhanced parenting program aimed at improving adjustment for children in Reserve Component families.

Wartime deployment of parents appears to be a significant stressor for school-aged children (Chandra et al., 2010), although it is important to note that the experience of growing up in a military family per se is not associated with children’s maladjustment (Jensen et al., 1995; Jensen, Xenakis, Wolf, & Bain, 1991). Physical separation from children during deployment is often significant, with the average deployment lasting 12-15 months. Moreover, service members are deployed an average of 2.2 times (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, 2007; Department of Defense Task Force on Mental Health, 2007). Parent deployment to a war zone is associated with child behavior problems,
distress, and transitions (Jensen, Grogan, Xenakis, & Bain, 1989; Jensen et al., 1996; Levai, Kaplan, Ackermann, & Hammock, 1995), with greater distress associated with longer deployment (Chandra et al., 2010).

Additional stressors associated with deployment to the current conflicts – particularly for NG/R populations - include mental health and substance abuse problems. Data from a longitudinal screening of returning soldiers from Operation Iraqi Freedom (OIF) indicated that 42.4% of NG/R soldiers, and 20.3% of active duty veterans required mental health treatment for PTSD or depression several months after reintegration (greater than at first screening; Milliken, Aukerlonie, & Hoge, 2007). Additionally, 15% of NG/R soldiers, and 11.8% of active duty soldiers endorsed at least one alcohol abuse screening question. Another recent study found increased risk of new onset binge drinking, heavy weekly drinking, and alcohol-related problems among NG/R soldiers, as well as combat troops, compared with active duty personnel (Jacobson et al., 2008).

The impact of parental substance use, PTSD, and depression in children is well-documented in the general population. Parental stress and distress, and subsequent parenting impairments predict increases in child behavior problems and youth substance use risk (Beardslee, Bemporad, Keller, & Klerman, 1983; Patterson, Reid, & Dishion, 1998). For example, parental substance abuse was predictive of initiation and growth in youth substance use in a study of 351 community 5th-12th graders (DeGarmo, Reid, Leve, Chamberlain, & Knutson, 2009). In a sample of 638 male NG soldiers returning from OIF, increases in PTSD symptoms over the year of reintegration were associated with self-reported parenting impairments (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010).

Given the associations of deployment and reintegration with an array of transition-related stressors, relationship challenges, substance abuse, and mental health difficulties, it is not surprising that evidence suggests that the detrimental impact of combat deployment on children may be primarily mediated through its effects on parenting practices (Palmer, 2008). Both normative and severe family stressors and transitions (e.g., father absence, divorce, socioeconomic stress) have been shown to negatively affect parent and family functioning and lead to increased rates of coercive parent-child interactions, which in turn, impair child adjustment (Beardslee et al., 1983; Belsky, 1984; Capaldi, 1991; Conger et al., 2002; Dishion & Patterson, 2006; Patterson, DeBaryshe, & Ramsey, 1989).

Parent management training interventions have been shown to improve parenting practices among a variety of populations, reducing children’s risk for externalizing problems. Parent Management Training-Oregon Model (PMTO) is a group of prevention and treatment programs shown to be effective among a wide range of populations dealing with family stressors. PMTO interventions have demonstrated not only short-term effects on parenting and child behavior, but also longer-term cascading effects on the family system: parenting, couple functioning, child functioning, and parent well-being (Patterson & Forgatch, 2010).

Given the evidence implicating combat deployment as a significant family stressor, we are conducting a randomized prevention trial of a PMTO intervention tailored to military families. The intervention, After Deployment Adaptive Parenting Tools/ADAPT, is a web-enhanced, group-based intervention aimed at addressing the particular challenges faced by reintegrating NG/R families. The program provides 14 weekly group sessions that integrate behavioral management and emotion socialization skills to support families dealing with the disruptions associated with deployment. Over the fourteen weeks, five core parenting practices associated with PMTO – skill encouragement, positive involvement, limit setting, problem solving, and monitoring - are delivered in the context of an active learning paradigm (Forgatch & DeGarmo, 1999). Because combat stress symptoms are associated with emotional functioning deficits (e.g., difficulties in emotional regulation, increased experiential avoidance), the PMTO curriculum is augmented with mindfulness, and emotion coaching practices designed to enhance parents’ emotion socialization skills (i.e., their capacity to help children label and respond to emotions, and to bolster parents’ own emotion regulation skills). The intervention addresses other issues relevant to deployment and reintegration – for example, maintaining a ‘united parenting front’ to deal with the challenges parents face in co-parenting after a long absence.

Balancing work, home life, and Guard duties, is a challenge for NG/R families. In order to accommodate anticipated barriers to participation in the group, an online curriculum accompanies the group material. Six online modules cover the key parenting skills delivered in the group, via video vignettes, self-evaluations, and a moderated online discussion forum. The video vignettes demonstrate ineffective
and effective parenting practices with debrief narratives explaining key skills. NG/R leaders highlight the importance of effective parenting for child resilience and family well-being.

Contextual issues particularly relevant for NG/R families in the ADAPT curriculum, as well as content for the video vignettes, were gathered through a series of focus groups, interviews, and workshops on parenting conducted with several hundred Minnesota National Guard families, as well as a small pilot test of the ADAPT group program. These data revealed that families face common struggles related to social support during and after deployment, co-parenting with consistency, coping with combat stress, and related reintegration adjustment issues. Parents reported a strong commitment to helping their children through deployment and reintegration, and those who went through the pilot reported finding the skills extremely helpful. One mother noted that the program helped her “to get more pleasure out of parenting. I am able to focus on my child’s positive behaviors, and not just get hung up on what goes wrong”.

A randomized effectiveness trial of the ADAPT program is just underway, and will eventually recruit 400 reintegrating NG/R families in Minnesota. Families will be randomized to ADAPT or services-as-usual. Families participating in ADAPT will have access to both group and online material. More than half of the facilitators who have been trained to deliver the ADAPT groups are Guard personnel (and current and former VA employees), ensuring that if the program is found to be effective, it can be implemented within the NG/R after research funding has ended. Assessments including multi-method (observational, pen-and-paper, and physiological measures), and multi-agent (parent, child, & teacher) measures at baseline, posttest, 12, and 24 months will enable us to examine the effects of the intervention on parenting, child and parent functioning.

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**Family Forensic Psychology**

*Neil S. Grossman, Ph.D., ABPP, Editor*

**Families in Later Life:**

**Psycho-legal Issues**

*Neil S. Grossman & Barbara F. Okun*

Some of the changes that occur during the later period of the family life cycle require dealing with various psycho-legal issues in the domains of finance, health, and family structure/dynamics1. These issues may be particularly complex in divorced, blended, single parent, gay and lesbian and adoptive families. Family forensic psychologists (FFP) working with families in later life must be knowledgeable about these psycho-legal issues including the need to establish or revise health care proxies, wills, estate plans, plan for retirement and the need for changing family roles. FFP assist families in preparing for end-of-life issues such as the appointment of executor(s), health care proxy, power of attorney, and trustees. They help families find answers to common questions such as: How transparent should the elder parents be about their financial affairs? What part should their adult children take in making decision about financial affairs? How should the family manage conflicts and resentment that
may develop as these issues are discussed? FFP may be called upon to help families find appropriate living arrangements, health and social services for their elderly parents. They must also have the competencies necessary to evaluate guardianship, testamentary capacity, and ability to execute business contracts, as they may be asked to provide expert witness testimony. FFP work with attorneys to address the psycho-legal issues of families in later life; together, psychologists and attorneys are better equipped to prevent family conflict over wills, inheritance, and finances.

The following example illustrates the importance of inter-professional collaboration in helping families embroiled in major conflict. In this instance, an attorney had already assisted the parents in estate planning; a non-revocable trust had been created and it was agreed that the parents would live in the house of one of the children. According to the trust agreement, the parents owned 50% of the house. All of the eight children had been informed about this legal arrangement. However, in the past year, family conflict and schism developed and several of the children were no longer speaking to their parents or each other. The sons were angry; they stopped visiting their parents, and when they had contact with them, talked in an abusive manner. Both parents were dealing with serious medical issues and needed assistance. The sons wanted to undo the trust, and so did the father, albeit for different reasons. A family meeting revealed that the father had a history of alcoholism and that he had been abusive towards his wife. The family forensic psychologist and the attorney worked as a team to address the conflict. The FFP attended to family dynamics, while the attorney focused on the legal consequences associated with possible strategies to resolve the conflict.

Conflicts about estate planning, caretaking and other end of life issues are more likely in families where divorce and remarriage have occurred, due to the competing loyalties of the multiple subsystems. For example, a 72-year-old man contacted the couple therapist that had worked with him and his first wife twenty years ago. He was now married to the woman with whom he had an affair during his first marriage. The children born of his first marriage blamed him for the divorce and had not been in contact with him since then. His second wife urged him to change his will, to cut out his biological children and grandchildren and to leave all his trust funds to his step children and step grandchildren. The fact that this man called the couple therapist that had worked with him and his first wife says something about his ambivalence and “unfinished business.” It was important for this man to find out about state inheritance laws, but also to initiate contact and possibly repair his relationship with his biological offspring before it was too late. The family psychologist suggested a consultation with a family lawyer familiar with elder affairs.

Each stage of the family life cycle requires that family members renegotiate their roles, responsibilities and functions within the family system. In later life, expectations about caretaking, lifestyle, responsibilities and roles are particularly important to discuss. In particular, FFP can help families talk about money – a topic that is often more taboo than sex in our culture. For example, a 76-year-old woman told her three sons that she was going to leave her house to the “ne’er-do-well” 50-year-old son who lived with her and never held a job, living off of his mother’s handouts. Her rationale was that the other two sons had families and were “successful.” These two sons objected, and one suggested they consult a family therapist. The family therapist facilitated open communication between family members. The successful sons expressed their resentment towards their mother “babying” their older brother; they also revealed feeling “punished” for being self-sufficient. While working with the family, the psychologist consulted an attorney to address the family’s legal issues. Legal options were identified and presented to the family, such as selling the house after the mother’s death and using one-third of the sale assets to establish a trust fund for the oldest son. The therapist also recommended that the family develop a plan so that the oldest son be equipped to deal with the changes associated with the death of the mother. The plan included job counseling and skill training. The mother’s need to take care of her son was also addressed.

Our point here is that in later life it is important to prepare for widowhood and changes in functioning and health. Preparation can prevent conflicts that may result in family schism. Estranged families can develop new forms of relationship by having difficult discussions with the help of professionals such as family psychologists, attorneys, physicians and financial advisors.

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Psychology Day at the United Nations

The APA-NGO (Non Governmental Organization) Delegation to the UN did a superb job of organizing a splendid event. Deanna Chitayat, our lead delegate, and the entire team invested countless hours of thought and effort deciding on the program, selecting and inviting presenters and arranging rooms for the events – given that the main UN building is undergoing renovation. Although our APA-NGO delegation is the main sponsor for this event, there was fine collaboration from the other psychological organizations’ NGO delegations such as IAAP, ICP and others.

Four years ago this idea was masterminded by Dr. Florence Denmark, then the chair of our NGO delegation, along with Dr. Merry Bullock, Director of the APA Office of International Affairs (OIF). It has blossomed from a half-day event with a small attendance to a now full-day event that was oversubscribed two weeks in advance with an audience numbering 450-500 that filled the auditorium.

The theme of this year’s conference was “Reach Them, Teach Them: The Role of Psychology in Achieving Universal Access to Education.” Achieving universal education is one of the eight Millennium Development Goals (MDG’s) that governments of the world agreed to reach by the year 2015. The event offers UN staff, ambassadors and diplomats, NGO representatives and students, the opportunity to learn what psychologists contribute to the United Nations, to exchange ideas and to establish multi-stakeholder relationships on global issues.

“Providing universal education is fundamental to solving global problems,” said Deanna Chitayat, Co-Chair of the organizing committee for Psychology Day. In her opening remarks at the conference she stated. “With 100 million children globally who are not attending primary school, psychologists must be in the forefront of finding out ‘Why?’ and answering ‘How?’” Besides education, issues addressed...
by psychologists at the UN range from ageing and trauma to social development, peace, human rights, organizational effectiveness, and rights of women, children, families, refugees and the disabled.

The morning session constituted a briefing by the UN Department of Public Information (DPI). Moderated by DPI Chief of NGO Relations, Maria-Luisa Chavez, panelists included Dr. Barbara G. Reynolds, Senior Advisor, Education, UNICEF, speaking on the role of psychology in achieving universal education; the President of the InterAmerican Society of Psychology, Maria Regina Maluf from Brazil, addressing methods to teach children endangered by poverty. Liberian refugee and current graduate student in the United States, Foday Sackor, shared his gripping personal experiences about education in war-torn Liberia and in a tent city where he had lived years ago.

Carol Goodheart was present to represent APA Council and her introduction of the afternoon session set just the right tone. I was privileged to have been invited to do the plenary address for the afternoon session. Entitled “The Pivotal Role of the Family in Their Child’s Learning,” I sought to relate education, an essential component of the six basic institutions of all societies, to the family, economics (financial), politics (governmental), religion, and health (physical and mental). These institutions are foundational and circumscribe what exists and what is possible in each of the other domains. My presentation incorporated a discussion of the MDG goals and the 2010 report by the UN Girls International Education Task Force; it also took into consideration the diverse socioeconomic strata within and between countries. At a more basic level, my speech addressed the following topics: parents’ role in developing attitudes toward education; study skills; respect for teachers; safe learning environments at home, on the way to school and in school; the creation of parent-teacher associations; political advocacy; overcoming religious barriers to education for girls; welfare/poverty and lack of parents as major deterrents. The questions that followed my presentation were all thought-provoking and led to a lively discussion.

Among the events that marked Psychology Day at the UN were three workshops: 1) Innovative ideas and projects in the Honduras, Madagascar and Uganda; 2) Innovative technology in K-12 STEM education and leveraging new technologies to serve diverse populations; 3) Challenging places and situations: education in Haiti; abolishing school fees in Africa; and educating young people during and after violence.

After this jam-packed day that seemed to take us on a rapid jet trip to many different parts of the world, there was an international reception by and for the various NGO delegates, the student volunteers who had been so helpful in keeping the day running smoothly, and all of the presenters and guests at the Alcala Restaurant, near the UN. Interchanges were lively and spirited and the food delicious.

Psychology Day at the UN is a major contribution that APA, through the OIA and our NGO delegation, makes to the international scene and the pursuit of peace and justice. If you can ever arrange to attend it, I think you will not only find it worthwhile but quite informative and illuminating.

Florence W. Kaslow, Ph.D., ABPP, is Board Certified in Clinical, Family and Forensic Psychology. She runs a clinical, coaching and consulting practice in Palm Beach Gardens, Florida, and is a Distinguished Visiting Professor at Florida Institute of Technology Graduate School. She is a past president of the Society for Family Psychology, has been chair of its International Committee since its inception, and is currently co-chair of CIRP – APA’s Committee on International Relations in Psychology.
Building a Professional Identity in Family Psychology:

Bridging Training and Professional Practice

In recent columns, I have discussed the transition from student to early career family psychologist. To continue with this theme, I would like to emphasize the importance of maintaining a professional affiliation through Division 43 throughout this transition. As students, we all know how difficult it can be to deal with the burnout associated with graduate school. The life of a psychology graduate student is exhausting-balancing coursework, research, clinical hours, internship applications, dissertation, and everything else on a grad student’s plate is a feat not easily mastered. Understandably, although excitement abounds at the thought of shedding the student role, the work involved with the transition to early career can feel just as daunting as graduate school itself. From finding a post-doc position to studying for the licensing exam to paying off student loans, the transition to early career is one more hurdle we, aspiring psychologists, face.

One of the most helpful ways to overcome this hurdle—that is, to bridge training and professional practice—is to develop a professional identity in family psychology. There are many ways to accomplish this—through research, practice, and other scholarly involvement in the field, for example. Perhaps the best way, however, to build a professional identity is through building and maintaining professional connections. For example, as students, we have the opportunity to seek mentorship from those we admire in the field; as we transition into early career, these mentors can become our colleagues.

As with any field, networking is an important part of building and maintaining professional relationships. Involvement with the division is a wonderful way to network with potential colleagues. For example, the annual APA convention offers an opportunity to meet and network with fellow students and professionals in the field of family psychology. This year, there will be several Society events especially pertinent to student and early career psychologist members. In addition to the Family Psychology Social Hour and President’s Reception, there will be several events focused on information about training and professional development as well as mentorship opportunities (check your convention planner or email me at kcj@spu.edu for more information).

In addition to maintaining professional and networking connections, continued affiliation with the division offers an important and unique way to remain invigorated in the field. Training and continuing education opportunities, division publications, and web-based information, including the listserv and the updated website (www.division43apa.org) enable us to stay abreast of exciting innovations in research and practice in family psychology. It is important for us students to remember that, as we continue our involvement with the division, our professional identities continue to grow.
Call for Society for Family Psychology Student Research Award

Students who are presenting first-authored posters at the APA Conference are encouraged to apply for the Society for Family Psychology Student Research Award. The winner receives $250 and the opportunity to publish a summary of his or her work in an upcoming issue of The Family Psychologist. Contact the Committee Chair, Dr. Caroline Clauss-Ehlers (cc@gse.rutgers.edu) for more information.

Eligibility Requirements:
- Students may nominate themselves, or be nominated by a mentor.
- Must be a current student or have conducted the research while a student (e.g., dissertation research).
- Any student who is presenting a poster at the Conference that is relevant to Family Psychology may be considered.
- The student must be a member of the Division at the time of submission, though s/he may become a member when s/he submits the poster to the Committee. (Contact the Committee Chair for more information.)

Materials to Submit:
- The originally submitted abstract (this requirement may be dropped at the Committee's discretion, as the abstract is often redundant with the two pages submitted)
- Two pages summarizing the study
- One page of tables and/or figures if desired

Evaluation Process:
- Send your submission via E-mail to the Committee Chair.
- The Chair will collect the submissions, remove identifying information, and send out the submissions to the Committee members to review.
- Committee members will rate each submission, and then send the ratings to the Chair.
- The Committee will work together to choose a winner.
- The winner is announced by the Committee Chair at the Presidential Reception at the APA Conference. The certificate and check are awarded at that time.

Evaluation Criteria:
Ratings are made on 1-5 scales based on 6 criteria:
- Innovation
- Theoretical/conceptual framework
- Methodological/statistical rigor
- Writing quality
- Contribution to family psychology
- Global rating

2011-2013 Committee Members:
- Caroline Clauss Ehlers (Chair)
- Anthony Chambers
- Beth Corliss
- Erika Lawrence
- Amanda Stewart
This issue of *The Reference Corner* includes reviews of two books relevant for working with families who have experienced disruption: military and divorced families. The reader will surely find something of interest in these two books, *Counseling military families: What mental health professionals need to know* and *Parental alienation: DSM-5 and ICD-11*. These books include a discussion of family development and diverse family structures, and together propose a relational understanding of disruptions in the family life cycle. They also seek to improve competence in working with military and divorced families.

If you are interested in serving as a reviewer for *The Reference Corner*, please email me your areas of interest. Contributors retain a complimentary copy of the book. If you are the author or editor of a new or upcoming book in family psychology that seems appropriate to review in this column, please send a copy to me to be considered for review as closely as possible to the publication date.

Send books and galleys to: Marina Dorian, Ph.D., *The Reference Corner* Column Editor, Alliant International University, California School of Professional Psychology, 10455 Pomerado Road, San Diego, CA 92131; E-mail: mdorian@alliant.edu.

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### Book Reviews


Reviewed by Anka A. Vujanovic, William S. Unger, & Suzannah Creech

The effects of the wars in Iraq and Afghanistan continue to have a far-reaching impact on American society, as exposure to war significantly affects not only military service members but also their family members. The overarching purpose of Dr. Lynn K. Hall’s book, *Counseling Military Families*, is to provide a reference for civilian mental health professionals to facilitate the acquisition of information related to improving education about and service provision to military service members and families. Dr. Hall, a Professor of Counseling in the School of Education at Western New Mexico University, brings great academic and clinical expertise in the realm of marital and family therapy to this volume. The book is a well-written guide for counselors, particularly those without significant exposure to military culture and is designed to promote a better understanding of the socio-cultural and mental health needs of this unique population, to elucidate the psychosocial stressors faced by military personnel and their families, and to encourage the use of empirically-supported treatment modalities. The major contribution of this book is in explicating the need to understand military culture prior to and during the provision of treatment services. Unfortunately, considerably less attention is given to integrating this information into effective treatment strategies, the addition of which would have greatly enhanced the utility of the book.

The book provides information and insight into some of the unique aspects of working with soldiers and their family members. It is comprised of 261 pages of text with 10 chapters divided into three different sections. The three sections broadly correspond to the author’s identification of three
necessary clinical competencies, enumerated as “(a) becoming aware of our own behavior, values, biases, preconceived notions, and personal limitations; (b) understanding the worldview of our culturally different clients without negative judgment; and (c) actively developing and practicing appropriate, relevant, and sensitive strategies in working with our culturally diverse clients.”

The introductory section of the book (‘Part 1: Setting the Stage’) offers an overview of the military structure, including definitions of active duty and National Guard and Reserves positions, an outline of the military hierarchy, and relevant empirical information on the diverse socioeconomic backgrounds and value systems of today’s military personnel. In addition to being an introduction to the topics discussed in the book, the opening chapters give a cogent rationale for the clinical significance of learning more about military culture in relation to providing more effective services to military individuals and their families.

Part 2 (‘The Military Family’) is focused on educating mental health providers about military culture and its impact on the family system, with specific emphases on evolving relationships with spouses and children of military service members. General family issues, such as divorce and parenting, are explicated through the unique challenges faced by military families. Dual military couples, educational experiences and developmental issues of children of military personnel, and effects of diverse family structures (e.g., single-parent families, step-families, retired veterans) on individual service members, other family members, and the familial system are presented to further contextualize the issues with which military families might present for treatment.

The final section of the book (‘Working with Military Families’) elucidates prominent mental health issues related to deployment, posttraumatic stress disorder, family violence, alcohol use, and financial stress. The inevitability of grief, loss, transition, and the relevant emotional toll on the family, is framed as a major psychological factor within this population. General definitions and overviews are provided for major therapeutic interventions, including cognitive-behavioral treatments, solution-focused brief therapy, and family systems therapy. Techniques for addressing posttraumatic stress disorder and deployments are discussed in individual sections, while strategies for working with military stepfamilies and military men are elucidated individually as well. The final section concludes with two family case studies that constitute brief clinical summaries of information discussed in the book. It is somewhat unfortunate that the book does not provide a more in-depth analysis of intervention programs and strategies, and does not pay more attention to the empirical literature and new directions in intervention research.

Overall, Counseling Military Families is a clinically useful reference guide for mental health professionals of various backgrounds, but especially those lacking significant knowledge of military culture. The book provides a comprehensive, detailed overview of the military and its structure and hierarchy, the strengths and challenges of working with military families, and effective clinical interventions for implementation with this unique population. This makes the book a valuable resource for all mental health professionals working with military personnel and their families.

Anka A. Vujanovic, Ph.D., is a Staff Research Psychologist at the National Center for PTSD-Behavioral Science Division, VA Boston Healthcare System, and Assistant Professor of Psychiatry at Boston University School of Medicine. Her research program is focused upon the study of biopsychosocial risk and maintenance factors related to posttraumatic stress disorder and co-occurring substance use disorders.

William S. Unger, Ph.D., is the Chief of the Post-traumatic Stress Disorder (PTSD) Service at the Veteran’s Affairs Medical Center in Providence Rhode Island. He has over 20 years experience in research and the treatment of PTSD. He serves as a regional PTSD Program Mentor for the Department of Veteran’s Affairs. He is a Clinical Assistant Professor at the Alpert Medical School of Brown University.

Suzannah Creech, Ph.D., is a graduate of the clinical psychology program at Texas A&M University and the PTSD/Women’s issues internship at the Medical College of Georgia. She is also a graduate of the Brown Psychology Training Consortium where she received advanced training in treatment for PTSD at the Providence VA Medical Center. Dr. Creech is now a fellow at the National Center for PTSD, VA Boston Healthcare System, and a Research Psychologist at the Providence VA Medical Center.
The concept of parental alienation syndrome has been a very controversial one. Some mental health and legal professionals find it very credible; others dispute that it exists. The 70 contributing authors to this book, which is based on substantial research, make a strong case for the existence of parental alienation behaviors that are detrimental to the “targeted” parent as well as to the children alienated from him or her. They are referring to extruded parents who were not abusive, addicted, “deadbeats” regarding financial obligations and other parenting responsibilities, or individuals who had committed a crime or otherwise objectively engaged in behaviors that would have been harmful to the children.

The original document which undergirds this book was collaboratively authored by contributors from 12 countries as an objective way to try to have parental alienation behavior included in the American Psychiatric Association’s DSM-V and also the more international ICD-11, both currently in the formulation and writing stages. The contributors not only come from different cultural backgrounds; they are drawn from the field of history as well as mental health, forensic and clinical psychology, and law. This array adds to the depth and breadth of the analysis and recommendations. This volume is edited by Dr. William Bernet, a Professor in the Department of Psychiatry at Vanderbilt University of Medicine. I found it to be an informative and thought-provoking treatise.

The authors define parental alienation as “a mental condition in which a child – usually one whose parents are engaged in a high conflict divorce – allies himself or herself strongly with one parent (the preferred parent) and rejects a relationship with the other parent (the alienated parent) without legitimate justification. This process often leads to painful schisms when the child(ren) and alienated parent, who previously had an affectionate and mutually satisfying relationship, lose their reciprocal loving connection and the potential joys of a close parent-child interaction. Sometimes this fault line continues for many years. The process of bringing about such severe alienation has been labeled “divorce poison” (Warshak, 2010). When the poisoning is so severe that the cut off is irreparable, despite the kindest, best intentioned reaching out by the alienated parent to his/her child, and when numerous kinds of excellent therapeutic interventions have been tried and failed, the lingering sadness and sense of loss of the alienated parent continues. The authors make strong statements conveying that parental alienation is not just a minor fault line in the life of a family but can develop into a serious mental condition. Given the usually false and often propounded belief that the alienated parent does not deserve to be with the child because he or she is unworthy or dangerous, the alienated child loses one of the most significant relationships to which he/she is entitled in his/her life. The child also is deprived of whatever that alienated parent has to offer. The sense of rejection, loss, hurt, being tossed asunder and unloved can cause the alienated parent to become confused, depressed, disillusioned, and/or outraged. When all efforts to reunite with the child fail, hopelessness and helplessness may ensue.

This book is an expanded revision of a 2008 proposal on “Parental Alienation Disorder”, which was submitted to the DSM-5 Disorders in Childhood and Adolescence Work Group. It was written with the aim of communicating the validity, reliability and prevalence of this relational disorder in many countries and in different cultural groups, and the necessity of including this behavioral pattern as a diagnosable condition in the DSM-5 and ICD-11. Any clinicians who have worked with families pre-, during and post-divorce, and seen and heard the emotional drama and chaos parental alienation can wreak, will easily recognize the types of people described in the clinical vignettes.

Twenty reasons are listed as to why parental alienation should be included as a diagnosis, and recommendations are made for a new diagnosis in DSM-5. Those in the Society for Family Psychology who are interested in relational diagnosis will find these particularly useful as practice guidelines. The authors recommend that the material included in Appendix A of the book, “Proposed Criteria for Parental Alienation Disorder”, be incorporated in the portion of the DSM regarding mental disorders. They also propose that the material in Appendix B, “Proposed Criteria for Parental Alienation Relation- al Problem”, be adapted for discussions of relational problems. They also suggest that their definition of
“behavioral and emotional disorders with onset usually occurring in childhood and adolescence” (Chapter V) and “problems related to negative life events in childhood” (Chapter XXI) be included in the ICD-11.

When the DSM-IV was in the offing, the Division for Family Psychology initiated a Task Force on Family Diagnosis of which I was the original Chair. The Task Force was influential in the formation of the Coalition on Relational Diagnosis. The Coalition brought together fourteen professional organizations which, prior to the final deliberations of the DSM-IV, requested the creation of a DSM Work Group. This request was not fulfilled, showing how difficult it is to change the individual focus of the DSM and to help those in charge of the DSM project to develop a relational understanding of mental disorders. This is all the more important because the narrow focus on the criteria for individual pathology neglects the relational contexts that influence maladjustments in healthy personality development.

*Parental alienation* is a “must read” that is clearly written and includes a comprehensive reference list. It will inform the work of practitioners in the field of couple and family psychology, psychiatry, divorce, parent/child relationships, law and mental health. It may also help children of divorce to better comprehend the reasons for and dynamics of their estrangement from one parent, and perhaps help facilitate attempts at reconciliation. After reading this book, I hope that the DSM-5 and ICD-11 committees will have the courage to include “parental alienation condition” in their relational/social diagnoses. This would prompt mental health professionals to find new interventions for healing the tragic consequences of parental alienation.

**Reference**

*Florence W. Kaslow,* Ph.D., ABPP, is Board Certified in Clinical, Family and Forensic Psychology. She runs a clinical, coaching and consulting practice in Palm Beach Gardens, Florida, and is a Distinguished Visiting Professor at Florida Institute of Technology Graduate School. She is a past president of the Society for Family Psychology, has been chair of its International Committee since its inception, and is currently co-chair of CIRP – APA’s Committee on International Relations in Psychology.

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**APA Council of Representatives**

**February 2011 Meeting Summary**

*Journal of Couple and Family Psychology*

Of great importance to SFP, the Council approved a new Division 43 journal, *Journal of Couple and Family Psychology*. Mark Stanton is the inaugural Editor for the journal.

*Dues*

Doctoral-level members of APA will see their dues reduced next year as a result of action taken by the Council of Representatives at its February meeting. The reduction in full members’ dues, from the current $287 to $247 beginning in 2012, is part of an overall redesign of the association’s dues schedule as proposed by the Membership Board. The revised schedule moves the association from a dues schedule based on discounts for specific constituency groups to reduced costs for all full members. Early career members will still enjoy reduced dues for their first eight years of membership. This action rescinds a 2011 Council decision to grant a $25 dues discount to APA members who are also members of the Federation for the Advancement of Behavioral and Brain Sciences, the Association for Psychological Science, the Society...
for Neuroscience, the state, provincial and territorial psychological associations and the four national ethnic minority psychological associations.

The Council also approved in principle changes to the current eligibility requirements for life status members. These changes require amendments to the Association Rules and Bylaws and therefore will be put before a vote of the full membership this fall.

Budget
The Council approved the 2011 association budget, including operating expenses of $106,857,300 and forecasted revenue of $106,877,300.

Guidelines and Task Force Reports
The Council adopted six new or revised guidelines in the areas of parenting coordination; practice in health care delivery systems; psychological evaluations in child protection matters; assessment of and intervention with people with disabilities; evaluation of dementia and age-related cognitive change; and psychological practice with lesbian, gay and bisexual clients.

The Council adopted as APA policy the Principles for Quality Undergraduate Education in Psychology. These principles replace an earlier version and are an outgrowth the 2008 APA National Conference on Undergraduate Education in Psychology. The guidelines articulate a set of learning goals and outcomes that should be attained by all psychology majors. See the full guidelines at http://www.apa.org/ed/precollege/about/psymajor-guidelines.pdf

The Council also established a new task force to create guidelines for psychologists’ use of telepsychology.

The Council accepted several presidential task force reports:

- the 2010 Presidential Task Force on Advancing Practice. The work of the task force included the launch of PsycLINK, the APA practice wiki, an online resource for information sharing and collaboration amongst psychologists. Visit the wiki at http://psyclink.apa.org/display/ITS/PsycLINK+-+The+Practice+Wiki

- the 2010 Presidential Task Force on Caregiving. The work of the task force included the creation of a Web-based resources “briefcase” for psychologists and members of the public on care-giving issues. See the web-based briefcase at http://www.apa.org/pi/about/publications/caregivers/index.aspx


“I’m very proud of the work of the association as reflected in the actions taken by Council at this meeting,” APA President Melba J. T. Vasquez, Ph.D., said at the close of the 2 ½-day meeting. “The guidelines and task force reports are now a part of the official APA record and will help psychologists do their jobs and continue to serve the public.”

Diplomate Credentials
The Council voted to allow the publication of diplomate credentials in the APA Membership Directory if the credential is in a specialty or proficiency area that is officially recognized by APA through its Commission for the Recognition of Specialties and Proficiencies in Professional Psychology and meets other criteria as established by the Council’s vote. These criteria include that the credential is offered by a non-profit group and is awarded based on a review and verification of the individual’s training, licensure, ethical conduct status and an assessment of the candidate’s competence in the specialty area by way of an examination.

Psychology and the Environment
The Council adopted a resolution affirming APA’s recognition of the importance of the psychological aspects of the way humans relate to the environment and supporting psychologists’ involvement in research, education and community interventions in improving public understanding of global climate change impacts and ways in which psychology can help mitigate those impacts.

Council and Committee Seats
A proposal to provide seats on the Council for representatives for the four ethnic minority psychological associations was postponed to be raised before the Council at its August 2011 meeting. Three of the four associations are now represented on the Council by appointed non-voting delegates. AB-Psi (The Association of Black Psychologists) is represented by a non-voting Observer to Council.

In other action, Council enlarged the Committee on Early Career Psychologists from six to seven members.

Your Division 43 Council Representatives,
Susan H. McDaniel, Ph.D.
Michele Harway, Ph.D.
Low sexual desire and sexual dysfunctions are widespread, and therapists often find them among the hardest couples’ problems to treat. Couples with severe relationship or personal problems often fare particularly poorly. This case-based workshop highlights a fast-paced isomorphic approach (Crucible Therapy) integrating sex and marital therapy, self-differentiation, brain science, and interpersonal neurobiology. This mélangé allows clients to create desire, passion, personal growth and better relationships simultaneously.

The workshop will engage participants through interesting case examples, making the workshop material easier to remember. It walks participants through the process of deconstructing the couples’ presenting problems, setting them up for treatment (1/3 of workshop), and actually treating multiple problems with sexual desire, sexual dysfunctions, and emotional intimacy (2/3 of the workshop). It also offers practical knowledge of differentiation-based treatment applicable to non-sexual problems.

**David Schnarch**, Ph.D., is the author of the best-selling *Passionate Marriage, Constructing the Sexual Crucible*, and his newest book *Intimacy and Desire*. Dr. Schnarch has recently been chosen to receive the AAMFT 2011 Award for Outstanding Contribution to the Field of Family Therapy. **Dr. Morehouse** is Co-Director of the Marriage and Family Health Center and The Crucible Institute of Evergreen, Colorado, and currently serves as VP for Practice for the Society of Family Psychology. Both presenters are AAESTC certified sex therapists with Diplomate Status.

Take advantage of this unusual opportunity to help our division while benefiting from this top-notch workshop that will challenge your thinking and inspire you in your professional work. If you want to learn more about the cutting edge of sex therapy today, including the integration of sex and marital therapy and its importance to systemic family psychology, this is the workshop for you!

To register and read more about this workshop including learning objectives please go to: [www.apa.org/convention/ce-workshops/preconvention/005.aspx](http://www.apa.org/convention/ce-workshops/preconvention/005.aspx)
**Convention Program**

Please check APA Convention Program for updates and possible changes to time & location.

<table>
<thead>
<tr>
<th>EVENT</th>
<th>DATE - TIME</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td><strong>Symposium:</strong> <strong>Advances in Family Psychology Research and Therapy</strong></td>
<td>Thursday, Aug. 4 11:00 am - 11:50 am</td>
<td>Convention Center Room 144C</td>
</tr>
<tr>
<td><strong>Symposium:</strong> <strong>A Difficult Balance -Treating All Family Members and Relationships When One Child Is Seriously Ill</strong></td>
<td>12:00 pm - 12:50 pm</td>
<td>Convention Center Room 149A</td>
</tr>
<tr>
<td><strong>Poster Session</strong></td>
<td>1:00 pm - 1:50 pm</td>
<td>Convention Center Halls D and E</td>
</tr>
<tr>
<td><strong>Symposium:</strong> <strong>Masters in Family Psychology</strong></td>
<td>2:00 pm - 3:50 pm</td>
<td>Convention Center Room 143A</td>
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<tr>
<td><strong>Symposium:</strong> <strong>Family Stress and Resilience in Military and International Marriages</strong></td>
<td>Friday, Aug. 5 8:00 am - 8:50 am</td>
<td>Convention Center Room 154B</td>
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<tr>
<td><strong>Symposium:</strong> <strong>One Family, Four Approaches - Intervening With a Real Family</strong></td>
<td>10:00 am - 11:50 am</td>
<td>Convention Center Room 149B</td>
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<tr>
<td><strong>Division 43 New Fellows’ Addresses</strong></td>
<td>3:00 pm - 3:50 pm</td>
<td>Convention Center Room 102A</td>
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<tr>
<td><strong>SOCIAL HOUR</strong></td>
<td>5:00 pm - 6:50 pm</td>
<td>Grand Hyatt Washington Hotel Constitution Ballroom B</td>
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<tr>
<td><strong>Symposium:</strong> <strong>Achieving Specialty Competence in Couple and Family Psychology</strong></td>
<td>Saturday, Aug. 6 8:00 am - 9:50 am</td>
<td>Convention Center Room 149A</td>
</tr>
<tr>
<td><strong>PRESIDENTIAL ADDRESS:</strong> <strong>Working With Immigrant Families Across the Life Span - Insights and Challenges</strong></td>
<td>10:00 am - 11:50 am</td>
<td>Renaissance Washington Hotel Meeting Rooms 12, 13 and 14</td>
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<tr>
<td><strong>Symposium:</strong> <strong>Couples With Multiple Caregiving Responsibilities and the Work-Family Interface</strong></td>
<td>12:00 pm - 12:50 pm</td>
<td>Convention Center Room 149A</td>
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<tr>
<td><strong>Poster Session</strong></td>
<td>1:00 pm - 1:50 pm</td>
<td>Convention Center Halls D and E</td>
</tr>
<tr>
<td><strong>Symposium:</strong> <strong>Immigrant Family Psychology - Innovative Clinical and Research Issues</strong></td>
<td>1:00 pm - 1:50 pm</td>
<td>Convention Center Room 102A</td>
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<tr>
<td><strong>Symposium:</strong> <strong>Family Functioning and Health Risking Behaviors Among College Students: Eating Disorder Symptoms, Self-Harm, and Alcohol Consumption</strong></td>
<td>Sunday, Aug. 7 8:00 am - 8:50 am</td>
<td>Convention Center Room 154A</td>
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## HOSPITALITY SUITE PROGRAM

Grand Hyatt Washington

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<tr>
<th>DAY - TIME</th>
<th>TOPIC</th>
<th>CONTACT PERSON</th>
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</table>
| Thursday, Aug. 4  
3-4 pm       | What is it like to be a family psychology student in an individually psychology program?  
(OPEN TO ALL)                          | Kendra Jones, M.A./CSPP Students           |
| 4-5 pm                  | The Role Personal Development Plays in Love Relationships, Families and in Therapy  
(OPEN TO ALL)                                  | CSPP Students                             |
| 5:30-7 pm             | Early Career Panel  (OPEN TO ALL)                              | Kendra Jones, M.A.                        |
| 8-10 pm               | ABPP Reception: Becoming Board Certified  
(OPEN TO ALL)                                                 | Andrew Benjamin, J.D., Ph.D., ABPP         |
| Friday, Aug. 5  
8-2 pm       | Division 43 Board Meeting  (SUITE CLOSED)                                                | George K. Hong, Ph.D., ABPP               |
| 5-7 pm                  | Division 43 Social Hour  (OPEN TO ALL)                                                | Grand Hyatt Washington Hotel  
Constitution Ballroom B                       |
| 8-10 pm               | Presidential Reception and Awards Ceremony  
(OPEN TO ALL)                                                             | George Hong, Ph.D., ABPP                  |
| Saturday, Aug. 6  
8-9 am       | ADHD, Parent Abuse and Co-Sleeping  
(OPEN TO ALL)                                                              | Robert Pressman, Ph.D., ABPP             |
| 9-11am                | Strengthening a Culturally Affirmative and Social Justice Agenda  
(OPEN TO ALL)                                                      | Gonzalo Bacigalupe, Ed.D.                |
| 11-12pm               | Membership Committee Meeting  (OPEN TO ALL)                                           | Larry Kuhn, Psy.D.                        |
| 12-2 pm               | Working the System: Internship Application and Survival Strategies  
(OPEN TO ALL)                                                   | Robert Welsh, Ph.D., ABPP                |
| 2-4 pm                | Education for Family Psychology: Current Status and Future Directions  
(OPEN TO ALL)                                                      | Stephen Cheung, Psy.D.                   |
| Sunday, Aug. 7  
9-11 am          | Breakfast and Brainstorming!  
(OPEN TO ALL)                                                       | Ruth Morehouse, Ph.D.                    |