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BULLETIN

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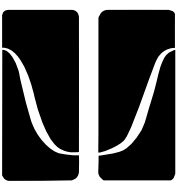

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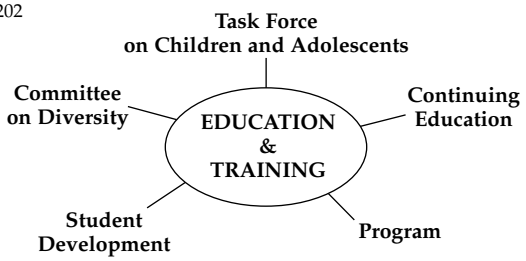

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PRESIDENT'S COLUMN

Diane J. Willis, Ph.D.

The New Millennium

I am very honored to serve as the President of Division 29 during this millennium year 2001. Following in the footprints of past outstanding presidents of the Division is both humbling and challenging. I feel fortunate to have on the Executive Committee and Board of Directors leaders in the field and practice of psychology, proven leaders in the APA governance including four past-presidents of APA, and psychologists well-known for their research in psychotherapy or psychopathology! Division 29 is most fortunate to have this wealth of expertise and commitment.

As a clinical child (pediatric) psychologist my professional career has been devoted to education and training of psychologists at the internship level and development of new service (therapy-assessment) models for meeting the mental health needs of culturally diverse and difficult to serve populations (the poor, American Indian children, youth and families, abused or traumatized children, children who have been affected by parental substance abuse, and children with disabilities and/or chronic health related problems). I have spent considerable time developing services for chronically ill infants and providing therapy and consultation to their families. I have also spent years doing therapy with maltreated children and their families. The last five years of my career has been focused on ways to prevent mental health problems in the young, provide training and consultation to others on the needs of young children and their families, and train individuals to address and treat the issues of child physical and sexual abuse.
As a consequence of my career-long interest in children and their families, I have asked people who have similar interests to work with me. This year we are fortunate to have several new faces in the Division governance through committees and Task Force assignments to put forward my emphasis on therapy with infants and children, the integration of psychotherapy and health, and the dissemination of psychotherapy information beyond the Division listserv and Division publications. The following areas will provide a focus for the year 2001:

Focus on Dissemination of Psychotherapy Knowledge

Dr. Michael Lambert and Dr. Charles Gelso have agreed to be the first psychotherapists to write articles for State Psychological Association newsletters (SPA's) under the heading of "Division of Psychotherapy Updates." Dr. Lambert was asked to write a brief article in lay language for the benefit of legislators and policy makers on the efficacy of psycho-therapy. His excellent article can be used by States to support the

fact that psychotherapy works. I would urge each member of the Division to talk to your State newsletter editor and make sure that Division 29 becomes visible in your newsletter through the contributions of our outstanding and renowned members. Watch your newsletters! This visibility for the Division will hopefully increase membership, but of far greater importance, it will disseminate practical and useful knowledge for psychologists at the State level, many of whom are members of our division.

Focus on Medicaid Reimbursement for Young Children

The APA Practice Directorate agreed to my request to help develop reimbursement guidelines under Medicaid for the mental health treatment of very young children (e.g., infants). This will be an interdivisional project as I invited Division 53 (Clinical Child Psychology) and Division 54 (Society of Pediatric Psychology) to join our Division in this important effort. Division 53 appointed Dr. Dick Abidin from the University of Virginia; Division 54 appointed Dr. Kathy Katz from Georgetown University; and I appointed Dr. Robin Gurwitch from University of Oklahoma Health Sciences Center from our Division to work on this project. Ron Palomares of the Practice Directorate has already contacted a few States to inquire about the kinds of reimbursement practices they have developed or obtained through Medicaid when psychologists or other licensed mental health professionals treat this young population.

Focus on Therapies with Children and Youth

Dr. Sheila Eyberg, clinical child psychologist from the University of Florida at Gainesville, and Dr. Beverly Funderburk from the University of Oklahoma Health Sciences Center, will co-chair the Task Force on Children and Youth. This committee will not only develop articles for the *Bulletin*, but will also write Tip Sheets for the American Indian Head Start Quality Improvement Center (AIHSQIC) on issues designed to train Head Start and Early Head Start workers on early identification of child disorders, and treatment ideas for common behavior problems seen in EHS and HS. Division 29 will receive credit for the development of the Tip Sheets, which will be disseminated across the United States. Negotiations are ongoing for at least minimal reimbursement for the writing of Tip Sheets, but costs of publication will be born by the AIHSQIC. Within this committee there will be a major emphasis on treatments that work with difficult-to-manage children and training or re-training therapists on new therapy techniques that work with this young population. As an aside, I showed a videotape of Dr. Eyberg's Parent Child Interaction Therapy model to a Senate Committee in Oklahoma and they were so impressed with the results of two families that they allocated $400,000 to the Child Study Center to make certain young difficult-to-manage children are treated properly. Interns at OUHSC all learn this technique and some in private practice earn the bulk of their income seeing young children with aggressive or out-of-control behavioral problems.

Focus on the Integration of Psychotherapy and Health

In 1996, the APA Council of Representatives approved the designation of psychologists as "health service providers."Within this framework, psychologists did not need to limit their practice to the delivery of traditional "mental health" services. However, many of our Division 29 members have had difficulty making a shift in their practice to embrace the challenge of incorporating and targeting certain clientele (e.g., those with chronic illness, stress-induced illnesses, or those who suffer health problems secondary to behaviors such as smoking) into their practice.

This year Dr. Frank Collins, Clinical Training Director at Oklahoma State University, will focus on the integration of psychotherapy and health by taking one problem behavior that causes enormous health problems and demonstrating how psychotherapists can incorporate within their practices a focus on healthy behaviors. Dr. Collins developed a symposium on smoking cessation and the practice of psychotherapy for the APA convention. One of the speakers will address the use of medication to help patients reduce or eliminate their smoking habit, and another focuses on clinical guidelines for smoking cessation and what every psychologist should know about brief interventions for smoking cessation. Dr. Collins will spend this year developing a series of articles helpful to psychotherapists on smoking cessation, and he plans to submit them to our own journal for review. Sensitizing therapists to the notion that they are health service providers will take time.

Focus on Students and Membership

There will be an initiative to have APAGS represented at Division 29 meetings and to include psychology students on Task Forces and Committees. Dr. Sheila Eyberg is already including students on the Child and Adolescent TF and students will be represented on the membership and diversity committees. The new co-chair of the membership committee, Dr. Craig Shealy from James Madison University, will work with Dr. Sam Hill to increase membership. They will also work with Louis Castonguay and Jeffrey Hayes on recruiting students for Division 29 membership. Of course, each and everyone of us must do our part in recruiting new members and reenlisting members who have dropped their membership.

Other News

Drs. Jan L. Culbertson and Susan Corrigan, University of Oklahoma Health Sciences Center, along with Tracey Martin, our Administrative Officer, have done a yeoman's job pulling together an outstanding program for the APA convention.

Finally, we welcome Dr. Doug Snyder, Texas A & M University, to the Division leadership. He will serve as Fellows Chair during this year. Any member can make nominations for Fellow status to Dr. Snyder direct, including self-nominations.

I look forward to working with the Board of Directors and the membership this year and I welcome your comments and suggestions for improving the Divisions outreach to others.

MID-WINTER 2002 IS GOING BACK TO THE FUTURE

Psychotherapy Through the Life Span

Robert J. Resnick, Ph.D. President-elect

In, 2002 the Division of Psychotherapy will return to the original format of the mid-winter meetings with a theme of, "Psychotherapy Through the Life Span." There will be only two tracts of programming, ample time and place to meet informally with colleagues and friends, and opportunities to meet senior psychotherapists for consultation.

Plans include poster sessions as well. The American Psychological Association Insurance Trust(The Trust) have agreed to provide their highly rated and well-received six hour workshop: "Risk Management in Professional Psychological Practice." Six Continuing Education Credits will be awarded to attendees. We are, also, investigating the possibility of getting general continuing education credits for some or all of the other programming. The focus of the programming is, what else, psychotherapy. The general theme of the 2002 Mid-Winter the use of psychotherapy and psychotherapeutic techniques through the life-span and programs will reflect the general theme of "Psychotherapy Through the Life Span." One track will feature the "Legends of Psychotherapy, and one track will be dedicated to "cutting edge" therapies.

The program committee and the mid-winter committee are still forming. Volunteers can be "old blood," "new blood," but not "coagulated blood"! If any of you are interested in being involved in the process please let me know(rresnick@rmc.edu, 804-270-9595). The committees are fortunate to have Matty Canter,Ron Fox and John Norcross who have agreed to be consultants. The committee, as of this writing, has Jon Perez, Leon Vandecreek, and myself. Needed a person with child, family, and geriatric interests.

The dates of the Mid-Winter 2002 are: Thursday, February 21st (day of arrival) to Sunday, February 24th departure with some programming for who have afternoon departures. The place: The Chapparel Suites Hotel in Scottsdale, Arizona. This is a beautiful resort hotel, very well located to shopping, attractions and fine restaurants. Each unit is an apartment, the hotel provides a complimentary, cooked to order breakfast. Lunch on Friday and Saturday will be part of the program so that friends and colleagues can meet and dine together. Thursday night a welcoming reception is planned. Friday night is still being discussed. If you have suggestions, again, please let me know. If any of you would like to be part of the process as serve on the Program and/or Convention Committee, again, please let me know (rjresnic@hsc.vcu.edu or 804-270-9595). Our attempt is to recreate the meeting and atmosphere of the early Division of Psychotherapy mid-winters — smaller, intimate and very interactive. Join us in going back to the future, reinventing ourselves, and returning to our roots. I guess by now you get the idea. Each issue of the Bulletin will provide updates, but mark your calendars now.

Studying the Graduate Advising Relationship: New Concepts and Findings

Charles J. Gelso and Lewis Z. Schlosser

The relationship between a psychology doctoral student and her/his advisor may be crucial to the student's development as a psychotherapy practitioner and researcher. This relationship may well have substantial effects on professional interests, confidence, and competencies. The advising relationship also may affect, or at least have the potential to affect, long-term outcomes such as career choice specialization (e.g., therapist vs. scientist), and professional identity development. Despite its apparent importance, very little theory and next to no research have been evidenced on the advising relationship, it qualities and effects. Those of us who are steeped in the graduate training of scientist-practitioners in psychotherapy have had to fly by the seat of our pants — to rely on trial and error learning in our advising work. Our suspicion is that the outcome has been variable — naturally some great graduate advising occurs, but if you listen to students, one also hears many horror stories. We believe the situation would benefit substantially from the development of theory and research on the advising relationship. In fact, some beginning research efforts have been made recently, and our intent in the present article is to discuss this research and its implications for the training of therapy practitioners and researchers.

While advising relationships have been largely under-examined, the concept of mentoring has received increasing attention in the business and in the industrial/organizational psychology literatures. Research has revealed that positive mentoring relationships are associated with protégé professional development and career advancement. Translated to psychotherapy training, mentors might be students' academic advisors, clinical supervisors, and/or other professionals. Theoretical and empirical connections have been made between the therapy supervision relationship and relevant trainee outcomes. As noted, however, theory and (especially) research on the advising relationship have been extremely sparse. Therefore, it is important to assess how advising (in addition to supervision) relationships might affect relevant outcomes for psychotherapy trainees. The studies below describe the initial attempts to explore the advising relationship and its correlations with relevant outcomes for therapists and therapy researchers.

In the first published study on advising relationships, Schlosser and Gelso (in press) constructed and validated a measure of advisor-advisee working alliance from the perspective of psychology doctoral advisees. This measure, the Advisory Working Alliance Inventory — Student Version (AWAI-S), demonstrated excellent internal consistency and test-retest reliability, as well as sound beginning validity. Of note was that the advisory working alliance appeared to be divisible into three factors: Rapport (between advisor and advisee), Apprenticeship, and Identification-Individuation. Thus, the good working alliance between advisor and advisee is marked by an interpersonal connection reflecting respect, encouragement, and interpersonal warmth (Rapport). It is also marked by the advisor working to teach

the student the ins and outs of the field, including staying focused on important tasks (Apprenticeship). Finally, the good alliance is characterized by some degree of student identification with the advisor, consciously or unconsciously (Identification-Individuation). When advisory working alliances have been found to possess these ingredients, graduate students function better in the tasks that are asked of them. We do not yet know how the advisory working alliance relates to the development of the psychotherapist (the current findings have more bearing on the therapy researcher), but we suspect that the effects are potent. Importantly, these three factors bear a very strong resemblance to the factors that have been found to make for a sound working alliance in clinical supervision (Efstation, Patton, and Kardash, 1990).

In a follow-up to their first study, Schlosser and Gelso (2000) are currently developing an advisor version of the AWAI. This measure, the Advisory Working Alliance Inventory — Advisor Version (AWAI-A), will be completed by faculty in counseling psychology doctoral training programs. In terms of understanding working alliance, research and theory from psychotherapy and therapy supervision has demonstrated the utility of assessing views from both members of the dyad. Thus, the AWAI-A is being developed to compliment the existing student version (AWAI-S). In addition to the scale development, the researchers seek to understand the effects that the advisory working alliance has on students' interest in scientific and practitioner activities.

In a study currently ongoing, Schlosser, Knox, Moskovitz, and Hill (2000) are using a qualitative approach to explore advisees' perceptions of their advising relationships. Whereas the first study described above focused solely on advisory *working alliance*, the aim of this study is much broader, hoping to paint a more complete picture of the advising *relationship*. Students responded to a series of questions focused on the major areas of their advising relationships. Initial findings suggest that students in positive advising relationships report qualitatively different experiences than students in negative advising relationships. Students in positive advising relationships describe their experience as being a mentor-protégé relationship, where they feel respected, supported, and encouraged. They have positive role models who help them navigate graduate school effectively. In contrast, students in negative advising relationships describe their advising experience as harmful; these students often feel ignored, unimportant, and neglected. They feel a lowered self-efficacy for professional activities and a lack of guidance in terms of progressing through their graduate program. These findings, which extend an earlier qualitative study on research advising (Gelso, 1997), emphasize the importance of good advising relationships in enabling students to progress through graduate school.

Some of the students' responses to the questions illustrate Schlosser and Gelso's (in press) three factors described above (Rapport, Apprenticeship, and Identification-Individuation). Two students provide contrasting examples of advisory rapport. One student stated that "I think it [the advising relationship] is really good, I have a lot of respect for her, and I know that she has respect for me", whereas another student expressed that "I expected my advisor to give a <expletive> about me...to respect me...and to show me that he knew I existed and mattered. I haven't gotten any of that". When talking about being guided by her advisor about the tasks of graduate school, one student reported developing "knowledge, understanding, skill, and confidence", whereas another student discussed feeling left alone to fend for herself with "twice a year meetings with my advisor,

solely to pick classes". One student's remarks appear to cut across all of these factors, touching upon each of the domains described above,

"I really respect her and I think she is incredibly competent and if she perceives me as being competent, I can't believe she is wrong about that. So, it's been nice in sort of increasing my own sense of competence and how confident I am about my ability to be a psychologist. So it's been a positive experience but there is also probably a little bit of sadness we're just having...like when kids leave home."

The clear impression from observations like these is that the advising relationship (either positive or negative) can play a crucial part in graduate student development.

Given the relative infancy of the research in this area, continued work on advising relationships is warranted. Since some initial research has applied a therapy supervision construct (i.e., working alliance) to advising, and since the advising relationship is seen in a similar fashion to therapy supervision (Schlosser & Gelso, in press), it follows that other supervision concepts might be applicable to advising. For example, perceptual distortions (i.e., transference and countertransference) that affect the overall advising relationship may be present in advising dyads. Also, there are likely to be aspects of the advising relationship not encompassed by working alliance or by distortion. Thus, it is important to consider each of these components when examining the advising relationship.

In addition, more research examining psychotherapy-related outcomes of advising relationships is necessary. Longitudinal research could test if the advising relationship can predict long-term outcomes (e.g., career choice, therapy competence, and professional identity). We believe that further examination of the advising relationship will enrich our understanding of the ingredients of effective training for psychotherapists and psychotherapy researchers.

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PSYCHOTHERAPY WITH AFRICAN-AMERICANS

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Psychotherapy with African-Americans is a monumental undertaking and one for which white psychotherapists are rarely prepared to undertake. However, before we can deal with the patient we must deal with the psychotherapists and the environment in which the process takes place. Much has been written on this subject. Unfortunately, very little of that which has been written has any scientific validity. As African-American Psychologists (and others) have become more familiar with the literature and its misrepresentations of African-Americans and the fact that it serves to reinforce negative racial stereotypes-they have rejected these theories and have been writing their own. Traditional theories do not explain, adequately, the dynamics of African-Americans. Since the days of the Civil Rights Movement and the politicization of African-Americans every institution in American life has been under attack and the mental health field has also felt the impact. All American Institutions play a part in perpetuating and reinforcing white racist attitudes and practices, (Thomas & Sillen, 1979). The prevailing belief among white psychiatrists, psychologists and social workers was that racism was a cancer in our society, but, their special training and dedication made them immune. Thomas and Sillen (1979) stated further that essentially, what mental health practitioners overlooked was the institutionalization of racism, the fact that the oppression of African-American people was so thoroughly built into every social substructure. Consequently, its members are characterized by an almost universal tendency to develop unconscious racial bigotry (Rosen & Frank, 1962). A number of writers have noted the need for white and Africa-American psychotherapists to come to terms with their feelings about race before attempting to treat members of minority groups (Adams, 1950; Curry, 1964a; Grier & Cobbs, 1968; Heine, 1950; Rosen & Frank, 1962; and, in particular, much of the psychoanalytic literature cites this need. Unfortunately, much of the psychoanalytic literature is digested, uncritically, (Gardner, L. H., in Pugh, R. W., 1972) and therapists approach his/her African-American clients harboring assumptions, mental sets, and beliefs of questionable validity gathered from the professional literature, from the attitudes and pronouncements of his/her training supervisor, and from his/her own conscious and unconscious attitudes about African-Americans. There is no evidence anywhere in the psychoanalytic literature that training analysts give adequate attention to the analysis of unconscious antiblack prejudice in white candidates. As a result, many psycho-analytic papers on the "Negro Personality" (especially the African-American male) express patronizing and paternalistic attitudes.

In *The Mark of Oppression* (Kardiner, A., & Ovesey, 1951) the authors, using a sample of 25 Africa-American clients, described the following characteristics as being fairly prominent in the personality organization of African-Americans (Pugh, 1972):

1. Superficiality
2. Apathy and resignation
3. Repressed hostility
4. The wish to be white
5. Identification with feces
6. Intragroup aggression
7. White ego-ideal
8. Inclined to gamble
9. Magical thinking
10. Inclined to alcoholism
11. Unconsciously resentful and antisocial
12. Weak superego development
13. Disorderly, unsystematic
14. Sexual freedom

15. Reject education
16. Poor discipline in childhood
17. Maternal neglect & rejection
18. Little respect for parents
19. Psychologically crippled
20. Distrustful
21. Live for the moment
22. Hedonistic

Doob (1965) states that these formulations are intended to describe a model personality pattern in terms of which the entire African-American group is to be understood. Such dribble is unethical nonsense. Lauretta Bender (1939) wrote that characteristic traits in African-American children such as laziness and the ability to dance are a reflection of specific brain-impulse tendencies. There are many other examples of paternalistic, ethnocentric, irrational, racist and unscientific statements about Afro-Americans that appear in the literature. These negative attitudes about African-Americans leads to the unconscious [and sometime conscious] racial stereotypes in the material produced concerning African-Americans that is the greatest threat to real understanding and effective psychotherapeutic interaction in the white therapist/Black client diad. Hollingshead and Redlich (1958) demonstrated the tendency of white middle-class therapists to discriminate against members of minority groups and the poor. A study by Yamamoto, James, Bloombaum, and Hatten (1967) states that Africa-Americans who seek mental health services in a clinic staffed by white professionals are less likely to receive dynamic individual or group psychotherapy, are seen for fewer sessions, and have higher attrition rates than white clients. These authors stated that there is a positive relationship existing between therapist ethnocentricity and African-American attrition rates. Failures in such settings are often attributed to "resistance" on the part of the Black clients or, simply, their inability to profit from insight oriented psycho-therapy.

White Therapist/Black Male Situation — Challenges and Pitfalls

Pugh (1972) states that the history of race relations in the United States has so sensitized us all that the initial phases of any interracial relationship between strangers is likely to be characterized by cautious attempts by each party to discern gross or subtle indications of the racial attitudes of the other. Both parties, so engaged, on the basis of what is perceived or fantasized, adjusts his/her behavior in such a way as to minimize vulnerability and maximize the ability to cope. Curry (1964) states that when the therapist is white and the client is African-American due consideration must be given the complicating aspects of culturally conditioned interaction tendencies that will influence **transference** and **countertransference** phenomena, but, are actually independent of them.

Where the white therapist is inclined to deal with personal conflict through defensive flight and avoidance, the African-American client who stirs up unconscious racial attitudes in him/her is likely to be rejected either through referral to another therapist or through the use of more impersonal treatment procedures such as **drug therapy.** The white therapist might also resort to defensive denial, failing to recognize and deal not only with his/her own racial feelings, but also with those of his/her African-American client.

In the African-American/white therapist diad very often the therapist tends to ward off his/her own racial hostility and conflict by employing very strong reaction formation. For example, the white therapist becomes over sympathetic and overindulgent-trying to conceal feelings of guilt about his/her racial attitudes, (Adams, 1950). Another defensive maneuver is to overlook severe psychopathology in his/her African-American clients (Grier & Cobbs, 1968).

Initially, the African-American client approaching a white therapist experiences

considerable anxiety about racial differences (Kennedy, 1952). In psychoanalytic psychotherapy there must be anxiety (psychic pain) in order for any significant "movement" to take place. The literature is replete with studies about the "failure" of African-American clients in psychotherapy. Reading about the "resistance" of African-Americans patients you will discover such descriptive terms as, fear, suspicion, verbal constriction, strained and unnatural reactions, less verbal facility, (Calnek, 1970). The fact is, African-American clients in the beginning stages of psychotherapy with a white therapist with test him to determine to what degree, if any, is he accepted as a human being and is free to express feelings that might make him vulnerable to rejection, insult and humiliation. Consequently, establishing rapport can take much longer (if it is ever established) than it would if the two people in the diad were white. Failure to recognize this has resulted in volumes that tell how difficult it is to establish a working alliance with African-Americans. Another defensive maneuver of some African-American clients is avoid expressing (repression) his/her resentment of the discrimination to which s/he is subjected in order to avoid alienating his white therapist, (Sattler, 1970).

There, obviously, can be other therapeutic issues of African-Americans that need to be addressed. However, effective psychotherapy with African-American clients requires dealing the very intense feelings about race and experiences of discrimination. The goal for the white therapist is not to "treat the Black Problem," but, rather to assess the client and address all of his/her issues. The background against which the behaviors of African-Americans takes place is racism and/or sexism and all of the issues related thereto must be dealt with if the psychotherapy is to be effective. Some of those issues are: (Ivey, A. E., Ivey, M. B. & Simek-Morgan, L., 1993)

1. **Worldview**. The way the therapist and his/her clients make sense of things depends upon the therapist's way of making meaning in the world. Each individual makes unique meanings, but those meanings also have universal human qualities.
2. **Cultural Intentionality**. Although we are all unique humans, we are also influenced by multicultural factors. It is critical that as a therapist you develop awareness in yourself and others of how issues such as race/ethnicity, culture, and gender affect the way you and your clients construct meaning in the world.
3. **The Scientist-Practitioner**. Counseling and psychotherapy are based in scientific study. it is our task as responsible clinicians and counselors to draw upon research as we plan our interventions.
4. **Ethics**. All our helping interventions rest on a moral base. As a therapist/ counselor, you will be constantly called upon to make ethical decisions. Effective practice is ethical practice. What is good mental health for the oppressor could not possibly be good mental health for the oppressed. It follows, logically, that theories designed to explain the behavior of Euro-Americans can not be used to explain the behavior of African Americans and other people of African descent.

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FOR KIDS' SAKE

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We are pleased to continue this column, begun by Robert J. Resnick, Ph.D. to focus on the needs of children and the therapists who work with them. The column will expand from twice annually to every issue of the *Bulletin*. Upcoming articles will look at several empirically supported treatment programs for children and adolescents and discuss the application of these treatments in practice. This column describes Parent-Child Interaction Therapy and its application to the field of child abuse.

Parent-Child Interaction Therapy: Applications in the Field of Child Abuse

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Parent-Child Interaction Therapy (PCIT) has been shown, through extensive evaluation, to be an effective therapy for families of young children with active behavior problems such as Oppositional Defiant Disorder (Eyberg & Boggs, 1998; Brestan & Eyberg, 1998). PCIT is a parent-training approach that combines elements of play therapy, social learning theory, and family systems approaches. Parents are directly coached as they play with their child in this two-stage treatment model that requires an average of 12–13 weekly sessions. The treatment ideally involves the use of a "bug in ear" microphone and a one-way mirror, with the therapist coaching the parent from behind the mirror, although in-room coaching is used when the special equipment is not available. The first phase of PCIT teaches parents a set of skills designed to enhance the parent-child relationship by having the parent attend to the child in a positive fashion. The second phase of PCIT involves coaching parents in a set of skills designed to increase the consistency and effectiveness of discipline, while continuing the development of the relationship-enhancing skills introduced in the first half of treatment. PCIT was developed with a commitment to evaluation and assessment, and numerous published reports are available (Brestan & Eyberg, 1998). The effectiveness of PCIT has been demonstrated in terms of reductions in child behavior problems, often to within the normal range on various standard measures and in terms of changes in parents' interaction style (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998; Eisenstadt et al., 1993). Generalization into the home and school settings have been shown (Zangwill, 1983; McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991) and maintenance of treatment effects up to six years post intervention (Edwards, et al., 2001) offer exciting support for this short-term therapy. At the 1st Annual Parent-Child Interaction Therapy Conference in May 2000, PCIT practitioners and researchers from all parts of the U.S. and as far away as Australia gathered at the University of California – Davis Medical Center to share research findings and clinical insights.

Several researchers have begun to evaluate the effectiveness of PCIT with the population

of physically abused children (Borrego, Urquiza, Rasmussen, & Zebell, 1999; Balachova, Chaffin, Funderburk, Valle, & Brestan, 2000). Chaffin offers a coherent rationale for applying behavioral parent training, a treatment designed to modify disordered child behavior by changing parents' behavior, to the physical abuse population where changing the parent's behavior is the primary goal rather than an intermediate step to reducing child behavior problems (Chaffin, 2000). The children of physically abusive parents do not necessarily exhibit behavior problems, but these children nevertheless tend to be perceived by the parents in a very negative fashion, and positive parent-child interactions tend to be limited or nonexistent (Urquiza & McNeil, 1996). Chaffin notes that, because physically abusive parents tend to perceive their child negatively, they may be more receptive to a treatment program that offers effective child management strategies.

As therapists experienced in PCIT are all aware, live coaching of parents with limited child management skills as they attempt to direct very young children with seemingly unlimited potential for inventive misbehavior is not for the faint-hearted. In early discipline sessions the hallways may ring with the howls of a four-year-old's protests as the parent is coached through the process of having the child clean up toys. The therapist endeavors to stay one step ahead of the action, directing the parent with explicit instructions ("Watch out, he's going to throw the block. Duck. Good. Now calmly tell him to put the block in your hand. That's right; keep your voice calm. There, he did it. Now praise him for minding.") as the child and parent together learn the steps of consistent discipline.

This "hands on" approach appears uniquely effective for parents with limited cognitive resources or psychological sophistication. The short-term nature of the treatment is vital for families in chronic stress who are poor candidates for long-term therapy and families who are restricted by managed care or DHS treatment plans to a limited number of sessions or a short duration of treatment. On the other hand, the task of coaching discipline in vivo with a parent with a documented history of poor anger control in the realm of child management must be approached with extreme caution. In traditional PCIT, the therapist will often set up mildly frustrating experiences for the child (e.g., switching from a preferred toy to a less preferred toy or to cleanup) in order to provide opportunities for parents to practice discipline strategies with the therapist's guidance. With a physically abusive parent of a non-behavior disordered child, the same frustrating situation might be coached to facilitate a parent's recognition and validation of the child's feelings rather than as a situation requiring discipline strategies to obtain compliance. With physically abusive families, therapists use more modeling, guided rehearsal and role playing as opposed to relying exclusively on live coaching to impart discipline skills, taking a slower but less hazardous path to skill development. Urquiza's group at UC-Davis has taken the innovative approach of using "Mr. Bear," a large stuffed bear on whom the child and parent take turns role-playing discipline scenarios. Just as in PCIT with non-abusive families, a primary goal of discipline training is to have the parent over-learn the steps of consistent, modulated discipline so that they will be likely to automatically rely on these skills during moments of stress.

A hallmark of PCIT is its emphasis on relationship enhancement through training the parent in a set of "PRIDE" skills, a mnemonic for **p**raise, **r**eflective listening, **i**mitation of the child's play, **d**escription of the child's appropriate play, and **e**nthusiasm or genuineness. In practice with families with a history of physical abuse, more

sessions often need to be devoted to developing PRIDE skills than for non-abusive families. Physically abusive parents tend to have overly negative perceptions of their child, seeing the child as one who requires more harsh discipline than other children. Parents often need to be taught about normal child development to begin to realize, for example, that all two year olds can be oppositional or all four year olds can be overly boisterous, etc. On the other hand, when children are in foster care, fewer sessions of the first phase of PCIT may be required because some foster parents already practice many of the PRIDE skills or master them rapidly.

I assumed when I began working with families referred for physical abuse that treatment would be court-ordered. In fact, cases are often closed when the parent agrees to *begin* treatment, with no one monitoring whether they actually follow through, much less benefit from therapy. Families are frequently unmotivated for treatment and angry at "the system," which in their mind may include me, and almost uniformly are struggling with severe economic and psychosocial stress. Not surprisingly, the dropout rate among this population is quite high in standard parenting treatment groups. Preliminary results indicate a lower dropout rate than more traditional parenting groups for physically abusive parents, perhaps due to the concrete nature of the treatment. In addition to receiving support and encouragement from the therapist, parents get to experience tangible evidence of their increasing competence as their children respond with expressions of affection and increased cooperation.

In summary, PCIT is a rewarding and challenging avenue through which to approach the daunting task of improving parenting in physically abusive families. Initial findings provide promising findings in terms of reductions in reported child behavior problems on the Behavior Assessment Scale for Children and the Eyberg Child Behavior Inventory and reductions on the Child Abuse Potential Inventory and the Parenting Stress Index (Chaffin, personal communication; Urquiza et. al., 2000). More data with larger samples is needed, and the ultimate test of treatment utility will be the rate of subsequent reports of abuse in these families. But for now it appears that this empirically supported treatment for young children with conduct disorders has promising applications in the field of physical abuse.

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NOVEMBER, 2000

DEAR COLLEAGUES:

OUR DIVISION IS PEASED TO MAKE AVAILABLE TO ALL OUR MEMBERS, WITHOUT CHARGE, *ELDER ABUSE and NEGLECT: SEARCH of SOLUTIONS (See insert)*. THIS EXCELLENT BROCHURE PREPARED BY THE PUBLIC INTEREST DIRECTORATE OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, HAS RELEVANCE FOR PSYCHOLOGISTS WHO ARE WORKING WITH OLDER ADULTS AND THEIR FAMILIES.

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ELDER ABUSE AND NEGLECT

IN SEARCH OF SOLUTIONS

"Every person—every man, woman, and child—deserves to be treated with respect and with caring."

"Every person—no matter how young or how old—deserves to be safe from harm by those who live with them, care for them, or come in day-to-day contact with them."

Older people today are more visible, more active, and more independent than ever before. They are living longer and in better health. But as the population of older Americans grows, so does the hidden problem of elder abuse, exploitation, and neglect..

Every year an estimated 2.1 million older Americans are victims of physical, psychological, or other forms of abuse and neglect. Those statistics may not tell the whole story. For every case of elder abuse and neglect that is reported to authorities, experts estimate that there may be as many as five cases that have not been reported. Recent research suggests that elders who have been abused tend to die earlier than those who are not abused, even in the absence of chronic conditions or life threatening disease.

Agnes, 85 years old, lost her husband last year. Because of her own problems with arthritis and congestive heart failure, Agnes moved in with her 55-year-old daughter, Emily. The situation is difficult for all of them. Sometimes Emily feels as if she's at the end of her rope, caring for her mother, worrying about her college-age son and about her husband, who is about to be forced into early retirement. Emily has caught herself calling her mother names and accusing her mother of ruining her life. Recently, she lost her temper and slapped her mother. In addition to feeling frightened and isolated, Agnes feels trapped and worthless.

Like other forms of abuse, elder abuse is a complex problem, and it is easy for people to have misconceptions about it. Many people who hear "elder abuse and neglect" think about older people living in nursing homes or about elderly relatives who live all alone and never have visitors. But elder abuse is not just a problem of older people living on the margins of our everyday life. It is right in our midst:

- Most incidents of elder abuse don't happen in a nursing home. Occasionally, there are shocking reports of nursing home residents who are mistreated by the staff. Such abuse does occur—but it is not the most common type of elder abuse. At any one time, only about 4 percent of older adults live in nursing homes, and the vast majority of nursing home residents have their physical needs met without experiencing abuse or neglect.
- Most elder abuse and neglect takes place at home. The great majority of older people live on their own or with their spouses, children, siblings, or other relatives—not in institutional settings. When elder abuse happens, family, other household members, and paid caregivers usually are the abusers. Although there are extreme cases of elder abuse, often the abuse is subtle, and the distinction between normal interpersonal stress and abuse is not always easy to discern.

- There is no single pattern of elder abuse in the home. Sometimes the abuse is a continuation of long-standing patterns of physical or emotional abuse within the family. Perhaps, more commonly, the abuse is related to changes in living situations and relationships brought about by the older person's growing frailty and dependence on others for companionship and for meeting basic needs.
- It isn't just infirm or mentally impaired elderly people who are vulnerable to abuse. Elders who are ill, frail, disabled, mentally impaired, or depressed are at greater risk of abuse, but even those who do not have these obvious risk factors can find themselves in abusive situations and relationships.

Elder abuse, like other forms of violence, is never an acceptable response to any problem or situation, however stressful. Effective interventions can prevent or stop elder abuse. By increasing awareness among physicians, mental health professionals, home health care workers, and others who provide services to the elderly and family members, patterns of abuse or neglect can be broken, and both the abused person and the abuser can receive needed help.

What Is Elder Abuse?

Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult. Elder abuse also can take the form of financial exploitation or intentional or unintentional neglect of an older adult by the caregiver.

- Physical abuse can range from slapping or shoving to severe beatings and restraining with ropes or chains. When a caregiver or other person uses enough force to cause unnecessary pain or injury, even if the reason is to help the older person, the behavior can be regarded as abusive. Physical abuse can include hitting, beating, pushing, kicking, pinching, burning, or biting. It can also include such acts against the older person as over- or under-medicating, depriving the elder of food, or exposing the person to severe weather—deliberately or inadvertently.
- Emotional or psychological abuse can range from name-calling or giving the "silent treatment" to intimidating and threatening the individual. When a family member, a caregiver, or other person behaves in a way that causes fear, mental anguish, and emotional pain or distress, the behavior can be regarded as abusive. Emotional and psychological abuse can include insults and threats. It can also include treating the older person like a child and isolating the person from family, friends, and regular activities—either by force or threats or through manipulation.
- Caregiver neglect can range from caregiving strategies that withhold appropriate attention from the individual to intentionally failing to meet the physical, social, or emotional needs of the older person. Neglect can include failure to provide food, water, clothing, medications, and assistance with the activities of daily living or help with personal hygiene. If the caregiver has responsibility for paying bills for the older person, neglect also can include failure to pay the bills or to manage the elder person's money responsibly.

Madeline is 75 and suffers from congestive heart failure. She lives alone, with home health nurses and nurses' aides coming in daily to provide nursing care and personal assistance. She depends on the home health agency's personal assistant to help her with the routine tasks around the house and to provide interaction with someone from the

outside world. At first, the assistant was sweet to Madeline, but lately, the assistant has started ignoring Madeline's requests, snapping at her, and bumping into her with the vacuum cleaner or dusting brush while cleaning. Madeline thinks the assistant is bumping her on purpose, but she doesn't know for sure, and she's afraid to confront her.

- Sexual abuse can range from sexual exhibition to rape. Sexual abuse can include inappropriate touching, photographing the person in suggestive poses, forcing the person to look at pornography, forcing sexual contact with a third party, or any unwanted sexualized behavior. It also includes rape, sodomy, or coerced nudity. Sexual abuse is not often reported as a type of elder abuse.
- Financial exploitation can range from misuse of an elder's funds to embezzlement. Financial exploitation includes fraud, taking money under false pretenses, forgery, forced property transfers, purchasing expensive items with the older person's money without the older person's knowledge or permission, or denying the older person access to his or her own funds or home. It includes the improper use of legal guardianship arrangements, powers of attorney, or conservatorships. It also includes a variety of scams perpetrated by sales people for health-related services, mortgage companies, and financial managers—or even by so-called friends.

Sometimes older adults harm themselves through self-neglect (e.g., not eating, not going to the doctor for needed care) or because of alcohol or drug abuse. In this pamphlet, the focus is on elder abuse that is perpetrated by others. However, one of the most difficult problems family members face is achieving a balance between respecting an older adult's autonomy and intervening before self-neglect becomes dangerous.

Older adults who show signs of dementia may become abusive as part of the disease process, and the object of the abuse may be another older adult, for example, a spouse who is caring for the impaired elder. The abuse may take the form of hitting or gripping the caregiver to the extent of causing bruises, or creating hazards such as setting furniture on fire. Although the behavior can be explained by the impairment, it is still unacceptable.

Importantly, while abuse comes in many guises, the net effect is the same. Abuse creates potentially dangerous situations and feelings of worthlessness, and it isolates the older person from people who can help.

Cues That Cannot Be Explained Medically May Signal Elder Abuse

Many of the symptoms listed below can occur as a result of disease conditions or medications. The appearance of these symptoms should prompt further investigation to determine and remedy the cause.

Physical Abuse

- Bruises or grip marks around the arms or neck
- Rope marks or welts on the wrists and/or ankles
- Repeated unexplained injuries
- Dismissive attitude or statements about injuries
- Refusal to go to same emergency department for repeated injuries

Emotional/Psychological Abuse

- Uncommunicative and unresponsive
- Unreasonably fearful or suspicious
- Lack of interest in social contacts
- Chronic physical or psychiatric health problems
- Evasiveness

Sexual Abuse

- Unexplained vaginal or anal bleeding
- Torn or bloody underwear
- Bruised breasts
- Venereal diseases or vaginal infections

Financial Abuse or Exploitation

- Life circumstances don't match with the size of the estate
- Large withdrawals from bank accounts, switching accounts, unusual ATM activity
- Signatures on checks don't match elder's signature

Neglect

- Sunken eyes or loss of weight
- Extreme thirst
- Bed sores

Why Does Elder Abuse Happen?
There is no one explanation for elder abuse and neglect. Elder abuse is a complex problem that can emerge from several different causes, and that often has roots in multiple factors. These factors include family situations, caregiver issues, and cultural issues.

Family Situations and Elder Abuse
Family situations that can contribute to elder abuse include discord in the family created by the older person's presence, a history and pattern of violent interactions within the family, social isolation or the stresses on one or more family members who care for the older adult, and lack of knowledge or caregiving skills.

Intergenerational and marital violence can persist into old age and become factors in elder abuse. In some instances, elder abuse is simply a continuation of abuse that has been occurring in the family over many years. If a woman has been abused during a 50-year marriage, she is not likely to report abuse when she is very old and in poor health.

Sometimes, a woman who has been abused for years may turn her rage on her husband when his health fails. If there has been a history of violence in the family, an adult child may take the opportunity to "turn the tables" on the abusing parent by withholding nourishment or by overmedicating the parent. But that doesn't have to be the case—many adult children who were badly treated by their parents become attentive caregivers.

Family stress is another factor that can trigger elder abuse. When a frail or disabled older parent moves into a family member's home, the lifestyle adjustments and accommodations can be staggering.

In some instances, the financial burdens of paying for health care for an aging parent or living in overcrowded quarters can lead to stress that can trigger elder abuse. Such a situation can be especially difficult when the adult child has no financial resources other than those of the aging parent.

Sometimes, there may be marital stress between an older couple when they must share a home with their adult children. Or, the new living arrangements could cause tension between an adult child and his or her spouse. When problems and stress mount, the potential for abuse or neglect increases.

Social isolation can provide a clue that a family may be in trouble, and it also can be a risk factor for abuse. Social isolation can be a strategy for keeping abuse secret, or it can be a result of the stresses of caring for a dependent older family member. Isolation is dangerous because it cuts off family members from outside help and support they need to cope with the stresses of caregiving. Isolation also makes it harder for outsiders to see and intervene in a volatile

or abusive situation to protect the older person and to offer help to the abuser.

Caregiver Issues and Elder Abuse
Personal problems of the caregiver that can lead to abusing a frail older person include caregiver stress, mental or emotional illness, addiction to alcohol or other drugs, job loss or other personal crises, financial dependency on the older person, a tendency to use violence to solve problems. Sometimes the person being cared for may be physically abusive to the caregiver, especially when the older person has Alzheimer's or another form of dementia.

Caregiver stress is a significant risk factor for abuse and neglect. When caregivers are thrust into the demands of daily care for an elder without appropriate training and without information about how to balance the needs of the older person with their own needs, they frequently experience intense frustration and anger that can lead to a range of abusive behaviors.

The risk of elder abuse becomes even greater when the caregiver is responsible for an older person who is sick or is physically or mentally impaired. Caregivers in such stressful situations often feel trapped and hopeless and are unaware of available resources and assistance. If they have no skills for managing difficult behaviors, caregivers can find themselves using physical force. Particularly with a lack of resources, neglectful situations can arise.

Sometimes the caregiver's own self-image as a "dutiful child" may compound the problem by causing them to feel that the older person deserves and wants only their care, and that considering respite or residential care is a betrayal of the older person's trust.

Dependency is a contributing factor in elder abuse. When the caregiver is dependent financially on an impaired older person, there may be financial exploitation or abuse. When the reverse is true, and the impaired older person is completely dependent on the caregiver, the caregiver may experience resentment that leads to abusive behavior.

James is a financially secure 90-year-old man who has been healthy and active until the last year. He has finally agreed to move in with his oldest daughter, Lorraine, who now believes her father "owes her" more of his money than her brother and two sisters are entitled to. She talks her father into giving her power of attorney for his bank accounts "as a convenience," then writes herself large checks that she tells herself are for "expenses." Soon she has come up with excuses to transfer a significant portion of his investment holdings into her name. James has no energy to oversee his finances and is totally trusting that his daughter has his best interests at heart.

Emotional and psychological problems of the caregiver can put the caregiver at risk for abusing an older person in their care. A caregiver who is addicted to drugs or alcohol is more likely to become an abuser than one who does not have these problems. Indeed, caregiving can lead to greater use of alcohol, in an attempt to mange stress. Also, a caregiver with an emotional or personality disorder may be unable to control his or her impulses when feeling angry or resentful of the older person.

Cultural Issues and Elder Abuse
Certain societal attitudes make it easier for abuse to continue without detection or intervention. These factors include the devaluation and lack of respect for older adults and society's belief that what goes on in the home is a private, "family matter." Certain cultural factors, such as language barriers, make some situations more difficult to distinguish from abuse or neglect, and it is important not to ignore abuse by attributing the cause to cultural

differences. However, before reporting abuse, anyone working with older people should be sensitive to cultural differences and not mistake these for abuse or neglect. Definitions of what is considered "abuse" varies across diverse cultural and ethnic communities.

Lack of respect for the elderly may contribute to violence against older people. When older people are regarded as disposable, society fails to recognize the importance of assuring dignified, supportive, and nonabusive life circumstances for every older person.

The idea that what happens at home is "private" can be a major factor in keeping an older person locked in an abusive situation. Those outside the family who observe or suspect abuse or neglect may fail to intervene because they believe "it's a family problem and none of my business" or because they are afraid they are misinterpreting a private quarrel. Shame and embarrassment often make it difficult for older persons to reveal abuse. They don't want others to know that such events occur in their families.

Religious or ethical belief systems sometimes allow for mistreatment of family members, especially women. Those who participate in these behaviors do not consider them abusive. In some cultures, women's basic rights are not honored, and older women in these cultures may not realize they are being abused. They probably could not call for help outside the family and may not even know that help is available.

How Can We Prevent Elder Abuse?

The first and most important step toward preventing elder abuse is to recognize that no one—of whatever age—should be subjected to violent, abusive, humiliating, or neglectful behavior. In addition to promoting this social attitude, positive steps include educating people about elder abuse, increasing the availability of respite care, promoting increased social contact and support for families with dependent older adults, and encouraging counseling and treatment to cope with personal and family problems that contribute to abuse. Violence, abuse, and neglect toward elders are signs that the people involved need help—immediately.

Education is the cornerstone of preventing elder abuse. Media coverage of abuse in nursing homes has made the public knowledgeable about—and outraged against—abusive treatment in those settings. Because most abuse occurs in the home by family members or caregivers, there needs to be a concerted effort to educate the public about the special needs and problems of the elderly and about the risk factors for abuse.

Respite care—having someone else care for the elder, even for a few hours each week—is essential in reducing caregiver stress, a major contributing factor in elder abuse. Every caregiver needs time alone, free from the worry and responsibility of looking after someone else's needs. Respite care is especially important for caregivers of people suffering from Alzheimer's or other forms of dementia or of elders who are severely disabled.

Social contact and support can be a boon to the elderly and to the family members and caregivers as well. When other people are part of the social circle, tensions are less likely to reach unmanageable levels. Having other people to talk to is an important part of relieving tensions. Many times, families in similar circumstances can band together to share solutions and provide informal respite for each other. In addition, when there is a larger social circle, abuse is less likely to go unnoticed. Isolation of elders increases the probability of abuse, and it may even be a sign that abuse is occurring. Sometimes abusers will threaten to keep people away from the older person.

Counseling for behavioral or personal problems in the family can play a significant role in helping people change lifelong patterns of behavior or find solutions to problems emerging from current stresses. If there is a substance abuse problem in the family, treatment is the first step in preventing violence against the older family member. In some instances, it may be in the best interest of the older person to move him or her to a different, safer setting. In some cases, a nursing home might be preferable to living with children who are not equipped emotionally or physically to handle the responsibility. Even in situations where it is difficult to tell whether abuse has really occurred, counseling can be helpful in alleviating stress.

What You Can Do About Elder Abuse

If you suspect that an older person is being abused or neglected...

Don't let your fear of meddling in someone else's business stop you from reporting your suspicions. You could be saving someone's life. The reporting agencies in each state are different, but every state has a service designated to receive and investigate allegations of elder abuse and neglect. Even if these agencies determine that there is only potential for abuse, they will make referrals for counseling. (Call the Eldercare locator at 1-800-677-1116.)

Do not put the older person in a more vulnerable position by confronting the abuser yourself unless you have the victim's permission and are in a position to help the victim immediately by moving him or her to a safe place.

If you feel you are being abused or neglected...

Your personal safety is most important. If you can safely talk to someone about the abuse (such as your doctor, a trusted friend, or member of the clergy) who can remove you from the situation or find help for the abuser, do so at once. If your abuser is threatening you with greater abuse if you tell anyone, and if the abuser refuses to leave you alone in a room with others who could help, you are probably afraid to let anyone know what is happening to you. A good strategy is to let your physician know about the abuse. The physician has a legal obligation to report the abuser and to help you find safety.

If you are able to make phone calls, you can call protective services or a trusted friend who can help you find safety and also find help for the person who is abusing you.

If you feel you have been abusive or are in danger of abusing an older person in your care...

There is help available if you have been abusive to an older person or if you feel you want to hurt someone you are caring for. The solution may be to find ways of giving yourself a break and relieving the tension of having total responsibility for an older person who is completely dependent on you. There are many local respite or adult day care programs to help you.

If you recognize that abuse, neglect, or violence is a way you often solve problems, you will need expert help to break old patterns. There is help and hope for you, but you must take the first step as soon as possible. You can learn new ways of relating that are not abusive. You can change. Talk with someone who can help—a trusted friend or family member, a counselor, your pastor, priest, or rabbi. If alcohol or drugs are a problem, consider contacting Alcoholics Anonymous or some other self-help group.

Therapists specialize in helping people change destructive behaviors; to find a competent therapist, ask your physician or your health plan for a recommendation. If you cannot afford private therapy, call your city or state mental health services department to find out what your options are.

The most important thing for you is to be honest—with yourself and with those who want to help you—about your history of violent behavior and about your abusive relationship with the older person. Someone's life—and your own—may depend on it.

Where To Go for Help

National Center on Elder Abuse
1225 Eye Street, NW, Suite 725
Washington, DC 20005
(202) 898-2586
Fax: (202) 898-2583
www.gwjapan.com/NCEA
NCEA is a resource for public and private agencies, professionals, service providers, and individuals interested in elder abuse prevention information, training, technical assistance, and research.

Eldercare Locator is sponsored by the Administration on Aging (AoA). If you know the address and ZIP code of the older person being abused, Eldercare Locator can refer you to the appropriate agency in the area to report the suspected abuse.

1-800-677-1116
Area Agency on Aging
Most states have an information and referral line that can be helpful in locating services for victims or potential perpetrators of elder abuse and neglect. Check your local telephone directory.

Medicaid Fraud Control Units (MFCU)
Each state attorney general's office is required by federal law to have an MFCU that investigates and prosecutes Medicaid provider fraud and patient abuse and neglect in health care programs and home health services that participate in Medicaid.

Adult Protective Services
In many states, Adult Protective Services is designated to receive and investigate allegations of elder abuse and neglect. Every state has some agency that holds that responsibility. It may be the Area Agency on Aging, the Division of Aging, the Department of Aging, or the Department of Social Services.

National Domestic Violence Hotline
The hotline provides support counseling for victims of domestic violence and provides links to 2,500 local support services for abused women. The hotline operates 24 hours a day, every day of the year.
1-800-799-SAFE
TDD 1-800-787-3224

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President-elect, Division 29
4520 Ridgeline Dr.
Norman, OK 73072
diane-willis@ouhsc.edu

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Work Address _____

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City _____

State_____ **ZIP** _____

Telephone _____

E-mail _____

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- **Smoking cessation & treatment approaches**
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ESSAY

Child Maltreatment: *Some Neglected Professional Issues*

T. Richard Saunders, Ph.D.

I read with considerable disgruntlement the article in a recent issue of *Psychotherapy Bulletin* about mandatory child maltreatment reporting (Barnett & Fiorentino, 2000). The good news was that Barnett and Fiorentino focused the attention of Division of Psychotherapy members on this very difficult problem. It is easy to associate ourselves with such statements as, "...suspected abuse or neglect of minors presents a number of significant challenges for psychotherapists," and "...thorough knowledge of one's relevant state laws and regulations is a requirement" (Barnett & Fiorentino, 2000, p. 27). Unfortunately, the bad news is that Barnett and Fiorentino mention, but do not elaborate sufficiently, the chief sources of the problem, or the necessary means for addressing those sources.

From my perspective, having been a consultant for years on literally hundreds of cases of child maltreatment, suspected and proven, including many alleged perpetrators as well as victims and other family members, the chief problems in this field are the flawed child maltreatment statutes, the failed enforcement mechanisms behind them, and other matters that are essentially public policy. I believe that by focusing on reporting decisions by psychologists, Barnett and Fiorentino emphasize the wrong solution, for the wrong audience, at the wrong time.

Although I wish to be brief, I think it is vital to illustrate these points with a couple of specific examples, one from the public media and the other from my own practice. To their credit, Barnett and Fiorentino do mention the difficulties involved in the statutes and in the enforcement mechanisms in each state. Like the recent federal election and voting problems in Florida, however, the anecdotal evidence is that political appointees and elected officials only recognize these issues and address them with proper resources after the fact, after the harm has been done.

Briefly stated, the issues are these: despite the cumulative presence of millions of reports of child maltreatment, and the cumulative experience over many years since the original statutes concerning (then) physical maltreatment were enacted, the fundamental concept of the reporting statutes has not been re-examined, the "threshold" problem of when to report has never been addressed, investigative processes have never been made uniform, and there are few if any standardized methods agreed to for follow-up of child maltreatment reporting.

This situation has proceeded unchecked for years, while the "law" on child maltreatment has expanded apace. The statutes now include various forms of abuse, several of which are not satisfactorily defined in behavior. Professional publications on this topic (e.g.,Haugaard, 2000, p. 1038) leave little doubt about the source of the problem, and it is political, not professional. Like the issue of whether or not controlled drinking is a viable goal for a substance abuse program, we have the dilemma that the professional literature says one thing, and the political forces say something else.

Often, the people suffering from this reign of confusion and political foolishness are maltreated children, not psychotherapists. "Child advocates" gain great credence from political figures, many of whom wish to pose as friends of "the family," or of the downtrodden, as a part of their cynical efforts at self-advancement. Though for the sake of discussion I will not cite any of these individuals here, some of them have been featured in the pages of American Psychologist.

Protests from the field about child reporting laws are also nothing new. According to Lenore Walker (1990), when she chaired an APA Committee on this topic several years ago, many psychologists from a number of different perspectives agreed that the system erected around child maltreatment reporting is badly flawed, unnecessarily destructive of the psychological assessment and treatment process, and insufficiently attentive to the needs of children. To be able to adjudicate efficiently, guidance is needed for all the professionals involved, with regard to what the core issues are in any maltreating or suspected maltreating family, and what the range of interventions are which are likely, or at least possibly, effective. Instead, many cases drag on interminably, using "best evidence" that is often grossly flawed and marginally reliable, much less valid.

Furthermore, "reports" are often generated by motivated parties, who may have vengeful or economic reasons for reporting, or else they originate from mandatory reporting sources, such as psychotherapists, who may either knowingly or unknowingly collude with these parties to make reports that are intended to harm people around these children, not protect them. How often these tainted reports happen, of course, is a matter of speculation. However, I can say with certainty that in my own full-time practice, though it may not be representative because I am known in the professional community as a child and adolescent therapist as well as a frequent consultant on child maltreatment issues, reporting questions arise every week, if not every day.

Systemic Flaws

There could hardly be a better example of systemic failure than the recently reported (Higham & Horwitz, 2000) case of Brianna Blackmond. According to the Washington Post, the facts are pretty straightforward. Brianna, then age 23 months, and her sister were returned to their mentally retarded mother on Christmas Eve of 1999 in the District of Columbia, after a hearing before Judge Evelyn Queen of the Superior Court. Within a few days of that return, Brianna was killed under circumstances that are not yet adjudicated, by one of her caretakers. Her mother as well as another woman are criminally charged in the matter.

At the hearing, again according to press reports, the attorney representing Brianna's mother allegedly made false statements to the judge, indicating that both the Department of Social Services case worker and the attorney for the children had consented to the childrens' return. That attorney is reportedly facing disbarment by the District of Columbia governing body with jurisdiction over lawyers. Supposedly, the case worker failed to file a timely report on the case, a common occurrence in the District, where workers are overwhelmed with their case loads and often cannot keep up with the flow of mandatory paperwork in child maltreatment cases (Higham & Horwitz, p. 12).

Apart from the tragic destruction of an innocent life, for a child who had earlier benefited from a very satisfactory foster care placement, I for one was grateful that no psychologist had been asked to examine the mother, because of the possible influence of the APA "Guidelines" for child maltreatment examinations, which most assuredly could have been used to blame that individual (Saunders, Walker, & Bloch, 1997) as well.

I notice, for example, that there is no disbarment proposed or likely possible for Judge Queen, nor is there any attempt to sanction her judicially by her colleagues for failing to ascertain the truth or completeness of the representations made to her. No criminal conspiracy or related charges were placed against any of the other adult parties, nor has there been any serious action yet about identifying and correcting the systemic issues (lack of criteria and procedures, overwork, high case loads, case management weaknesses, etc.) that preceded and indirectly, at least, "caused" this tragedy to occur.

The point of this example is that we live in a society and a culture that says it values children, but tolerates incompetent, irresponsible, and destructive behavior, not just from professionals in and out of law with responsibility for protecting children, but also from their parents and other adults with a family obligation to those children. It is this lip service and systemic failure that Barnett and Fiorentino ignore, and that I think is at the heart of what psychologists in every state, and in every clinically oriented Division of APA, should be actively working to correct.

The statutory problem of reporting threshold is a real and serious one, as we shall see from my second example.However, Brianna's case illustrates the lack of seriousness with which officials sometimes (or often!) view child maltreatment— whether it is reported or not, confirmed or not, repeated or not, and serious or not. That the consequences can be deadly is undisputed.

I believe that it is here we need to concentrate the resources of professional advocacy in psychology: psychologists need to develop improved procedures for initial intervention, family and child assessment, treatment, and prevention of reinjury. We should not be concentrating our resources on other psychologists; we need to be advocating that an indifferent and at least sometimes incompetent system be required to identify and protect youngsters who are truly at risk. We can and should be spared petty value judgments about whether and which forms of child discipline are reportable, while concentrating on what forms of child discipline work, and what features of parenting contribute to healthy child development.

The Reporting Fiasco

I recall seeing a 35-year old man years ago, who had a lengthy history of substance abuse (prescription pain killers and marijuana, mostly), a mildly retarded spouse, and four dependent children ranging in age from 12 to 4. The youngest child had been identified as a Pervasive Developmental Disorder at an urban teaching hospital. The father's initial clinical presentation was depression, and he made fairly rapid progress in treatment, as he identified and rectified many of the sources of his mood problems. He was able to decrease his drug dependency markedly, with careful follow up in a collateral specialized drug treatment unit, with which the therapist collaborated.

That left the problem of the spouse and the children. As the patient arrived unilaterally at the conclusion that he was going to divorce, he ran afoul of Maryland law, which stipulates a 2-year waiting period when there is no agreement between the spouses, and a 1-year period if there is an agreement. However, spouses who have responsibility for children are eligible for child support payments and "use and possession" of the former marital home, for up to 3 years post-divorce. But, one party has to initiate the waiting period by leaving the home, and that party is usually in practice disadvantaged with respect to custody, visitation, and financial arrangements.

How to remove the unwanted spouse, gain the house, and start the waiting period, all at one swoop, without further ado? Why, use the child abuse reporting statute invoked at the next "accidental" injury with child manipulation, have the "offend-

ing" parent accused and removed during the investigative period, and file for divorce, all at the same time. Then, hopefully (from the point of view of the motivated reporter) the investigation of child maltreatment will be sufficiently confirmed or ambiguous, so the offending party cannot return to the home. A clever spouse can also claim "domestic violence" if a fight occurs, and then in Maryland, sole possession of the home and temporary custody of the children can also be gained, without significant attorney fees. The possible link between domestic violence and child-directed violence can be noted, and the motivated reporter is well on his way to accomplishing all his (divorce and monetary) goals.

All this was advised the patient by a resourceful attorney, and most of what is described above occurred, except that the trial judge (a lower court under Maryland law) dismissed the domestic violence part of the case, but still maintained an order to the spouse not to return home until the child abuse charge was fully resolved. This could not occur for quite some time, and in the meantime, the divorce case proceeded.

An even more clever ploy in this type case is to create circumstances in which a therapist must report the child abuse. This from an attorney's standpoint has the advantage that a third party, not the principle in the case, has affirmatively acted in "the best interest of the child," and made a report with some (uncertain) level of "suspicion." In this writer's experience, this "suspicion" can consist of a single session with a therapist, in which a parent reports something allegedly said by a child outside the hearing of the therapist, which (to the parent) suggests abuse.

This can be as little as a statement such as, "Mommy hit me," or "Daddy touched me," perhaps accompanied by some indication of a physical injury or sexual contact. In Maryland law, all this is conceivably "reportable" as child maltreatment, no matter how contrived the circumstances.

As Barnett and Fiorentino (2000, p. 28) note in their article, the so-called "reporting decisions" under scenarios like these are essentially impossible to resolve. I regard them as statutorially imposed, irrational maneuvers that lack even a shred of common sense, much less any cause for obedience. Indeed, I would argue that under many readily conceivable circumstances, rational adherence is impossible. Despite this fact, the Maryland Board of Examiners, for example, states as one of its most frequent causes of actions against psychologists in the reporting period of 1995-2000 (M.Sanzone, personal communication, January 1, 2001) a category that includes child maltreatment reporting nonadherence.

Obviously, this is not an argument for nonreporting of child maltreatment. It is, however, a call for legislation that is truly reasonable and capable of being followed. It is also a call for a system of child justice that works, and works quickly, to protect children without trampling the constitutional rights of parents, and the treatment needs of individual children. This writer objects most strenuously to the tendency for the state to push its way into the consulting room, violate patient privilege and confidentiality with impunity, and impose haphazardly a set of statutes that conceals base political motives and posturing by mountebanks, both within and outside the professions.

I hope that psychological associations and knowledgeable individual psychologists will join with other professions—including law, nursing, social work, pediatrics inter alia—to produce new and more productive child maltreatment statutes, with the needed legal and professional resources to back them with programs both to prevent and control child maltreatment. I am sure that Barnett & Fiorentino, Seth Kalichman, and all other professionals can agree with these goals.

In short, let's stop preaching to the choir and focusing on peripheral details. Let's also stop implicit criticism of psychologists for not complying with vague and unenforceable legislation that encourages deception and false reports, not to mention unconscionable manipulation of children, psychologists, and the courts. We cannot bring Brianna Blackmond back; let's instead work to bring into existence a legal and professional system that preserves confidentiality and assures resources to needy children and their needy parents.

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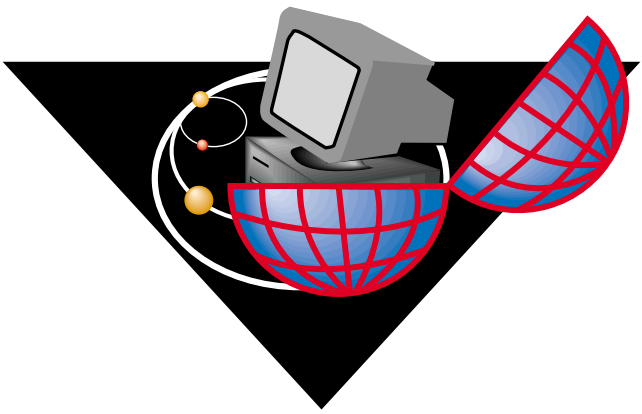

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THERAPEUTIC TOUCH IN PSYCHOTHERAPY

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The author extends her appreciation to Dr. Leon VandeCreek for his mentoring and support during the writing of this article.

Therapeutic Touch in Psychotherapy

Healing touch has been used throughout the ages. However, in the mental health field, the use of touch in psychotherapy is controversial due to the connections between physical contact and sexuality. This article examines the potential dangers and benefits of therapeutic touch as well as guidelines for its effective and ethical use in psychological settings.

Taboo and Nontaboo Touch in Psychotherapy

Smith (1998) contended there are two major forms of touching that are taboo in a professional psychological setting. The first is that of physical contact based on erotic, seductive or sexual interest in a client. The second taboo involves hostile or aggressive touch. Smith further outlined five forms of touch that are not explicitly taboo in a therapeutic setting. The first is that of inadvertent touch which results from a lack of attention or coordination. What is of concern here is the intentionally seductive or hostile therapist whose touch may be disguised to appear accidental. A second touch category is that of markers used during conversation to make a point, or get or maintain someone's attention. A third type of non-taboo touch are socially stereotyped gestures such as handshakes and a greeting embrace. Another type of touch flows from the therapeutic relationship and may involve behaviors such as holding, hugging, and hand holding. Finally, there is touch that is clearly prescribed as a technique with a clearly defined purpose and method.

Countertherapeutic Effects and Contraindications of Touch

An important issue to consider is that touch may bring to the surface and release deep psychic pain before a client (or therapist) is prepared to process it. Thus, language-based inter-ventions may allow more adequate time for developing rapport, trust and a sense of safety in which deeper affect and profound emotional pain can be released and tolerated (Cornell, 1997).

Nowhere are these issues more important than when working with clients whose histories include sexual abuse. As Lawry (1998) stated, assessing whether to use touch with these clients is extremely complicated and is contraindicated in early sessions due to the potential for retraumatization. Hunter and Struve (1998) suggested that touch may also be problematic for other populations such as those who have experienced physical abuse, assault or neglect, those with attachment difficulties, sexual addictions, eating disorders, and intimacy issues among others. For these clients, unsolicited physical contact, contact that remains undiscussed, and possible abuse of power may be particularly damaging due to the recapitulation of childhood dynamics and related feelings (Doverspike, 1999).

In some situations touch should not ordinarily be used regardless of therapist safeguards or practices. According to Durana (1998), touch is usually contraindicated for clients who are paranoid, actively hostile or aggressive, or who implicitly or explicit-

ly demand touch. Hunter and Struve (1998) stated that touch is also inappropriate during the first session, when the client has not asked for physical contact or such contact would not advance therapeutic goals, the therapist is uncomfortable using touch in a therapeutic setting, the therapist or client is sexually aroused due to material that has been discussed, or if time is insufficient to allow for discussing the meaning of the touch for the client.

Cultural Considerations

Power differentials (professional vs. client, male vs. female) must be considered when assessing the usefulness of touch (Hunter & Struve, 1998; Lawry, 1998) due to the potential for touch in a psychotherapeutic setting to recreate previous client-experienced dynamics of submission and victimization, entrapment, anger, fear, vulnerability, and feelings of worthless-ness. An additional consideration in making physical contact with clients is the effect of cultural and subcultural differences on the use and interpretation of touch. As Halbrook and Duplechin (1994) indicated, touch has layers of meaning depending on one's culture, socialization and individual experience. One such example relates to the fact that in the United States nonsexualized touch is rare, especially for men, except prior to puberty. Thus, for men who generally do not give or receive nonsexual touch, regression transference may be elicited by the use of nonerotic touch in psychotherapy. Also affecting the use and interpretation of therapeutic touch is how personal space is defined within a culture. Hence, as Smith (1998) pointed out, a therapist may be seen as "distant, respectful, or invasive" (p. 41) depending on the socialization and experience of the individual client. Because of these considerations professional judgment and caution must be exercised in initiating physical contact with a client.

While there is a growing body of literature on multicultural theory and counseling (Aponte & Wohl, 2000; Sue, Ivey, Pedersen, 1996), very little has been written specifically on the use of touch with ethnically diverse populations. However, one may infer that caution should be exercised in using touch with minorities, especially if the practitioner is a member of the majority population. As a variety of authors point out (Comas-Diaz & Greene, 1994; Greene, 1997; Pedersen, Draguns, Lonner & Trimble, 1996), due to a history of oppression in the United States as well as ongoing racism and discrimination, members of a minority may experience the therapy situation with Caucasian clinicians as a recapitulation of the power differentials extant in society. This is particularly true for male clinicians working with Hispanic and Asian female clients whose cultures reinforce beliefs that women must subjugate themselves to any man in authority (Bradshaw, 1994). It is incumbent that we inform ourselves of a client's cultural context before using a powerful tool such as touch in session.

Therapeutic Uses of Touch

As several authors have noted, touch is critical for human survival and healthy emotional adjustment (Durana, 1998; Hedges, Hilton, Hilton, & Caudill, 1997; Hunter & Struve, 1998). In the therapeutic setting, the responsible use of touch may have positive effects on the therapist-client relationship. For instance, research has shown that clients with whom handshakes, or touches to the arm, shoulder or back were used tended to have a higher opinion of their therapist's expert knowledge and emotional attractiveness, greater trust and sense of bonding with their therapist, tended to self-disclose more, and evaluated therapy more positively (Durana, 1998; Halbrook & Duplechin, 1994; Hunter & Struve, 1998).

There are other purposes for which touch may be used efficaciously. Cornell (1997) noted that "the use of touch will evoke,

address and hopefully help correct such historical experiences and distortions as: deprivation and neglect; overstimulation, intrusion and bodily violation, or sexualization; parental narcissistic use of the child; deadening of vitality and use of the body as an instrument" (p. 33). Thus, ethically used therapeutic touch may have profound healing effects.

Other benefits accrue to therapeutic touch as well. Some of these include providing a link to external reality during times of intense emotional pain, communicating acceptance and esteem which can reduce client feelings of worthlessness or shame, and modeling new ways of relating in which the client can be experienced and valued as a whole person with individual needs (Geib, 1998; Hunter & Struve, 1998). Additionally, defining therapeutic relationship boundaries and limits with a more powerful helper may be therapeutic in and of itself for some clients (Sommers-Flanagan, Elliott, Sommers-Flanagan, 1998).

Decision Rules/Guidelines

When considering the use of touch with an individual client, therapists may consider a number of helpful guidelines. Lawry (1998) cautioned therapists to consider issues related to gender and power dynamics and offers a set of questions therapists can ask themselves, the answers to which may govern the use of therapeutic touch. These questions include:

—How do I personally feel about touch? (Do I have personal issues about touch that need to be resolved prior to initiating touch with clients?)
—Am I sexually attracted to this client?
—What client need is being met by touch and is there any other nonphysical way to effectively meet that need?
—Does my client have sufficient ego strength? (For example, as evidenced by the ability to process interpersonal material in the therapeutic relationship and set limits in relationships with powerful others.)
—What level of dissociation or depersonalization is this client currently experiencing?
—Does this client want sexual gratification from me?
—Is this relationship developed and balanced enough to tolerate the potential intensity of touch?

Koocher and Keith-Spiegel (1998) suggest other questions that may be useful in deciding to initiate physical contact:

—How will touch affect the therapeutic relationship?
—Is this client likely to misconstrue my intentions?
—What kind of touch (in terms of body parts, duration, intensity, frequency) should be used?
—(And perhaps most telling): If my professional colleagues saw me touching this client, would they agree that I am behaving ethically and meeting only my client's needs?

Geib's 1982 qualitative study offered guidance as to how therapists may use touch with positive client results. Her findings indicate that four therapist practices enhance therapeutic outcomes. a) The therapist created an environment in which the client felt she was in control and could initiate, terminate or decline physical contact. b) Clients felt they were touched solely for their own benefit and to address their needs, not those of the therapist. c) The therapist initiated an open discussion of limits and boundaries, possible sexual feelings that might be aroused, and the meaning of the touch to the client. These therapists also asked prior to touching and checked for discomfort as they went along (e.g., "Is this raising anxiety?") (p. 117). d) Physical and emotional intimacy grew congruently as safety and trust developed. These therapist practices allowed clients to

prepare for, plan, receive and control physical contact with resultant positive outcomes for clients.

Theoretical and Ethical Issues

Smith (1998) urged therapists to examine the theoretical underpinnings for their decisions about touch. For instance, strict psychoanalysts would most likely observe an absolute taboo on touch while humanists tend to view authentic touch as a vital and emotionally corrective experience for clients. Thus, therapists may look to theory for guidance in shaping their use of touch.

A second, and equally important consideration, is that of ethics. Such issues include whether using touch is congruent with who the therapist is and stems from that authentic self, and whether touch is being used to legitimately meet genuine client needs (i.e., to assist the patient's process and not merely to reduce practitioner anxiety or otherwise soothe the therapist).

For all clients, informed consent should be obtained prior to using therapeutic touch. Smith (1998) suggested that obtaining permission consists of two parts: a) Detailing for the client the intention and purpose of the touch as well as what the touch itself will involve (e.g., body parts, duration); and b) Requesting consent in a noncoercive manner. For additional ethical guidance, readers are referred to the Ethical Principles of Psychologists and Code of Conduct (APA, 1992) (particularly the General Principles, 1.11 Sexual Harassment, 1.14 Avoiding Harm, 1.19 Exploitative Relationships, and 4.05 – 4.07 regarding sexual intimacy with clients). Ethical Guidelines for Feminist Therapists (Feminist Therapy Institute, 1987) and state legislative and administrative codes should also be consulted for guidance regarding the use of touch in therapy.

In Conclusion

As most authors agree, touch is a powerful therapeutic tool. In using this intervention, it is incumbent on the therapist to be self-aware, to be cognizant of client needs and the status of the relationship, and to accept ultimate responsibility for setting limits and boundaries. Lawry (1998) recommends that abstention may be "the position of choice for beginning therapists, for therapists who employ short-term treatment modalities, for therapists who are uncomfortable with touch themselves, and for all others as a 'default' position when there is ***any*** question as to the therapeutic benefit and appropriateness of touch" (p. 202). Because of the many layers of meaning touch holds as well as its power to release profoundly painful affect, clear clinical thinking, self-scrutiny, supervision and/or peer consultation are required for utilizing touch in a therapeutic and ethical manner.

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The Pivotal (but Neglected) Relationship of Psychotherapy Integration and the Scientist-Practitioner Model: *Implications and Recommendations for Psychotherapy Training*

By Georgios Lampropoulos, Ball State University

Summary

This paper integrates for the first time the two separate bodies of literature in the areas of Psychotherapy Integration (PI) and the Scientist-Practitioner (S-P) model of psychotherapy. Based on an examination and integration of the main ideas from the two fields, it illustrates that, although developed separately, these movements are inherently connected and they complement each other. After describing the historical, empirical and conceptual relationship of the two movements, the implications of this relationship for psychotherapy are outlined and training recommendations are offered. PI is conceptualized as a key ingredient in the optimal expression of the S-P model, which greatly enhances S-P training and practice.

First, a brief description of a prioritized, clinically realistic, and cost-effective approach to the S-P model is provided; then, PI is introduced in every step of the S-P based clinical activity. Specifically, advantages, difficulties, and training/practice recommendations are discussed on how clinicians can systematically (a) consume the empirical literature in a transtheoretical but realistic way; (b) assess and diagnose clients in a transtheoretical but economic way; (c) formulate and test transtheoretical clinical hypotheses and integrative/eclectic case conceptualizations; (d) select and apply appropriate treatments using empirical and transtheoretical criteria; and, (e) systematically evaluate the process and outcome of therapy by assessing clinically meaningful and transtheoretical variables. Brief case examples of transtheoretical/integrative/eclectic client assessment and treatment and selection are also presented in the relevant sections to illustrate the foregoing suggestions.

Additional general recommendations for purposeful and economic S-P training and practice are offered, along with general issues related to PI training. Lastly, the complementary subjects (to the foregoing S-P and PI topics) of clinically relevant research and PI research are briefly mentioned, particularly, the point of their convergence (i.e., naturalistic research in integrative/eclectic practices).

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