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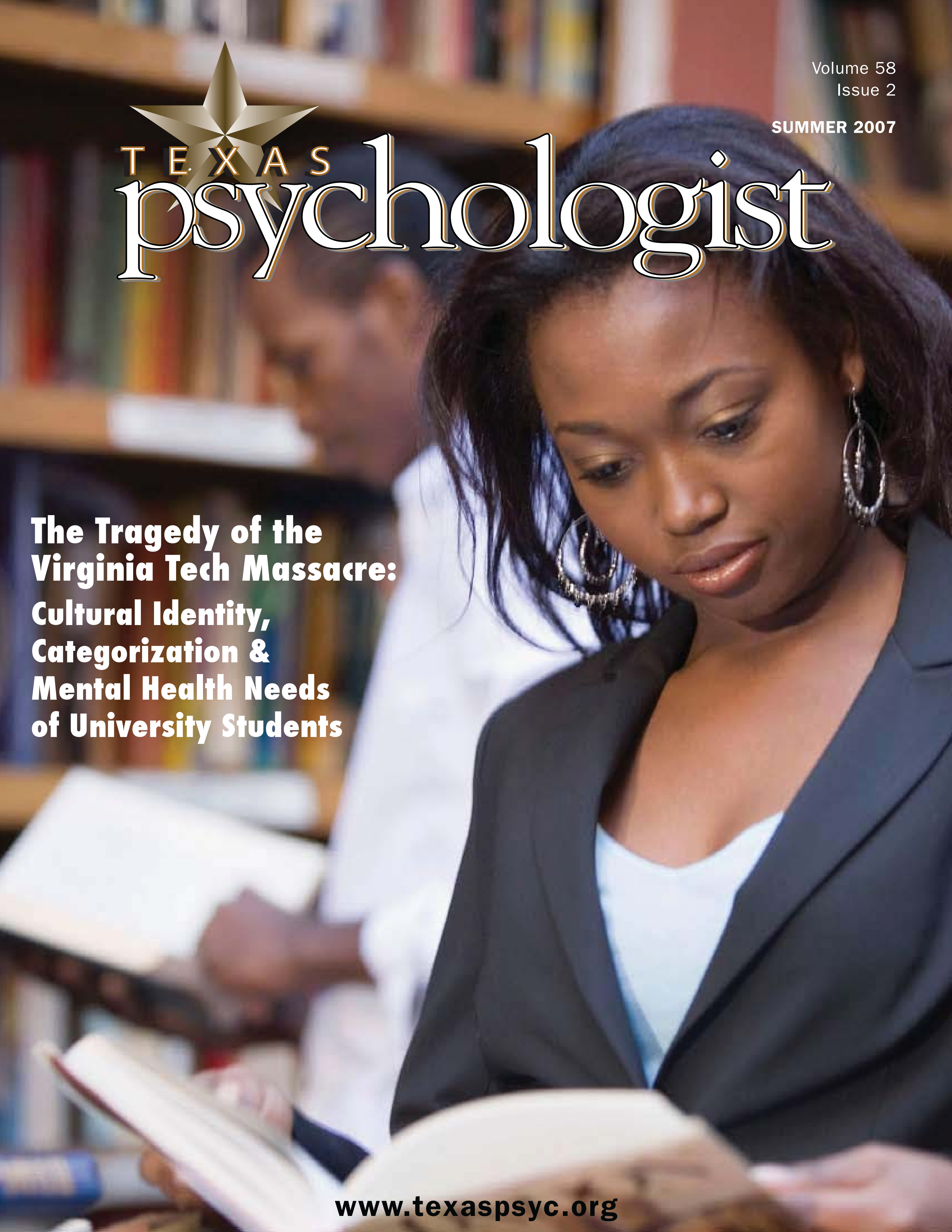

The Tragedy of the Virginia Tech Massacre: Cultural Identity, Categorization & Mental Health Needs of University Students

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TEXAS psychologist

FEATURES

DEPARTMENTS

Is Your Doctorate Superfluous?

Should individuals with a master's degree be licensed as independent psychologists? The Texas Association of Masters in Psychology is arguing for independent practice for psychologists. TxAMP used to be called TAPA, and despite the name change it remains that small but very well organized group of licensed psychological associates (LPAs) that has pursued independent licensure for many years, carrying their arguments to both the state board (TSBEP), and the state legislature. TXAMP contends that the 2005 Sunset reauthorization of the TSBEP mandated that TSBEP change the LPA scope of practice, (an incorrect reading of the law). The staff and leadership from TPA have been working overtime to respond to this distortion of the legislation.

TXAMP has called on TPA *"to put aside emotion and fear tactics and to use those analytical thinking skills in which you were trained in your doctoral programs. Those of you who work with LPAs know how competent many of us are."* Obviously, this misses the point: psychology is and always has been a doctoral profession and the legislature made absolutely no move to change the scope of practice. But TXAMP is not deterred and their membership has worked very hard to get letters from an array of policy-makers, professors, and practitioners to urge TSBEP to the conclusion it MUST study our proposal. TXAMP began to argue that LPAs would fill deep needs in underserved parts of the state where there are no licensed psychologists. They have made veiled allusions to racial injustice by implying that there is an absence of doctoral level psychologists in the Valley resulting in poor or no access for Hispanic communities. While this argument might garner sympathy, it isn't valid; it was supported by false and skewed data on the relative distribution of licensed psychologists and LPAs. They tried again at the TSBEP in the spring of 2006, again referring to the Sunset reauthorization.

The practical effect is that there is no longer any language in law which requires any supervision of LPAs. And there is no reason for the TSBEP to delay further in their duty to adopt rules. (TAPA website, Feb, 2006)

Perhaps hoping that distortions are more compelling when reiterated imperiously, they repeated their willfully erroneous interpretation of the Sunset reauthorization.

TSBEP's choice is not whether to adopt rules for the independent practice of LPAs, but rather which rules to adopt and how quickly this is to be accomplished. The law is clear and support for timely implementation has been voiced from around the state. Inaction can only be the result of pressure from parties within the profession who are dissatisfied with the law as passed. These persons seek to confuse the issue with endless, more-than-necessary and unrelated study with the desire that the process will be continually delayed up to the next legislative session, during which they could attempt to get a new law passed that is more to their liking Meanwhile, the public and LPAs are waiting. It has been one year since HB1015 was filed. Its has been ten months since it passed the legislature and nine months since the governor signed it into law. TXAMP proposed rules for adoption seven months ago in July. The committee to study the issue was named in November and has had three months to provide information on the rules. It is time for this board to adopt the necessary rules.

Finally, we would remind the Board that recommendations of the Sunset Commission are not binding. However, actions by the Legislature are binding. It is not up to the Board to decide whether to write the rules, only which rules to write. We request that rules be adopted without further delay. (TAPA website)

TXAMP made another appeal to the TSBEP in May, 2006, but (finally) their motion was effectively laid to rest on the grounds that the board did not have legal authority to modify what the legislature defined as the scope of practice for LPAs. Their report of this meeting accused TSBEP members of a misuse of power, of maintaining TPA's "monopoly" and of failing to serve the public and they conclude by calling on all members to contribute to a war chest for their further actions. By this year, TXAMP moved their argument to the legislature. Senator Leticia Van de Putte and Senator Eddie Lucio filed SB 1505, and Representative Veronica Gonzales has filed HB 3301, identical bills that would give independent practice to LPAs. They asked their members to contact legislators and to "grab your checkbooks and piggy banks, because this is a huge effort that is going to take a huge amount of MONEY to accomplish." Note that TXAMP has friends in both houses of the legislature who carry their bills and they are amassing funds.

What does TXAMP want? In the last legislative session, they proposed that

- LPAs may work without supervision
- TSBEP would be required to implement this law by December, 2007
- Department of HHS (Medicaid) would be required to pay LPAs for psychological services
- The requirement for supervision of LPAs in the Insurance Code be removed
- LPAs could be reimbursed through HMOs.
- Those who have given up the LPA license

could get it back (a tacit recognition that the majority of people who have had LPAs have obtained other certification instead of or in addition to the LPA)

- A provisional license for new graduates from masters programs

Indeed, TXAMP would redefine what it means to be a psychologist in Texas. They would eradicate the doctoral standard for the independent practice of psychologist---the doctoral standard has been the standard of quality care in Texas and nationally for the past three decades. Nevertheless TXAMP wants to portray itself as the guardian for all of psychology in Texas. According to one of their website postings from the recent legislative session: *We don't think it is an exaggeration to say that not only your future, but the future of mental health care in Texas, will be decided in the next legislature (TAPA website)*

Thanks to exhausting efforts by TPA staff and leadership, TXAMP failed in the session that just finished. It is certain they will be presenting further legislation to redefine psychology in the next legislative cycle. They are busy NOW organizing their campaign. They feel that they have momentum. Be warned.

All postings cited above can be found through the TXAMP website at www.txapa.net TxAMP has a new website at www.txamp.org . Check them both out.

* * * * * * * * * * *

There's a lot to catch up on in this issue. TPA President David Rudd and TPA Executive Director David White each recount the successes and failures (!) we experienced in the recent legislative session. We have one update from the Disaster Response Network and one from Rob Mehl who is spearheading our political organizing as president of the Association for the Advancement of Psychology in Texas.

As these folks note, there was a whirlwind of activity as psychology seems besieged on many fronts, but there is also a great deal of animosity directed toward mental health issues at a more general level. The hardworking staff at Mental Health America of Texas (formerly the Mental Health Association of Texas) have assembled a long list of myths and disinformation that has been promulgated by various groups interested in discrediting the concept of mental illness and/or the efforts of practitioners and researchers who work with the mentally ill. These groups use the stigma of mental illness and the animosity toward the mental health industry to promote their own narrow agendas. They distort and confabulate in order to weaken mental health laws and practices and they have been very active in Texas. MHAT has provided a well documented synopsis of many of these distorted messages, along with corrective rebuttal information. Each of us has a duty to educate the public with the best evidence and to counter these scurrilous tactics.

Former TPA President Melba Vasquez contributes this issue's Public Interest column, discussing some of the responses to the tragic mass shooting at Virginia Tech. We also have substantive articles on a wide range of topics, on evidence based interventions for infidelity, parallel process in supervision, and the use of questionnaires in custody evaluations.

As always, pass this issue to a colleague and recruit a new member for TPA!

WELCOME NEW MEMBERS

February 26, 2007 – May 31, 2007

Member

Matthew Baysden, PhD
Christopher Bellah, PhD
Susanna Bernat, PsyD
Karen Bierman, PhD
V. Shannon Burkett, PhD
James Calvert, PhD
Kelly Cukrowicz, PhD
LouAnn Mock, PhD
Mary Porter, PhD
Bruce Rodgers, PhD
Loretta Rudd, PhD
Dina Trevino, PhD
Anand Vyas, PhD
Venette Westhoven, PhD

Associate

Luba Levy, MA
Tamara Robinson, MA

Student

Kristina Brokaw
Ramona Burroughs
Kyle Clayton
Larissa Edwards
James Eismann
Sparkle Hamilton
JoAnna Hawryluk, MA
Patricia Hoffman
Christine Jacobsen, MA
Connie Martinez
Claudia Moreno
Margaret Morse, MS
Peter Nichols
Shawne Ortiz, MA
Jill Palmer
Sara Pollard
Jennifer Rockett, MA
Daven Salmi, MS
Barbara Shaw
Angela Sims
Brooke Smith
Mary Taylor
Elizabeth Uhl
Emily White

No Spin Allowed

For psychology to be successful in Texas, we simply have to have to be a winner in the Legislature. This is true not just for practitioners, but academics and researchers as well. What does it mean to be a winner? We have to get legislation passed, plain and simple. We're well passed the days of proposing legislation, getting it filed and having a hearing, only to get voted down in committee or on the floor. We need to expect and demand success; meaning pro-psychology and pro-mental health legislation being passed.

As I'm sure you're all aware, the 80th Texas Legislature recently adjourned. To say the least, it was an interesting session. How did TPA and psychology do? I'm not going to spin this one for you. We didn't accomplish our goals. We had three pieces of proposed legislation (hospital privileges, the doctoral standard in psychology, and use of extenders in clinical practice). Although we were successful in getting the doctoral standard and extenders bills filed, we weren't able to maneuver to get a committee hearing and, accordingly, didn't get them to the floor for a vote.

Granted, we were successful in defending yet another attack on the doctoral standard, with psychological associates presenting a grossly distorted and factually inaccurate argument to bolster their assault on independent practice. They weren't successful. The problem is neither was TPA.

I don't know about you, but I'm not satisfied with stalemates. Our doctoral standard bill would have clarified the doctoral standard as essential for independent practice, something that has been codified in TSBEP board rules for more than three decades. It's not about altering the scope of clinical practice it's simply about putting in statute what has been the practice of the state board since its inception.

Thanks to the David White and the TPA forensic group, spearheaded by Paul Andrews and Mary Alice Conroy, we had some limited success in getting the sex offender license bill modified to apply only to "criminal offenders". This change will result in considerably more flexibility for psychologists and other mental health providers working in this area. The restoration of CHIP resulted in 127,000 children being added to the roles; certainly a good thing. The addition of $240 million to the TDCJ budget for mental health and substance abuse treatment is also a good outcome.

Granted, not a single piece of proposed legislation identified as "scope of practice" in any healthcare area got a committee hearing and nothing got to the floor. But we can and will do better. We've raised the bar of expectations and it's critical that we don't lower it. We certainly made strides in getting our members involved. And for that let me say Thank You!

We had many, many members actively involved, engaged and energized about the legislative process. We've established, and will be more effective in maintaining, relationships with legislators over the interim. Rob Mehl is doing a fabulous job heading up AAPT; he's putting together a grassroots network that will help fill this void, and do so in effective fashion. Ollie Seay is also doing some great work on this front.

I think the TPA Board understands what has to be done in order to be successful in the Legislature. Success in the Legislature will filter into practitioner's offices, workplaces and classrooms around the state. Psychology as a profession is defined (and ultimately regulated) by the Legislature. To that end, we had an initial strategy meeting last week and the Board will have a strategic planning retreat (at board members own expense no less) in late July. We've already started working on the next session. The next two years will indeed be busy. We'll be holding fund raisers for legislators and will ask you to join us. You'll also be asked to join our grassroots network, build and maintain a relationship with your legislator.

It will be an interesting two years. We've got many issues to address. At the forefront are the doctoral standard, hospital privileges, prescription privileges and the use of extenders. In order to battle the 800 pound gorilla in the room (the Texas Medical Association), we'll have to be committed over the next two years. TMA successfully blocked all scope of practice legislation this session. As the sixth largest political action committee in the nation, you can understand why they're successful.

But we've joined the Texas Patient Choice Alliance, along with other doctoral healthcare providers, and will have some help next session. Please join us now to prepare for 2009! What we do in the next two years will determine our success or failure in the 81st Legislature. And there won't be any spin.

The GOOD, BAD and UGLY

I am sure that by now each of you have read the newspaper about the unusual legislative session we just completed. I cannot think of any session that I have been involved with that had so much political bickering and squabbling.

The 80th legislature started off with an effort to unseat House Speaker Tom Craddick and it ended the same way. In between these unbelievable power struggles, the legislature found wisdom to pass bills for steroid testing for high school athletes, giving teachers a $425 pay raise, protecting children by toughening the penalties for sexually assaulting children, and reforming the Texas Youth Commission. What they did not do is expand legalize gambling, pass a statewide restaurant smoking ban, or cap the number of guaranteed college admissions for students graduating in the top 10% of their high school classes.

THE BAD

With so much uncertainty in the halls of our state house, it is no surprise that TPA was not even able to get a hearing on what we truly believed was a 'housekeeping bill' . HB 3155 would have codified the current rules in which a licensed psychological associate practices under the supervision of a psychologist. This bill was viewed as a 'scope of practice' bill which, in the legislators' eyes, we were changing the "current practice system" and were limiting the way current psychological care was being provided. No matter how many times we explained this was not the case, they, in their lack of mental health care knowledge, could not even grant us a public hearing so that we could explain the facts or even educate them on the facts.

We also tried to provide an understanding to the legislators that HB 1546 would serve in the best interest of the citizens by granting psychologists the authority to delegate services just as physicians do now. This bill, which really had no opposition, still was not even given a hearing.

While we are discussing bill that did not get a hearing, I think we can take some credit for blocking HB 3301 (SB 1505) which was backed by the Texas Association of Psychological Associates. This bill would have granted them independent practice.

THE UGLY

Sex Offender Treatment Provider

In 2003 the state of Texas created an agency called the Council of Sex Offender Treatment. At that time, all mental health professionals were required to register with this agency if they were treating sex offenders. In 2005, this agency strengthened its power by requiring that all providers be LICENSED by this council. To make matters worse, the definition of sex offender was:

"Sex offender" means a person who:

(A) is convicted of committing or adjudicated to have committed a sex crime under state or federal law;

(B) is awarded deferred adjudication for a sex crime under state or federal law;

(C) admits to having violated state or federal law with regard to sexual conduct; or

(D) experiences or evidences a paraphiliac disorder as defined by the Revised Diagnostic and Statistical Manual, including any subsequent revision of that manual.

Therefore, from September 1, 2005 to the present, if you provided therapy to an individual who "admits to having violated state or federal law with regard to sexual conduct "or "experiences or evidences a paraphiliac disorder", then you are in violation of state law and could fined up to $5,000. The good part of this story is that we were able to tighten up the definition of sex offender during this legislative session. HB 2034, which will go into effect September 1, 2007, creates the new definition of sex offender:

"Sex offender" means a person who:

(A) is convicted of committing or adjudicated to have committed a sex crime under state or federal law;

(B) is awarded deferred adjudication for a sex crime under state or federal law; or

(C) is convicted of adjudicated to have committed, or awarded deferred adjudication for an offense that is based on sexually motivated conduct.

As you can see, you violating this law because you encounter someone in therapy who might have committed the offense but has not be convicted or adjudicated does not put you at risk for practicing without a proper license.

Now the bad news. Assume you follow the proper requirements and become licensed as a sex offender treatment provider because you are seeing a sex offender. You now have to deal with a new set of confidentiality rules. Because HB 2034 states that the CSOT rules

TRUMP the rules you are obligated to follow under Texas State Board of Examiners of Psychologists. The new law reads,

"a sex offender treatment provider licensed under this chapter is subject to the rules of the council, in relation to the person's provision of sex offender treatment, rather than the rules of the licensing entity by which the provider is licensed or otherwise regulated."

After we complained vehemently about this clause, authors added,

"A sex offender treatment provider who acts in conformance with the rules, policies, and procedures of the council is not subject to any administrative sanction against the provider by the licensing entity by which the provider is licensed or otherwise regulated".

Therefore, current confidentiality rules from CSOT are:

CONFIDENTIALITY. (a) Except as provided by Subsection (b), all information and materials subpoenaed or compiled by the council in connection with a complaint and investigation are confidential and not subject to disclosure under

Chapter 552, Government Code, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the council or its employees or agents involved in the complaint and investigation.

(b) The information described by Subsection (a) may be disclosed to:

(1) persons involved with the council in a complaint and investigation;

(2) professional sex offender treatment provider licensing or disciplinary boards in other jurisdictions;

(3) peer assistance programs approved by the board under Chapter 467, Health and Safety Code;

(4) law enforcement agencies; and

(5) persons engaged in bona fide research, if all individual-identifying information is deleted.

All the aforementioned provisions were passed within the last 24 hours of the session.

If that does not rattle you enough, SB 44 was passed and requires professionals who deal with family violence offenders to attend training and be accredited by the Texas Department of Criminal Justice. In short, this new law requires that all professionals attend a battering intervention and prevention service program. The non-profit agency Texas Council on Family Violence was instrumental in getting this law passed. The following is an excerpt from the bill that sums up what the program entails. Please note that even though this is not a license, the Criminal Justice Department will collect a "one-time fee" for you to conform to their guidelines.

ADOPTION OF PROGRAM GUIDELINES; ACCREDITATION

PROCESS. With the assistance of the statewide nonprofit organization described by Section 3(1) and after notifying the licensing authorities described by Section 3(10), the division shall adopt guidelines for programs and shall accredit programs and providers providing battering intervention and prevention services as conforming to those guidelines. The division shall collect from each program or provider that applies for accreditation under this section a one-time application fee in an amount set by the Texas Department of Criminal Justice.

THE GOOD

Did anything GOOD good happen this session? I also try to be the eternal optimist, BUT…there is just nothing to be too happy about. YES, there is something good about this session and that is TPA and all of its leaders have made a profound decision that will forever change the fabric of this association.

That decision is that this is YOUR ASSOCIATION and YOU are now responsible to assure we are successful in the legislative arena. We are no longer counting on an outside lobbyist to carry our message to the legislators….it is YOUR RESPONSIBILITY.

In 2 years when I write the recap for the 81st Legislative Session all the successes will be directly associated with the effort YOU put into it. No more sitting back and having someone else do the work. You picked a profession that is regulated by this state. It is your responsibility and duty to the profession to get involved in the legislative process and to shape the outcome of psychology in Texas.

So welcome to the staff. You are officially one of TPA's Legislative Consultants. The coffee is down the hall, we start at 8:00 AM…..let's get going, we have lots to do.

It is your responsibility and duty to the profession to get involved in the legislative process and to shape the outcome of psychology in Texas.

The Tragedy of the Virginia Tech Massacre: Cultural Identity, Categorization & Mental Health Needs of University Students

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This column has been developed in order to communicate psychological research and knowledge that informs us about issues relevant to marginalized groups in society. Doing so allows for us to convey key information to the membership as a means of promoting human welfare, an important part of TPA's mission. Because this, as well as other of the topics may be controversial in nature, it is important to note the following disclaimer:

The information in the following article is provided by the author, with consensus of the Social Justice Task Force, to facilitate analysis and discussion of the issues presented. It is not intended to represent official policy of the Texas Psychological Association or the opinions of its membership.

Introduction

This is the first of two articles that will be written about various aspects of the tragedy of the Virginia Tech massacre.

On April 16, 2007, Seung-Hui Cho set off the deadliest U. S. mass shooting on the campus of Virginia Tech University. In two separate attacks, this tragic young man killed 32 people and wounded several more before committing suicide. Cho had U. S. permanent resident status, and had moved to the United States with his family from South Korea at age 8. He was majoring in English. He had a history of difficulty. In 2005, he was accused of stalking two female students, was declared mentally ill by a Virginia special justice and ordered to seek outpatient treatment. At least one professor had referred him to seek counseling, and had expressed concerns to administrators about him ("Virginia Tech massacre", 2007).

The shooting tragedy sparked intense debate about several issues including gun laws, (e.g. access by those with mental illness), the responsibility of college administrators, the responsibility of university and other mental health systems, the prediction of dangerous, and the critical balance of the responsibility to provide confidentiality and to protect the public from dangerous clients. While Cho's psychological diagnosis remains speculative, it was clear that he was troubled, and that the system failed him. Underlying these issues was reference to his South Korean identity.

This article will focus on issues of cultural identity, categorization and stereotyping, as well as recommendations made to Congress about the needs of mental health students on college campuses.

South Korean Identity

When the citizenship of the shooter became known, South Koreans expressed shock and a sense of public shame; a candlelight vigil was held outside the Embassy of the United States in Seoul ("Virginia Tech massacre", 2007). South Korea's ambassador to the U. S. called on Korean Americans to participate in a 32-day fast, one day for each victim, for repentance. Members of Cho's family issued messages of grief and apology. Concerns for the safety of Koreans living in the U. S. were expressed.

Robert Siegel, National Public Radio's commentator on All Things Considered, conveyed a poignant opinion on April 18, 2007. He suggested that despite being a South Korean national living in America, Cho's upbringing, and his problems, were distinctly American (Siegel, 2007). Siegel pointed out that Cho's Asian identity was hardly a distinction. At Virginia Tech, there is an Asian American student union, with six associations, two sororities and two fraternities.

Siegel further pointed out that his emotional difficulties made him typical of no specific group; the Columbine massacre was similarly not a foreign country's terrorism, but reflective of the ability to access guns, an American interpretation of liberty. Siegel ends his commentary by stating: "Seung-Hui Cho killed and died as one of us. …This is an American killing fellow Americans with little to do with any cultural differences but rather having to do with distancing and isolating himself from his own society." (paragraph 12).

The Asian American Psychological Association (AAPA), an organization dedicated to the advancement of the psychological well-being of Asian Americans, issued a statement as a press release on April 18, 2007, entitled "Asian American Psychological Association Mourns Virginia Tech Tragedy." The AAPA joined with the rest of the nation in mourning the tragic loss. The statement included expression of condolences, and identified the fact of the complexities of the incident, including of the search for explanations.

Finally, the AAPA cautioned against focusing on issues of race, ethnicity and culture. More specifically, "We caution against simplifying the situation in this way. Although the alleged perpetrator has been identified as a Korean American immigrant, it is important to remember that no person's actions are solely related to their race and/or culture."

While race and culture do affect individual's behaviors, AAPA cautioned "…against the assumption that this tragedy is representative of Asian Americans." (paragraph 3) The AAPA also cautioned against retaliation directed at members of the Asian American community. As of this writing, it appears that no such backlash has occurred.

Categorization is a helpful psychological process that we engage in when we perceive others; that is, we place them in a category, in order to reduce the overwhelming information in our lives into manageable chunks of information that go together (Allport). This normal process leads to associating various traits and behaviors with particular groups, even if they are inaccurate for most individuals from those groups. Stereotyping and generalizing are consequences of this process.

A risk in engaging in this otherwise helpful process is that we can end up placing people in "in-groups" and "out-groups." It is common to have automatic, and subconscious biases, and negative attributions and interpretations about people in the "out-group." Unfortunately individuals in racial/ethnic minority groups are often placed in out-groups. Furthermore, when one of these individuals in the public eye does something wrong, or makes a major mistake, those negative stereotypes are reinforced, and keep racial/ethnic minorities in the out-group of our categorization schema.

Hence, the concern from the South Korean community, the Asian American Psychological Association, and even from a mainstream journalist, NPR's Robert Siegel. Our responsibilities as psychologists include to discourage such stereotyping and inappropriate categorization. Continued work to place disenfranchised groups in "in groups" is an important and ongoing goal, especially in our work, but also in the society in which we live. We must be alert to events that promote such destructive categorization, such as the Virginia Tech tragedy.

Safety on College and University Campuses

One of the consequences of the Virginia Tech shooting is the focus on the availability of mental health services on college and university campuses. The American Psychological Association provided a press release (April 24, 2007) about the testimony of psychologist Russ Federman, Director of Counseling and Psychological Services at the University of Virginia who testified before the Senate Committee on Homeland Security and Governmental Affairs on the mental and emotional health of college students. Dr. Federman described the critical need for more funding to meet the increased demand for student mental health services in the nation.

Dr. Federman reported that a 2006 national survey of Counseling Center Directors reported that 8.9 percent of all enrolled students sought psychological help in the past year. One third of the students were depressed; one-fifth had anxiety disorders, and most students sought help with crises. College counseling centers are faced with high-volume, high-risk and very serious illnesses.

Dr. Federman also addressed the complex and critical balance between students' rights to confidentiality and the university's need to inform authorities and students' parents when a student poses danger to him/herself or others.

He offered the following recommendations:

Increase funding for the Campus Suicide Prevention programs to allow campus counseling centers to hire more staff and make clinical services more available.

Invest in funding for campus student services that promote student outreach, education and prevention. Teaching students healthy lifestyles is the strongest prevention against depression and other mental illnesses.

Improve student peer connections. Peers can encourage each other to get help if needed.

Support research and policy development initiatives by organizations that help with understanding and responding to university/college mental health issues. (paragraph 6)

Funding cuts at all levels of mental health services in the past decade may very well be a significant factor in the tragedy of Seung-Hui Cho's failure to receive the intensive services that he so clearly needed.

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Treating Infidelity: An Integrative Approach to Resolving Trauma and Promoting Forgiveness

Douglas K. Snyder, Texas A&M University
Donald H. Baucom, University of North Carolina
Kristina C. Gordon, University of Tennessee

"How could you do it?" Sophie exclaimed. "You told me it was over. Now you're emailing her again. Is this ever going to end?" Sophie exploded in a mix of tears and anger reminiscent of her reaction when she first learned of Micah's affair. This time Micah responded with his own anger. "What do I have to do to get you to understand that life goes on? I'm no longer seeing Rachael. I'm tired of your punishing me." Their therapist felt equally frustrated. They'd been working together for nearly four months, and at this point the couple seemed stuck. Every step forward seemed followed by a step backward.

Clinicians are frequently likely to encounter individuals coping with infidelity – whether in the context of couple therapy aimed at recovery from an extramarital affair, individual therapy with someone struggling with his or her own affair or responding to a partner's affair, or interventions with children contending with consequences of a parent's infidelity.

Representative community surveys indicate a lifetime prevalence of sexual infidelity of approximately 21% among men and 11% among women (Laumann, Gagnon, Michael, & Michaels, 1994). Broadening infidelity to encompass emotional as well as sexual affairs increases these rates among men and women to 44% and 25%, respectively (Glass & Wright, 1997). Infidelity is the most frequently cited cause of divorce (Amato & Rogers, 1997), with approximately 40% of divorced individuals reporting at least one extramarital sexual contact during their marriage (Janus & Janus, 1993). Surveys of couple therapists indicate that they regard extramarital affairs as among the most difficult conflicts to treat (Whisman, Dixon, & Johnson, 1997).

We've developed an integrative approach to working with couples struggling to recover from an extramarital affair (Baucom, Gordon, & Snyder, 2005; Gordon & Baucom, 1999; Snyder, Baucom, & Gordon, 2007; Snyder, Baucom, & Gordon, in press).

This approach draws on the theoretical and empirical literature regarding traumatic response as well as interpersonal forgiveness. It incorporates empirically-supported interventions from both cognitive-behavioral and insight-oriented approaches to treating couple distress. This affair-specific intervention is the only couple-based intervention designed specifically to address both individual and relationship consequences of infidelity to have been empirically examined and supported in clinical research (Gordon, Baucom, & Snyder, 2004).

Treating Affairs and Promoting Recovery: A Three-Stage Approach

We view affairs as major relationship betrayals that significantly disrupt spouses' basic beliefs about their relationships, their partners, and themselves. Because affairs violate individuals' basic assumptions about how their relationship and their partner operate, they frequently result in emotional and behavioral symptoms consistent with post-traumatic stress reactions. Following an affair, partners often lose predictability for their future and a loss of control, leading to deepened feelings of unbearable anxiety and despair. As long as injured partners don't have a clear understanding of why the affair or trauma occurred, they can't trust their participating partner not to hurt them again; instead, their partner may continue to function as a stimulus for floods of painful emotion.

At the same time, participating partners often struggle with their own feelings of guilt, shame, anger, or depression and thus end up ill-equipped to respond effectively to their injured partner's strong expressions of emotions.

Based on these clinical observations, conceptualizing affairs as an interpersonally traumatic event provides useful implications for planning effective therapy with these difficult couples. For example, we view many of the responses observed in injured partners during the aftermath of an affair as resulting from disruption of their basic beliefs and their strong need to reconstruct a shattered world view, all the while protecting themselves from further interpersonal harm.

If recovery from an affair is conceptualized as a response to an interpersonal trauma, then the recovery process can be understood as unfolding in three major stages that parallel the stages involved in the traumatic response. These include: (a) absorbing and addressing the traumatic impact of the affair, (b) constructing meaning for why the affair occurred, and (c) moving forward with one's life within the context of this new understanding.

Stage 1: Addressing the Impact of an Affair

Following disclosure or discovery of an affair, one or both partners may report inability to complete the most basic daily tasks of caring for themselves or their children and may be unable to function effectively outside the home. Questions of whether to continue living together, how to deal with the outside affair person, whom to tell of the affair and what to disclose, how to attend to daily tasks of meals or childcare, or how to contain negative exchanges and prevent emotional or physical aggression – all need to be addressed early on to prevent additional damage from occurring to the partners or their relationship.

Intervening effectively with affair couples requires that you establish and maintain an atmosphere of safety and trust by limiting partners' aggressive exchanges within sessions in an empathic but firm way. Allowing partners to describe how they've struggled thus far needs to be balanced by a structured process that limits domination by discussion of the affair details, intervenes in the crisis to help the couple determine how best to get through the coming weeks, and promotes a collaborative effort to understand more fully the context of what's happened in order to be able to reach more informed decisions down the road.

During Stage 1 it's important that you avoid getting lost in the chaos of partners' own emotional turmoil; this requires slowing interactions, keeping discussions focused on the most urgent or immediate decisions, and containing negative exchanges during sessions. Establishing and maintaining a therapeutic alliance with both partners can be particularly challenging; for example, injured partners often find it difficult to tolerate therapists' empathic responses to participating partners' guilt, hurt, or loneliness. Just as important as containing destructive negative exchanges is confronting some couples' "flight into health" as a way of avoiding distress in the short term; instead, with such couples you'll need to promote tolerance for examining the affair more intensely in order to promote more enduring resolution in the long term.

Beyond these general principles, Stage 1 requires you to implement specific interventions targeting difficulties commonly experienced by partners during the initial recovery phase. These include (1) setting clear and strong boundaries or limits on how partners interact with each other and with persons outside their relationship; (2) promoting essential self-care attending to physical well-being as well as both social and spiritual support; (3) teaching time-out and venting techniques as a way of regulating difficult negative emotions; (4) facilitating emotional expressiveness and empathic listening regarding the impact of the affair, along with offering a rationale for the importance of this process; and (5) helping both partners to recognize and cope with "flashback" phenomena including intense feelings, images, or recollections of the affair.

Stage 2: Examining Context and Finding Meaning

After addressing the initial impact of the affair in Stage 1, the second stage of treatment focuses on helping the couple explore and understand the context of the affair. This second stage typically comprises the heart of treatment and demands the greatest amount of time. Couples need a roadmap for recovering trust and intimacy. Injured partners, in particular, need ways to restore emotional security and reduce their fear of further betrayals. Both partners often crave mechanisms for restoring trust – injured partners for regaining it, and participating partners for instilling it. Reestablishing security comprises an essential precursor to letting go, forgiving, or moving on emotionally – either together or apart. Following an affair, couples who fail to restore security either remain chronically distant and emotionally aloof, craft a fragile working alliance marked by episodic intrusions of mistrust or resentment, or eventually end their relationship in despair.

Specific components comprising Stage 2 interventions are designed to promote partners' shared comprehensive understanding or formulation of how the affair came about. For injured partners, this understanding contributes to greater predictability of whether the participating partner will be faithful in the future and a more balanced and realistic view of their partner (either a softening of anger or confrontation of enduring negative qualities). For participating partners an expanded understanding helps them accept responsibility for decisions resulting in the affair. For both partners, a comprehensive and accurate understanding of factors contributing to the affair prepares them for necessary individual and relationship changes aimed at reducing these influences if they decide to stay together, and prepares them for a thoughtful decision to end the relationship in some instances.

Attempting to develop a clear understanding of why the affair occurred serves as the framework for interventions in this stage of recovery. You'll need to guide partners in examining aspects of their relationship, stresses from outside the marriage, and issues specific to each of the partners for their potential role as predisposing or precipitating influences leading up to the affair, factors that influenced the maintenance of the affair and eventual discovery or disclosure, and influences bearing on partners' subsequent responses or recovery (Allen et al., 2005).

Depending on the couple's level of skill and their motivation to listen to and understand each other, you may need to help structure discussions between the partners as they explore and attempt to understand the context of the affair.

As their therapist, the couple will rely on you to highlight certain points, reinterpret distorted cognitions, or draw parallels or inferences from their developmental histories that the partners aren't able to do themselves. You'll also look for patterns and similarities between what the partners have reported in their individual histories and the problems they're reporting in their own relationship. Understanding how past needs and wishes influence an individual's choices in the present may be a critical element to understanding why the individual chose to have an affair, or how the injured partner has responded to this event.

After examining potential contributing factors across diverse domains, the therapist helps the couple to integrate the disparate pieces of information they've gleaned into a coherent narrative explaining how the affair came about (Snyder, Gordon, & Baucom, 2004). Achieving a shared understanding of why the affair occurred is central to partners' developing a new set of assumptions about themselves, each other, and their relationship. Upon constructing a shared narrative of the affair, you and the couple can then examine what aspects of their relationship may need additional attention and how this can be accomplished in order to help them avoid future betrayals. In this respect, the therapy begins to move from a focus on the past to a focus on the present and future of the relationship.

Stage 3: Moving On

Even after you help a couple to contain the initial negative impact of an affair and then guide them through a systematic examination of factors that were part of the context of the affair, either partner can remain mired in the past or indecisive about the future. Injured partners' hurt, anger, or fear of future betrayals may persist or periodically resurface in intense or destructive ways. Participating partners may also struggle with unrelenting guilt, unresolved resentments toward their partner that potentially contributed to the affair originally, or lingering attachment to the outside affair partner or ambivalence about remaining in the marriage.

In order to move forward, the couple needs to achieve three goals by the end of this third stage: (a) develop a realistic and balanced view of their relationship, (b) experience a release from being dominated by negative affect about the event, and for the injured partner to relinquish voluntarily one's right to punish the participating partner, and (c) carefully evaluate their relationship and reach healthy decisions about moving on separately or together.

Treatment strategies in Stage 3 initially emphasize helping partners examine their personal beliefs about forgiveness and how these relate to their efforts to move on from the affair. Additional interventions are designed to help partners address individual or relationship barriers to moving on. For example, partners may report difficulty related to beliefs that forgiving their partner is "weak" or is equivalent to declaring that what happened is acceptable or excusable. Or partners may equate forgiving with forgetting, or with rendering oneself vulnerable to being injured in a similar way in the future.

Sometimes one individual is still dominated by anger about his or her partner – for example, because of perceived power imbalances following the affair or failure to regain an adequate sense of safety in the relationship. Alternatively, the anger may point to unresolved relationship issues or violated assumptions that weren't resolved in earlier stages.

Additional interventions facilitate partners' integration of what they've learned about themselves and their relationship – well beyond the affair – to reach an informed decision about whether to continue in their relationship or move on separately. For couples deciding to move on together, interventions emphasize additional changes partners will need to undertake either individually or conjointly to strengthen their relationship and reduce any influences that potentially make it more vulnerable to another affair in the future. If one partner or the other reaches an informed decision to end the relationship, the couple will need you to help them implement that decision in order to move on separately in ways that are least hurtful to themselves and others they love – including children, other family members, and friends.

Empirical Evidence for This Affair-Specific Intervention

We've presented preliminary evidence for the efficacy of this treatment approach in a replicated case-study of couples recovering from infidelity (Gordon, Baucom, & Snyder, 2004). Consistent with anecdotal literature, the majority of injured partners entering this treatment initially showed significantly elevated levels of depression and symptoms consistent with a posttraumatic stress disorder.

Concern with emotional regulation and struggles to understand their betrayal dominated. Relationship distress was severe; feelings of commitment, trust, and empathy were low. By termination, injured partners demonstrated gains in each of these areas. Most importantly, gains were greatest in those domains specifically targeted by this treatment, such as decreases in PTSD symptomatology and mastery over successive challenges of the forgiveness process. Treatment effect sizes were moderate to large and generally approached average effect sizes for efficacious marital therapies not specifically targeting couples struggling from an affair (Snyder, Castellani, & Whisman, 2006).

Participating partners in this study exhibited as a group only modest disruption of individual functioning in terms of depression or anxiety, but displayed moderately high levels of overall dissatisfaction with their marriage. Although the average reduction in marital distress was modest for the participating partners, the treatment was not without impact on them. When describing the impact of treatment, participating partners expressed that the treatment was critical to (a) exploring and eventually understanding their own affair behavior in a manner that reduced likely reoccurrence, (b) tolerating their injured partners' initial negativity and subsequent flashback reactions, (c) collaborating with their partners in a vital but often uncomfortable process of examining factors contributing to the affair, and (d) deferring their own needs for immediate forgiveness until a more comprehensive process of articulating the affair's impact, exploring its causes, and evaluating the risks of reoccurrence had been completed.

Based in part on these empirical findings, as well as our clinical experience implementing this approach with scores of couples recovering from infidelity, we have developed a self-guided manual for couples struggling to recover from an affair (Snyder, Baucom, & Gordon, 2007). This resource provides couples with a conceptual framework for understanding their experiences and assists them in moving through successive stages of dealing with initial impact of the affair, arriving at a shared formulation of how the affair came about, and reaching an informed decision for how to move on – either together or separately. Structured exercises guide partners through each stage. Although written in a manner that encourages both injured and participating partners to work through each stage collaboratively, either partner can use this resource individually or in conjunction with individual or couple therapy. A companion clinician's manual for treating couples recovering from infidelity will also be available soon (Baucom, Snyder, & Gordon, in press).

Summary

For couples, an extramarital affair comprises one of the most difficult relationship experiences from which to recover. For therapists, couples struggling with issues of infidelity are among the most difficult to treat. Effective treatment – and optimal recovery – require an integrative approach that (a) recognizes the traumatic impact of an affair, (b) builds relationship skills essential to initial containment of trauma and effective decision-making, (c) promotes partners' greater understanding of factors within and outside themselves that increased their vulnerability to an affair and influence their recovery, and (d) addresses emotional, cognitive, and behavioral processes essential to forgiveness and moving on – either together or separately.

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Recent Developments in Parallel Process

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Clinicians and their supervisors have long studied transference, countertransference, and parallel process as a way to uncover unconscious dynamics that are transpiring in the process of psychotherapy. In his classic 1905/1977 work, psychiatrist Lewis Wolberg devoted a chapter to the topic of negative reactions to a client by a therapist. He warned that therapists may, unwittingly, project their own values onto patients or respond to them in nontherapeutic ways as a result of their identification with significant individuals from the past. In recent years, clinicians continue to observe transference, countertransference, and parallel process at work in the therapeutic arena. However, at this point there is a greater degree of sophistication regarding these phenomena. For example, some authors are viewing parallel process through new lenses, such as relational theory. Others have introduced scientific inquiry into this domain, wherein empirical research has been historically lacking. Still other researchers are beginning to document common forms of countertransference and parallel process that are disorder- or population-specific. Thus, the construct of parallel process is evolving as researchers and clinicians gain greater insight. As theory and research become more sophisticated in this area, therapists can understand more fully how transferential issues manifest in various therapeutic scenarios and how to address them.

Background

Parallel Process and Transference in Supervision As early as 1955, Searles (as cited in Morrissey & Tribe, 2001) began to describe a process of "reflection" that occurs in therapy, in which the clinician briefly has the experience of identifying with the client's emotions and persona. Doehrman (as cited in Morrissey & Tribe, 2001) elaborated on these ideas and became one of the first prominent authors to articulate the essence of parallel process. She spoke of a resonance between the therapist's experience with her client and the supervisor's experience with the therapist. Without realizing it, the therapist may create a reenactment of the therapy relationship with the supervisor. Corn (2001) noted that "shared situational factors" common to the early childhood experiences of both therapist and client may evoke a parallel process, such that an unconscious repetition of parent child conflict emerges (p. 257). Other authors have questioned the idea of a mere role enactment and posit instead a dynamic of projective identification; such has been the debate in the psychodynamic literature (Ricci, 1995). In this definition, the client unconsciously transfers her affect into the supervisee who subsequently transfers this affect into the supervisor (Grind berg, 1979 as cited in Morrissey, 2001). Regardless of which definition authors have chosen, however, Ricci noted that far greater attention has been paid to parallel process from the "bottom-up" as opposed to the "top-down" perspective. In other words, the inevitable existence of maladaptive exchanges in supervision that replicate themselves in therapy relationships has received much less attention to date than the opposite scenario.

However, Astor (2000) described a common trap of just this kind into which supervisors may fall. In an effort to be collegial, a supervisor may be inclined to discuss his own cases with his supervisee. The outcome, however, may be undesirable, as the supervisee may experience such an effort as an abandonment of the supervisee's own concerns. In turn, the supervisee may avoid dealing with important material with his client. In contrast, Astor discussed a scenario with one of his own supervisees in which supervision worked effectively. The supervisee described how her client was yelling at her and threatening her, which tapped into the supervisee's own Oedipal drama. The client's strong demand for love and inability to tolerate frustration "invaded" the therapist, and only when the supervisor contained these feelings was the therapist able to analyze them and, in turn, contain them in the client. Thus, under the best of circumstances, supervision provides a safe, supportive environment that enables the therapist to understand the client's internalized relational paradigms (Corn, 2002).

Because of a possibility that these paradigms may be similar to those of the therapist, the astute supervisor will provide an opportunity for the therapist to explore any commonalties as a way to identify both negative countertransference and parallel process. Corn (2001) described an example of just such a situation in her own work. In therapy, she, unknowingly, was enacting a scenario from her family of origin in which she became emotionally distanced to the point of sleepiness in every session. This reaction was typical of her and her father's behavior, a defense against her mother's pattern of totally controlling them when they complied with her wishes or scorning them when they refused to cooperate. Because these dynamics were similar to those of Corn's client's family, unsurprisingly her client assumed the maternal role, castigating her for being an ineffective clinician. Only when these issues were processed in supervision and Corn felt accepted was she able to transfer this experience into her work with the client, creating a new resolution to his unhealthy early childhood history.

A Relational Model of Transferential Constructs

In contrast to the historically hierarchical view of transference and parallel process in supervision, some contemporary theorists are examining these kinds of dynamics in light of relational theory. They conceptualize supervision as an arrangement involving bi-directional influence, in which the issues of both parties are at play (Ganzer & Ornstein, 1999). This model is consistent with constructivist and ecological theories, which are becoming prominent in the field of psychology and are certainly at the core of counseling psychology's ideology. As opposed to the traditional view of supervision, in which the supervisor locates and interprets the supervisee's countertransference issues with the client, a relational supervisor will attempt to engage in a mutual, reciprocal dialogue. The supervisee is encouraged to freely express her experience of the client as it is formulating (Rock, 1997 as cited in Ganzer & Ornstein, 1999). The supervisor comments in response, but her perspective is not necessarily considered superior to the therapist's point of view. After all, relational writers argue, the therapist is the individual most closely involved in the clinical work, so her views are most worthy of consideration. By following this procedure, relational theorists believe that disruptions or impasses in supervision can be minimized. These authors assert that this minimization will result in client benefit, because they believe parallel process can work in reverse, from a top-down perspective. When this occurs, supervisees are thought to enact any difficulties they have encountered with their supervisors in therapy, adding a destructive element to their clinical work. Therefore, by reducing negative interactions in supervision, the client's experience is likely to be better.

Quantifying the Incidence of Transference/Parallel Process

Another promising trend in transferential-literature is the relatively recent advent of empirical research. Raichelson et al. (1997) used the Parallel Process Survey to empirically validate the construct; they found that regardless of theoretical orientation, participants believed in the existence of this phenomenon. Their findings also suggested that looking for and interpreting parallel processes are common tools used in supervision, applying to multiple theoretical orientations. However, psychoanalytic supervisors and supervisees unsurprisingly reported an increased belief in the existence of parallel process than those of other orientations. Finally, they found clear effects of parallel process on the supervisee participants by self-report. While this research did not indicate that parallel process interventions are fundamental to progress or adequate by themselves as a sole supervisory technique, it did support that parallel process exploration is one of the many dynamics that transpire within supervision.

Transferential Experiences Specific to Certain Disorders and Populations

A number of authors have also begun to examine parallel process and transference as they manifest in specific therapeutic situations; among these are disorder-specific and population-specific manifestations. DeLucia-Waack (1999), for example, investigated therapists who serve clients with eating disorders and found, unsurprisingly, that the heightened focus on body image and awareness of food in session had an impact on the clinicians. Changes in eating habits and exercise regimens were noted by the clinicians, but not consciously at the time they occurred.

Additionally, the irrational and skewed belief systems present in eating-disordered clients may be unconsciously adopted by therapists. Thus, the informed supervisor will be careful to function as a reality check as well as serve in a supportive role. Such a supervisor should be alert to the themes that commonly present in eating disordered clients, so that these may be recognized and processed in supervision if they are assumed by the clinician. Such themes include: perfectionism, dichotomous patterns of thinking, diminished awareness of internal drives for hunger and emotion states, seeking external reinforcement, desire to please and caretake, a sense of helplessness or being out of control, and diversion from feeling states. There are also a number of common countertransference issues that can impede the counseling process for a client with an eating disorder. One of the primary problems involves overidentifying with the client, which transforms the relationship into one without appropriate boundaries.

Another area of concern has to do with control issues, which are typically part of an eating disorder. When a counselor overreacts to these issues, she may become involved in a power struggle, bored with the client, or assume too much responsibility for him. Thus, in supervision, the counselor and supervisor should examine when appropriate boundary-setting is needed. Secrecy regarding how much one binges, purges, exercises, or eats is another common tendency among eating-disordered clients. Overreactions to such reticence are not unusual for counselors and can disrupt the healing process. Because eating disorders are difficult to treat, counselors may feel helpless, ineffective, or inadequate, a countertransferential experience of the client's perception that he is not making improvement. Finally, often clients with eating disorders have problems with expression of affect. They may avoid it to an extreme, or, conversely, display excessive amounts of feeling to the point that their life is chaotic. The therapist should therefore process the feelings that are evoked in her during supervision in order to ensure they are appropriately modulated. As noted earlier, certain transferential experiences also appear to occur as clinicians work with specific populations. For instance, Deering (1994) has written that child psychotherapy is especially prone to parallel process enactments, because children engage in therapy to a large extent on a nonverbal, symbolic level. Because a child may be incapable of putting into words what he experiences, often the therapist may be unable describe what happened in therapy with his supervisor, resorting literally to play enactments in supervision. At older ages, adolescent clients engage in limit testing frequently. Therefore, the challenge to the therapist's authority by the child is often in turn displaced onto the supervisor, who has the opportunity to experience the trials the therapist is undergoing in his work. Deering (1994) also alerts readers to five common scenarios that may trigger a parallel process. First, if a child cancels therapy sessions and the therapist also cancels supervision, he replicates the child's avoidance of processing the issues at hand.

Second, as with adults, eating-disordered children may make a huge effort to avoid affect and use intellectualization as a defense against feelings of anger and sadness. If intellectualization begins to take place in supervision as a parallel process, the supervisor will do well to shift the focus back to the affect that is being suppressed. Third, children who are especially emotionally needy place huge demands on a therapist, who may in turn become highly dependent on her supervisor.

Fourth, those children who are passive to the point of seeming invisible in therapy may never become the focus of supervision, remaining invisible there as well. Finally, the supervisor of a therapist who uses a mechanistic "weekly summary" approach to sessions may find that a superficial relating of events also takes place in supervision, creating a need for the supervisor to delve into the continuing issues or unifying themes that are being avoided.

Recognizing and Intervening in a Parallel Process

Lastly, the recent transferential literature contains a number of articles providing concrete recommendations to supervisors who seek to improve their skills in recognizing and correcting parallel processes. Deering (1994) outlines three of the most common signs that a parallel process is taking place. Supervisors should examine "atypical behavior by the trainee, sudden changes or transference distortions in the supervisory relationship, and inexplicable therapeutic impasses" (Deering, 1994, p. 108). Addressing these concerns should be undertaken with the supervisee's levels of expertise and comfort and the relative strength of the supervisory relationship in mind. Direct confrontation would be the technique of choice when approaching a fairly self confident and advanced supervisee with whom one has a strong alliance. However, when supervising a more defensive supervisee, or one with whom supervision has been more tenuous, Deering recommends an unconscious resolution of the problem. For example, changing the emotional tenor of supervision may in turn change the tenor of the delivery of therapy. Another author, Ricci (1995), suggests using empathy and an intersubjective style to reduce the anxiety of defensive supervisees so that they may take in the suggestions offered in supervision. Finally, Morrissey and Tribe (2001) make the point that supervision must ultimately be rooted in care and concern for the client and/or the supervisee; while their assertion seems to be a restatement of the obvious, this principle must continually be on the supervisor's mind for supervision to be effective. They argue that safety and support are critical components of the supervisory relationship, facilitating the therapist's ability to examine her interactions with the client and how they relate to the interaction occurring in supervision. Ultimately, these kinds of insights can foster a clinician's general awareness of the contextual issues impinging on her practice.

Clearly, psychologists' understanding of transference and parallel process has evolved greatly throughout the past.century. Clinicians and researchers continue to examine how this phenomenon manifests itself in various therapeutic settings, resulting in a more sophisticated conceptualization of the construct. Such increased understanding and awareness have also allowed authors to provide a number of useful suggestions for recognizing and addressing parallel process when it becomes a part of the client-counselor-supervisor triad. These kinds of contributions can be of great benefit to therapists and their supervisors, and of course, ultimately to those they serve.

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A New Organization Within AAPT: You Are The Key Contact

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Now that the legislative session has closed, AAPT and TPA have begun to quickly look forward to the next session. Much has been learned about the legislative process; much we knew already. We have struggled to make an impact on the Legislature and the legislative process, and I believe we have increased our effectiveness. However, there is still more work ahead.

Financial contributions and traditional lobbying remain as important as ever. However, legislators are largely unaware of who we are and what we do. While political contributions do open the door and create an atmosphere of mutual support, we cannot outspend our opponents. Our persuasiveness and logic are not sufficient in the face of counter-arguments, misinformation and sometimes lies. We need more.

The relationship established between psychologists and individual legislators is the key. We know that in our practices, psychotherapy is effective only in the context of a relationship. Some say that the relationship itself is the curative force. Of course, it is the trust that develops in a relationship that opens us to input from others, allows us to believe it and gives us the courage to act on it. It is the same with legislators. We must create and utilize relationships with legislators, and we must out-organize our opponents.

The new organization: On March 13th, 2007, AAPT began developing a plan for an effective grassroots network which would help establish a relationship between every legislator and at least one psychologist. This network would utilize the energy at the local level more effectively, institutionalize the network based on structure rather than individual initiative, employ a feedback system to monitor progress and the stance of each legislator, as well as provide effective lobbying training. On June 14th the AAPT board adopted the plan for the Grassroots Network. The AAPT board will select at least one psychologist per legislator to serve as the Key Contact. The Key Contacts will meet on a regular basis with his or her assigned legislator to develop the relationship. Information to be shared with the legislator will be disseminated from TPA and a feedback report will be provided on the outcome of the meetings. Key Contacts will be expected to attend TPA's Training Workshops. Key Contacts will also be expected to inform Local Area Society membership and leadership about the legislative issues. There will be a Lead Coordinator of the Grassroots Network who will serve on the AAPT board. At least four Regional Coordinators will oversee four or more groups of legislative districts. With this structure we hope to institutionalize the Grassroots Network as an effective legislative tool for many years.

We need for you to SERVE. Call the TPA office (512-280-4099 or 888-872-3435) to become a Key Contact and join us in this exciting opportunity.

TPA would like to make recommendations (to the Governor's appointments secretary) of persons who are well informed about critical issues facing psychology. If you would like to nominate yourself or a colleague to one of the upcoming openings for licensed psychologists or if you know a civic minded citizen who might serve as a public member, send a vita and statement of interest to Brian Stagner, 408 Tarrow, College Station or (preferably) by email at bstagner@psych.tamu.edu

The updated list of AAPT, TPF and Legislative Champion contributors will be available in the fall issue.

Parent Questionnaires in Psychological and Custody Evaluations

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Psychologists who evaluate and treat children and adolescents face a special diagnostic dilemma. The dilemma is apparent in the following illustration of a common presenting problem.

Alec, age 7, frequently loses his temper and is easily annoyed. His parents want to know if Alec's behavior is normal. If it is not, they want to know why he behaves this way and what they can do about it.

Before gathering more data, we can entertain several hypotheses. Alec's behavior may not be significantly different from that of his peers. Or, Alec may have had a difficult temperament since infancy, a stable personality variation to which his parents have not adapted optimally. Or, his behavior may be a reaction to stressful life events, a sequella of learning disabilities, a symptom of depression, a consequence of inadequate parenting, or a symptom of family dysfunction. Or, it could be any combination of the above, or none of the above.

Each possibility raises additional diagnostic questions. If Alec's behavior is normal, what motivated the consultation? If his temperament is difficult, what specific traits create problems, and how do these traits affect his school and social adjustment? If Alec is reacting to stress, what is the source? If he has learning disabilities, what areas of cognitive functioning need to be assessed more completely? If Alec is depressed, how did he get to be this way?

Each explanation of Alec's problems suggests a different treatment approach. To evaluate the various options, we need a wide range of information. This should include a comprehensive developmental history, a history of stressful life events, a history of school adjustment, and a family history of psychological problems. Also, we need to assess Alec's temperament, motor and cognitive strengths and weaknesses, peer relationships, and family dynamics (Chess & Thomas, 1984). We must also determine the presence or absence of many other symptoms and personality assets that will contribute to our understanding of Alec's problems and our treatment recommendations. In most cases, we will need information from both parents to assess their contributions to the problems and to determine the proper focus of treatment efforts.

In addition to the sheer volume of information required to assess children properly, we face two additional challenges prompted by DSM-IV diagnostic considerations (American Psychiatric Association, 1994). First, for many of the most prevalent childhood disorders (e.g., Oppositional Defiant, Attention-deficit Hyperactivity, Separation Anxiety) the diagnostically significant behaviors occur primarily in natural settings such as home or school. These behaviors are not always visible in our office, particularly during initial contacts. Children are often unable or unwilling to report these behaviors accurately. For these reasons, parents' and teachers' observations of children's behavior are usually important in the detection and diagnosis of childhood disorders.

The second diagnostic challenge is that many childhood disorders are characterized by attributes and behaviors that occur, to a lesser extent, in most children. For example, in considering the diagnosis of Oppositional Defiant Disorder for Alec, we need to determine if he loses his temper more frequently than most children of the same mental age.

If all the relevant information is obtained only through psychodiagnostic interviews and psychological testing, the cost of a thorough evaluation would be exorbitant. In practice, many psychologists choose to focus on some content areas to the exclusion of others. An alternative approach is to administer parent questionnaires and checklists. Such instruments assist clinicians in obtaining comprehensive information in a cost-effective manner.

A good questionnaire has several benefits:

- Questionnaires help parents clarify and organize their perceptions of their child and thus make better use of the consultation.

- In responding to questions concerning their child's earlier development, parents can consult written records and other caregivers to aid recall of developmental facts. During an interview these sources typically are not available, thus often compromising the accuracy of the information obtained. Although parents' distortions of their child's development are clinically relevant, we also require accurate facts in order to identify developmental delays and detours.

- A completed questionnaire is a permanent record that documents the thoroughness of our evaluation (e.g., for legal purposes) (Behnke, 2005).

- A questionnaire allows us to obtain detailed information from parents in situations where we may want to limit direct contact. In evaluating suspicious or highly resistant adolescents, for example, too much contact with parents in the initial phases of the evaluation can increase the adolescent's worry that the therapist is acting merely as an agent of the parents. This can interfere with the establishment of a good working alliance. Yet, in order to better understand the adolescent's problems, we may require developmental data that are best supplied by parents.

Most parent questionnaires rely either on open-ended questions or on checklists (e.g., the Child Behavior Checklist) (Achenbach, 1991). The first approach provides valuable descriptive information, but may result in important areas not receiving adequate attention. Often, parents do not spontaneously report facts that are of great interest to the clinician. In some cases parents fail to appreciate the value of their knowledge and thus neglect to mention important facts. In other cases they may not recall facts. The checklist approach may be less likely to be affected by memory lapses and defensive operations: often it is easier to neglect to mention a fact than to explicitly deny it. However, this approach forces respondents to choose between a few alternatives, neither of which may adequately capture their personal situation.

Behavior checklists and open-ended questionnaires each may be appropriate in particular situations. Perhaps the most useful approach is to combine the two in instruments that present checklists and rating scales but also invite respondents to elaborate and provide additional information.

An additional problem inherent in behavior problem checklists and in many clinician's reports is an inadequate attention to a child's strengths. A focus on positive personality attributes provides a necessary balance to the usual focus on pathology, helps the clinician discover assets that can be of service during treatment, and reassures parents that the clinician is interested in obtaining a complete picture of their child's psychological functioning (Seligman & Csikszentmihalyi, 2000).

Many clinicians have come to rely on computerized scoring and interpretation of clinical instruments. What is not as widely recognized, though, is that computerized administration allows a questionnaire to be individualized while still maintaining a standard set of questions and checklists. For instance, in a questionnaire I developed that William Whitehead adapated for online administration, when the respondent indicates that a child's parents are separated or divorced, a number of additional items are subsequently requested, such as the court-ordered possession schedule, the residential schedule as it is actually practiced, and information pertinent to stepparents. Computerized questionnaires can also provide narrative reports that offer diagnostic hypotheses and integrate research data with the responses to the questionnaire, thus providing material that may inform evaluation reports. Psychologists are reminded that narrative statements in computer-generated reports offering interpretive hypotheses that go beyond organizing and summarizing responses do not always enjoy the same degree of empirical support as the source instrument's overall psychometric foundation might suggest; one should not rely exclusively on such narrative statements without additional support.

It must be stressed that no questionnaire or inventory takes the place of clinical interviews with the child and the child's major caregivers. Used properly, these instruments are a valuable source of information, but they need to be interpreted in the context of additional information from multiple data sources (American Psychological Association, 1994). Nevertheless, because of the many benefits of these instruments, I have come to regard their use as standard diagnostic procedure. Regardless of which inventory or questionnaire is used, I encourage colleagues to try this procedure and judge for themselves.

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Richard Warshak designed several questionnaires for two NIMH studies. His parent questionnaire has been used by child clinicians and custody evaluators throughout the country and abroad since 1988. It organizes demographic data, presenting problems, and symptoms indexed to DSM-IV criteria. It assists in evaluating a child's temperament, motor, cognitive, and personality strengths and weaknesses, peer relations, developmental, medical, and family histories, histories of school adjustment and stressful life events, and a child's differential treatment of each parent. The questionnaire can be completed online at home by parents with a narrative report sent to the clinician immediately upon completion of the instrument. Further information is available at www.wpqonline.com or via email at warshak@att.net.

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Lisa Firestone, PhD – Sex, Love and Relationships: Combining Sexuality and Intimacy
(11/16/2007 – 1:00pm -4:00pm)

Alan Kazdin, PhD – Title TBD
(11/16/2007 – 8:30am -10:00am)

John Norcross, PhD - Psychologist Self-Care: Ethically and Effectively Leaving it at the Office
(11/15/2007 – 9:15am -12:15pm)

Invited Addresses by

Samuel Knapp, EdD - Patient Focused Risk Management: A Perspective Based on Ethical Foundations
(11/16/2007 – 1:00pm -4:00pm)

Samuel Knapp, EdD - Ethical Issues and Boundaries for Psychologists
(11/17/2007 – 1:00pm -4:00pm)

Les Morey, PhD - Introduction to the Personality Assessment Inventory
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