

American Family Therapy Academy

NEWSLETTER

NEWSLETTER

Fall/Winter 2004
Number 91

American Family Therapy Academy



Theory • Research • Practice

This is inside front
cover. AFTA office plac-
ing

In This Issue

From the Editor's Desk, *Betty Mac Kune-Karrer* 4
Photo Album 28

TWENTY-SIXTH ANNUAL MEETING

Some Reflections on the Conference Theme of "Building Bridges: The Challenges of Connecting," *Peter Fraenkel*. 5

PLENARIES

I. Bridges Among Genes, Parenting and Marriage: A Personal Account of Attempted Crossings, *Beatrice L. Wood* 7
II. The State of Integration in Family Systems Theory, Practice, and Research, *Gonzalo Bacigalupe* 14
III. The Bridge Between Biological Psychiatry and Family Systems
 Walls and Bridges: A Review of the Issues Between Biopsychiatry
 and Family Systems Therapy, *Norbert Wetzel** 18
 Preventing Psychosis with Family Intervention:
 A New Frontier for Family Therapy, *William R. McFarlane** 24

*These are two of the three presentations from Plenary III

INTEREST GROUPS

Research: A Dialogue Between Researchers and Clinicians on Cross-Cultural Adoption
Michael Colberg and Martha Edwards 30
The Narrative of the Therapist/Researcher/Theoretician, *Robert Carroll*. 32
Larger Systems, *Mary Whiteside* 34
Racial Domination and Privilege, *Cheryl H. Litzke* 35

OTHER

Women's Institute, *Barbara Rothberg* 36

INTERVIEW

Andrea Canaan, *Jodie Kliman* 37

IN MEMORIAM

Doris Diamond, *Rosalind Edelstein* 39
Loren R. Mosher, A visionary and romantic, A voice in the wilderness, *Larry Allman* 40

DEPARTMENTS

Joint Human Rights/Family Policy Forum: Further Erosion of Immigrants' Rights, *Laura Roberto-Forman* 42
Books in Review, *Thorana Nelson (Editor)* 48

From the Editor's Desk

Betty Mac Kune-Karrer

As I informed you in my column in the Spring Issue, at the February Board Retreat, the *Newsletter* Editorial Board was given the task of re-thinking the functions of the *Newsletter* and making suggestions for its improvement. After several on-line discussions and a meeting of the Editorial Board in San Francisco, we have reached several conclusions. The most significant change is that the format and purpose of the *Newsletter* is completely changed.

As reported in the *AFTA Update*, the *Newsletter* discussions reflected that while the *Newsletter* has served the membership well throughout the years, it has become a publication that has had to serve multiple demands: i.e., publish articles of interest, Annual Meeting reportage, as well as social news. With the best of intentions, the *Newsletter* evolved into the literary equivalent of "neither fish nor fowl." This task is compounded with the difficulty of finding people to write. While there are some referenced, journal-like pieces, our "newsletter" category means that academic institutions do not consider it a publication that can be credited to the writer. Therefore, we considered a new publication called the *AFTA Monograph Series*, which will meet academic requirements.

The new *AFTA Monograph Series* will be theme-based and guest-edited. We have found that theme-based, concise and perspectivist issues afford a satisfying depth and nuance that mirrors the topic-focused Plenaries at the Annual Meeting. People write about what they are passionate about, and if they can get credit for it, great! The *AFTA Monograph Series* will continue to be published twice a year as a hard copy and on-line. Presently, we are considering the possibility of selling subscriptions to non-AFTA members. The Spring 2005 Issue will be our first guest-edited *AFTA Monograph Series* issue. Jodie Kliman has agreed to be the guest editor; her topic is tentatively called "Systemic approaches to healing and peace-building in regions struggling with war and terror."

This issue – our last traditional *Newsletter* issue, reports on the San Francisco Annual Meeting. Peter Fraenkel did an outstanding job of organizing this conference and deserves high accolades. The first article in this issue presents his

introductory thoughts, which beautifully contextualizes the Meeting theme, "Building Bridges: The Challenge of Connecting."

Beatrice Wood and Gonzalo Bacigalupe report on Plenaries I and II, respectively. Both articles are thoughtful and clearly articulate the concepts in the various presentations in each of these plenaries. I was not able to get a summary for plenaries III and IV; however, I copied two of the presentations in plenary III, "The Bridge between Biological Psychiatry and Family Systems", from the AFTA website: Norbert Wetzel's "Walls and Bridges: A review of the Issues Between Bipolar Disorder and Family Systems Therapy" and, McFarlane's "Preventing Psychosis with Family Intervention: A new Frontier for Family Therapy."* Both presentations wet our appetite about this fascinating theme.

The issue also reports on the Meeting Interest Groups and the Women's Institute. We continued promoting interviews with new members with Jodie Kliman's interview with Andrea Cnaan. As in previous issues, we cover the Departments with the combined Human Rights and Family Policy Committee report, as well as four Book Reviews. There are also two articles remembering AFTA members who died this year.

I hope you are looking forward to our new *AFTA Monograph Series* starting with Jodie Kliman's highly relevant and crucial theme in the Spring of 2005.

Betty Mac Kune-Karrer, MA, LMFT, is a senior therapist and supervisor at the Family Institute of Chicago at Northwestern University.

*You can also download these presentations from the Members Only page on the AFTA web site, www.afta.org.



Some Reflections on the Meeting Theme of “Building Bridges: The Challenges of Connecting”

Peter Fraenkel

Marco Polo describes a bridge, stone by stone.
“But which is the stone that supports the bridge?”
Kublai Khan asks.
“The bridge is not supported by one stone or another,”
Marco answers, “but by the line of the arch that they form.”
Kublai Khan remains silent, reflecting. Then he adds:
“Why do you speak to me of the stones? It is only the
arch that matters to me.” Polo answers: “Without
stones there is no arch.”
(Calvino, Italo. *Invisible Cities*. p. 82.)

Bridges. For each of us, the word conjures up particular ones we’ve crossed, or dreamed of crossing. Bridges. The word also works at the level of poetry, metaphor, imagery, and emotion; it captures some of our deepest longings to connect to others different from us, and perhaps, our fears of connecting to those others. For us therapists, teachers, researchers, and larger systems practitioners in family therapy and systemic change, there are many wonderful possible outcomes of building bridges among ourselves and among colleagues with different points of view, needs, and intentions: the possibility of more usefully complex ways of understanding and responding to those we serve; the possibility of research that more fully addresses the needs of clinicians, and of clinical wisdom that informs research; the possibility of a more complete integration of theory, research, and practice with the particular challenges and resources of the diverse groups, which we represent and with whom we work. With these potential benefits, there are also challenges; thus, the theme of the meeting, *Building Bridges: The Challenges of Connecting*.

What if two parties building the bridge have unequal power, unequal voice? Does the bridge open the way for domination, colonization of one person or group by another? What if the bridge is built only by one party, forcing the other into a relationship? What if the bridge connecting

two parties isn’t sufficient to hold the weight of the material brought across it? How do we create relationships among persons and among groups, between approaches to working with families and between families, and aspects of the larger social context – relationships that are mutually beneficial and not harmful to one or another party?

These are some of the larger questions we began to answer together as we moved through an exciting Annual Meeting, which explored the following: bridges among family and larger systems; the complexities of love, biological inheritance, and family interaction; psychopharmacology; different theories, practices, and research methods; families and the context of work; cross-cultural adoption; human rights and immigration; and a range of other topics all refracted through the lens of the wide variety of families and contexts with whom we work. As Program Chair, it was a delight to witness how AFTA members and guests resonated to the theme of bridges and carried it through all aspects of the program, as well as in informal hallway conversations. Even our musical entertainers, an incredible opening night performance by Holly Near; a jazz cruise under and around the Golden Gate Bridge; the fantastic urban world beat sounds of Hyim and the Fat Foakland Orchestra on Saturday night, sang out about bridges.

Now, just for the record, I’d like to clear up a little confusion about which came first – the conference location or its theme. A number of you approached me during the conference and said, “Oh, yeah, that was great to pick the theme of bridges with the conference being in San Francisco!” In fact, the theme came first, then fortuitously the location. When Lois Braverman approached me in February 2003 to ask if I’d be Program Chair, she asked me to pick a theme that I could really get excited about. Without missing a beat, I said “Bridges.”

All my life, I’ve been drawn to the creative tension that emerges from simultaneously holding similarities and

differences in mind and heart. As a young kid growing up in an ethnically and racially diverse town, I found it fascinating to visit the homes of my schoolmates and experience their families' languages, their rhythms and tones of speech, and their family rituals and traditions, such as how they decorated their homes; and then compare the differences as well as the similarities to the language, rituals, and aesthetics of my own family. I was upset when we moved to another state and town into a community that was much more culturally homogeneous. However, I found other ways to continue exploring cultural differences and similarities, as well as differences and similarities among my various interests – music, nature, psychology, philosophy, poetry, and politics.

Fast forward to the present, where I teach family therapy in a psychodynamically oriented clinical psychology program, create community-based programs and do research with persons whose race, class, and ethnicity are different from mine; where I live in a bicultural marriage and have bilingual kids; and where I respond to the world through the dual perspectives of language and music. There are lots of ways in which the theme of building bridges that are enlivening for all parties proves to be a useful guiding metaphor in my life!

Judging from the positive experiences of those who attended the conference this June, I'd guess we all have our bridges that we're building or crossing everyday. I'm

deeply grateful for having had the opportunity to bring together the diverse talents and passions of the members of this organization for an invigorating four-day gathering, and to see the theme of "The Bridge" realized among us in so many wonderful ways. May we continue to explore our differences AND our similarities as we continue on as a community of bridge-builders.

Peter Fraenkel, outgoing Program Chair, is Associate Professor of Psychology, City College of New York, and Director of the Center for Time, Work, and Family.



Plenary I: Bridges Among Genes, Parenting and Marriage: A Personal Account of Attempted Crossings

Beatrice L. Wood

Many of us have wondered “what next” for family therapy. The field began with a paradigm shift (general systems theory), expanded in a veritable explosion of theory and innovative clinical practice, moved to a stage of empirical verification and, to some degree has plateaued in terms of theory development. David Reiss' plenary gave a stunning glimpse into a potential trajectory for family systems theory, research and practice. This line of work is so singular in its concept, and so potentially profound, that it might even be considered a paradigm shift, one that could infuse our field with new creative energy and inspiration.

The gene-environment dialectic and family systems.

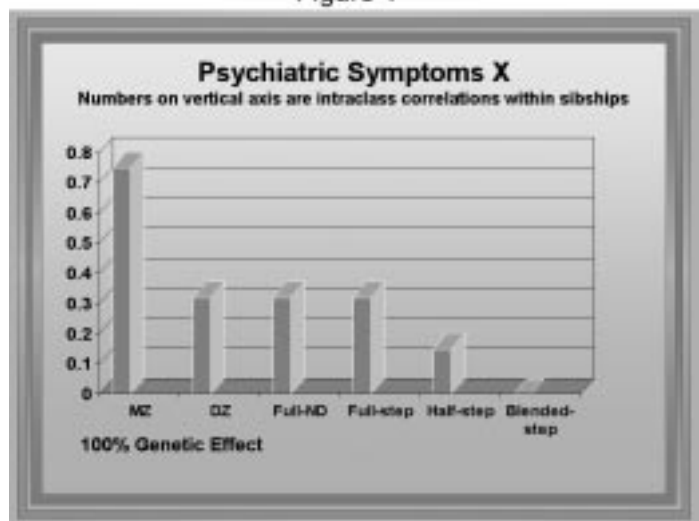
David Reiss and others, notably Lyman Wynne, have bridged and synthesized two scientific discourses, behavior genetics and family systems theory, into a new domain of inquiry that might best be characterized as “relational behavioral genetics.” Findings from these studies demonstrate that genetics and relational processes are inextricably entwined in determining individual and family outcomes. That is to say, genetics influence not only individuals, but family relational process as well, and family relational process influences the unfolding of genetically based vulnerabilities (and presumably strengths) of individuals.

How do these studies work? Some definitions and basic principles.

Behavior genetics seeks to identify and understand the contribution to developmental outcomes of genetic influences plus two types of environmental influences: shared and non-shared environment. *Shared environment* refers to the social and physical factors, shared by siblings in the same family, that affect development. Shared environmental influences will contribute to similarities in the siblings. *Non-shared environment* refers to the social and physical factors, distinct for each child in the family that affect development. Non-shared environmental influences contribute to differences in the siblings. Behavioral studies use a design that analyzes the patterns of differential correlations (measures of similarity) between siblings of varying

genetic relatedness (monozygotic twins, dizygotic twins, full siblings, half siblings, or genetically unrelated step-siblings) for a given variable, in order to determine the extent to which the variable is influenced by genetic and environmental factors. By studying these sibling pairs within each of their families, these studies can disentangle the extent to which individual outcomes are due to genetic vs. environmental influences. For example, if an outcome, e.g. Psychiatric Symptom X, were entirely due to genetic influences, the pattern of correlations would decrease in a step-wise fashion from the most to least genetically related pairs. (See Figure 1)

Figure 1

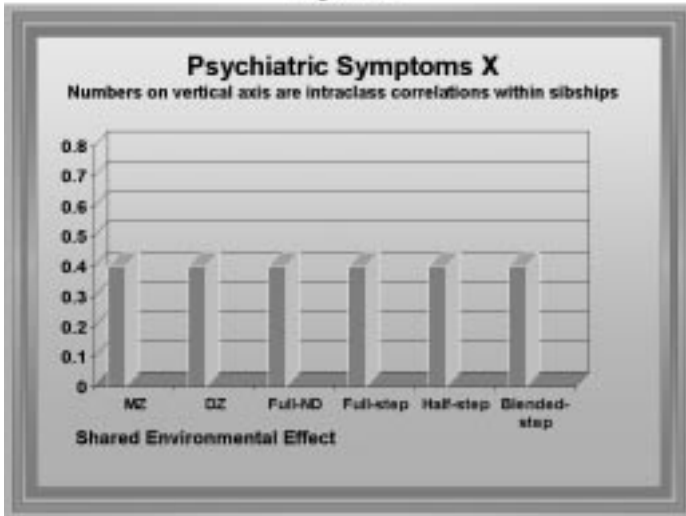


If Psychiatric Symptom X were due entirely to shared family influences (“shared environment”), then the correlations would be equivalent across the sibling types (given that each of the sibling pair type lives within a family. (See Figure 2)

Patterns of differential correlations that are in between these two extremes can be statistically analyzed to factor out the genetic from the shared family environment. The variance in the patterning of correlations that is not due to

genetic nor to shared environment is due to non-shared environmental influences (family and non-family) plus error of measurement.

Figure 2



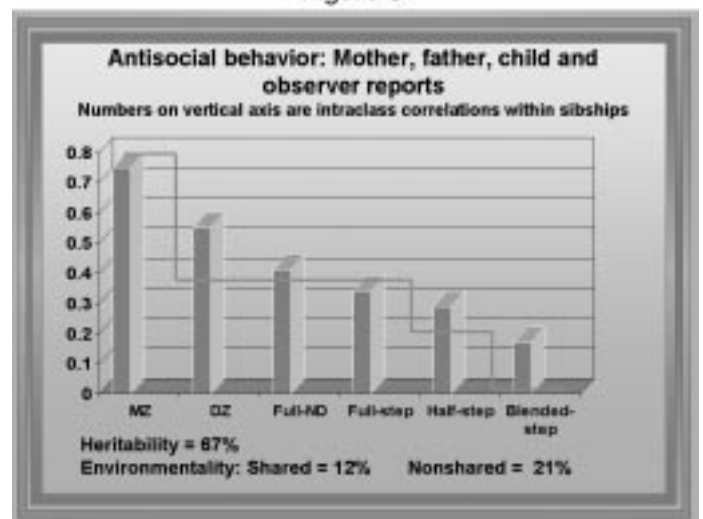
There are two principal ways of understanding the manner in which genetic and environmental factors operate together: genotype-environment correlation and genotype-environment interaction. Three types of genotype-environment correlation are commonly described: passive, evocative, and active. Passive genotype-environment correlation results simply from each parent sharing 50% of his or her genes with their children and parents providing the environment in which their children live. Therefore, any correlation between the child's genotype and the environment may occur because the environment provided by the parents also is correlated with the parents' genotypes. When the child's genotype evokes a response from the environment, evocative genotype-environment correlation is said to have occurred. For example, a child who has a difficult temperament is likely to elicit responses from others that signal anger or frustration. Active genotype-environment correlation occurs when individuals actively seek out environments that are correlated with their genotype. Using the same example of difficult temperament, a child who is difficult and aggressive may be more likely to select peers who are also aggressive, increasing their likelihood of fitting in, but also of increasing their problem behaviors. In genotype-environment interaction, a genetic factor expresses itself more readily in some environments than in others. For example, a person at genetic risk for alcohol abuse might be more likely to succumb to alcohol abuse in the context of a stressful environment or marital dysfunction.

Some show stoppers...

The Non-shared Environment in Adolescent Development (NEAD) study, a 12-year, two-point (early and mid-adolescence) investigation of 720 sibling pairs and families based on the above design, was conceived to study the relative influence of shared and non-shared family environmental factors on adolescent disorder (depression and antisocial behavior) and competence (problem solving and sociability). The predictive association between parenting and adolescent adjustment had been expected to be primarily environmental. The question posed was to what extent these influences were family-wide, i.e. shared by the children in the family, or specific to the individual child (i.e. non-shared environmental effects). One intriguing discovery that emerged was the extent to which genes appeared to affect both adolescent outcome and family relational processes. The relative contribution of genes vs. shared and non-shared environment varied according to the relational and outcome variable. However, overall, shared environment had surprisingly little effect, non-shared environment was variably influential depending upon the outcome variable, and genes had a relatively consistent effect. Figure 3 represents the outcome of one analysis from the NEAD study which demonstrates the relative contributions of genetic influences along with shared and nonshared environmental influences on adolescent anti-social behavior.

This robust genetic finding was initially disconcerting to those who privilege the influence of family processes as an explanation for developmental outcomes. But what unfolded was even more interesting and compelling: genotype by environment correlations. Specifically, findings showed that the same genetic factors that influence the antisocial adolescent behavior, also influence the parent-child relational process (mother's negativity towards the

Figure 3



adolescent). This is most likely due to genotype-environment correlation, (evocative genotype-environment correlation) one possible mechanism of which is that a genetically expressed behavior evokes a particular pattern of response from a family member (such as a parent).

Findings from the NEAD study inspired a complementary study called the “Twin Mom Study” using a sample of twin mothers of adolescents from the Swedish Twin Registry. This study was undertaken, in part, to analyze the relative effects of genes vs environment on maternal depression. It was found that non-shared environment accounted for 73% of the total variation in depression, genetic factors 27%, and shared environment none. Here, even though marital processes are evoked by genotypic differences among the women, that evocative process plays no role in their adjustment - in striking contrast to the adolescents in the NEAD study. Marital process and depression (as well as positive features of mothers' mental health) are linked to marital satisfaction without any connection to genotype. This is, interestingly, a sibling-specific effect (though it needn't be). Apparently, the common rearing environment of twins has little impact on their marriage. Twins marry different types of men and co-construct very different marriages - a matter of great significance for “relational behavior genetics.”

Another line of inquiry examines genotype-environment interactions. Tienari and Wynne's Finnish Family Study of Schizophrenia suggests the critical nature of relational process in determining genotype expression. Their longitudinal adoption study demonstrated that adopted offspring of biological mothers having schizophrenia spectrum disorders (n=190) were no more likely than offspring of mothers without psychiatric disorder (n=192) to have symptoms in the schizophrenia spectrum, provided that the adoptive families did not have communication that was problematic, critical or narrow in affect. This finding suggests that dysfunctional family relational process plays an essential role in the expression of the genetic vulnerability.

What's in the works?

Perhaps the most exciting discoveries are yet in the works. The Early Growth and Development Study follows birth mothers, birth fathers and adoptive families using longitudinal design. This design permits the study of the dynamic interplay between genetic factors, individual behaviors and relational process across development to identify specific relational factors (adverse and muting) that influence outcome. The goal is to identify foci for intervention in genetically informed intervention trials. The design is multi-wave and multi-level as illustrated in Figure 4, 5 and 6.

Figure 4

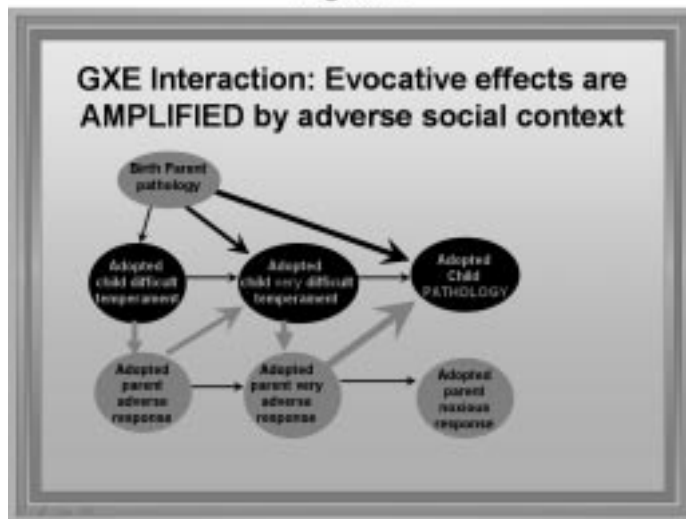


Figure 5

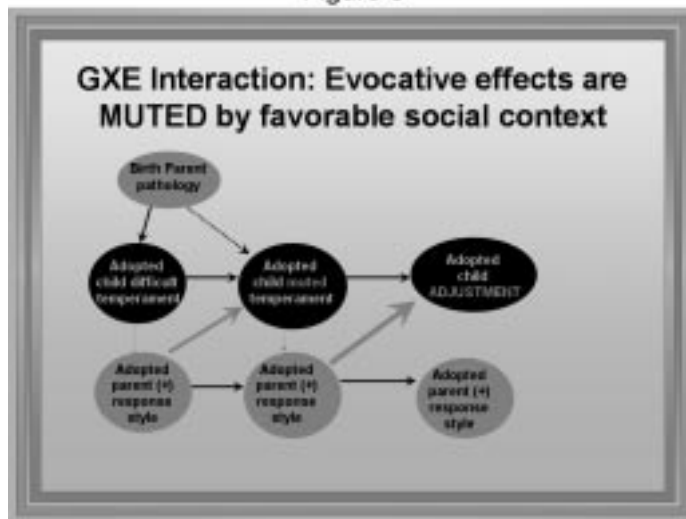
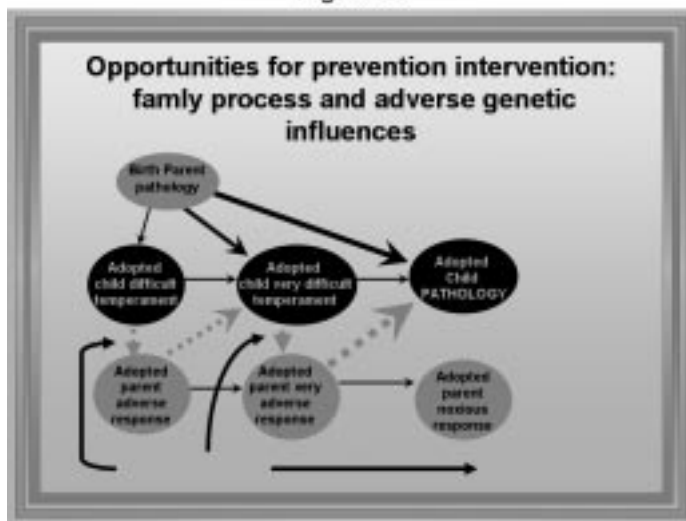


Figure 6



Implications for family systems theory, research and practice.

Although the effects of genetic factors on relationships may not be surprising, what is revolutionary is the suggestion that family relational process may influence gene expression. One powerful implication of such findings is that they indicate that family systems theory and practice may, and perhaps should, move into a stage which prioritizes prevention. Preventative family intervention would include shaping family relational process so as to prevent genetic expression of undesirable outcomes, such as depression, conduct disorders, psychosis and other emotional and psychological disorders. (See report of McFarlane's plenary in this issue) Hopefully prevention could also include shaping relational process so as to release genotype expression of positive attributes.

What role can family systems clinicians and researchers play?

This research is in its infancy. Dr. Reiss passionately made a bid for family clinician-scholars and researchers to join in this exciting venture. Family clinicians have expert observations that may guide selection of which family relational dimensions might usefully be investigated in relational behavioral genetics studies. Dr. Reiss also called for family researchers to team up with behavior genetics researchers to expand knowledge in this area.

Challenges to the field of family systems theory, research and practice.

The conceptualization, methodology, and data analytic procedures involved in this research are extremely complex. The results themselves are complex and challenging to understand and critically evaluate. Most of us currently active clinicians and researchers have not been trained to participate in this very different way of thinking, much less to incorporate this thinking into our clinical work or research. It is tempting to enjoy the show (the plenary) and go on thinking, practicing and investigating as we have before. But this would be a loss since there is a great deal that the field of family systems theory and practice has learned over the years that could inform this research trajectory. Perhaps the next generation of family systems clinicians and investigators can carry the torch. But who is going to teach them the necessary theoretical and research skills for this new endeavor? Perhaps this is a challenge best addressed by AFTA, considering how as an academy it may influence the training of the next generation. Perhaps an ongoing Interest Group?

In a modest attempt to stimulate a dialogue to address this challenge, we will place a copy of this article on both

the Family Process and the AFTA websites, including a collection of relevant abstracts from the literature for those who wish to know more about this research approach and its findings. In addition we include a few representative abstracts below.

Family Process website: www.FamilyProcess.org

AFTA website: www.afta.org

“Paradigm shift” or “back to the future”?

I guess I have to admit that this new theoretical and research domain called “relational behavior genetics” may really not be a paradigm shift. It is, after all, essentially a general systems paradigm, with attention to multi-level systemic interaction, including dynamic and reciprocal causal effects. Moreover, it is a more complete and elegant systems theoretical approach, incorporating biology (genes) and development systematically into its theory. Perhaps a “paradigm shift back to the future” would be more in keeping.

Authors

Neiderhiser, Jenae M; **Reiss, David**; Pedersen, Nancy L; Lichtenstein, Paul; Spotts, Erica L; Hansson, Kjell; Cederblad, Marianne; Ellhammer, Olle. (2004).

Title

Genetic and Environmental Influences on Mothering of Adolescents: A Comparison of Two Samples.

Source

Developmental Psychology. (2004) Vol 40(3), 335-351.
American Psychological Assn, US

Abstract

(from the journal abstract) This study examined 2 samples of adolescents and mothers using a child-based design (Non-shared Environment in Adolescent Development [NEAD] project, N = 395 families) and a parent-based design (Twin Moms [TM] project, N = 236 twin family pairs) to compare genetic and environmental influences on mothering. For both samples, the same measures of positivity, negativity, control, and monitoring were used. The use of matched child-based and parent-based samples enabled passive and non-passive genotype-environment (GE) correlations to be approximated, providing information about process. Passive GE correlations were suggested for mother's positivity and monitoring. For mother's negativity and control, primarily non-passive GE correlations were suggested. In several cases, both types of GE correlation were indicated. Finally, observer ratings of negativity and monitoring were influenced only by environmental factors. (PsycINFO Database Record (c) 2004 APA, all rights reserved)

Title

Child effects on family systems: Behavioral genetic strategies.

Source

Crouter, Ann C. (Ed); Booth, Alan (Ed). (2003). *Children's influence on family dynamics: The neglected side of family relationships*. (pp. 3-25). Mahwah, NJ, US: Lawrence Erlbaum Associates, Publishers. x, 269pp.

Abstract

(from the chapter) In this chapter, the author notes that the field of quantitative behavioral genetics draws inferences about genetic and environmental influences on behavior using genetically informed designs. Nowadays this field is often conceived as a preliminary and indirect peek at the influences of specific genes in behavior. According to this view, we are now on the threshold of a new era in which advances in molecular genetics will provide a much clearer and more precise view of how specific genes shape our thoughts and actions. In fact, these familiar tools now promise developments that are more realistic and closer at hand, serving to unravel the relationship between family dynamics and child development. First, they can help us properly weigh the role of children themselves in evoking and influencing the dynamics of their own families. Second, these tools can help clarify reciprocal child and parent influences as they unfold across development. Third, they can help delineate those aspects of families that make them more or less vulnerable to these influences. The chapter reviews some of the logic of quantitative behavioral genetics and illustrates its relevance for understanding child effects and reciprocal responses from families. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

Authors

Towers, Hilary; Spotts, Erica; **Reiss, David**.

Title

Unraveling the complexity of genetic and environmental influences on family relationships.

Source

Walsh, Froma (Ed). (2003). *Normal family processes: Growing diversity and complexity* (3rd ed.). (pp. 608-631). New York, NY, US: Guilford Press. xvii, 678pp.

Abstract

(from the chapter) This chapter provides an overview of some of the conceptual and methodological advances that have occurred in the study of gene-environment (GE) influences on family relationships. Information relevant to the study of family systems and processes is covered, with a particular focus on the following areas: (1) sensitivity of the

family environment to variation in genotype (GE correlation); (2) sensitivity of genotype to the environment (GE interaction); (3) sibling-specific (or "non-shared") environments; and (4) the role of environmental factors shared by family members in shaping family relationships. (PsycINFO Database Record (c) 2003 APA, all rights reserved)

Authors

Reiss, David; Cederblad, Marianne; Pedersen, Nancy L; Lichtenstein, Paul; Elthammar, Olof; Neiderhiser, Jenae M; Hansson, Kjell.

Title

Genetic probes of three theories of maternal adjustment: II. Genetic and environmental influences.

Source

Family Process. Vol 40(3), Fall 2001, 261-272. Family Process, US

Abstract

Presents the 1st report of the Twin Mom Study, an investigation of 3 hypotheses concerning influences on maternal adjustment (MA). These hypotheses concern the role of the marital and parent-child relationships in mediating genetic influences on MA and on the importance of the mothers' marital partners as a specifiable source of influences on their adjustment not shared with their sisters. The study's sample of 150 monozygotic (MZ) twins and 176 dizygotic (DZ) twins was drawn randomly from the Swedish Twin Registry. The sample included the marital partners of these twins and their adolescent children. Self-report and coded videotapes were a source of information about family process. Results focus on comparability of American and Swedish samples on scales measuring psychiatric symptoms, and on an analysis of genetic and environmental influences on 9 measures of MA. Results suggest comparability between the US and Sweden. Genetic influences were found for all measures of MA, particularly in the psychological manifestations of anxiety and for smoking. The pattern of findings also underscored the importance of influences unique to each sibling within the twin pair, thus focusing attention on the potential role of marital partners in MA. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Authors

Reiss, David; Pedersen, Nancy L; Cederblad, Marianne; Lichtenstein, Paul; Hansson, Kjell; Neiderhiser, Jenae M; Elthammar, Olof.

Title

Genetic probes of three theories of maternal adjustment: I. Recent evidence and a model.

Source

Family Process. Vol 40(3), Fall 2001, 247-259.

Family Process, US

Abstract

Derived 3 hypotheses on maternal adjustment from integrating findings from genetic studies with other contemporary research on maternal adjustment. First, mother's marriage mediates the influence of her heritable, personal attributes on her adjustment. Second, mother's recall of how she was parented is partially genetically influenced, and both her relationships with her spouse and her child mediate the impact of these genetically influenced representations on her current adjustment. Third, characteristics of mother's spouse are important influences on difference between her adjustment and that of her sister's. These sibling-specific influences are unrelated to mother's heritable attributes. The article develops this model, and a companion article (see record 2001-05166-002) describes the Twin Mom Study (D. Reiss et al, 2001) that was designed to test it as well, as its first findings. Data from this study can illuminate the role of family process in the expression of genetic influence and lead to specific family interventions designed to offset adverse genetic influences. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Authors

Reiss, David; Neiderhiser, Jenae M; Hetherington, E. Mavis; Plomin, Robert.

Title

The relationship code: Deciphering genetic and social influences on adolescent development.

Book Series Title

Adolescent lives; 1.

Source

(2000). xviii, 532pp. [Source?](#)

Abstract

(from the jacket) The book presents the theory of genetic influence while highlighting the social processes in the family as they pertain to adolescents. These ideas are based on the analysis of a 12-yr longitudinal study of the influence of both family relationships and genetic factors on adolescent development. The sample consisted of 720 pairs of same-sex adolescent siblings and their parents. The pairs included 6 different sibling types of differing

degrees of biological relationship, from monozygotic twins at 1 extreme--siblings who are genetically identical--to genetically unrelated stepsiblings at the other. The study's team of investigators used a wide variety of measures, including self-reports and interviews, analyses of videotaped family interactions, measures of stressful life events, and information on the adolescents' social world outside the family. The results show specific mechanisms that link genetic factors and the social environment in psychological development. (PsycINFO Database Record (c) 2002 APA, all rights reserved)

Authors

Tienari, Pekka; Wynne Lyman C.; Laksy, Kristian; Moring, Juha; Pentti, Nieminen; Sorry, Anneli; Lahti, Ilpo; Wahlberg, Karl-Erik.

Title

Genetic Boundaries of the Schizophrenia Spectrum: Evidence From the Finnish Adoptive Family Study of Schizophrenia

Source:

Am J Psychiatry 2003; 160, 1587-1594

Abstract:

Objective: Identification of the genetically related disorders in the putative schizophrenia spectrum is an unresolved problem. Data from the Finnish Adoptive Family Study of Schizophrenia, which was designed to disentangle genetic and environmental factors influencing risk for schizophrenia, were used to examine clinical phenotypes of schizophrenia spectrum disorders in adopted-away offspring of mothers with schizophrenia spectrum disorders. Method: Subjects were 190 adoptees at broadly defined genetic high-risk who had biological mothers with schizophrenia spectrum disorders, including a subgroup of 137 adoptees at narrowly defined high risk whose mothers had DSM-III-R schizophrenia. These high-risk groups, followed to a median age of 44 years, were compared diagnostically with 192 low-risk adoptees whose biological mothers had either a non-schizophrenia-spectrum diagnosis or no lifetime psychiatric diagnosis.

Results: In adoptees whose mothers had schizophrenia, the mean lifetime, age-corrected morbid risk for narrowly defined schizophrenia was 5.34% (SE=1.97%), compared to 1.74% (SE=1.00%) for low-risk adoptees, a marginally non-significant difference. In adoptees whose mothers had schizophrenia spectrum disorders, the mean age-corrected morbid risk for a schizophrenia spectrum disorder was

22.46% (SE=3.56%), compared with 4.36% (SE=1.51%) for low-risk adoptees, a significant difference. Within the comprehensive array of schizophrenia spectrum disorders, schizotypal personality disorder was found significantly more often in high-risk than in low-risk adoptees. The frequency of the group of non-schizophrenic non-affective psychoses collectively differentiated high-risk and low-risk adoptees, but the frequencies of the separate disorders within this category did not. The two groups were not differentiated by the prevalence of paranoid personality disorder and of affective disorders with psychotic features. Conclusions: In adopted-away offspring of mothers with schizophrenia spectrum disorders, the genetic liability for schizophrenia-related illness (with the rearing contributions of the biological mothers disentangled) is broadly dispersed. Genetically oriented studies of schizophrenia related disorders and studies of genotype environment interaction should consider not only narrowly defined, typical schizophrenia but also schizotypal and schizoid personality disorders and non-schizophrenic non-affective psychoses.

Author

Neiderhiser, Jenae M.

Title

Understanding the roles of genome and envirome: methods in genetic epidemiology.

Source

British Journal of Psychiatry. 178 (Supplement 40): s12-s17, April 2001.

Abstract

Background: In order to understand studies of psychiatric epidemiology focusing on the 'genome' and 'envirome', basic knowledge of the logic and methods is necessary.

Aims: To provide a review of typical methods used in genetic epidemiology.

Method: Reviews of the research designs usually employed in quantitative and molecular genetic studies. Genotype-environment correlation and interaction are also discussed.

Results: Quantitative genetic studies indicate that genetic influences are important for both psychiatric disorders and behavioral traits. Specific gene loci can be tested for associations with both psychiatric risk and behavioral traits by

means of molecular genetic techniques. There has been little examination of genotype-environment correlation and interaction, although the few reports that have appeared suggest that these complex relationships are important.

Conclusions: Advances in quantitative and molecular genetics now permit more careful examination of genotype-environment interaction and correlation. Studies combining molecular genetic strategies with measurement of the environment are still at an early stage, however, and their results must be awaited.

Beatrice Wood, is an Associate Professor of Psychiatry and Pediatrics at Children's Hospital of Buffalo.



Plenary II: The State of Integration in Family Systems Theory, Practice and Research

Gonzalo Bacigalupe

Reading the program description for this plenary about integration, a critic of the state of family therapy affairs may again confirm that family therapists are often strange birds in the world of mental health and systems change. We want complexity to be part of our identity as much as we would like to be able to simplify things when we face situations that drive us into feeling stuck and/or desperate. Historically, we have loved therapeutic models informed by theories emerging in the hard and social sciences as well as the humanities. This fascination for large encompassing conceptual ideas and the something that will bridge it all have also been the subject of our scholarly work. This plenary made me think about this fascination and the ways we may be shifting this way of creating theory, research, and practice. This bias towards complex theories has been part of our attempt at intervening in ways that are responsive to larger systems and the contextual dimensions that host us in the worlds we live. I do not believe they are part of intellectualizing maneuvers by the marginal voices of a group of professionals but the efforts at making sense of the worlds our patients and we inhabit. Part of this task has been to attempt the integration of different theories, practices, and methodologies into new wholes.

More important though than these, by now, fairly consensual thoughts about the state of the family therapy profession in the United States, my first reaction after listening to the plenary participants were the questions I raised in the small discussion group after the plenary: What constitutes an accountable form of scholarship in these times? What is our responsibility as scholar-clinicians towards the communities we serve? I think our plenary presenters addressed these questions without telling us that this was going to be their talk. Are we a bridge that suggests the tremendous possibilities of a mid-age professional field, an evocative and sometimes wild plethora of theories, and a real curious yearning for engaged dialogue with others? The presenters, Juan Luis Linares, Virginia Goldner, and William Pinsof, as well as the moderator of this plenary, Celia Falicov, evoked these and many other thoughts as I wrote this account.

Celia Falicov, former President of AFTA, opened the

plenary by telling us about a dream she had when she became interested in family therapy. While in a supermarket, she had left her filled cart to go to another aisle to pick-up something she needed. When she returned, the items in the cart were gone. Celia was quick to connect this story with what she thought was the crux of family therapy learning, she had to “lose everything” she had learned before. She soon discovered, though, that leaving behind what she had acquired would not be enough to work with different patients. She went back and claimed what she had acquired previously, while embracing new and emergent methods to treat. Leaving behind what we have learned and not integrating into our present practices, according to Falicov, has contributed to the fragmentation of the family therapy field and has diminished building bridges within our field and across other professionals in mental health. In her introduction, she characterized the three distinguished presenters as “superb guides” in helping us integrate “theory and practice and clinical research practice,” and invited the audience to collaboratively embrace difference.

Relational Nurturing: The Task of the Ultramodern

Juan Luis Linares is the co-director of the family therapy program at the Hospital St. Creu & St Pau (Barcelona, Spain) and President of the European Family Therapy Association. The core of his presentation was to discuss how “relational nurturing” might bridge modern and post-modern sensibilities. Therapeutic “models have avoided treating love as the central phenomenon of the human condition.” There has been a paradoxical failure to account for love in our models even though the core of our work is relationships. Linares suggested that family therapists are still recovering from the traumatic critique thirty years ago by the parents of young adults diagnosed with psychosis who accused family therapists of blaming them for the illness. Child abuse has been the second trend that has also impacted our field and thus, again, the questioning of parental competence by therapists. These trends, according to Linares, have distracted therapists from paying attention to the potential nurturing role that therapists could focus on:

“the process of restoring the loving bonds which have been partially or completely severed.”

Paraphrasing Maturana’s ideas about love, Linares emphasized that men and women are primarily people “who love and secondarily beings who harm each other”. The talk here turned to the Paleolithic age, reminding me of Riane Eisler’s work (1988), a period in which relationships of solidarity and love characterize our ancestors’ lives. The entrance of power as the organizing relational device would have changed this. According to Linares, love has been progressively “obstructed” in the complex intersection of gender, social class, and ethnic rift.

Perhaps this is why—because it is easier to recognize the complexity of the power relationships which obstruct love—we are also better placed to detect the complexity of love itself, of completely obstructed love. And perhaps the time has come, in order to address these interwoven complexities that work both in favour of and against love, to introduce the concept of relational nurturing, a concept that is more operative and less susceptible to simplification (even if less susceptible to sublime simplification) than that of love. (Linares)

Relational nurturing would be the concept that in its pragmatic, cognitive, and emotional aspects would allow systemic practitioners to overcome the simplified views of love as a “purely affective phenomenon.” For clinicians, assessing and intervening at the various levels in which love exists, and for the scholar, the work would be to investigate the implications of having any of the dimensions that constitute relational nurturing obstructed would lead to the problems that lead people to therapy. If one dimension is inhibited, a child may suffer, but an observer of the family may still doubt that the parents do not love their children. Linares hypothesizes that “different ways of obstructing love produce different illness.” This is an interesting turn because in this point the systemic paradigm serves to link clinicians to a form of relational psychopathology, a piece that many of us would find less compelling. Linares, nonetheless, believes that a postmodern sensibility would not be contradictory here. If we were to take seriously Foucault’s ideas about power as a web of interactions, then families would not just be a “transmitter” but a substantial protagonist and an “active intermediary between society and the individual.”

Linares challenges us to incorporate lineal causality and assimilate it together with postmodern sensibilities. For instance, he suggested that parental responsibility could be thought within a lineal causal perspective while not invoking a simplistic reductionist approach. To achieve this integration, he coined the term “ultramodern” (Linares, 2001). The ultramod-

ern therapist employs strategies and techniques within a position of “solidarity” rather than “objective neutrality” incorporating a socially responsible medical model. Linares is uncomfortable with the postmodern critique of the medical model as “authoritarian and non-collaborative”. Joining those using the medical model in responsible ways would be more efficient. Thus, for an ultramodern approach the main goal is the “complete restoration of loving relationships.” Towards the end of his presentation, Linares outlined the general principles that guide such a therapist including the classical use of systemic reformulation, emotionally intelligent interventions, and the demonstration of a practical spirit.

Romantic Love: Putting Romantic Love on the Conversation Table

Virginia Goldner is the director of the Gender and Violence Project at the Ackerman Institute for the Family and the founding editor of the journal *Studies in Gender and Sexuality*. Goldner challenged us to think about romantic love. Goldner, like Linares, thinks clinicians avoid speaking about love even though it is part of our primary experiences. Despite its central role, our field has been neglectful; only five articles in more than four decades of *Family Process* have the word love in the title.

The word that constitutes the ultimate test case, the word by which we privately measure the authenticity of our involvement with another person? ... Romantic love is, in fact, one of those profound dimensions of psychic life that is directly knowable and experience near. ... Love hurts. (Goldner)

For couples romantic love is central according to studies that Goldner cited. Other authors have suggested that for couples to stay together, developing better communication skills, the usual complaint of couples coming to therapy, is not enough to hold relationships together. Goldner suggests that we lack a strong conceptual set to address love in couple relationships. We have spent too much time worrying about the pragmatic aspects of these relationships, and too little time listening and thinking through the experience of love.

Recent developments in psychoanalysis, according to Goldner, may shed light onto the inadequacies of systemic ideas. An analysis of the contributions of psychoanalyst Stephen A. Mitchell (Mitchell, 2002) about the history of romantic love formed the basis of this section of Goldner’s presentation. Goldner told us that the book was not only conceptually appealing but was, at mid-life, personally transformative of her own marital relationship. Mitchell starts from the premise that marriage, as a cultural artifact, provides married individuals a false sense of having achieved maturity. Romantic love’s disappearance (my own interpretation of Mitchell) has a profound effect on those partici-

pating from a pseudo-mature relationship. Marriage culturally sanctions our avoidance of the “challenges of long-term intimacy.” The audience reacted to Goldner’s description as one would react to a good read in the *New Yorker*, nervous laughter while listening to a really profound matter. Passion and romance are degraded in long-term relationships because we are afraid of how dependent we become of the other. Flirting with the person with whom we are in stable relationships would be taking a necessary risk. A detailed analysis of how this mechanism develops in relationships revealed a fascinating picture in which the personal, the relational, and the cultural were all intersecting. Couples, therefore, need to take risks in their relationships.

Goldner interjected her own view onto Mitchell’s psychodynamic and individualistic (although complex) approach. She does not assume that relationships originate in a place of safety, but it is only in a holding context that couples can “take the personal risks which may be necessary to enliven defensively deadened relationships.” “Security and adventure, romance and dependency” pull people in “opposite directions.” The presentation argued that these polarizing tendencies intersect, converge, and become new entities, creating a history. There are relational histories, not purely psychodynamic phenomena. Attachment theory was the other tool in the reconstruction of a relational romantic love conceptualization.

Childhood attachment serves as a template for romantic love... a hardwired extension of parent-child bonds: inevitable, crucial, catastrophic if severed. (Goldner)

In a truly integrative fashion, Goldner situates these ideas in the realm of the both/and rather than the dual polarities framework that Mitchell’s construct seems to support. In this regard, “safety and adventure” are “mutually catalytic” rather than centrifugal forces. A secure child, therefore, like my own group therapist would say, is the one whose able to risk “fear and dependency.” Elaborating on the clinical implications of these ideas, Goldner concluded with our own old but useful systemic idea. Integrating these insights can only occur if we are willing to accept and ground our work in paradox. I am sure there is more to come from these sets of fascinating ideas.

Process Research and the Process of Change in Integrative Therapy

William Pinsof, president of The Family Institute and adjunct professor at Northwestern University, examined two aspects of integration: integrative problem centered therapy and process research (Pinsof, 1994, 1995, 2002; Pinsof & Wynne, 2000). Almost a decade ago, Pinsof (1995) defined Integrative Problem Centered Therapy as:

a coherent, cohesive, and comprehensive framework for integrating individual and family psychotherapies. It is predicated upon twin assumptions: each pure form model has its particular ‘domain of expertise’ and these models and their domains of expertise ‘can be interrelated to maximize their assets and minimize their deficits (p.104).

This time, his carefully designed presentation was directed to helping clinicians understand the relevancy of empirical research in the real world of community mental health services. Pinsof defined the characteristics of empirically validated treatments (EVT) with its “gold standard” method, the randomized clinical trial (RCT):

- *Random assignment of patients to treatments and therapists to patients within treatments*
- *Targeting of single, well-defined mental disorders (DSM-IVR)*
- *Rigorous pre, post and follow-up outcome evaluation*

EVT also includes the “standardization of treatment through manualization and process evaluation—adherence ratings.” RCT and EVT have been emerging as dominant players in the mental health world because they are increasingly guiding financial, institutional, and corporate decisions about what mental health treatments to support.

Pinsof then analyzed some of the major obstacles in the implementation of empirically based treatments. RCT and EVTs have been criticized because the “results are not clinically relevant to family therapists.” Manualized therapies, according to Pinsof and probably with the concurrence of the audience listening, “differ from ‘real life’ therapies.” Therapists operate contextually, making decisions on a case-by-case situation, and are responsive to feedback on the part of the patient and the family. Moreover, the target of RCTs is a “single, well-defined mental disorder, unlike real life therapies.” Finally, the information gathered during the research will always be group and population based and not necessarily case-specific. Therefore, a successful EVT may not necessarily help a group of patients or families. As a result, Pinsof believes that EVTs “will only be widely implemented if therapists are forced to use them.” To counteract this situation, therapists could adopt the idea of medicine as the “artful application of scientific knowledge.”

After this introduction, Pinsof looked at process research and the research carried out at The Family Institute. Their project has relied on the work of 90 therapists with 4,000 cases and 35,000 outpatient visits at several clinics, including three that serve Latino patients in their preferred language. The research project’s aims are:

- *to describe and measure how people change in therapy,*

- to describe and measure relevant therapist behaviors associated with particular client system change profiles, and
- to develop a methodology for feeding back client change and therapist behavior information during therapy.

Pinsof's team employs the Systemic Therapy Inventory of Change (STIC), a set of two self-report questionnaires that "tap changes in the relevant domains of clients' lives regardless of the type of therapy." Based on several tests of reliability, Pinsof defended the STIC research value. A clinical example grounded these ideas, suggesting the usefulness of these instruments in the work of therapists. The STIC results pointed out some intriguing findings about the progress of therapy for each individual in a couple. Measuring couple dynamics as well as the therapeutic process (i.e., therapeutic alliance), emphasizes domains that are less model-driven and integrative of psychological, biological, and systemic dimensions.

Pinsof is convinced that the movement towards sound empirically informed systemic psychotherapy would transform psychotherapy. It not only implies an integration of conceptual relevance but also brings into the clinical interaction the use of quantitative feedback in a collaborative fashion that may reverberate through the therapist and family as well as the larger institutional systems in which therapy occurs.

Quantitative feedback is one essential, but insufficient form of feedback. The essential and complementary (to science) roles of intuition and clinical wisdom are not an either/or, but a both/and proposition. (Pinsof)

This statement summarizes well the spirit and intention of this plenary, to integrate in complex and artful ways the wealth of developments in which family therapy continues to walk. Family therapy continues to be influenced (integrating and reacting to) by hegemonic ideas about what constitutes good research as much as by the knowledge that emerges from the humanities, psychoanalysis, anthropology, as well as our clinical practices and continuous reflexive process of de-silencing what we have made invisible or neglected in previous developments.

References

- Eisler, R. (1988). *The chalice and the blade: Our history, our future*. San Francisco, CA: Harper & Row.
- Goldner, V. (1988). Generation and gender: Normative and covert hierarchies. *Family Process*, 27(1), 17-31.
- Goldner, V. (1989). Sex, power, and gender: The politics of passion. In D. Kantor & B. Okum (Eds.), *Intimate environments: sex, intimacy, and gender in families* (pp. 28-53). New York, NY: The Guilford Press.

Goldner, V. (1998). The treatment of violence and victimization in intimate relationships. *Family Process*, 37(3), 263-286.

Goldner, V. (1999). Morality and multiplicity: Perspectives on the treatment of violence in intimate life. *Journal of Marital and Family Therapy*, 25(3), 325-336.

Goldner, V., Penn, P., Sheinberg, M., & Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. *Family Process*, 29(4), 343-364.

Linares, J. L. (1996). *Identidad y narrativa: La terapia familiar en la practica clinica*. Barcelona, Spain: Paidos.

Linares, J. L. (2001). Does history end with postmodernism? Toward an ultramodern family therapy. *Family Process*, 40(4), 401-412.

Linares, J. L. (2002). *Del abuso y otros desmanes: El maltrato familiar, entre la terapia y el control*. Barcelona: Paidos.

Linares, J. L., Castello, N., & Colilles, M. (2001). La terapia familiar de las psicosis como un proceso de reconfirmacion. *Redes: Revista de Psicoterapia Relacional e Intervenciones Sociales*, 8, 9-29.

Mitchell, S. A. (2002). *Can love last? The fate of romance over time* (1st ed.). New York: W.W. Norton.

Pinsof, W. M. (1994). An overview of integrative problem centered therapy: A synthesis of family and individual psychotherapies. *Journal of Family Therapy*, 16, 103-121.

Pinsof, W. M. (1995). *Integrative problem-centered therapy: a synthesis of family, individual, and biological therapies*. New York, NY: BasicBooks.

Pinsof, W. M. (2002). The death of "Till death us do part": The transformation of pair-bonding in the 20th century. *Family Process*, 41(2), 135-158.

Pinsof, W. M., & Wynne, L. C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy*, 26(1), 1-8.

Gonzalo Bacigalupe is associate professor at the University of Massachusetts Boston Family Therapy Program and research and associate professor at the University of Massachusetts Department of Family Medicine and Community Health.



Plenary III: The Bridge Between Biological Psychiatry and Family Systems

Walls and Bridges: A Review of the Issues Between Bio-psychiatry and Family Systems Therapy*

Norbert Wetzel

I would like to start my comments about the issues between Bio-Psychiatry and Family Systems Therapy with a clarification. Initially, I had intended to provide you with an objective analysis of the issues. The more I surveyed the topics involved, the more I became aware of my inability to remain dispassionate and “objective”.

Here, then, is one family therapist’s passionate and subjective view of the current state of the discourse between biological psychiatry and family therapy. As you may find out during our subsequent conversations, adopting an engaged position within a vigorous discourse may actually help move the process of integration forward.

Let me start with a general comment about the current state of the professional dialogue within the “mental health system”: This discourse is a conversation between partners of unequal power.

One of the main walls preventing understanding and interaction between the mental health professions is the fact that the inter-professional discourse is by no means unconstrained or without powerful interference by societal forces that have a huge economic interest in its process and outcome.

It is very difficult to participate in an open-ended search for scientific truth if your professional career and economic survival depend on the degree of your adjustment to the dominant “wisdom” of the field. I am talking here about practitioners who depend on referrals and on their professional reputation in public. Most family therapists are at the lower end of the professional hierarchy. They often lack the training or the professional stamina to oppose the prevailing ideas and, for instance, question a psychiatrist’s decision to prescribe medication.

The current, popular and prevailing societal view assumes that moods, emotions, thoughts, and behaviors are “biologically determined”, i.e. that they are some sort of outgrowth of a person’s genetic predispositions and of neuro-physiological

brain processes which, when not functioning properly, need to be treated with medications, just like any other disease.

This dominant view is actively promoted and enforced by numerous public institutions and economic interests such as community mental health agencies, schools, physicians, advertisements, the media, the judicial system, pharmaceutical companies, and health insurance organizations, not to mention numerous well organized parent groups, often financed by the pharmaceutical industry. Advocates for more traditional forms of psychotherapy or for family therapy are clearly in a minority in the public market place.

Professional exchanges with our psychiatrist colleagues about psychiatric drugs should, therefore, never be seen as deliberations between partners of equal status. Nor do they take place within an unconstrained context. They are not “domination free communications” (Habermas, 1972), rather they take place in a context where it has become axiomatic that at least for more severe mental illnesses treatment begins with the prescription of medications (Kavanaugh, 2004), pharmacological intervention is the treatment, all else is ancillary.

It may be appropriate, considering this state of the professional discourse, to remind you here of the words with which the philosopher Immanuel Kant encapsulated the meaning of “Enlightenment”: “Sapere Aude!” “Make use of your own mind!” Or better: “Have the audacity to think for yourself!” Such audacity is badly needed in a professional world in which people are socialized to think, speak and communicate in pre-fabricated, pre-defined formulaic terms, in which our professional language is hijacked by the forces dominating the prescription market, and in which it is easy to give in and simply follow the suggested, even imposed “medical” solutions for any kind of clinical disorder.

Let's review the societal context in detail.

Societal Context

There is little controversy about the fact that in the US we live and participate in a dysfunctional, unjust, racist, and profoundly fragmented so-called "mental health system". Just as in a family system under stress, the members of the "health system", i.e. the professionals, the consumers, the governmental bureaucracies, the health insurance corporations, and the pharmaceutical companies are pitted against each other or have formed all sorts of unholy alliances.

The dysfunctional "mental health system" and, consequently, the frozen interdisciplinary discourse are embedded in a societal context that supports a reductionistic view of human emotions, behaviors, and experiences as produced by the human brain and its bio-physiological processes. Enormous technological and pharmaceutical advances emphasize that the product manufactured by the medical system is the cure of a sick body, not the healing of a person who is ill. "Mental illness" is a brain disease to be treated with medication.

A complex network of major participants in the health system defines, influences, and maintains the status quo with considerable consequences as to how "mental health" practices ought to be carried out. Schools, prisons, psychiatric hospitals, general and pediatric medical practices, human service agencies, and state mental health departments usually follow the prevailing medical biological point of view, at times with threats and coercive means. Most often, for the consumer that means medication with little or insufficient counseling.

I would like to highlight a few aspects of this picture of an unjust, confused, often corrupt system of "mental health" within which our colleagues and we struggle to perform according to the highest ethical and professional standards.

- Professionals of all disciplines in this system (not only social workers, psychologists, or family therapists, but also psychiatrists) are under tremendous stress to prescribe drugs for psychiatric diagnoses, because the societal forces are present in the treatment room and define the clinical interview.

- I am particularly concerned, as many colleagues are, about the over-prescription of psychotropic medications for children, often without any diagnostic procedures and for increasingly younger children (beginning age two). The marketing of a drug has become the marketing of the disorder for which it provides the cure. The more salient examples are the drugs for ADD and ADHD, for bipolar disorder, for major depression and for a variety of other newly designed "disorders" such as "social anxiety disorder" or "oppositional defiance disorder". Very few of the medications are approved by the FDA for children.

Family therapists, in particular, have to wonder whether state of the art individual and/or family therapy together with adequate school reforms or classroom interventions would arrive at better outcomes without the need for medication, particularly long term. Medication for children often seems, in the eyes of a context-sensitive family therapist, to be a way of numbing children, parents, and professionals in the face of untenable environmental, educational, or familial contexts.

- I am focusing here less on so-called major psychiatric disorders in adults, i.e. major depression, schizophrenia, or bipolar disorder. The interplay between genetic, bio-physiological, personal, and familial factors in the etiology of these disorders seems even more complex than for other conditions for which drugs are prescribed so liberally. As family therapists we need to wonder, however, why it seems so out of place these days to treat someone diagnosed as schizophrenic or manic-depressive with individual and family therapy alone.

Within such a deeply divided "mental health system", the professional discourse is sorely lacking in candor. There is little respect, and even less willingness to listen to each other or to understand the other's positions. Walls of suspicion separate the different professional groups, representatives of professional organizations attack each other in the political arena for their share of the market, bridges that could connect the disciplines to promote professional exchanges have collapsed, and a common language that could facilitate mutual understanding does not exist.

On one side there are psychiatrists, pediatricians, family physicians and specialty MD's who generally have little training in doing psychotherapy. Even if they see themselves as capable of resisting the pressures from sales people representing the pharmaceutical companies or from their patients (or parents of their patients), research shows that prescriptions follow the drugs suggested by the pharmaceutical companies for the current disease marketed.

On the other side, there are family therapists and psychotherapists, in general, who continue to believe in the power of the "talking cure" (S. Freud). They tend to underestimate the power of physiological and organic processes, substance abuse, and medical disease processes and often do not inquire about these issues in their clients' lives. Consequently, in the eyes of psychiatrists, non-medical therapists underestimate how pharmaceuticals can contribute to the well being of people and to the progress of talk therapy. Then there are therapists who exaggerate the effects of psychotropic medications. Ignorance and reluctance to become well informed leads non-medical therapists to an uncritical acceptance of the psychiatrist's authority regarding the use of medication for their clients.

To sum it up: The particular societal pressures, constraints, and mind controlling factors inherent in the current “mental health system” leave us as professionals with a dilemma: Either we adjust to the so-called reality and work as participants in the system, often with patients who are numbed, drugged, and made compliant to a degree that makes family therapy virtually impossible. Or we hold on to our critical stance in the tradition of the Enlightenment and face increasing irrelevance, especially as advocates of psychotherapy or family therapy without the use of medication for people diagnosed with major psychiatric disorders.

Let me turn, briefly, to the issue of

Research: The current state of affairs

One source of ongoing mistrust between bio-psychiatrists and psychotherapists, especially relationally focused family therapists is the current state of affairs in the area of research. Again, the field is divided and the participants are of unequal power.

Biologically oriented psychiatrists are usually unfamiliar with the research basis for the claims of treatment success and transformation of individuals and families made by psychotherapists and family therapists. With the current societal climate and the pressures to medicate people, particularly those diagnosed with “mental illness”, it is even less likely that serious research will get funded for exclusively psychotherapeutic treatment of people diagnosed with schizophrenia, bipolar disorder, or major depression.

Things are strikingly different in the field of biologically oriented psychiatric research, especially regarding the development of new psychotropic medications. Due to the sheer limitless budgets of drug companies an entire industry of researchers, academic and private institutions, and research labs are involved in the development and testing of new psychotropic drugs.

Yet, there is a growing body of literature in the scientific community, both inside and outside the family therapy field, that has raised very serious questions and rendered most, if not all, research in the field of psychotropic drugs suspect.

The questions focus on:

- the validity of the widely accepted bio-chemical and bio-physiological model of brain functioning;
- the scientific and ethical reliability of the entire research underlying the broad acceptance of psychotropic drugs as a cure for emotional and behavioral disorders;
- the claims, beliefs, and practices popularized and maintained by groups with commercial interests in these drugs, such as the pharmaceutical companies, the AMA, or HMO's.

The current state of research and scientific exploration,

therefore, deepened the split between biologically oriented psychiatrists and psychotherapists, particularly family therapists.

Epistemological Perspective

Beyond all these professional and societal reasons I believe the discourse between Bio-psychiatry and Family Systems Therapy suffers from a clash of two diverse epistemological paradigms. In my view, we must address the chasm between the professions at that level and initiate a renewal of the interdisciplinary conversation through the process of philosophical inquiry.

The medical sciences in general, psychiatry in particular, and many psychotherapeutic schools as well are stuck, epistemologically speaking, in Descartes' dualism and Newton's classic realism. Many of our psychiatric colleagues as well as social workers and psychologists remain dazzled by the technological and pharmaceutical breakthroughs of modern medicine that are owed to the classic realist view of the world as a giant collection of objects that we can accurately measure and research.

Bio-psychiatry, therefore, keeps its focus on what has priority, medically speaking, i.e. the bio-physiological aspects of a person, the physical, chemical, biological, and physiological processes of the human organism that can be measured, researched, and compared with similar processes in the realm of animals. It is left to psychotherapists and family therapists, in turn, to deal with the mind or the psyche, i.e. with personal experiences, with psychic conflicts, and with cognitive or emotional deficiencies while psychotropic medications take care of the body.

This Cartesian dualism is dominant on both the professional level of scientific discourse and on the clinical level in the treatment of so-called “mental disorders” with pharmacological interventions.

One may adopt the classic realism paradigm for many aspects of daily life or for the construction of all sorts of great machines, yet for the human world it is woefully inadequate and often destructive, not only in terms of the medical field. It blocks out the relational aspects of reality, purports to enunciate “the truth”, is blind to the uniqueness of others, and fails to provide a basis for the joint creation of meaning.

It seems to me that family therapy is based on a different paradigm in which therapy is conceptualized as an encounter between people who are engaged in a particular form of conversation. Our model of the relational process in family therapy is rooted in post-modern constructionist relational Epistemology.

At the core of our inner experience we find ourselves involved in a continuing relational process with others that

occurs prior to our own decision. This relationship process between us and others is reciprocal and enormously complex. Our existence as related beings logically precedes our cognition of others. We are always logically first participants, then observers. As participant observers our choice of perspective, i.e. scientific, empathic, artistic, investigative, or combative determines the kind of “reality” we can “see”. The “world”, therefore, is a project constructed jointly in the minds of the observing participants in a complex reciprocal process. Our mind’s project of the “world” and of the people around us is not a mere phantasm because the project rests on the ongoing relational process in which the “observer” is part of the “observed” and as such profoundly defined by and defining the other. The other remains, however, while accessible within the complex relational process, at the same time forever beyond the comprehension of the observing partner, i.e. the other is not a comprehensible, i.e. quantifiable object.

The rigorous application of this relational paradigm to clinical practice gets us out of the medical, i.e. dualistic and classic realist model of thinking and puts the emphasis on the interpersonal language and collaborative process between the people involved.

Espousing relational epistemology opens up multiple perspectives for a dynamic discourse between bio-psychiatry and family therapy.

- Most important, it allows the members of the different health and human services professions to choose the perspective with which they want to construct a specific relational context and process. The classic realist view with its focus on bio-physiological brain processes does not become invalid or obsolete, but one among many possible views and, when applied, stays embedded in a relational process between the partners. After all we are embodied minds, not meta-physical spirits.
- Second, most human phenomena that we subsume under the heading “symptoms” manifest themselves on a social level, i.e. become manifest as parts of interactions and communications between people. So it seems pragmatically plausible to look for and understand these phenomena on the interpersonal level first. Now, it may be equally useful for a therapist working with individuals to study a person’s intra-psyche life or for a psychiatrist to look for genetic or bio-physiological variations corresponding with a certain behavior. A sociologist may look at the socio-economic and cultural context to understand an individual’s actions. As long as each partner in the discourse does not claim to have found the “objective” truth, i.e. as long as nobody claims the paradigm of the classic realism, this “kaleidoscope of perspectives” (Wetzel & Winawer, 2002)

will enrich the picture and contribute to understanding.

- Third, it is precisely the unique contribution of the relational epistemology to support cross disciplinary discourse between talk therapists and bio-psychiatrists. The diverse views of the different professions become equally “legitimate” and contributory to the understanding of complex human attitudes and behavior patterns, subject only to the rigor and, hopefully, uninhibited candor of the evolving professional debate and research.
- Guided by the relational paradigm, we can also begin to recognize the complex correlations and interfaces between the various levels of understanding and responding therapeutically, i.e. the societal, familial, individual, bio-physiological, and genetic levels. As emphasized by David Reiss, therapy leading to productive and satisfactory marital and family relationships is likely to impact the brain physiology or the consequences of the genetic makeup of a person, just as a healthier bio-physiological organism in turn may support the healing of an individual or the well being of an entire family.
- Finally, there is a hierarchy of levels of perception, understanding, and responding. We can proceed from the interpersonal level narrowing our lens toward a person’s developmental history and individual trauma, to his/her particular cognitive or emotional skills, to intra-psyche conflicts, to bio-physiological or genetic deficits. Each level may warrant specific exploration and may be amenable to a range of therapeutic responses, including medication. Equally, we can broaden our perspective and choose to consider the community surrounding an individual or family, as we may look at specific societal events and processes, at a family’s immigration history, or at a client’s experience with societal racism.

Let’s look at Gender, Culture, and Social Class from a relational perspective.

Based upon the above outlined epistemological reflections the most salient critique of bio-psychiatry’s reductionism from the perspective of a relational construction of the clinical process comes into view.

Rooted in the Cartesian split between body and mind, between physical organism and personal self, does bio-psychiatry not end up just treating the physical organism and thereby losing the person and leveling everybody to sameness?

I would like to exemplify this question by drawing your attention to just three of the aspects of our common humanity toward which biologically focused psychiatry by definition remains blind unless the medical intervention is embedded in a therapeutic relationship based on the relational paradigm.

(1) Every human being exists as a woman or as a man, i.e. we are gendered beings. From the point of view of bio-psychiatry that does not seem to matter much, since the dominant model of the bio-physiological processes within the brain seems to be the same for women and men. From the perspective of relational epistemology, of course, there is no abstract human being, rather each individual comes into view as a woman or a man and is uniquely human as such.

The discourse between psychiatry and psychotherapy, therefore, has to address questions, such as: What does it mean to a woman or a man, to a girl or a boy in their understanding of their gender role to be “diagnosed” as “having a psychiatric disorder” and to have to take medication? Prescribing medications without a therapeutic relationship in which the constructions of a client’s or family’s gender roles are explored, including the meaning of medication for this client, does this not constitute a form of sexism on the part of the medical expert?

(2) Every human being is born into a specific culture and participates in a cultural, ethnic, and racial heritage and community, however tenuous that tradition may be. By definition, the biologically focused psychiatrist can not perceive nor conceptualize the profound uniqueness of a person’s cultural identity, since biologically there is only one human race.

Unless, by adopting a relational epistemology, we integrate a bio-physiological perspective into the relational process connecting client, family, and therapist, how are we able to have a creative inter-disciplinary discourse about the values, stories, traditions, beliefs, spirituality, and the history of suffering of the individual client cultures we encounter? Is it not just another form of racism to prescribe psychotropic drugs to someone about whose culture we know nothing, who did not have the chance to be understood in terms of the cultural meaning of his/her symptoms, and from whom we learned nothing about the meaning of taking drugs in his or her culture?

(3) Bio-psychiatry’s vision, focused on the organism, is also obstructed from noticing another facet of the human reality. Our sensitivity as relational therapists for the socio-economic context of our clients reveals how deeply each of us is marked as an individual by the particular economic and social factors determining the life chances and circumstances of her or his family. With a lens that is sharpened by the focus on the socio-economic factors in the context of a particular individual or family we understand how much the entire “mental health” process and the underlying concepts assume an average middle class person as the unit of diagnosis and intervention.

The effects on people’s psychological health of poverty, of growing up in deprivation and without hope to transcend one’s environment, of contextual and structural violence in one’s neighborhood, of being part of the “underclass” in a society of enormous wealth are hardly researched and understood. Again: Is it not another form of class dominance to diagnose an individual and prescribe medication without understanding and interacting within a relationship and learning about this patient’s life context, i.e. her or his daily struggle for survival, the dangers in the neighborhood, the specific living conditions, the constant insults of societal oppression?

A Word about the Language of the Professional Discourse

Bio-psychiatrists and family therapists have such a hard time interacting professionally and understanding one another as part of a professional discourse because they do not speak the same language.

Family therapists see the psychiatric language codified in the DSM as objectivistic, as devoid of gender, culture, or class specifics, as an instrument of the dominant bio-medical view of the experts, in general, as an unreliable system of categories that compress people into boxes to fit the classifications of the professional diagnostic elite.

Psychotherapists and family therapists use a descriptive language rooted in listening as part of the relational reciprocal process of therapy. They search for the relational and contextual meaning of their dialogue partners’ language and construct together innovative meanings that support a more satisfying life. Because it is context sensitive, the relational language is resource-oriented and inclusive, not pathology oriented and exclusive.

Conclusion

In my view, the professional discourse between AFTA members of diverse professional backgrounds and interests as well as between bio-psychiatrists and psychotherapists in general would greatly benefit if AFTA members would initiate an inquiry into the complexities of using or not using medication as part of psychological treatment. How we respond as clinicians to our clients’ request for help is ultimately a question of professional ethics.

Allow me, therefore, to refer to two voices from the past that may inspire our professional discourse and our clinical work. Their dialogue encapsulates for me the relational paradigm and bridges more than 2000 years, connecting a Roman ex-slave and a German professor.

In his late work about Ethics, Immanuel Kant quotes the Roman ex-slave and poet Terentius, “Homo sum. Humani nihil a me alienum puto.” Kant’s unique translation is the

result of his lifelong occupation with Ethics: "I am a human being. Everything that occurs to other human beings occurs also to me."

Let's continue or begin the discourse between our diverse professional worlds with intellectual audacity in the tradition of the Enlightenment. And, following the ex-slave, let's live and practice with relational empathy and compassion rooted in radical solidarity.

Bibliography

Dorman, D. (2003). *Dante's Cure. A Journey out of Madness*. New York: Other Press.

Duncan, B.L. & Miller, S.D. (2000). *The Heroic Client. Doing Client-Directed, Outcome-Informed Therapy*. San Francisco: Jossey-Bass.

Glennmullen, J. (2000). *Prozac Backlash. Overcoming the Dangers of Prozac, Zoloft, Paxil, and other Antidepressants with safe, effective Alternatives*. New York: Simon & Schuster.

Habermas, J. (1972). *Knowledge and Human Interests*. Boston: Beacon Press.

Joseph, J. (2003). *The Gene Illusion. Genetic Research in Psychiatry and psychology under the Microscope*. Ross-on-Wye, UK: PCCS Books.

Kant, I. (1784; 1990). *Foundations of the metaphysics of morals and, What is enlightenment. Translated, with an introduction by Lewis White Beck*. (2nd ed., rev.) New York: Macmillan.

Kant, I. (1797; 1996). *The Metaphysics of Morals. Transl. & ed. By M. Gregor*. New York: Cambridge University Press.

Karon, B.P. & VandenBos, G.R. (1994). *Psychotherapy of Schizophrenia. The Treatment of Choice*. Northvale, NJ: J. Aronson.

Kelso, J.A.S. (1995). *Dynamic Patterns: The Self-Organization of Brain and Behavior*. Cambridge, MA: MIT Press.

Liddle, H.A., Santisteban, D.A., Levant, R.F., Bray, J.H. (2002). *Family Psychology. Science-Based Interventions*. Washington, DC: American Psychological Association.

Luhrmann, T.M. (2000). *Of Two Minds. The Growing Disorder in American Psychiatry*. New York: A. Knopf.

Peukert, H. (2004) *Erziehungswissenschaft - Religionswissenschaft -Theologie - Religionspädagogik. Eine spannungsgeladene Konstellation unter den Herausforderungen einer geschichtlich neuartigen Situation. In: Groß, E., Erziehungswissenschaft, Religion, Religionspädagogik*. Münster: LIT Verlag, pp. 51-91.

Prosky, Ph.S. & Keith, D.V. (ed.) (2003). *Family Therapy as and Alternative to Medication: An Appraisal of Pharmland*. New York: Brunner-Routledge.

Stacey, R.D. (2003). *Complexity and Group Processes. A Radically Social Understanding of Individuals*. New York: Brunner-Routledge.

Siegel, D. J. (1999). *The Developing Mind. How Relationships and the Brain Interact to Shape Who We Are*. New York: Guilford Press.

Wampold, B.E. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings*. Mahwah, NJ: Lawrence Erlbaum.

Wetzel, N.A. & Winawer, H. (2002). *School-Based Community Family Therapy for Adolescents at Risk. In: Kaslow, F.W., Massey, R.F., Massey, S.D. (eds.) Comprehensive Handbook of Psychotherapy*. Vol. 3. New York: John Wiley & Sons; pp. 205 – 230.

Whitaker, R. (2001). *Mad in America. Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. Cambridge, MA: Perseus Books.

Contact information:

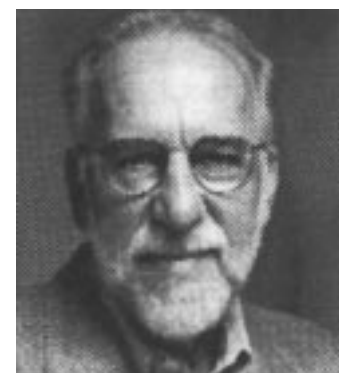
The Center for Family, Community, and Social Justice, Inc., Princeton, NJ

www.cfcsj.org

wetzel@rci.rutgers.edu

609-921-2551 x 2

AFTA member Norbert A. Wetzel is co-founder (with Hinda Winawer) and director of the Center for Family, Community, and Social Justice, Inc. at Princeton Family Institute. He was part of Helm Stierlin's Heidelberg Family Institute from 1976-1977.



*Copied from the AFTA web site, www.afta.org.

double ss written
like this?

Plenary III: The Bridge Between Biological Psychiatry and Family Systems

Preventing Psychosis with Family Intervention: A New Frontier for Family Therapy*

William R. McFarlane

Functioning as an effect of psychotic episodes

A biosocial hypothesis

Major psychiatric disorders are the result of the continuous interaction of specific brain defects with specific social and environmental inputs.

Biologic risk factors

- Genetic risk
 - 80-85% heritability
- Non-genetic biologic risk
 - Prenatal infectious (influenza)
 - Prenatal toxic exposure (lead)
 - Obstetrical complications
 - Traumatic (head trauma, perinatal up to adolescence)
 - Autoimmune (Rh incompatibility, increasing risk with multiple births)
 - Nutrition (starvation, omega-3 deficiency)
- Non-heritable genetic risk (age of father >50; probably accumulating natural mutations in spermatogenesis)

Cortical volume reduction, in childhood-onset schizophrenia, ages 14-19

Effects of family expressed emotion and medication on relapse in schizophrenia

Interaction of genetic and family influences on subclinical thought disorder

Early prodrome

Portland Identification and Early Referral

(PIER)

Project Overview

Professional and Public Education

- Reducing stigma
- Information about modern concepts of psychotic disorders
- Increasing understanding of early stages of mental illness and prodromal symptoms and signs

- How to get consultation, specialized assessments and treatment quickly
- Ongoing inter-professional collaboration

Clinical Strategies

Signs of prodromal psychosis

Schedule of Prodromal Syndrome (SOPS), McGlashan, et al

A clustering of the following:

1. Marked changes in behavior, thoughts and emotions, such as:
 - Unusual perceptual experiences
 - Heightened perceptual sensitivity
 - Magical thinking
 - Unusual fears
 - Disorganized or digressive speech
 - Uncharacteristic, peculiar behavior
 - Reduced emotional or social responsiveness

Signs of prodromal psychosis

2. A significant deterioration in functioning

- Unexplained decrease in work or school performance
- Decreased concentration and motivation
- Decrease in personal hygiene
- Decrease in the ability to cope with life events and stressors

3. Withdrawal from family and friends

Other entry criteria

- Ages 12-35
- Brief psychotic episode (< 1 month)
- Prodromal symptoms or recent deterioration (>30% GAF decrease) in youth whose parent or sibling has a psychotic illness
- Young people with schizotypal personality disorder combined with recent deterioration (>30% GAF decrease) are also at risk.

Family-aided Assertive Community Treatment (FACT):

Clinical and functional intervention

- Psychoeducational multifamily groups
- Case management using ACT principles and methods
 - Integrated, multidisciplinary team
- Supported employment
- Collaboration with schools, colleges and employers
- Cognitive assessments used in school or job
- Low-dose atypical antipsychotic medication
 - .25-3 mg risperidone, 2.5-7.5 mg olanzapine, 10-20 mg aripiprazole

Key clinical strategies in family intervention specific to prodromal psychosis

- More individualized, multidimensional family assessment
- Thorough orientation regarding psychosis onset
- Education about psychosis, stress and emotional moderation
- Maximum social support for all members of the family
- Psychoeducational MFG for stress reduction, optimal problem solving, CD reduction, social support, sharing, cross-parenting, buddy development
- Solving developmental, family, vocational, educational, social and romantic problems that threaten stability

Key clinical strategies in family intervention specific to prodromal psychosis

- Strengthening relationships and creating an optimal, protective home environment:
 - Reducing intensity
 - Adjusting expectations and performance demands
 - Minimizing internal family stressors
- Marital stress
- Sibling hostility
- Conceptual and attributional confusion and disagreement
 - Buffering external stressors
- Academic and employment stress
- Social rejection at school or work
- Cultural taboos
- Entertainment stress
- Romantic and sexual complications

Key clinical strategies in family intervention specific to prodromal psychosis

- Treatment for parents and siblings, if psychiatric disorders present, especially depression
- Single family PE, if necessary, because of logistics or extreme family duress

- PRN single family crisis intervention as needed
- PRN family or marital therapy in rare instances
- Creating reduced-stimuli environments for school and work
- Collaborative clarification of normal adolescent issues vs. symptoms and disability
- Adapting school and work characteristics to current cognitive functioning
- Focusing more on symptoms and functioning, less on diagnosis

PIER: Twelve month outcomes

Preliminary data for SOPS-positive prodromal cases from the first 24 months of intake:

n = 44

Intake: May 7, 2001- May 6, 2003

Outcome: May 7, 2002- May 6, 2004

PIER referral sources

Demographics of referred and treated cases

Screening and treatment entry

Conversions

Scoring 6 on SOPS, at any time, year 1
n=39

- Cases not converted 34 87.2%
- Cases converted, 1-3 days 0 0.0%
- Cases converted, 4-6 days 2 5.1%
- Cases converted, 7-30 days 2 5.1%
- SOPS conversions 1 2.6%
 - Scoring 6, 4d/week for >30 days
- Schizophreniform disorder 0 0.0%
- Total days in conversion 75 (of 14,235)

Course of conversion

n = 8, year 1 and 2, to date

PACE, PRIME and PIER

12 month outcome

Relapse outcomes in clinical trials 1980-1997

SOPS scores at baseline and

12 months

GAF: Baseline and 12 month

SOPS positive cases:

Non-schizophrenic diagnoses and false positives

Prodromal psychotic symptoms (n = 39) +

- Bipolar spectrum 5 12.8%
 - Major depression 2 5.1%
 - False positives 1 2.6%
 - Schizophrenia spectrum 31 79.5%
- Estimated treated incident population for schizophrenia
- Population 260,000
 - ECA incidence rate 1 / 10,000

- Expected incident population 52
- Schizophrenia spectrum cases 31
- Treated population, maximum <60%
- Declined treatment 4
- Identified population, maximum <67%

Admissions to principal psychiatric hospital, 5/7/03-5/6/04

Clinical observations

- Family types
 - None observed to date.
- Great variety
 - Majority are loving, supportive, some with one parent with CD.
 - A few are highly dysfunctional.
- High proportion of relatives with psychiatric disorders.
- Most prodromal young people develop hostility and irritability.
 - Many begin to be extremely frightened, distracted and increasingly disorganized.
- Almost all family members are anxious, frightened, confused; many are annoyed, resentful, critical and impatient with increasing failures and withdrawal.
- Mis-attribution often leads to disagreements along stereotypical gender lines, leading in turn to increasing marital distress, leading to increasing general tension in relationships, anxiety at psychological level and increasing and persisting arousal at the psychophysiological level.
- Nodal point for increasing symptoms is stress, inducing dopaminergic, noradrenergic neural activation.
- The nodal and essential family element is ignorance about the prodromal state, which is, by definition, all but universal at present in lay and professional cultures

Maternal rejection in prodromal psychosis and chronic schizophrenia

(Scale range = 1-7)

Differences between treated prodromal and post-psychotic states

Prodromal young persons have manifested:

- Maintenance of insight (prevention of loss)
- Continued dysphoric and ego-dystonic response to prodromal symptoms
- Higher sensitivity to treatments
- High acceptance of, and adherence to, treatment
- Less resistance to family inclusion by patient
- Stronger family involvement
- Higher motivation to continue schooling and/or work

- More trusting therapeutic relationships
- More gratitude
- Higher likelihood of improving course of functioning

Conclusions

- Public education is beginning to influence attitudes, knowledge and behavior.
- Increasingly accurate referrals are coming from outside the mental health system.
- May be affecting the final common pathway to psychosis for many cases
- Family intervention, at least, is accompanied by high treatment acceptance and retention, including medication.
- Family and psychosocial intervention may be having an effect on functioning beyond medication effects.
- Deficiencies for family-based treatment
 - Variety of family realities
 - Other unknown variables not targeted
 - Other known variables not targeted: CD

Conclusions

- Medication at low doses is adequate but appears essential for prevention of imminent psychosis.
- Very low conversion rates accompany evidence-based, comprehensive treatment.
- A substantial, though presently unknown, proportion of the incident population can be identified and prevented from developing psychosis, in the short term.
- Family therapists need to return to schizophrenia, with this new perspective.

Early Detection, Intervention and Prevention of Psychosis

- Family psychoeducation, supported education/employment and ACT components

vs.

- Family education and crisis intervention only
- Low-dose antipsychotic medication by indication, by protocol, all cases. Antidepressants and mood stabilizers by symptom indication.

Role of Family Assessment

- To identify interpersonal stressors in the family relationships of prodromal young people
 - Determine young person and family members' contributions to these dynamics
- To identify relationships that might buffer stressors from within and outside the family
- To determine what specific components of the family system are affected by treatment
 - If even one person is affected by treatment, the whole system will change to accommodate

Dimensions of Family Assessment

- Interpersonal Affectivity
 - Positivity
 - Negativity
 - Interpersonal Control
 - Effectance
 - Acquiescence
- PIER Sponsors

PIER has been made possible with the generous support of:

- Center for Mental Health Services
- NIMH
- Robert Wood Johnson Foundation
- Maine Health Access Foundation
- Bingham Fund
- Betterment Fund
- Brain Foundation
- State of Maine
- American Psychiatric Foundation
- UnumProvident Foundation
- Wrendy Haines Fund

“...genetics loads the gun and the environment pulls the trigger.”

-Judith Stern

Differential relapse rates by number of prior hospitalizations, NY FPSP

Competitive employment:

FACT combined with supported employment

Twelve-month Outcomes

PACE

Melbourne

PRIME

New Haven, NC, Calgary, Toronto

PIER

Portland

PACE

- Randomized comparative trial:
 - Needs-based intervention (NBI) vs. Specific preventive intervention (SPI)
- NBI:
 - Supportive psychotherapy
 - Case management
 - Family education and support
- SPI: Above components plus:

- Risperidone 1-2 mg/d
- Cognitive therapy
 - » Understanding and controlling symptoms
 - » Reducing distress

• N = 59, with an additional 33 refusers

– Refusers had lower symptoms

PACE: 6 and 12 month outcome

Psychoses during and after treatment

PACE: 6 and 12 month outcome

Ratings of functioning before and after treatment

PRIME Olanzapine trial

• Randomized, double-blind controlled trial:

– Placebo control vs. olanzapine

• Placebo control group:

– Supportive psychotherapy

– Case management

• Olanzapine: Above components plus:

– Olanzapine 5-20 mg/d

• N = 60, at four sites in US and Canada

PRIME: 12 month outcome

SOPS-criteria psychoses during treatment

Hospitalizations

• Cases hospitalized 4 10.3%

• Hospitalizations 5

• Days in hospital 54 (range: 6-18 d.)

• Days per treated case 1.4

Components of the SRM Assessment

Describing Each Person Relative to the Family System

*William R. McFarlane,
M.D., University of
Vermont, Maine Medical
Center*



*Copied from the AFTA web site, www.afta.org.



**P
h
o
t
o**

**A
l
b
u
m**





**P
h
o
t
o

A
l
b
u
m**



Interest Group: Research: A Dialogue Between Researchers and Clinicians on Cross-Cultural Adoption

Michael Colberg and Martha Edwards

Co-sponsored by the Cultural and Economic Diversity Forum and Research Interest Group

Co-Chaired by Paulette Hines, Jane Ariel and Martha Edwards

Cross-cultural adoption is a complex but often overly simplified set of relationships and experiences. In this joint session, researchers and clinicians joined in a discussion to identify the layered issues that emerge in cross-cultural adoptions, to illustrate these issues, and to explore how families can address them in a way that facilitates the growth and development of their adopted and biological children.

During our session, we viewed the documentary *First Person Plural*, which gave us a moving, first-hand view of the journey Deanne Borshay Liem took to bring her American adoptive family together with her Korean birth family. Two researchers, Ellen Pinderhughes and Ruth Chao, vividly laid out the issues concerning cross-cultural adoption, in general, and illustrated these more specifically from international Chinese adoptions. Discussants Casi Kushel, Benina Gould, Michael Colberg, and Patricia Colucci, with Ellen and Ruth, provided the glue that pulled it all together in their insights about what we had seen, heard, and experienced in the video and research presentations. Let us attempt to summarize these two stimulating and knowledge-filled sessions.

First Person Plural chronicles the journey of Deanne Borshay Liem from her impoverished Korean birth family to a Korean orphanage, where she was placed for safekeeping, through the Korean-American adoption system, to her California adoptive family, where she became the youngest and only adopted child of three children. In the film, Borshay Liem highlighted the lengths to which she went to appear to fit seamlessly into her adoptive family. She was so successful that her older sister, a California blonde, could boast that everyone always knew that they were sisters because they looked so much alike.

This fitting in comes at a price, however. The children lose touch with an essential piece of who they are. They then go into their adolescence and adulthood with a schism between their birth and adoptive heritages, which often leaves them susceptible to depression, anger, and alienation from their families and from themselves.

The film did a wonderful job of showing Borshay Liem's resilience and the process of reclaiming her heritage and integrating the various pieces of herself into an integrated and coherent whole. Even though she had the support of both her adoptive and birth families, they were not always able to understand how daunting a task it was to have lived such a complex childhood. Families often feel that denying the presence of difference is a way of bringing their adopted children closer to them rather than seeing that it sets the stage for their children to feel estranged from essential pieces of who they are. The discussion pointed to the fact that we, as therapists, have a responsibility to help families become aware of the developmental tasks that are present for children who have been moved out of one family and into another, and of the complications when they simultaneously cross national and racial boundaries.

The panel emphasized how important it is to understand that adoption per se brings with it developmental challenges that make what is normal for families formed through adoption different than what is expected of families that have been formed through biology. Each layer of diversity brings with it its own unique characteristics, and they should be looked at and respected in order to understand the complexity present in the family system.

Had Borshay Liem's family contacted researchers Ellen Pinderhughes or Ruth Chao, she may have had an easier time as a child. Ellen Pinderhughes, Associate Professor of Psychology at Tufts University, clarified the many layers of issues with which one must become familiar when addressing cross-cultural adoption. First, there are the nor-

mative issues that all families face as they rear their children to be successful adults in society. The socialization goals that parents have for their children and the ways they work toward these goals are shaped both by their membership in a cultural group and by their own childhood experiences. Second, there are the many issues that all adopted children face. These include: 1) a sense of loss of connection to their birth parents and birth families; 2) a feeling of being different from other children and from other families; 3) a lack of shared history with their adoptive families; 4) loyalty conflicts between birth families and adopted families; 5) the challenges associated with developing a strong identity; 6) attachment and other relationship issues; 7) the communication and understanding about the adoption; and 8) the lack of entitlement that adoptive parents sometimes feel about being parents. Third, a cross-cultural adoption may involve differences across cultures within the United States, differences across racial groups, and/or differences across national boundaries. Thus, in addition to the issues of racial and cultural identity and the potential for racial prejudice, cross-cultural adoption may also include the challenges of different languages, immigration, and health/developmental complications.

An understanding of these sensitive and complex issues is critical for therapists in order to be successful with families engaging in a cross-cultural and/or international adoption. For families, this means making a transformation into a multicultural family (not simply a cross-cultural family). In a multicultural family, the parents' socialization efforts reflect not only their own socialization experiences but also the cultural and ethnic origins of their children, which become the foundation for the transformed family. This entails an understanding of the child's culture and the developmental issues that a child of color might face. It also involves flexibility to incorporate the child's culture into the family in developmentally appropriate ways – not simply through books or cultural events but also as more direct family connections to friends and cultural groups. What might this look like more practically? Ellen's suggestions include wrestling with what it means to raise a child of color, establishing family rituals that blend different cultural backgrounds, preparing a child for addressing the bias he or she might encounter, advocating for the child in the neighborhood and school, and thinking about what it means to live in particular locations and making conscious decisions about where to live. Above all, it is critical that a child feels that it's not only permissible but also important to embrace both his adopted family and its culture, and his or her culture of origin.

Ruth Chao, Associate Professor of Psychology at University of California-Riverside, was herself preparing

to adopt a baby girl from China. She blended this unique perspective with her understanding of adoption, parenting, and culture to give us a more personal and specific look at the implications of international adoptions from China. Ruth reviewed the one-child policy in China and the effect it has had on international adoptions from China. First, she dispelled the myth that Chinese families abandoned their daughters in favor of having sons. In truth, it appears that 90% of the Chinese girls who were abandoned were actually second or third daughters and if their families kept them, they would incur heavy penalties.

Since it is illegal to abandon or leave children, parents have virtually no opportunity to provide essential information about their families and about their child's medical histories; the children sometimes don't even know where they were found or who found them. As a result, children adopted out of these circumstances may feel the additional loss of the chance ever to know anything about their family history or earliest experiences. Thus, adoptive parents are urged to find out as much as possible about the orphanage where their children lived and to search for any scrap of information about how their children came to the orphanage by talking to the caretakers at the orphanage, going to the site where the baby was found, or tracking down and talking with the person who found the baby.

In Ruth's personal experience with the adoption agency, parents were required to attend two full-day classes to prepare them to adopt their children. One morning was devoted to cross-racial and cross-cultural competence. The experience involved viewing videos of interviews with college-age and adolescent adoptees and a visit from a Korean woman who had been adopted by an American family in the 1950s. She was struck by how this woman's gratitude and loyalty to her adoptive family precluded her exploring her links to her birth family or even her birth country. The social worker that ran the session was very uncomfortable with the frustration and anger expressed by some of the adolescents and young adults interviewed on the videotapes that were shown to the adoptive parents. Rather than helping the parents understand these emotions as understandable reactions to loss, feelings of estrangement, confusion over identity, and experiences of prejudice and oppression, he attempted to reassure the parents that "this is not how Asian adoptees feel."

Clearly there is much to be done to help mental health professionals understand cross-cultural adoption in order for them to help adopted children and their families navigate these complex waters in order to build relationships that embrace these complexities. We are very grateful to our presenters, discussants, and filmmaker to help us move a step forward in this profession.

Michael Colberg is a therapist, advocate, teacher, and author who has worked with and on behalf of LGBT parented adoptive families for many years. He has private practices in New York City and in Dutchess County, New York. Michael also holds parenting workshops at Trowbridge House in Millerton, New York.

Martha Edwards is the Director of the Center for the Developing Child and Family at the Ackerman Institute for the Family in New York City. She is Chair of AFTA's Research Committee and Coordinator of the Early Career Membership pilot project.



Interest Group: The Narrative of the Therapist/Researcher/Theoretician

Robert Carroll

Facilitated by Robert Carroll and Jan Goldman

“The difference between theory and practice is that in theory they’re the same, but in practice they’re not.”

--Yogi Berra

Following the plenary on the state of integration of clinical theory, practice and research, this year’s interest group served as a forum for discussion of how theory and practice come together and pull apart. If there are bridges between theory, practice and research, we hoped to find them in our own personal narratives and in the sharing of these stories with one another. Several poems were read and writing exercises were used to facilitate the process of exploration. The pieces written were then shared in the Interest Group.

Included in the poems read were “Lost” by David Wagoner, “the laughing heart” by Charles Bukowski, and “Wild Geese” by Mary Oliver. These poems follow:

Lost

by David Wagoner

Stand still. The trees ahead and the bushes beside you
Are not lost. wherever you are is called Here,
And you must treat it as a powerful stranger,
Must ask permission to know it and be known.
The forest breathes. Listen, It answers,
I have made this place around you,
If you leave it you may come back again, saying Here.
No two trees are the same to Raven.
No two branches are the same to Wren.
If what a tree or bush does is lost on you,
You are surely lost. Stand still. The forest knows
Where you are. You must let it find you.

the laughing heart

by Charles Bukowski

your life is your life.
don't let it be clubbed into dank
submission.
be on the watch.
there are ways out.
there is light somewhere.
it may not be much light but it beats the
darkness
be on the watch.
the gods will offer you
chances.
know them, take them.
you can't beat death
but you can beat death
in life,
sometimes.
and the more often you
learn to do it,
the more light there will
be.
your life is your life.
know it while you have
it.
you are marvelous
the gods wait to delight
in
you.

Wild Geese

by Mary Oliver

You do not have to be good.
You do not have to walk on your knees
for a hundred miles through the desert, repenting.
You only have to let the soft animal of your body
love what it loves.
Tell me about despair, yours, and I will tell you mine.
Meanwhile the world goes on.
Meanwhile the sun and the clear pebbles of the rain
are moving across the landscapes
over the prairies and the deep trees,
the mountains and the rivers.
Meanwhile the wild geese, high in the clean blue air,
are heading home again.
Whoever you are, no matter how lonely,
the world offers itself to your imagination,
calls to you like the wild geese, harsh and exciting--
over and over announcing your place
in the family of things.

Robert Carroll is a Family Psychiatrist in private practice in Los Angeles. He is Assistant Clinical Professor of Psychiatry at UCLA. He is also a poet and storyteller, and he has toured nationally as a member of the Los Angeles Performance Poetry Slam Team. He has been working with therapists and other healthcare professionals, helping them to write their own narratives about their lives and the work they do.



Interest Group: Larger Systems

Mary Whiteside

Facilitated by Laura Chasin and Mary Whiteside

The interest group followed the stimulating plenary presentations on work/family balance. Speakers Nancy Boyd-Franklin and Toni Zimmerman were available for additional reflection and comment. Our speakers had listed multiple large system forces in their presentations, which led to the following question posed to the group: Which of these larger organizational issues impact you most in your practice/research/work life? How do you respond?

Discussion ranged widely and touched on ideas about our personal work/family balance and our own workplaces, the workplace issues for our clients, organizational consultation, and the impact of political and governmental policies.

Ideas about what we can do:

- Utilize guided selected readings to stay informed on current policy issues affecting us and our clients.
- Teaching/helping our clients to be empowered, making policy information available to them.
- Better utilize the AFTA listserv in exchanging ideas about best practices, feedback on common dilemmas, important resources, and action alerts.
- Work with human resource people increasing their knowledge and encouraging creative solutions.
- Be resources to one another to keep us energized as we do this difficult work.
- Include AFTA members in important public policy positions; let's make sure we invite them to inform us at conferences.

Participants provided feedback on future directions for the interest group. Participants expressed concern that members whose practices include organizational consultation are not finding a relevant forum at AFTA for their interests. We agreed that the title "Larger Systems" did not speak to the more compelling issues for the members. The strongest interest expressed for next year was to plan a place for members to discuss the challenges of working with nonprofit organizations. The focus would be on sharing strategies, techniques, best practice programs, knowledge, and action stands for public policy. Members interested in planning for next year's group should contact Pat Romney, interest group chair, at promney@romneyassociates.com.

Mary F. Whiteside, Ph.D. is affiliated with the Ann Arbor Center for the Family, Ann Arbor, Michigan.



Interest Group: Racial Domination and Privilege

Cheryl H. Litzke

One group member's response to the AFTA Annual Meeting's Racial Domination and Privilege Interest Group

Whiteness is essentially an invisible issue. It has remained so due to our possessive investment in not wanting to give up the powerful and privileged position that goes along with being white. Talking about something that is invisible is like talking about air. It is so much a part of our being. Unless we were in danger of losing it, we do not seem to recognize its presence. How can I talk about something that I take for granted just like every other "colorless" person in America? How can I know what power and privilege I hold until I do not have it any more? What are the factors that have me hiding this privilege of not having to face my whiteness and all that it means to be white even from my own conscious awareness? What is it that I need to challenge? I am, whether I like to think about it or not, a stakeholder in this process of being invested in keeping whiteness largely an unexamined concept.

What happened in the group discussion was enlightening. I was struck by what I saw as a pattern in our group that instead of talking about our white power and privilege, group members began the group by discussing ways that we, too, had been marginalized, oppressed, or discriminated against either due to the fact that we were Jewish or female, had grown up poor, or something similar to that. There was something unsettling about this. It hit close to home. It is too difficult to discuss the issue of being in the privileged group. As a white female, it would be easy for me to focus on ways that I have been marginalized in a male-dominated society. There are more than a few experiences of marginalization and disenfranchisement that I could recall and tell about, which would continue the pattern of rendering my whiteness along with its attendant power and privilege invisible. The very act of focusing on white racial power and privilege is new to someone like me who sees herself as identifying with those who are disempowered, oppressed, or marginalized. It is a change of the second-order kind. In fact it is a shift that feels downright uncomfortable.

To acknowledge privilege and do nothing about it seems incongruent to me. If I were sitting at a table with all kinds of wonderful food and there were starving children in the room, how could I just talk about it? Wouldn't I have to share that food

with those who do not have access to it ordinarily? What seems even more important is that I would need to look at the forces and structures that are in place that allow me to have all that I want and need and others to have a tougher time?

There is another struggle that makes me uncomfortable with the discussion of white power and privilege. It is the matter of sound bites. I believe it is an important discussion to have but what is overwhelming and often wells up inside of me is the fact that my whiteness never has to be experienced or called attention to in terms of how it disenfranchises others. It is being called up here in terms of this particular sound bite, that of "power and privilege". How can we do this? How can process and content not cancel out each other? As I write this, I run the risk of being misunderstood. Would you come to a group that was titled, "Whiteness (and all that it means) with its Oppressive Structures and Behaviors and the White Desire to Keep It That Way"? We just do not have adequate language for all of this yet.

I imagine that I am not alone in my state of discomfort. The issue that I really do not want to face about my white racial power and privilege is the issue of my possessive investment in its continuation. As I write this I feel my shame. I feel called to do something different, to think and act differently, to venture into these worlds unknown, to chart new territory of what it means to move over or to yield center, and to consider "other"; and how this calls for a change in me and my position in relation to the rest of the world.

My possessive investment in continuing the invisibility of white power and privilege has a long history. Its history runs along economic as well as political lines. I am part of a white culture, which has been organized around conquest versus connection. Moving over and giving others a seat at the table is definitely a change of the second order kind. I have to acknowledge this in spite of feeling my shame about it. I have to act as well as discuss.

To challenge the prevailing discourse, which is often based on a singleness of mind as opposed to a multiplicity of voices, is very threatening and seemingly dangerous. I am afraid of being misunderstood, as it seems that the only folks who are talking about whiteness are those who exalt "white power". That is really scary. We can easily point to those hate groups as evil and dangerous; they are the visible ones. What I want to talk about when I talk about making "whiteness visible" is the

idea that we can no longer assume whiteness, white reference-making, or white dominance in our discourse just as we can no longer assume heterosexuality in our orientation.

The way white people have been told, by other white people, to think about this is to be “color blind.” The color blindness gets translated into racial equality. It also points to “context blindness.” Of course people are people. I am more than a label or a “context variable.” I am a person. But how can I miss the point? I live in a society that does not assign the same value to every context variable that a person might have. I live in a society that grants more privilege and power to those whose skin color is white. How can we not take into account how value is assigned? So when asked how I experienced the group, I have to say, sadly, that for me (and I am a part of the group) it was more of the same discussion process that I have experienced before concerning this very difficult topic. The process as well as the content is difficult. How do others’ words reach our ears, especially when those words challenge or seem foreign to us? It is easy to dismiss what we strain to understand. I need to not give up on being understood or on understanding

another group member. My comments to others need not be judgmental or pontificating. I am in the other and the other is in me. As white people with “power and privilege,” we are all alike in this way.

To all of this I say let us keep trying, let the conversations and challenges continue, or better yet begin all over again.

Cheryl H. Litzke is an assistant professor in Programs in Couple and Family Therapy at Drexel University in Philadelphia.



Women’s Institute

Barbara Rothberg

At this year’s Women’s Institute, Betty Pristera and I had a simple goal: for women to connect and have fun. We aimed to create an environment where women would feel open to share their experiences and not feel compelled to follow very specific directives.

With that in mind, we offered a basic probing question as a point of reference for each group to discuss, but clearly stated that this was only a suggestion, which people seemed to appreciate. The program was loosely organized in order to leave space and flexibility for women to share. We suggested that the groups divide into six small groups, however, they opted to divide themselves into three groups. Each group took off into its own direction, keeping the themes of relationships, struggle and the support of other women central.

Love, trust, ambivalence and acceptance of choices were the main topics of one of the groups. Another group centered their discussion on the struggles around speaking up in the face of discrimination and affronts that women suffer. This group also highlighted the importance of other women’s support to get through difficulties. The third group had a theme of

empowerment through struggles to become strong and independent women. While each group was in session, much laughter was heard and warmth expressed.

As we tried to bring the program to an end, no one wanted to leave the room and end their discussions. The program lasted more than half an hour longer than scheduled, and many women still continued to talk. Lovely connections were made and most important people had a wonderful time.

The feedback we received was extremely positive; in one comment a woman said she always wanted to be at the men’s institute because they talked of having a personal and meaningful experience, and now she can boast of the same experience!

Interview: Andrea Canaan

Jodie Kliman



Profiling Andrea Canaan is a great chance to visit a friend who left Massachusetts to live with her partner Joann Johnson in San Francisco. Andrea was born in New Orleans, and earned a BSW in social welfare at the Southern University of New Orleans and a MSW in community organization and planning at Tulane

University School of Social Work. Andrea has been executive director or program director of small mental health and other service programs, starting at the New Orleans Area YWCA. Going west, she directed Berkeley's Pacific Center for Human Growth serving GLBT people, the Women's Mental Health Institute, and the Iris Project. Seeing the desperate need for culturally competent therapists, Andrea became a therapist, then clinical director, of Hope Haven Madonna Manor, a facility for 96 adolescent boys mostly of color. As the only staff member of color in all these settings, she made a passionate commitment to her own clinical development and to ensuring that more women of color enter our field. At Family Services of the East Bay, a traditional middle-class outpatient mental health facility focusing on individual psychotherapy for adults and children, she honed her clinical skills.

On moving east, Andrea began doing family therapy at the Cambridge Youth Guidance Center, taking Sallyann Roth's family seminar. She also took Family Institute of Cambridge (FIC) seminars: Sallyann Roth and Kaethe Weingarten's on narrative and Hugo Kamy's on spirituality. I first met Andrea at a FIC workshop, when Michael White consulted with her and a family. Michael's consultation was marvelous, but Andrea riveted me. She was so present, so attentive to the smallest nuances of a mother and son's conversation with Michael. Also impressed, Ann Hartman and Joan Laird asked her to teach classes on racism and on family therapy at the Smith School of Social Work. Hugo Kamy invited her to the Boston College School of Social Work to teach fundamentals. Andrea describes those relationships as precious.

Andrea's FIC relationships led to deep and abiding connections to two closely linked professional homes in Boston and New Jersey. After Hugo, David Trimble, and I met

Andrea at FIC, we asked her to join our teaching collaborative, which includes Roxana Llerena-Quinn, Jay King, and Gonzalo Bacigalupe, at Boston Medical Center's Center for Multicultural Training in Psychology (CMTP), training psychology interns to treat people marginalized by race and class. It wasn't easy for a lesbian MSW to join a straight, six-psychologist collective at a hospital that expected a "Dr." before your name. When our group left to pursue other projects, Andrea and David kept teaching with all our guest lectures. The interns adored her. When we all joined Monica McGoldrick and Nydia Garcia-Preto's faculty for the Multicultural Family Institute's Culture Conference in New Jersey, Andrea became a frequent and beloved presenter. She recently co-presented with her daughter Leslie on racial, cultural, and gender affiliation identity.

Andrea returned to San Francisco to join her partner Joann in 2002. She applies social work and systems approaches in managing at Episcopal Community Services' Canon Barcus Community House, a permanent supportive housing for once-homeless families, which includes immigrants, families fleeing domestic violence, and those whose working and middle-class lives were lost to illness and unemployment, and people who had only known poverty. Some live with AIDS, disabilities, and dual or triple diagnoses. She coordinates tutoring, GED and job readiness, job search, leadership training, case management, mediation with Child Protective Services, and other family supports, as well as groups, community-building, and housing retention. She is proud of how her organization's vibrant and varied community welcomes and holds whole families who'd lived in cars, doorways and shelters. Her multicultural staff are mindful of cultural and class issues; a quarter of them were formerly homeless. Andrea finds EPC a wonderful place to work.

Andrea credits Massachusetts colleagues and friends, especially David Trimble, with "constantly and sweetly cajoling" her to join AFTA. She says, "I feel safe, honored, and respected with my own colleagues. But I have considered AFTA elitist. I had assumed that people would automatically assume that I had a PhD, or try to marginalize or erase my knowing and the power and authenticity of that knowing, if they knew I did not. The only reason I applied to AFTA is that

I had my colleagues' support to feel whole, powerful, knowing, and authentically supported enough to bring my whole self to the experience without leaving parts out or having parts hushed or made invisible. My colleagues knew who I was and didn't let color, class, age, academic, affectional preference, or other barriers impact our relationships or our support of each other."

Andrea has contrasting experiences of her AFTA meetings in San Diego and San Francisco. She found the San Diego presentations "balanced, with research always delivered along with the more specific view of research alongside anecdotal [clinical] or other kinds of presentations. In San Francisco, I felt more pressure to compartmentalize research topics, rather than continuing a conversation in a holistic way; pressure not to ask questions about service, people of color, women or exceptions; or pressure to not explore the bigger issues. It's not a horrible pinch, but I feel it. However, I'm not so uncomfortable that I don't want to be there. I felt tremendously stimulated, but if I didn't have my colleagues, it would've been harder to metabolize all the wondrous things going on there."

Asked what she does for fun, Andrea laughed, "I read mysteries, go to movies. Joann and I spent a month in Thailand last year. I have wonderful friends. I cook. When I am weary, I ask my partner to take me to church - she knows to take me for a ride to the redwoods or Marin and see wonderful places. I live in a paradise. I sip coffee and read, or study in wonderful cafés. A constant passion and companion is writing, painting, and women in the community. I always

make space for women, writing and art: a women's community of writers and artists of color. And I'm in LOVE. I am totally in love with the perfect woman for me. That's my story and I'm sticking to it! Another wonderful thing in my life are my daughters. Leslie has a master's in historical preservation. She's a city planner for a small city in Georgia, helping communities of color preserve cemeteries, buildings, histories, and archives. We write together and have conversations about how we acquire and transmit identity cross-generationally. She has taught me most all I know about allowing other human being to teach us how to hold and nourish them, allow them to grow and become what they were gonna be, no matter our meddling. My chosen daughter, Jane Tan, is a Chinese American wonder of a being. She's a banker in New York City. She and Leslie have been best friends since high school. We make family out of friendship, honor, respect, love, and commitment. I am privileged to have two delightful, vibrant, and accomplished daughters I am constantly pleased to support and love. I also like that they and my partner are quite accomplished with electronics, computers, or digital anything. For these things I am forever grateful."

Jodie Kliman is a psychologist and family therapist in practice in Brookline, MA. She is on the faculty of the Center for Multicultural Training in Psychology. She joined the AFTA Board in 2000 and served as Pre-Conference Workshop Co-Chair in 1995 and as AFTA Program Chair in 1997.



IN MEMORIAM

Doris Diamond

Rosalind Edelstein



Doris passed away on May 29, 2004.

Doris Diamond was a practitioner, teacher and administrator. She was anointed St. Louis Social Worker of the Year and Social Worker of the Year of the state of Missouri. I never knew her specific affiliations, but we exchanged many ideas in consultation regarding our clinical work or regarding strategic moves in administration. She lived in St. Louis, and I lived in Atlanta.

We were both clinical social workers. Fundamentally, we were both family therapists. We had met when each of us was looking for a roommate at AFTA meetings, where we developed our very enriching friendship. I cannot remember how many years ago that was. I do remember the fun we had together, with the meeting places as backdrops. We would share stories of our professional disappointments and successes; the politics of the agencies we were connected with and the politics of AFTA; and we would laugh about our own foibles. We laughed a lot together, like sisters. We saved stories from year to year. We each had a grown daughter and a grown son. We shared our pride and concerns about them. It felt soothing, nurturing, and loving.

I remember each meeting as commemorative of the experience we had. In San Diego, we played hooky from the meeting with Catherine Kikoski, walking across the bridge to Tijuana, Mexico, laughing about the adventure, but sighing about the sad children we saw. I remember the fun we had on the first cruise at the San Francisco meeting when she brought her husband, Bob.

Doris had a way of looking for and zooming in on the other's viewpoint. She had an innate tendency for affirming others, to avoid polarization. How can I forget the historical explosion in Baltimore at the Women's Institute, which started as an attempt to affirm differences, but opened up all kinds of differences that eventually needed to be dealt with. Remember her courageous attempt, as a member of the planning committee, to take responsibility and make a difference? We often laughed at my impatience and her acceptance of so much.

A few years ago, we did not room together. Doris came down with ovarian cancer and, later, other complications. I bought into her upbeat belief that she would get better. I grieve the loss of a loving woman who loved life, who accepted so much in others, and I grieve for myself and my loss. Her warmth and friendship is still with me.

Rosalind Edelstein is in private practice in Atlanta, Georgia.



IN MEMORIAM: LOREN R. MOSHER

A visionary and romantic, A voice in the wilderness

Larry Allman



On July 10, 2004, Loren Mosher died. He was one of the luminaries of our field. When Connie Ahrons asked me to write an article for the *AFTA Newsletter* about Loren Mosher, I immediately went to a book of sonnets written by R. D. Laing and found this verse, which reminded me of Loren's spirit:

*To live our life's the grand adventure: fit
For any hero. Nothing else can be
The meaning of our absurd mystery.
We'd like to think that there's some benefit
Somewhere, to something, someone, to the All,
That we're such sacks of comic lust: or good
For us that we are thus.*

(From *Sonnets*, by R. D. Laing 1979)

Loren Mosher was a visionary. For over thirty years we have been on an adventure as warriors in the mental health movement, being voices in the vast wilderness of contemporary psychiatry. He was a decade older, but we both had been trained in Boston in the world of Mass Mental Health Center and Boston State Hospital, and then re-trained by Gregory Bateson and R.D. Laing.

Mass Mental Health was both at the center of psychoanalysis, as well as the home of community psychiatry. It was also at the center of the community family therapy movement with such great family systems thinkers as Milton Greenblatt, Dave Kantor, Myron Sharaff, Fred Duhl, and Norman Paul.

Questions of mind were informed at Mass Mental predominantly by psychoanalysis. Loren emerged with a belief in therapy and a fascination with unraveling madness.

In the 1960's the power of analysis was not successful in dealing with the community's needs for mental health services. A new voice emerged from this frustration, and family

therapy was part of that voice. Loren taught the power of great therapy, having been a resident when Elvin Semrod chaired the Mass Mental Health Center.

In the sixties there was a strong conflict within psychoanalysis to expand to a contextual view of mind and therapy. The ideas of Gregory Bateson and R. D. Laing created a powerful flicker within psychiatry, accompanied by the expanding clinical mandate to be in the community. Loren benefited by being in Boston in the height of the community psychiatry revolution where personal freedom was the goal. Treating the schizophrenic patients in Boston with the support of an active public mental health system, which valued therapy as its prime tool, made a difference. The public system under Milton Greenblatt had a long tradition of valuing innovations in delivering mental health services. Loren learned early that therapy, family and community, interventions and even politics were parts of our profession. He passionately believed that we needed to re-think our ideas about mind and society. Loren went to London to work with R. D. Laing in 1966. He wrote *In Memoriam*, an essay for Laing, when he died in 1989. In that essay about his relationship with Laing, he writes:

I arrived in London with wife and two small children in tow in July 1966. Let me remind you of the London of the late 1960's – the miniskirt, LSD, The Beatles, or generally, sex, drugs and rock & roll. I arrived as a model candidate for the fast track to the power perks of an academic chain in a prestigious institution – Bachelor's at Stanford, Harvard Medical School, Harvard psychiatry residency, NIMH clinics, an associate in psychiatry, proper post-graduate research fellowship – in a place at a time when the entire consciousness of a culture was changing. I found my conventional self, a member of the silent generation, suddenly embedded in a scene with dramatically different expectations than those to which I had conformed for more than 30 years. Laing forced psychiatry from within to consider alternative ways of

viewing and more importantly understanding madness. (Mosher, Loren. In Memoriam: R.D. Laing. *International Journal of Therapeutic Communities*.)

Laing was advocating a phenomenological view of psychiatry. He advocated an alternative to the state hospital by developing places where people in mental distress might find refuge. Loren became the foremost advocate in America for this model of care based in understanding and accepting madness by providing caring contexts for people, to find a sense of home, which is at the core of therapeutic healing. Loren Mosher was a gifted clinician and always came from a loving place in his understanding of a person's experience of the world.

Upon returning from London, Loren became one of the great warriors of contemporary psychiatry. From 1968 to 1980 he was chief of the Center for the Studies of Schizophrenia at the NIMH. In that role he began a life-long research project showing how, by providing a supportive non-intrusive home-like environment, we could help schizophrenics live a better life. He created Soteria House, a treatment center under the leadership of Alma Menn, providing care contexts. Loren showed that these Laingian alternatives were more effective and therapeutic in helping people than medication.

After his distinguished career developing Soteria House, the *Schizophrenia Bulletin*, and supporting many alternative programs and research, he continued his adventure by taking on the public mental health system in Montgomery County, Maryland, and then in San Diego County. He always stayed true to his beliefs. At the core of his belief was his passion as a visionary, a physician, and social activist. He was always trying to make the world a more accepting and nurturing place. His battles even extended to his public resignation from the APA because of its over-involvement with the pharmaceutical companies. I respected the passions in that act. He was not in opposition to the APA; he was a voice in the best therapeutic tradition saying there are "better ways folks. Let's get back to the power of family therapy, community mental health and establishing caring places for the mentally ill." He was a true warrior!

For over thirty years, Loren researched and created clinical contexts throughout the world, which accepted people with their madness and supported them in helping decrease their distress. These centers lasted in America until the early 1990's and spawned similar centers throughout the world. Just before his death in July, he was in Switzerland being honored for the 20th anniversary of the Soteria-Bern Project in Europe. Loren was very proud of this accom-

plishment. All AFTA members should read and refamiliarize themselves with the power and passion of Loren's words and accomplishments. I will miss his vision. Loren and I were charter members of AFTA. There was a core group in the early days of the family therapy movement which viewed changing our personal and professional epistemology as the goal of our movement. Like psychoanalysis in its early days, we were a movement passionately wanting to change our thinking, to expand our view of mind to include the family and community center. We would huddle together in those founding meetings with a vision to not only develop better ways to deliver mental health services but to also expand ourselves. We believed that this new view of mind would also help us live fuller lives. We valued each other's visions and supported one another in our personal growth. We were friends, social-political radicals, and community activists working in community mental health.

Family therapy was a vehicle, a tool, within this paradigm shift. Dick Auerswald would often say we should spell family therapy in small letters to keep it from becoming a thing in and of itself. Many of the early pioneers of family therapy were skeptical that AFTA would promote the thing like quality of family therapy, rather than the ideological shift. Carl Whitaker and Sal Minuchin never joined. Dick Auerswald always sat in the back of the room with Loren, Judes, Alma, and me as well a bunch of other charter members. We were voices of the sixties within family therapy, a new epistemology. We all sought a new vision. Loren was one of our greatest warriors.

Ironically for the past fifteen years, Loren and I have shared yet another professional context. We both have been professors of psychiatry within the Department of Defense. Captain Mosher had been vice chairman of the Department of Psychiatry for the Armed Services Medical School. I was teaching at Tripler Army Medical Center in part of the same system in Honolulu. We shared this wonderful irony that here we were old radicals thriving in the largest federal mental health system, the military. However, we accepted that it made sense, since the military is the last vestige of a public mental health system.

Loren worked within the system to teach and be a poetic voice in the minds for yet another generation of psychiatrists. I would tease him that he was a "real colonel," while I was a mere "wannabe" as a civilian contract professor. However, we shared the belief that being in the system and engaging in being a voice was an important mission. Captain Mosher had a full military funeral in San Diego. He was a true warrior, a general.

Loren was also romantic like a lot of us from the sixties. We shared bottles of wine, and bore witness to the romantic dreams of our lives. We loved to play and party together, and talk about politics, madness, philosophy, and “sex, drugs and rock & roll.” We shared some holiday dinners and loved the women in our lives. Loren loved his wife, Judy Schreiber. He spent the last 16 years traveling the world like a visionary with Judy’s support and love. I’ll miss experiencing the two of them together. He was a loving and accepting father to his children, and he was a grandfather. Loren was a real human being!

I will miss my friend. His voice will always be in my mind. Bateson would say, “It takes two to know one.” I will continue to teach his ideas and value his creations in my adventure. But most of all, I will miss his sparkle, which helped me to find the sparkle in me and which keeps us going on this adventure. His life was an inspiration and an adventure.

Larry Allman, a charter member of AFTA, founded and directed family institutes in Los Angeles and Hawaii. He currently teaches psychiatric residents at Tripler Army Medical Center in Honolulu. He migrated to Hawaii from New York with Dick Auerswald thirty years ago.



DEPARTMENTS

Joint Human Rights/Family Policy Forum: Further Erosion of Immigrants’ Rights

Laura Roberto-Forman

In recent Forums and *AFTA Newsletter* columns, the Family Policy committee had been tracking and speaking on erosion of immigrant rights, especially following the attack on U.S. soil on September 11, 2001 (Levner, 2004). There was discussion in the *Newsletter*, notably Rachel Dash’s interview of Ms. Olshansky in the Spring 2003 issue and at the 2003 Forum, recommending that therapists consider consulting to detained individuals and their families, documenting our clinical experiences, joining with the advocacy community, educating our own communities, and developing an educational package. The issue addressed in 2004 focused on the following development:

A report prepared by the U.S. Justice Department’s Office of the Inspector in July 2003, criticized the government for its treatment of non-U.S. citizens held on immigration charges in connection with the government’s investigation of the terrorist attacks of September 11, 2001 (Dickerson and Weingarten, 2004).

In this year’s Joint Forum, we were privileged to hear Sarah Bronstein, supervising attorney with the Catholic Legal Immigration Network (CLINIC) in San Francisco, interview Ellen Pulleyblank Coffey on her experience with imprisoned immigrants and their families. In keeping with previous discussion recommending direct work with families and communities, Kaethe Weingarten, Vicki Dickerson, Rachel Dash, Hinda Winawer, Eliana Korin, and myself presented some of the faces, stories, and political experiences connected with these families as we have received them through clinical contacts, consultations, and journalistic research. The picture that has been emerging in the last three Forums has been chilling, including human rights violations as well as family policy failures.

In this article I will attempt to review the history of this detention policy toward immigrant families, as summarized by Sarah Bronstein, to discuss the larger-systems,

sociopolitical context embedding this policy, and to review clinical examples given in the 2004 Forum. I will also describe the Position Statement issued by this Joint Forum and ratified by the AFTA Board of Directors, and discuss options for action under consideration by Human Rights and Family Policy committees. The aim of the Forums and of this article is to disseminate what we are learning to the wider AFTA community and to organize another resource for immigrant families within AFTA.

History of U. S. Detention Policy

According to Ms. Bronstein, the use of detention for immigrants to the U.S. was codified in 1996 when Congress passed the law IIRIRA after the Oklahoma bombing. President Clinton and the legislature originally saw this incident as a terrorist attack. Afterward, detention was mandatory for any immigrant possessing a criminal record and for all asylum seekers whether children or adults.

Before the detention law, all foreign nationals entering the country were released pending a hearing. Children were allowed to stay with family or foster families. After the new law, they were usually put into juvenile corrections facilities, out of contact with family and without notification. By April 2004, 5,500 children and 200,000 adults were in prison. For example, many of us read occasional articles in the fall 2004 *New York Times* about young Elias Attie, a 16-year-old junior at Manchester Regional High School. His parents owned a small business and were legal permanent residents. His mother served on the city council. Elias's father was notified to report to immigration offices in Newark, New Jersey, for fingerprinting under the special registration of nationals from certain Middle Eastern countries required after 9/11. Elias accompanied his father. Elias's father was taken away to the Elizabeth detention center (prison). Because Elias was under 18, he could not be housed at the prison but neither was he returned to his mother. He was flown the next day to Georgia, to a juvenile correctional institute. He has been there for two years, and still has not had a hearing. At last report this spring, Elias and his father were both still in prison.

In David Cole's book *Enemy Aliens*, the Georgetown University law professor laid out further history of holding and deporting suspected terrorists without hearings since 9/11/01. In October 2001, our Attorney General created what is called a "foreign terrorist tracking force." Cole describes how as the number of foreign detainees rose throughout 2003, critics began pointing out that not one had been legally charged with terrorism. In response, our Justice Department stopped giving totals to the press and the public. Meanwhile, a provision called the Absconder

Apprehension Initiative expressly targeted 6,000 Arabs and Muslims among the more than 300,000 foreign nationals living in the U.S. who had outstanding deportation orders at the time his book was published. They were targeted to be deported first – when their hearing took place.

According to Ms. Bronstein, when the Homeland Security Act was passed, oversight of detained children came under the direction of Health and Human Services in the Refugee Resettlement office. It had required significant lobbying by several human rights groups to bring this about. After this time, children were concentrated into several more central locations in the U.S. instead of being scattered across the country and were not to be sent to juvenile prisons. There has not been any change in the deprivation of legal representation. A child without a lawyer is deported. It is no longer of consequence to the Justice Department whether the asylum-seeking child will be in danger if returned to his/her country of birth, or whether s/he has family there to take the child in. The judges hearing these children's cases do not have latitude in considering their circumstances. Detained children are not informed about procedures for asylum seeking or the special status due them as minors. None of the detention centers house families except a Berks County, Pennsylvania center where sexes are segregated and visitation is not legally mandatory for the center.

Detention conditions for adults, in contrast, have become worse in the past three years. Upon formally requesting asylum, a foreign national is sent directly to prison. Adults are immediately deported if there has been any legal offense in their past. Additionally for immigrants not seeking asylum, the INS is notified when green-carded or undocumented adults are jailed, and they are deported when their sentences have been served. A west coast newspaper reported this past spring on a young adult who was to be deported for a traffic violation several years earlier. Ms. Bronstein commented that for an incarcerated mother there are only two choices: to abandon her children here in the U.S. while she is deported, or to take the child back to whatever conditions the family had left in their homeland.

Witnesses and Detainees

Dr. Cole quotes Hermann Cohen in the introduction to *Enemy Aliens*:

The alien was to be protected, not because he was a member of one's family, clan, and religious community; but because he was a human being. In the alien, therefore, man discovered the idea of humanity (Cohen, 1985).

How does it affect U. S. citizens to observe these arrests, detentions, imprisonments, deportations, legal restrictions,

legal oppressions, and racial profiling of men, young boys, and Middle Eastern nationals? My practice office and the medical school for which I teach are located in Norfolk, Virginia, home of the U.S.'s largest naval base, of NATO and Cinclant, of the Commander in Chief of the Atlantic Fleet, and close to the base of the CIA. In the past year, military officers and enlisted sailors began returning from the occupation of Iraq. In family meetings, they expressed their distress, guilt, anxiety, and confusion. Some spoke with contempt, calling Arabic men "towelheads." Others were ashamed. There have been human rights charges brought against our forces administrating the Al Ghraib detention facility in Iraq and ethical complaints lodged against the medical staff treating tortured prisoners there.

There are 565 prisoners from various Middle Eastern countries being held at the Guantanamo Bay prison in Cuba. According to the August 12, 2004 edition of the *Virginian-Pilot*, a conservative and fairly pro-military civilian newspaper, our military court system heard the first prisoner cases in July as demanded by the U. S. Supreme Court. The military reviewers reaffirmed all of them as enemy combatants who do not qualify for release till their trials. All of the men and boys held there have been held for up to three years without legal charges or hearings.

A healthcare professional that returned home from three months of duty at Guantanamo was so traumatized by what he saw that he entered therapy and also wrote letters to various officials. He witnessed detainees held in cages rather than cells, and he participated in evaluations to distinguish suicidal from psychotic and malingering men. He interviewed prisoners, and was told that some were individuals swept up in informant operations for money or satisfaction of grudges. No hearings have been held outside of the four in July to ascertain the facts of any case. On July 30th, according to the *New York Times*, the Justice Department filed a federal ruling that prisoners in Cuba are not entitled to file petitions per our Supreme Court because they are foreigners being held outside the U.S. and do not enjoy U.S. Constitutional rights. My client experiences daily guilt, anxiety, tearfulness, spiritual and moral pain, insomnia, and chronic insecurity after seeing the rights of these non-U.S. prisoners stripped in front of his eyes.

AFTA member Eliana Korin presented information illustrating the plight of the immigrant community in New York, who observe and struggle to adapt to these policies in daily life. Working in a medical setting, she commented that she is positioned to witness clients who come for medical care and hear their life stories before they have succumbed to emotional symptoms. She remarked on the dra-

matic increase of stress related to new restrictions on the lives of these families, caused by our current political climate and the Patriot Act. She commented that these policies have limited their access to work and to social opportunities, and created an atmosphere of fear and otherness. They experience intimidation in relation to their children's school personnel and health professionals, who could report their immigration status and get them deported. They fear exposure because of the increased use of legal identification for security procedures in public facilities. They are made more aware of their non-naturalized status and second-class citizen positions. Korin noted reports she received on increasing ethnic discrimination in public and withholding of jobs. She presented two clinical cases, as well, of women raising families alone or with a jailed spouse, surviving abandonment after years alone or separated while abroad, and hoping for residency but fearful that it will be denied or pulled for any infraction. They are ineligible for healthcare and terrified of deportation. The harm to their children was clear in the women's testimony that they felt forced to consider possible extradition and inform their young ones; they could not mislead their children that all would be well in the coming years.

An AFTA Call to Action

Rachel Dash reviewed the position statement supporting the rights of immigrants of which she was the primary author. She also referred to the newly released book *The Intruders: Unreasonable Searches and Seizures from King John to John Ashcroft*, written by her recently deceased father Sam Dash. Hinda Winawer, Vicki Dickerson, and Kaethe Weingarten, outgoing and current Family Policy Chair and Human Rights Chair, circulated an action list and a position statement supporting the rights of immigrants, compiled by the Family Policy and Human Rights Committees. There was considerable discussion in the Forum regarding concern among AFTA members and a desire for a venue in which to act on these issues. Comments from the Forum discussion included interest in sharing the Forum findings with publications outside AFTA and with the community, concern about getting the notice of policymakers, and creating talking points for use in individual political action such as writing to Congress members this year. Forum attendees had personal experiences with security personnel and with watching friends and colleagues become targeted or profiled by police. The sense of being a disempowered witness was pervasive. Some have received reports from clients in the military distressed by their combat and affected with Post Traumatic Stress Disorder.

A follow-up meeting was held after this year's forum to examine options for further action. One issue of the new *AFTA Monograph Series* will focus on immigrant families and detainees. A resource packet for AFTA members is being organized under the direction of Hinda Winawer and will be available on the AFTA website as well as in paper print. A volunteer group will organize to offer pro bono services in conjunction with CLINIC in San Francisco. Members are encouraged to participate in voter registration this year, to contact the media to share information, and to disseminate AFTA's Position Statement.

In conclusion to this report, I offer comments by Elie Wiesel prepared for the graduation commencement at Old Dominion University in spring 2004. In his charge, he voiced his concern for our children, who are searching for ways to live in what he calls "a new century already filled with political and social convulsions" (Wiesel, 2004). He pointed out that "not to hear another person's pleas for compassion...is to impoverish oneself," and asked us to ponder, "where did we [of the 20th century] go wrong in history?" He reminded us that while power is temporary, truth is eternal, and that "to be free is essential, but to help others gain freedom is even more rewarding." AFTA has a place to speak out for freedom.

References

- Cole, D. (2003). *Enemy Aliens: Double standards and constitutional freedoms in the war on terrorism*. New York: The New Press.
- Dash, S. (2004). *The Intruders: Unreasonable searches and seizures from King John to John Ashcroft*. Rutgers University Press.
- Freeman, H. (Ed.). (1985). *Jeremiah, Soncino books of the bible* (In A. Cohen Ed), London: Soncino, 52.
- Levner, L. (2004). The erosion of the rights of U.S. Immigrants: Implications for family therapy practitioners, researchers and educators. *AFTA Newsletter*, (Spring) 27-29.

Laura Roberto Forman, is a professor in psychiatry at Eastern Virginia Medical School, who specializes in therapy of eating disorders and girls' and women's health in families. She is a past Secretary of the American Family Therapy Academy.



AFTA Position Statement Supporting the Rights of Immigrants

Immigrants play a vital role in U.S. society. Their participation in all aspects of communal life is critical to the vibrancy of our communities and our country. This statement from the American Family Therapy Academy supports the rights of immigrants and opposes the targeting and erosion of these rights. We speak out now due to our growing concern with U.S. policies towards immigrants. This statement cannot offer a comprehensive critique of U.S. immigration policy. However, it is based on our conviction that U.S. immigration law, specifically the oppressive immigration policies of 1996-1997, has steadily become more restrictive and harmful to families, separating partners from each other as well as parents from their children. Lack of access to healthcare, employment, and education has resulted in disastrous consequences for children and their parents. With the post September 11, 2001 passing of the Patriot Act seriously eroding the fourth amendment of the Bill of Rights against illegal search and seizure, the "war on terrorism" became a war on immigrants.

Immigrants are now denied the right to counsel, asylum seekers and other immigrants are subject to mandatory detention and deportation without judicial review, and immigrants with minor criminal records face deportation. Entire families have been confined for extended periods of time and unaccompanied minors are housed in adult jails often restrained, shackled, subject to strip searches, placed in solitary confinement, and separated from family members and systems of support. Children can be placed in foster care, rather than with family. Often detained families and children are denied healthcare, translators, sanitary living conditions, and adequate supplies of clothing and basic toiletries. Families are left destitute and grieving when their family members, who are usually the breadwinners, are detained. The women or partners left behind may not speak English or understand the system for seeking what limited help there might be for themselves and their children.

An array of federal regulations now permits actions that do not comply with the fourth amendment requirement of probable cause. For instance, homes can be entered without having to comply with the constitutional requirement to

give prior notice to the residents. Actions consistent with racial profiling are now commonplace. The attorney general has also authorized federal agents to infiltrate churches, synagogues, mosques, and other social gatherings of U.S. citizens to detect any sign of potential terrorist activity, introducing a pervasive fear in immigrants who are aware of the danger to their own and their families' safety and liberty in this present climate.

U.S. immigration policy makes it easy for employers to exploit immigrant workers, it denies adequate healthcare, separates and impoverishes families, makes women vulnerable to sexual abuse, limits access to employment for all and access to education for young people, and excludes immigrant voices from decisions that affect their lives. Immigrants are particularly vulnerable to discrimination based on race, ethnicity, national origin, gender, and sexuality.

Therefore it is the position of the American Family Therapy Academy that:

- 1) There be a comprehensive program that allows undocumented immigrants and refugees from all nationalities and living in the U.S. to obtain legal permanent residency.
- 2) Future immigrants should be able to come here legally and safely, have access to permanent residency, and not fear criminal prosecution for unlawful entry or exit.
- 3) Immigrant workers' rights should be promoted and protected; employer sanctions and the criminalization of work must be ended. Labor laws should be strictly enforced, and immigrant workers should have the freedom to join unions to improve wages and working conditions.
- 4) The human rights of all immigrants should be respected in the enforcement of immigration laws throughout the U.S. and at the nation's borders.
- 5) Immigrants should be able to adjust their undocumented status and reunite with families in a fair and timely way.
- 6) There should be an end to unfair political asylum and deportation processes and other barriers to acquiring and maintaining permanent residency.
- 7) All immigrants should have access to all public services and benefits including driver licenses, education, and healthcare.
- 8) Legal access and fair treatment of immigrants who are detained or in political asylum, or deportation procedures should be ensured.

- 9) Women and children who have been abused in their families should have their requests for asylum honored.
- 10) Protection, fairness, equality, and benefits should be extended to all immigrants.

As AFTA members who value the importance of the family, we shall:

- Advocate for family reunification and sanctuary from persecution;
- Insist that due process and fundamental human rights be upheld for immigrants and refugees;
- Monitor federal, state, and local immigration and refugee policies and voice objection when known abuses occur;
- Promote greater education and awareness at all levels of the effects of U.S. and other countries' foreign policies on immigration and refugee resettlement;
- Advocate for greater legal protection for individuals who provide sanctuary, legal aid, and support for people fleeing from persecution in their countries of origin;
- Support other groups (unions, advocacy groups, civil rights groups, etc.) and encourage our members to voice their concerns, to proactively support the issues that fall within the guidelines of this position statement, and to individually take political action.

Note: This position statement borrows freely from:

- The Citizenship Project
<http://www.newcitizen.org/english/manifesto.htm>
- The National Network for Immigrant and Refugee Rights
http://www.nnirr.org/projects/projects_legal.html
- The National Association of Social Workers
<http://www.socialworkers.org/resources/abstracts/abstracts/immigrants.asp>
- The National Immigration Project
<http://www.nationalimmigrationproject.org/default.html>
- The Center for Constitutional Rights,
<http://www.ccr-ny.org/v2/home.asp>
- The Florida Immigration Advocacy Center
<http://www.fiacfla.org/>
- Individuals who have been involved with AFTA, either as outside speakers or as AFTA members.

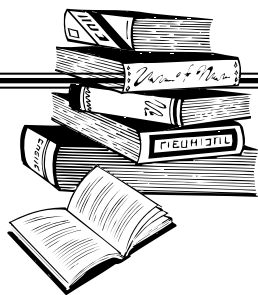
This position statement was developed by the members of the Family Policy Committee.

LIST OF POSSIBLE ACTIONS

1. Contribute one or more items to the AFTA Resource Packet presently entitled, "U.S Immigration Policy: The Impact on Children and Families"
 - i. Submit a resource to be listed: an article, film or documentary, or an experiential exercise that can be used for teaching.
 - ii. Write a brief annotation of an article or book that you would recommend about the experience of immigration, immigration policy, or the relationship of immigration policy to children, families and/or treatment, or about relevant political action.
 - iii. Help write, edit and/or "maintain" the resource packet.
2. Develop and participate in an AFTA online study group to review relevant articles related to immigration policy.
3. Develop or join an AFTA project to address immigration and detainment from a clinical and/or political action perspective.
4. Write or call your representative to Congress or your U.S. Senator to voice any of the following:
 - i. Concern about the threat to civil liberties of the Patriot Act.
 - ii. Endorsement of a specific aspect or of all of the recent AFTA position statement related to Immigration Policy and Human Rights.
 - iii. Reaction to the detention of "enemy combatants" and/or immigrants without due process.
5. Offer help to volunteer organizations in your area, for example:
 - i. First Friends: the Elizabeth Detention Center Visitor Project (NJ and NY), Tel: (908) 965-0455
 - ii. Riverside Church Sojourners Ministry for Detained Immigrants (NJ and NY), Tel: (212) 870-6808
 - iii. Additional support for detainees: Arab American Family Support Center, Tel: (212) 643-8000
6. Contact an immigration attorney and organize a meeting in your community at which he/she will discuss the Patriot Act.
7. Call your local school district (in collaboration with local immigrant advocacy groups) and offer to organize a workshop and/or panel about support of immigrant families within the school district.
8. Organize a study group for community members to learn from each other about the needs of different immigrant groups in the community.
9. Call an immigration attorney or an organization representing immigrants and offer to give one hour a week to work pro bono with an immigrant family.
10. Support first responders – Call your local ACLU office, offer 1 hour per week of pro bono therapy to staff who experience secondary trauma as a consequence of their work with detainees and families, or offer assistance to legal advocacy agencies, for example:
 - i. Contact The Center for Constitutional Rights, www.ccr-ny.org in New York City
 - ii. Contact the Florida Immigrant Advocacy Center, www.fiacfla.org in Miami, FL
11. Offer a one-time consultation to a local nonprofit mental health agency that serves immigrant families.
12. Rent or borrow a film about the plight of immigrants. Organize a film showing and discussion at your local public library, religious community, or school.
13. Contact Amnesty International in your area and offer assistance to support staff or families.

Hinda Winawer is a faculty member of the Ackerman Institute for the Family in New York and the Center for Family, Community, and Social Justice at Princeton Family Institute.





Books in Review

Thorana Nelson, Editor

Weingarten, Kaethe (2003). *Common Shock: Witnessing Violence Every Day, How We Are Harmed, How We Can Heal.* New York: Dutton. (Reviewed by Janine Roberts)

To prepare for seminars with people who work in hospice, I turned to *Common Shock*. To deepen my understanding of how my daughter's friend was affected when she was sexually harassed by a former teacher, I returned to it. To find language to name what I experienced in Colombia as I heard the stories of people there living with political violence, I found myself studying it again. Within this book, Kaethe Weingarten provides a very cogent, complex framework to understand how violence, whether it is bullying on the playground or wartime tortures and deaths, affects all of us. *Common Shock* is vigourously intellectual, yet based in daily actions people can take to counteract violence. As I read and reread it, I found information that was helpful for me in therapeutic and community work, in understanding my own psychological reactions, and for teaching and supervision. This is a book I will use for years. Or perhaps I should say books, as reading the over fifty pages of footnotes is almost like having a second book in hand. They are a trove of research, data, and other resources to examine.

Common Shock is a work of amazing generosity as the author makes available to us decades of reading, study, and work in the areas of trauma, illness, familial violence, and astute attentiveness to political events and their impact on people. The integrity with which Dr. Weingarten has put her ideas into practice and learned from those she has worked with, whether in a shelter for women and children in the U.S., in Kosovo or in South Africa; in her clinical work; and/or in situations of serious illness. All of these ideas are suffused throughout the book. She delves into the myriad ways in which violence affects us, the varieties of witnessing experiences, what is involved in compassionate witnessing, and how to transform violence. Each set of ideas is illustrated with nuanced and detailed stories that highlight experiences of people of all ages and backgrounds. Special attention is paid to the interface between community and family life, and how they influence each other. She does not only draw upon her wide range of work and traditional psychological sources, but interweaves in quotes and rich observations from literature, film, and memoirs.

The way the book is written exemplifies a collaborative narrative framework. Kaethe Weingarten openly shares her own

experiences, such as what happened to her family during the McCarthy era; her years with breast cancer; and her daughter's life with a rare genetic disease. This deep magnanimity invites the reader to look anew at their own life and the lives of others close to them. You can journey with the author and have the possibility of partaking not only of her ideas, but the asides and rests she provides as she grapples with the intensity of looking closely at such a consuming subject. The book is concentrated. At times I wanted more spaciousness in it. I needed to stop, digest, and come back to it later.

Each topic that is addressed is rooted in what people of all ages can do to respond, to prevent, and to change violence. Children are never left out of the author's thinking. Small, concrete suggestions of how to put beliefs into action are peppered throughout the book. One touching example is Kaethe's description of helping her son Ben at age four to bake bread in the somewhat recognizable shape of a violin and bow to give to their neighbors when their violin shop burned down. Yet none of these suggestions, nor for that matter theoretical ideas, are presented in a prescriptive or narrow way. Rather the book guides the reader through varied perspectives and lets one know how the author came to particular stances.

Common Shock also contributes a great deal to the family therapy profession. It provides a template for how family therapists can apply systemic ideas to myriad areas. As well, it lets a much wider audience than therapists into the arena of systemic ideas and demonstrates how they can be used, especially in polarized situations.

A clear and lucid voice is maintained throughout this book. It reminds us in essential ways and gives us entrance into the responsibilities we have as citizens to address all kinds of violence, including structural violence like poverty. The book is ultimately about the possibilities of hope and its centrality in our work.

Janine Roberts is the Past President of AFTA and is professor at the University of Massachusetts Amherst.



Kaslow, Florence W., Schwartz, Lita Linzer, (Eds.), (2003). *Welcome home! An International and Nontraditional Reader*. New York: The Haworth Clinical Practice Press. (Reviewed by Casi Kushel)

A friend and I were just talking about life with our adopted children. Between us we have three adopted children and three birth children. We have children adopted domestically and children adopted internationally; children adopted before their first birthday and children adopted as toddlers; one incomplete international adoption and one failed domestic adoption.

We are both family therapists who work with families pre and post-adoption and consult with parents about the myriad issues that arise raising these children. We talk about how difficult it is to keep abreast of the ever-changing legal, cultural, and pragmatic realities of international adoption. We talk about the specific cultural and political issues of different countries and times. We talk about which schools in our area are supportive and culturally sensitive.

But mostly we talk about the needs of our children and the day-to-day realities of raising children who were relinquished by or taken from their birth parents, especially those children brought here from distant places: children who lose not only their birth family, but their language, their culture, their sense of place, and a genetic mirror of their very faces. Our families and we are fortunate because we can compare notes, offer support and encouragement, and draw on our large and loving community of peers for expertise.

Until the publication of Lita Linzer Schwartz and Florence W. Kaslow's unique and informative international and nontraditional reader, most people wishing to grow their families through international and cross-cultural adoption lacked the opportunity to learn about the real experiences of real people who chose to adopt internationally.

In *Welcome Home!* co-editors Schwartz and Kaslow use personal accounts from a variety of adoptive parents with the same emphasis on the experience of adopting and raising these children that dominates the thoughts and feelings of adoptive parents everywhere. Along with information about why we adopt, where we adopt from and a look at some of the recent research on international adoption, Schwartz and Kaslow allow their adoptive parents room and range to tell their own stories. These are the stories that people considering international adoption want and need to hear.

In chapter 9, "*A Perfect Lottery*," a Swedish husband begins, "My wife and I thought we would be perfect parents. We are well educated-a psychologist and a social

worker, respectively-..." Since he and his wife at 34 and 39 years old "were not really seen as young in the eyes of the main organization for international adoption in Sweden" and since they were both divorced and he was Jewish ("Not every country accepts Jews as the recipients of their children, although this is not openly stated"), he and his wife decide to adopt privately in Poland.

They travel to Poland twice to visit an orphanage and answer (very politely) asked questions. "Behold! Before going back to Sweden, we were told we were accepted. It was quick and no bribes were required." He goes on to describe their return to Poland and their first less than auspicious meeting with a three-year-old girl who, after many twists and turns, became their daughter.

In "*Our Daughters from China Have Two Mommies*" the authors describe the adoption process as "a circuitous paper chase," and their lively and informative narrative includes the issue of having to choose one of them to file as a single parent because China, like many homophobic societies will not grant parenthood to same-sex couples. Their local agency, however, treated them as a couple in the course of a lengthy set of interviews and questionnaires. Now as members of a large local chapter of Families with Children from China they attend many cultural and social events with their two daughters.

One of the most important contributions to this conversation about international adoptions concerns the painful experience of struggling to raise children who had been horribly traumatized. One adoptive mother writes that she began to read the court documents on the flight home from Russia and found them chilling. She learned that her little girls had been starved and beaten and left out all night when they were barely three or four years old.

She describes their first six months together as a family as "sheer hell." She describes night terrors, screaming, head banging, and violence. None of the professionals were able to help - not the teachers, not the pediatrician, not the therapist. Eventually, one of the girls was hospitalized with a diagnosis of post-traumatic stress disorder. The other daughter does quite well and the family grew to include a seven-year-old boy who arrived as a Bridge of Hope camper.

In her closing chapter, Kaslow notes that the authors were gathered as a network sample and include mostly heterosexual married couples. Fathers wrote two of these narratives. Also included are one lesbian couple and two single mothers. "All," she says, "appear to be open-minded, liberal, flexible, courageous, tenacious, willing to take risks and altruistic."

They also appear to be comfortable with parenting across cultures, language and ethnicity. The children come from China, Russia, Poland, Cambodia, Greece, Iran, Latvia, and Thailand. All but two of the authors (who are Swedish) come from the United States. A real bonus is the voices of siblings and grandparents.

I found myself wondering what it would be like to hear the stories through the perspective of the children as they matured. I would also like to see a description of the character and traits cross-culturally adopted children think their parents should have. At least, I think I would. For now Schwartz and Kaslow have given us a valuable opportunity to enter the world of international adoption. Recommend this book to everyone you know who is considering this most amazing adventure.

Casi Kushel, M.S., MFT is the director of Finding Common Ground and creator of Conceived in the Heart Adoption Seminars. She consults for several Bay Area immigrant and refugee programs. In her private practice in Walnut Creek, CA, she specializes in intergenerational immigrant and refugee issues and transracial, domestic, and international adoptions.



Flemons, Douglas W. (2002). *Of One Mind: The Logic of Hypnosis, the Practice of Therapy*. W. W. Norton & Company. (Reviewed by Jerry Gale)

I was delighted to review the book *Of One Mind: The Logic of Hypnosis, the Practice of Therapy*. Our profession is being shaped and challenged by many strong discourses: evidence based treatments, attention to social justice, oppression and diversity, giving voice to clients, managed care, spirituality, neuroscience, biopsychosocial perspectives, standards of competency, questions of ethical accountability, and postmodern critical reflections. As a faculty member in a COAMFTE doctoral program, it is challenging to bring in all of these perspectives, let alone maintain a working appreciation of the seminal and paradigmatic changing ideas of our field's founders.

In reviewing the book *Of One Mind*, I have found a text that can take the transforming ideas of Gregory Bateson, Milton Erickson, and the developers of the interactional model (e.g., Jay Haley, John Weakland, and others), build upon them, and make them come alive and germane to practitioners of the 21st century. Providing a relational theory towards understanding change, this book offers specific practices for clinicians and supervisors of all schools of therapy.

In some ways, part of the title of the book, the logic of hypnosis, actually confines the book's potential. Flemons offers a clear and vivid articulation of the logic of relational

thinking. This includes all types of relationships, including that between clients, the client and the problem, the therapist and the client, therapist and supervisor, as well as the therapist with him/herself too. Although this book does offer direction to those practicing hypnosis, I think, at the same time, Flemons challenges the dominant view of hypnosis. Flemons is strongly influenced by the ideas of Gregory Bateson as well as Taoism (See Flemons, D. (1991). *Completing Distinctions*. Shambala Press). These influences provide the underpinnings of how Flemons invites the reader to think relationally.

In addition, this book is an excellent guidebook for practicing a relational way of thinking. More than just offering examples, Flemons guides the reader in how to think relationally in order to see events relationally. Clinical examples with transcripts and personal examples of his children's logic, gleaned through their developmental experiences, vivid imagery, useful metaphors, and specific strategies, are all provided. The book offers a compendium of suggestions for a host of clinical issues. Flemons is an excellent storyteller and brings the reader into his clinical vignettes of such issues as dying, coping with cancer, eating disorders, history of abuse, sexual dysfunction, the therapist feeling disconnected from a client, supervising stuck clinicians, therapist burn-out, ethical boundaries, effective use of one's own words, and much more. This book offers guidance and suggestions for beginning clinicians as well as seasoned supervisors.

While one may not be in concordance with all aspects of the model that Flemons is presenting, his ideas engage the reader in a critical (and relational) responsiveness. Hence, regardless of one's preferred model(s) and theories of change, this book takes the reader on a journey that leads to new understanding of his/her own practices and reflections.

Jerry Gale is director of the MFT doctoral program in the Department of Child and Family Development at The University of Georgia.



Greenan, D. E., & Tunnell, G. (2003). *Couple Therapy with Gay Men*. New York: The Guilford Press. (Reviewed by Jerry J. Bigner)

It is not often that we, as therapists, experience the unbalancing of ourselves that is called for in structural family therapy to help couples shift from preferred ways of interacting into new ways of relating. This text by Greenan and Tunnell manages to achieve just this effect by forcing the reader to examine and reexamine numerous personal as well as professional issues and paradigms that are involved in providing treatment for gay male couples. It will help the reader to reflect and reassess what they know or have learned about working with couples in general, working with heterosexual couples, and working with gay male couples.

This book provides one of the best and most comprehensive discussions of the psychological, cultural, and social aspects of gay male relationships and the developmental aspects of individuals who are gay men. While this approach has been presented by other authors, Greenan and Tunnell equip the reader with an understanding of gay male development that is discussed within the context of attachment theory and Bowen's differentiation of self model. The reader becomes educated and informed on these aspects of individual development that manifest in challenges encountered by gay male couples in forming and sustaining intimate relationships.

Greenan and Tunnell are adept in describing the connection between theory and therapeutic practice in working with gay male couples. The authors use the structural family therapy model of Minuchin to demonstrate their therapeutic approach. This text is especially helpful in this regard for therapists-in-training or those unfamiliar with this therapeutic model. Greenan and Tunnell first describe the basic therapeutic model and then follow with an example of how the model may be applied to working with a heterosexual couple. Then the reader is lead, step by step, through the model's application in working with gay male

couples. The authors provide a detailed explanation of structural family therapy as it applies to the unique challenges of gay male couples in distinction to heterosexual couples. A very well written case study provides an elaborate presentation of structural family therapy methods specifically focusing on a gay male couple's experiences.

Perhaps the greatest contribution of this text can be its ability to promote greater empathic sensitivity and understanding of therapists as well as those in training regarding the unique context of gay male couple relationships. It is likely to challenge one's unawareness of homophobic attitudes (even among those who might believe that they have conquered their biases) and to increase one's sensitivity to the unique challenges of gay men to form nurturing relationships in a homophobic society. Most training programs do not adequately address treatment approaches, philosophies, or methods needed for working with gay or lesbian couples. This text addresses the needs of therapists to meet treatment goals and interventions in working with gay male couples and should be in the libraries of all AFTA members.

Editor in Chief

Betty Mac Kune-Karrer

Managing Editor

Barbro Miles

Book Review Editor

Thorana Nelson

Editorial Board

Jane Ariel

Judith Myers Avis

Anne Bernstein

Celia Falicov

Paulette Hines

Ivan Inger

Jay Lappin

Thorana Nelson

Joellyn Ross

Volker Thomas

Kaethe Weingarten

Hinda Winawer

Editorial Advisor

Suzanne Putillo

Editorial Assistant

Susan Sculley

Advertising Managers

Jay and Joyce Lappin

AFTA Newsletter

1608 20th St. NW, 4th Floor

Washington, D.C. 20009

Non-Profit Org.

U.S. POSTAGE

PAID

WASHINGTON, D.C.

PERMIT NO. 3579

The Newsletter, the official publication of the American Family Therapy Academy, Inc., is published two times per year.

Members are invited to submit material for the Newsletter—notices of events, news and commentary, letters of opinion or facts, reviews, and essays.

Subscription Rate

\$24 per year for non-members

Editorial Offices, Address Changes, & Membership Information:

American Family Therapy Academy

1608 20th St. NW, 4th Floor

Washington, DC 20009

Payments for publications may be deductible for federal income tax purposes as ordinary and necessary business expenses to those purchasing publications. They are not deductible as charitable contributions. Please consult your tax advisor for specific advice.

Copyright © 2004 by American Family Therapy Academy, Inc. For permission to reprint, contact AFTA, 1608 20th St. NW, 4th Floor, Washington, DC 20009.

Advertising Information

Correspondence should be addressed to:

Jay Lappin, Advertising Manager, 1106 Newton Avenue, West Collingswood, NJ 08107. Telephone (856) 858-5346

Production Charges:

Advertisers who want typesetting and paste-up of their ads will receive an estimate in advance. Unmounted photostats or prints preferred. Camera-ready mechanicals (i.e., paste-ups) acceptable. No typewritten or dot-matrix printed ads will be accepted.

Camera-ready Advertising Rates and Mechanical Specifications:

Unit	Width (in.)	Depth (in.)	Cost
Full page	7	9 1/4	\$300.00
Inside covers	7	9 1/4	\$350.00
Half-page (horiz.)	7	4 1/2	\$200.00
Half-page (vert.)	3 3/8	9 1/4	\$200.00
Quarter page (horiz.)	7	2 1/8	\$90.00
Quarter page (vert.)	3 3/8	4 1/2	\$90.00

Classified Ads: \$45 for each set (or any part) of 50 words. Check must be included with ad.