San Gabriel Valley Psychological Association

Analyze This!

Named by CPA ~ Outstanding Newsletter of 2010!!

The Official Newsletter of the San Gabriel Valley Psychological Association

www.SGVPA.org AN OFFICIAL CHAPTER OF CALIFORNIA PSYCHOLOGICAL ASSOCIATION March/April 2013

CPA'S OUTSTANDING CHAPTER FOR 2013

Upcoming Lunch Meetings

Date: **Friday, March 8, 2013**
Topic: **The Dangers of Unanalyzed Aspects of the Analyst**
Speaker: **Elisse Blinder, PhD**

Date: **Friday, April 12, 2013**
Topic: **The Storied Self: A Quest for Coherence Amidst Constant Change**
Speaker: **Dan Goldin, MFT**

PLEASE RSVP NO LATER THAN THE FIRST MONDAY OF THE MONTH TO YOUR INTERNET EVITE, OR TO THE SGVPA MAIL BAG INFO@SGVPA.ORG.
CE credits available for Psychologists, LCSWs and MFTs

Monthly luncheons are held on the second Friday of the month at the Women's City Club, 160 N. Oakland Avenue, Pasadena, from 12:00 to 1:45 p.m.

Members Costs:
Luncheon, Service, and Parking Privileges...$22
CE credits...$20
Audit...$10

Non-Member Costs
Luncheon, Service, and Parking Privileges...$27
CE credits...$25
Audit...$15

Please note: Unclaimed lunch reservations will be billed to the individual--So please claim them!

PRESIDENT'S MESSAGE

Dear Colleagues,

I want to congratulate our chapter for making history! On Monday, January 21, I received word from Dr. Craig Lareau--immediate Past President of the California Psychological Association--that our chapter had been awarded CPA's very prestigious ***Outstanding Chapter for 2013 Award!*** I cannot express how wonderful an achievement this is for each of you, and for your hard working Board of Directors. Never in SGVPA's more than forty year history have we achieved such a milestone!

Our chapter garnered the attention of CPA for several reasons-- our grassroots political advocacy efforts, the number of dual members in CPA, the *"5-for-20" Campaign* for the PAC that we launched, our local community project, our programming, and our historic number of members. All that could not have been possible without each of your efforts and participation. This truly was a group effort, and a group triumph!

As heady as an accomplishment as this award might be, I hope you will *stay motivated* to continue as a member of SGVPA, of CPA, and your *active involvement* in our chapter activities. Never fear, I carry the weight and responsibility of insuring that SGVPA stays relevant--not only

(continued on p. 2)

to you individually, but also to the interests of our profession. When we all add our weight to the group effort, our organization is better for it, as are our local and state interests. So please, renew your SGVPA and CPA memberships, and donate to CPA's Political Action Committee (PAC)!

Looking ahead this year, your Board of Directors will continue to champion the programs that brought this award to our chapter: Relevant topics at our monthly luncheons and Special Interest Groups, consistent social justice opportunities, chances to contribute to worthy advocacy causes, and bountiful occasions to network, get to know your colleagues and stay *connected!*

Speaking of social events, I want to say a special thanks to all the folks that helped make our Fifth Annual January Jubilee another huge success! The enthusiasm of the volunteers among our members always amazes me, and this event was no exception. With approximately 130 folks in attendance, and a plethora of renewals and new members signing on, I'd say we just have to keep that party going!

Your President,
Stephanie Law, PsyD

It's Worth It!
Why CPA Membership is Worthwhile

By Melissa McMullin, PsyD
Representative to CPA

Membership renewal season is upon us. This is usually the time of year when I carefully evaluate my budget and attempt to determine which professional memberships are truly worth the investment. As your SGVPA representative to the CPA Board, I found myself questioning how to make a persuasive pitch for renewing your membership, or joining CPA in the first place. What does CPA really do for psychologists, anyway? What are the actual benefits of being a member? Although there is a much longer list--here are my top five reasons for joining CPA:

- **Staying informed.** Affordable Healthcare Act is upon us, and with it, the prospect of an overhaul of the way mental health services are delivered and paid for. While it is easy to put your fingers in your ears and chant "la, la, la" whenever concerns about protecting our scope of practice, and the future of Psychology, comes up in conversation, now more than ever we *must* stay informed, in order to be prepared, and to *act* to protect the very existence of our profession.

- **Free CEs!** Read the CPA Monitor bi-monthly, and get 2 CEs every other month. The CPA Monitor strives to provide up-to-date, useful information about advances in evidence-based practice, ethics, and the ever changing field of Psychology.

- **Practice resources.** Free ethics consultations, private practice forms, updates on insurance billing, HIPAA compliance articles, and even free merchant services are available to members.

- **Something for everyone.** With 8 divisions, ranging from clinical practice to public service to media and technology, there is an opportunity to stay involved and informed about the areas of psychology that matter most to you.

- **Insurance and discounts galore!** CPA is one of the only mental health professional organizations offering health insurance to its members. They also offer discounts on vision, dental, disability, home, and auto insurance (to name a few), not to mention discounts on CEs, and even car rentals.

There are even more benefits than I can describe here. Please stay invested in our profession and join--or re-join--CPA today!

Dr. Melissa McMullin can be reached at (323) 345-01402 or mcmullin.melissa@gmail,com

Welcoming Our New Student Co-Representatives to CPA

Hello to all! My name is Christin Fort, and I am pleased to greet you all as an incoming Co-Graduate Student Representative for SGVPA. By way of introduction, I hail from Detroit, Michigan, where I was born and raised. (Yes, I was raised in the actual city of Detroit, and not a suburb... I guess I get that question a lot.) I eventually moved to Los Angeles, by way of the Chicago area, to pursue my doctorate at Fuller's Graduate School of Psychology. I am currently a third year PhD student, with an emphasis on Marriage and Family studies.

Since matriculating at Fuller, I have joined a research team that is analyzing a dataset based on Urban Youth Ministry Workers in LA who have experienced trauma. This academic year, I also have the privilege of serving as the Clinical/Research Fellow for the Headington Research Lab. Under Dr. Cynthia Eriksson's guidance, we are committed to working with international humanitarian aid workers, and domestic urban ministry workers, who have experienced trauma. As a co-researcher for the Urban Project, I am grateful for the experience which the project provides. Eventually, I hope to combine my interest in couples work, and urban leaders, by serving as a researcher and clinician for couples who have committed themselves to full-time ministry.

As one of the newest members of the SGVPA Board, I am delighted to be joining the team with my partner, Jesse Malott. Together, we hope to serve as a bridge between our peers--budding psychologists-in-training--and you, the professionals we look up to, whose ranks we look forward to joining in a few short years. We have a host of ideas that we are already beginning to set in motion, and we look forward to collaborating with you!

Christin Fort can be reached at ChristinFort@Fuller.edu

Greetings of the new year! My name is Jesse Malott, and with Christin Fort, I am incoming as a Co-Graduate Student Representative of SGVPA in 2013. I look forward to this with SGVPA, and the privilege to work alongside such amazing people. As a current student, my perspective seems to be filled with thoughts of the future, but I should begin with a bit of who I am right now. I am a 3rd year PsyD student at Fuller Theological Seminary. My research activities include combat-related trauma, meaning-making, spiritual/religious coping, and complex trauma. I am largely committed to clinical practice, and becoming a well-rounded and competent clinician with specialties in complex trauma and spiritual/religious issues. I have been fortunate enough to serve in multiple non-profit organizations, including several years as clergy in a church. Outside of school, my clinical work, and various leadership roles, my time is spent with my beautiful wife of thirteen years, my four year-old son, our two long-term international students from mainland China, and Jack the dog.

I am delighted to serve as a student representative to the SGVPA Board this year, and Christin and I have already been discussing our goals. We have begun to gather a team who will work toward involving more students in SGVPA from the various graduate school campuses in the San Gabriel Valley. It is our hope that this year we may continue to develop the student mentoring program, to encourage students to advocate for mental health in our state, and to involve more students in the professional activities of Psychology in our region.

We are here to serve, and look forward to any advice and guidance from the seasoned professionals in our midst. Here's hoping for another great year of activity and growth in our organization!

JesseMalott can be reached at JesseMalott@gmail.com

Has Anyone Seen My Keys?

Distinguishing Between Normal Brain Aging and Dementia

By April D. Thames, PhD

By the year 2030, Baby Boomers aged 66 to 84 will comprise approximately 61 million of the US population. This trend poses a number of challenges in the context of clinical care. To illustrate, the risk of Alzheimer's disease (AD) doubles every 5 years for individuals between ages 65 and 85. Although the natural aging process involves changes in cognitive and functional abilities for most people, there is considerable public and scientific interest in early detection and management of what may be early dementia. For many individuals, the idea of losing pieces of one's memory, logic or reason is justifiably worrisome. According to a 2010 survey by the MetLife Foundation, people over 55 fear getting Alzheimer's more than any other disease. This upsurge in public awareness has increased the number of dementia-related referrals across the US. Although progressive forgetfulness is a common indicator of early AD, obvious questions arise, such as: How much forgetfulness is too much? Where do we draw the line between incidental episodes of forgetfulness (e.g., "Where are my car keys?") and more severe episodes such as forgetting the names and faces of loved ones?

Mild Cognitive Impairment (MCI) is considered an intermediate stage between normal aging (e.g., mild forgetfulness and cognitive slowing) and dementia, which is estimated to affect 10-20% of the US population. MCI is typically classified into two subtypes (amnestic and nonamnestic) depending on the presence or absence of memory impairment. The nonamnestic subtype of MCI is less common than the amnestic type, and is thought to precede non-AD types of dementias such as vascular dementia or frontotemporal dementia. Most, but not

all studies report that the prevalence of pre-dementia AD is higher among patients with amnestic type of MCI.

MCI can fluctuate over time and outcomes are difficult to predict. For instance, individuals with MCI may revert back to normal cognition, remain in the MCI state, progress to AD type dementia, or progress to a non-AD dementia. However, it is estimated that the more than 60% of people diagnosed with MCI do not progress to a dementia. The pattern of cognitive decline can vary widely between patients with dementia, particularly in cases of stroke or vascular dementia. As such, receiving a neuropsychological evaluation during the early stages of cognitive decline can provide a baseline against which to track subsequent changes in functioning.

To date, there is no standard battery for the assessment of MCI. Selecting the appropriate neuropsychological test battery is influenced by a number of factors including the nature and scope of the referral question, and the functional status of the patient. The clinician must be fully aware of advantages and disadvantages to the various assessments that are available for assessing cognitive decline. For example, dementia-rating scales have the advantage of being brief and less anxiety-provoking for the patient; however, these scales alone may not be sensitive to changes in cognitive function. Comprehensive neuropsychological assessments can provide greater sensitivity for detecting areas of cognitive impairment; however, the time required to complete a comprehensive assessment (typically 4-6 hours) runs the risk of the patient becoming fatigued, anxious and overwhelmed. Also, essential to distinguishing between MCI and dementia is an assessment of one's abilities to perform everyday or functional activities, such as cooking, shopping, driving, and grooming. While self-report measures are commonly used, they are limited by the patient's level of insight into his or her impairments. Therefore, clinicians may want to consider collateral sources such as family members and direct clinical observation to best capture functional capacity.

Currently, there is no cure for dementia. However, some pharmacological therapies such as cholinesterase inhibitors and memantine have been demonstrated to improve memory, attention, reason, and language functions. The strongest evidence towards reducing one's risk for dementia are similar to those suggested for reducing risk of heart disease. The Alzheimer's disease association reported that in a study of 1,500 adults, those who were obese in middle-age were twice as likely to develop dementia later in life. Recommendations such as eating a balanced diet, engaging in mind-stimulating activities, physical exercise, and learning memory compensation strategies are often suggested as ways to prevent dementia.

Psychologists who work with older adult populations have a professional responsibility for keeping up-to-date on the newest developments in the prevention and management of dementia. Until a cure is made available, our efforts should be directed towards utilizing reliable and valid diagnostic tools, educating the patient and family members about dementia, and promoting risk reduction behaviors.

Dr. April Thames can be reached at AThames@mednet.ucla.edu.

On the Dangers of the Unanalyzed Analyst

By Elisse Blinder, PhD
and
Suzanne Lake, PsyD

Psychotherapists have a problem. They want to help people with problems, but the main tool they bring to the task is *themselves,* including the relationship they build with the sufferers, in discerning where the difficulties stem from, and how to address them. To this end they apply their hearts and intellects, learning as much as they can, and applying whatever strategies in their "toolboxes" to help untie the knots that patients come in with. However, to the extent that their main tool--self--is compromised, their work stands to be compromised as well.

It's axiomatic among therapists operating from various psychoanalytic viewpoints that he or she must have had an analysis-- or at least extensive personal therapy--in order to be as objective, receptive, and well-integrated as possible in practicing their craft. But it's also true that no one--not even Freud himself!--is ever completely free of personal distortions and defenses. Hence, the problem.

From the beginning of subjective life, and the onslaught of stimuli, with internal and external demands, individuals develop ways of adapting. Using necessarily immature intellects, they draw on all the resources available to them to build intellectual and emotional constructs to help cope with and "make sense of" the situational and relational challenges they encounter. Simply put, these constructs and the way they are organized make up personality.

Actually, one useful model for understanding personality is the computer. Personality functions like an operating system into which have been bundled an array of hidden (forgotten or never verbalized) programs, that function as templates and imperatives for how the person perceives self and other, and automatically responds to those perceptions. The person doesn't know the programs are there, distorting and limiting her or his way of being in the world. But because they are riddled with primitive distortions, they pretty much inevitably lead to problems in living. The good news is that once the programs interfering with clear, realistic perceptions and responses are identified, they can effectively be "disabled." It's the therapist's job to join with the patient in seeking out the problem programs, using the unfolding therapeutic relationship to explore where they are, how they function, and where they came from.

In psychoanalysis speak, this is the process of analysis. The unconscious "programs" are what need "analyzing" to free the person from their control. Such programs may involve underlying feeling states (e.g., judgment, greed, anger), or notions like: It's dangerous to be open and honest; I must not to be successful; My thoughts are worthless; I have to be pleasing not to be to be attacked; I am not allowed to have strong feelings; I have to stay dependent to be safe; I have to stay tough, or others will destroy me; I have to take care of everyone, no matter what the cost. And so on.

As mentioned above, however, it isn't just the patient who is subject to the unhappy vicissitudes of rogue programs affecting the perception and response to self and other--it's the therapist as well. No matter how much personal therapy, no matter how much experience, no matter how much study, or supervision, the human psyche is so complex there is always the unanalyzed corner of it that may intrude on the therapist's best efforts to conduct therapy.

Therapists with unconscious distortions are "dangerous" because patients rely on them as benign sources of corrective reality, and because--like parents--therapists wield enormous power.

For example, Dr. A has unresolved needs to be be adored and goes out of his way to flatter a female patient, thinking he is "correcting her negative self perceptions." The woman feels seduced by him, and act out her feelings by having an affair. Dr. B, who suffered from a remote, unpredictable mother in childhood, thinks nothing of letting patients call and text him with their demands on his cell phone. He unconsciously identifies with their neediness, and feels that limiting their access by not responding would make them feel abandoned. Patients with difficulty managing interpersonal boundaries become more out of control and dysfunctional. Dr. C's unconscious abandonment fears lead her to preemptively terminate patients as a way of taking control of the inevitable separations.

For all of us as conscientious psychotherapists, it's important to remember that we can never reach a stopping point in personal growth. The good news is that as we continue scrutinizing our work, and seeking out professional consultations, many of the dangers of bringing our idiosyncratic distortions to bear can be avoided.

Please join us for more on this topic, when Dr. Elisse Blinder presents at the March luncheon!

Dr. Elisse Blinder may be reached by email at DrEBlinder@charter.net.
Dr. Suzanne Lake may be reached by email at DrSuzanneLake@aim.com.

Affordable Care and Accountability:
Whither Autonomy?

By Larry Brooks, PhD
Program and Continuing Education Chair

The prospect of Affordable Care Act (ACA) hangs uncertainly over the health care horizon. Increased regulation and consolidation of care providers is ahead, and will create a different landscape for all health care providers, particularly psychotherapists. California has already received millions of dollars from the US government to set up a health insurance exchange that will become the marketplace for individuals and small businesses to purchase health insurance. According to APA's Katherine Nordal, the drive to reform health care delivery systems is already well underway, with January 2014 set as the target date for its implementation.

Psychotherapists have been able to preserve a sanctuary for the individual private practitioner over the last 20 years, even as medicine has shifted to larger group practices, and public sector therapists often had to implement cost-saving "evidenced-based" models. The structure and paradigm of psychotherapy as we know it is not likely to remain untouched by the ACA. The foundation of this paradigm has been the relational contract between therapist and client, who have had the autonomy to collaborate on a mutually determined treatment. This foundation has supported the development of multi-theoretical perspectives and treatment approaches, allowing therapists to practice in two domains: 1) helping clients alleviate symptoms, and 2) helping clients grow emotionally. Emotional growth represents a higher order change than symptom relief, and involves the transformation of deeply embedded belief systems about self and others.

Three ideas dominate the discussion of the ACA, and will play a critical role in shaping the new healthcare landscape: *affordability, accountability,* and *integration of care*. The incentive to *contain costs* will most likely lead to a change in the fee structure. The fee-for-service model has contributed to the huge escalation of healthcare costs. *Global payments*--echoing the earlier notion of capitation--will represent a cost-cutting model whereby fixed fees for patient care will be pre-set, and health care providers will need to work within these budget constraints.

Accountability is the therapist's Achilles Heal, for whereas privacy and confidentiality are embraced, accountability has been regarded suspiciously. The evaluation of psychotherapy progress is a sensitive, complex, intersubjective process. Psychotherapy is a private relationship; yet when it becomes a covered benefit, the insurance company is contractually entitled to information about it. Within the systems of care that will emerge, psychotherapists will need to report on, and be held accountable for the effectiveness of their treatments.

Integration of care is the most complex part of the ACA, and reflects how healthcare will be organized across a continuum of services including hospital care, specialty groups, primary care, and mental health. Will psychotherapists become part of large primary care groups or will they be able to maintain their geographical distance without sacrificing their autonomy? The emphasis on integrated, cost-cutting systems of care indeed threatens the autonomy of the solo practitioner, and the paradigm of psychotherapy. These changes concern me since the value that psychotherapy offers to our culture is a separate place to care for the Psyche. As a psychoanalytically-oriented psychotherapist, I fear these changes. I realize I will have to move outside my comfort zone to adapt to the future.

It is imperative for therapists to educate themselves about the ACA in order to understand how their practice will be affected, and perhaps also to raise their voices in the policy-making discussions. With certain doors closing, other doors will open. Not only will there be more individuals covered by insurance, but with mental health services considered an essential health benefit, there will be greater utilization of these services. It will be important to work collaboratively with professional organizations to advocate for your profession. These changes will be a top-down process. The big power holders typically make the big decisions. The individual practitioner is not a power holder, and will not have any impact on the shape of changes set in motion by ACA-- except by joining forces with mental health advocacy organizations such as CPA.

Wilfred Bion speaks about the creative process that is involved in learning from experience and change. Creativity involves the dismantling of old models of viewing the world in order to allow for the emergence of new ideas that often are regarded by the Psyche, as well as by the social group, as threatening. Personal belief systems are containers that ground the individual in a familiar reality. Change involves rattling and breaking the container, and taxes the ability to tolerate disruption and anxiety. Yet the capacity for transformation involves both the acceptance of the limitations of external reality, and the lessening of one's personal omnipotence, as well as one's attachment to existing belief systems.

Dr. Larry Brooks can be reached by email at drbrooks@drlarrybrooks.com

Weed Revisited
Part II of a Two Part Series

By Daniel Goldin, MFT
Substance Addictions SIG Chair

I have a 27 year old patient we'll call Brett. He has three or four bong hits with his morning coffee, usually has a bowl in the car on the way to his part-time job at Jamba Juice, a joint on his lunch break, and then does continual bong hits through the night until he fades from pseudo-sleep into actual sleep, usually on the couch in front of the TV. This has been his routine for seven years. Our sessions involve a lot of talk about how weed relieves anxiety and allows access to surprising, alternate ways of thinking. Brett is a photographer who has a lot to say about his art, and about the work of others, but he hasn't produced much in the last five years-- a condition he accepts with his usual apathetic aplomb, "I'm in an R & D stage of my life."

In treating addiction, I have come to rely on some simple general ideas I can sum up in two quotes. The first is from Vladimir Nabokov: *The problem with drinking is the patient wakes up to find out that the operation has not been performed.*

Eventually life gets so bad that the addict cannot help but realize how drug use is destroying him. This is what AA folks refer to as "bottoming out." However, this state rarely leads decisively toward sobriety.

Our second quote from Howard Rachlin sums up the problem.: *Almost all alcoholics prefer to be sober than to be alcoholics. But they also strongly prefer to drink today than to abstain today; and since it is always today, they drink.*

Those who struggle with addiction labor under a fragile sense of time, one susceptible to sudden constrictions; a volatility that leads to ambivalence and loss of control. The addict knows his life is in ruins, but at moments of pain and temptation, the ruined landscape blurs suddenly into the background; there is only the present instant, swollen with need and wanting.

If I may grossly over-simplify: Treatment of addictions consists in helping the patient elaborate his feelings -- initially perceived as overwhelmingly diffuse or somatic -- into mutually felt stories that project from the past into the future. The operation gets performed, and the moment, whether of pain or temptation, becomes part of a larger, meaningful narrative. It is no wonder that the sharing of stories is a mainstay of AA.

Little of this applies to weed, however. Although smoking weed has been associated with early onset schizophrenia, testicular cancer, and a host of other alarming effects, for the most part there is no "bottoming out" for even the heaviest users of weed. The stoner may wake up one day at the age of 35, in a ghetto breadbox on his way to a marginal job, but he rarely wakes up in jail, or with his car wrapped around a pole.

Cannabis is psychotomimetic, mimicking in a milder form the negative symptoms of schizophrenia, such as apathy and loss of pleasure. Amotivation, difficulty learning new things and short term memory loss are the most frequent, pervasive effects of use, effects whose very properties are self-effacing. To top it off, the culture seems to have accepted weed as the one recreational drug without dire consequences--perhaps even with medicinal and mind-expanding effects. Denial is the favored defense for all addicts, but for stoners it is a side-effect of use, and corroborated by the culture.

So how does one reach Brett? Heavy users of weed are not so much ambivalent as indifferent, a characteristic that by its nature does not motivate one to change, even when brought to the fore. And yet... something seemed to stir beneath Brett's cannabis fog. His constant talk about art and photography touched upon a wish -- a wish to create -- and behind that faint wish lay a sense of lost potential. Chemically induced indifference could not totally destroy his desire to make a difference, to do things in the world -- in Brett's case, a wish with a lot of fear in it. Brett and I talked photography for hours and hours. One day he picked up his camera and began to shoot. It was only then that we began to explore his ambitions, and his concern that he had put them on pause. He continues to smoke weed every day, although not on mornings when he shoots. He has moved from apathy to ambivalence, the first step on what will hopefully be a long road to recovery.

Daniel Goldin, MFT, can be reached at DanielGoldin@gmail.com

Jammin' at the JJ!

SGVPA'S Signature Year-Opener Regales Crowds of Happy People Again

By Suzanne Lake, PsyD
Editor and Past President

It has become customary for me, in one of my various roles, to put pen to paper (or fingers to keyboard) as reporter on the annual January Jubilee. And friends, this fifth JJ was one of the best! For the first time, we hosted the party at the Women's City Club, and it proved a gracious and spacious venue that struck just the right notes. Burnished wood, oriental carpets, candles, and the soft music of a live, 3-piece string band wove into a splendiferous setting for members and others to come in from the rainy night that evening. They gathered around refreshment stations to sample scrumptious gourmet hors d'oeuvres, tasty wines, and that cool frosty water in tall glass dispensers with delicious fruit floating in it.

However, the pleasures of scene and socializing were only *part* of the evening, since we had some serious matters to attend to as well! President Stephanie Law opened the formal program--as well as her second year as our leader--by introducing new and returning Directors of the Board for the year. She highlighted the Chapter's many accomplishments in 2012. She reminded us of the importance of getting active and advocating for psychology (particularly in the policy decisions ahead that will affect all of us *significantly* under the Affordable Care Act). Then---and most dramatically of all--she announced that SGVPA had been selected by the California Psychological Association as the most impressive and successful chapter in the state! *Huzzah!*

Dr. Linda Bortell took home the individual honors of the evening, accepting SGVPA's Distinguished Member for 2013 award. Beyond Linda's mind-boggling list of professional achievements, President Stephanie noted Linda's passion for social justice, teaching, inclusiveness, and mentoring. Linda herself said about her years' long membership in SGVPA, "I have definitely received back more than I ever gave..."

Finally, it was time to institute the Founders Circle--a new program designed to recognize earlier leaders of SGVPA for all they've contributed-- to wit, paving the way to the heights our chapter has achieved today as *CPA's Outstanding Chapter of the Year!* Dr. Colleen Warnesky welcomed Past Presidents Paul Clement, Alan Karbelnig, Sam Alibrando, Lynn Becker, Linda Bortell, Deborah Peters, and Suzanne Lake (me!). As one of the inductees, I can say it was a humbling and warming experience to be up there with such impressive psychologists, basking in the light of history!

All in all, it was another JJ night to remember! And--did I mention that we won THE OUTSTANDING CHAPTER OF THE YEAR AWARD? Hard to top that... Although no doubt somehow we will... Stay tuned for the *next* JJ!

January Jubilee Gallery

Psychology and Family Law

On Judging a Book by Its Cover

By Mark Baer, Esq,

We all know the maxim, "you can't judge a book by its cover," since the cover may lead to quite misguided assumptions about the actual content of the book. This principle is one of the reasons that racial profiling is very controversial, and is often illegal. Judging a person based upon their profession is also flawed logic--because although generalizations can sometimes be made, they are necessarily often wrong in individual cases.

Take the example that many people fear working for or with *attorneys* (other than as their legal representative), because they believe that lawyers are more litigious than non-lawyers. This was the case when I was recently contacted by an SGVPA member who sought my advice about protecting herself legally, because she was seeing a hardcore litigator as a patient in therapy. She told me that he had not said or done anything that would cause her to believe that he might sue her, nor had she done anything she knew of that would subject her to a possible lawsuit. Rather, she had become consumed with the notion that she would ultimately end up in a legal battle with this patient, merely because he is a professional litigator.

I explained to her that how a lawyer behaves in his professional and personal lives is not necessarily one and the same. On the other hand, it is possible that since the attorney litigates for a living, he might be more apt to litigate his own personal matters. In fact, he would not even need to hire an attorney! (Let's ignore the saying that "an attorney who represents himself has a fool for a client.") However, it is also possible that because of his acute knowledge of the inherent flaws in the legal system, he would be disinclined to handle his own personal issues in such a manner. Unfortunately, this information did not readily alleviate her fears.

I then suggested to this psychotherapist that since lawsuits are matters of public record, it isn't difficult to determine how many times someone has been a party in a lawsuit. The records reflect whether they initiated the lawsuit or were named as a defendant. Moreover, the nature of the action would be included. I asked her whether she would have peace of mind if she knew that he did not have a history of personally initiating lawsuits. After she told me that she would be very relieved knowing such information, I suggested that she hire a private investigator to research the matter. I added that it should be relatively inexpensive and well worth the cost. I told her that if she learned that he *is* litigious, she might try and figure out a way to end her relationship with him sooner rather than later. On the other hand, if he had no such history, her concerns might be alleviated. I also told her that if she ever had such concerns in the future, she might consider having someone run a litigation history on the person *before*entering into a relationship with them. She was so grateful for my advice that she suggested that I write an article on this topic.

The ironic thing here is that although I happen to be a lawyer, I have the same bias. Recently in fact, when one of the applicants for my rental property happened to be a young attorney, I told my realtor that I would be very uncomfortable leasing my property to a lawyer. When I inquired about each of the other possible tenants, one of them sounded much more appealing to me--despite the fact that they insisted that the monthly rent be reduced by a couple hundred dollars. I found myself considering I would rather rent my house to them for less money than to a lawyer! However, my realtor counseled that he had background information on the couple, that they were extremely difficult tenants, and that they would almost inevitably be the worst choice. So I then took my own advice and looked into the young attorney's personal litigation history, and discovered that there was none. Unfortunately, considering that he was a relatively young attorney, this did not put my mind at ease, so I decided to meet with him before making a decision. The meeting went very well and I decided to lease the property to him. Nothing in life is certain. However, as they say, "an ounce of prevention is worth a pound of cure."

Mark Baer, Esq can be reached by email at Mark@markbaeresq.com.

Obsessive Ruminations
Psychology's Horrifying Descent Into the Medical-Industrial Complex

By Alan Karbelnig, PhD, ABPP

Almost everything wrong with professional psychology shouts out from this simple headline, *Guidelines for Psychological Practice in Health Care Delivery Systems.* This article, from the most recent issue of The American Psychologist (January 2013), mandates how psychologists should comport themselves in medical settings. Joseph Stalin would make room in his inner circle for the officials of the American Psychological Association (APA) who mandate that psychologists comport with the industrialization of medicine and, thereby, treat human beings as organisms, rather than as a seeing, hearing, sensing, touching, feeling persons.

Last Spring, a psychiatrist and I co-taught a class in British Object Relations Theory at the New Center for Psychoanalysis (NCP). We were discussing the nature of science when a student asked, "So, is medicine a science?" My colleague replied, "No, it's an industry." Her assumption shockingly validates that the vitality of our practice, its humanism, is being fed to the jaws of the medical industrial complex.

In keeping with the medical model, consider this autopsy of the *Guidelines for Psychological Practice in Health Care Delivery Systems*. *"Guidelines"* suggests rules and regulations related to grammar, to government, to the slaughterhouse. "*Health Care Delivery Systems"* is machine-speak, reminiscent of the way that cluster bombs may be delivered remotely using*MIRVs,* Multiple Independent Re-entry Vehicles.

The document begins, in part I, with: *Distinct Professional Identity Within the Health Care Delivery System.* When did clinical psychologists lose their unique identity and why would psychologists need advice regarding how to find it? Psychologists who work in health care settings would naturally understand that their scope of practice differs from physicians.

Guideline 2 calls for psychologists to *Seek to Understand the Internally and Externally Imposed Expectations and Requirements of the Systems Within Which They Practice.* We must work within "expectations" and have knowledge of the "requirements" related to health care "systems." Nietzsche, Heidegger, and Sartre would turn in their graves at the existence of such shameful, institutional propaganda.

Guideline 5 reads, *Psychologists Strive to be Involved in the Development of Institutional Policies Regarding Professional Scope of Practice and Participation in Service Delivery.* Here resides the clarion call for conformity. Above all make sure you get a share of the health care pie so that you can "deliver" your services to patient in hospice care who may need simply someone to talk to about the shame they feel about being sick, or the worry they have regarding the impact of their illness on their loved ones.

Yet another next Guideline, Number 10, reads, *Psychologists Are Encouraged to Offer Their Special Expertise in the Administration and Management of Both Psychological and Other Professional Practice within Health Care Delivery Systems.* This suggests that our "special expertise" includes the skill-set of helping out with systems such as the medical data technologies of a large metropolitan hospital or lending a hand (with a psychologist's special care) to work a dialysis machine.

These APA *Guidelines* seemingly encourage us to violate our own hard-earned privileging of the human person by allying ourselves with words suggestive of mass production and speed control. The terminology comes from industry, not from psychology. The words suggest that care has become commoditized – a product for sale – rather than a service being provided for those seeking healing.

Psychology can be of most help to humanity by focusing on what led to its separation from philosophy in the first place, an interest in the *psychology* of the human being. As socialized medicine enters the health care system, as it rightfully should, professional psychology should make sure to honor the *psychology* of patients, namely how they feel, how they are treated, and how well they are interpersonally supported. In recalling my recent post-operative experience at Huntington Hospital, what stands out in greatest contrast are the smiles of the nurses, the joke from the guy who cleaned out the trash at night, and my half-hour with Kai, the animal therapy dog. Could those Guidelines have allowed such a furry beast right there on my sterile white sheets? And yet those human persons, that gentle dog, represent the sum and substance of the psychology profession to which we proudly belong. Now that I'm out, I have thankfully filed away those ridiculous Guidelines, enjoying now only the memories of kindness, of love, and of that "good dog." Now, *that* is clinical psychology.

Dr. Alan Karbelnig can be reached at AMKarbelnig@gmail.com.

You're Awesome!

SGVPA Makes History at the State Level

By Linda Nelson, PhD
Governmental Affairs Chair

As Governmental Affairs Chair, I want to officially congratulate each of you for helping our chapter make history! Not only did we receive the "Outstanding Chapter for 2013 Award," but we were also the first chapter of the California Psychological Association's ever to launch a fund-raising campaign for its Political Action Committee (PAC) with our ***"5-for-20"*** campaign last year. Intended as an effort to recruit at least five individuals to donate $20 each to the PAC, our advocacy efforts were recognized and celebrated by CPA, because we created a model of fundraising for other chapters. Thank you, thank you, thank you to everyone who generously contributed to the 5 for 20 Campaign! You made a difference and YOU'RE AWESOME!! (And, if you haven't already done so, please go to the following link and donate *at least $20*: http://www.cpapsych.org/displaycommon.cfm?an-1&subarticlenbr=389)

Also, please note that CPA's Advocacy and Leadership Conference will be taking place this year from March 17 to 19 in Sacramento, culminating in Advocacy Day on Tuesday, March 19. Hundreds of psychologists and students from around the state gather for this event and visit legislators' offices at the capitol, advocating for issues that impact psychology and mental health.Never has this sort of advocacy been more important than now! More details will be forthcoming... Meanwhile, please consider participating!

Dr. Linda Nelson can be reached at lnelson@mednet.ucla.edu

ADVERTISEMENTS

PSYCHOANALYTIC TRAINING AT PCC

focuses on the unconscious core of the personality and explores the infantile anxieties and defenses that shape behavior and relations with the self and others. The elemental contributions of Freud, Klein and Bion structure the foundation of PCC's British Object Relations approach. Emphasis on analysis of primitive mental states is supported by year-long intensive courses in the Tavistock method of Infant Observation, in the original work of Freud, Klein's major papers and in the contemporary Kleinian and Object Relations developments. Bion's theories of thinking form a focal center of study.

CORE PROGRAM IN ADULT PSYCHOANALYSIS

- Certification with Psy.D. Degree
- Optional Ph.D. with Dissertation
- Accents Work in the Transference

INFANT, CHILD, ADOLOLESCENT PSYCHOANALYSIS

- Additional Certification Program
- Second Year of Infant Observation
- Origins of Primitive Mental States

PSYCHOANALYTIC PSYCHOTHERAPY PROGRAMS

- One year Adult or Child Focus
- Didactic Courses and Case Conferences
- Certificate of Completion Provided

OPEN HOUSE

SUNDAY, MARCH 10, 2013
11:00 AM - 2:00 PM
BRUNCH: 11:00 AM—12:00 PM
PRESENTATION: 12:00 PM

SPEAKER:
Albert Mason, M.B., B.S., Psy.D.
Supervising and Training Analyst

"THE SEARCH FOR THE CURE"

Dr. Mason will discuss his view of Psychoanalysis as the treatment of choice that brings about a true modification of psychic structure.

CONTACT PCC OFFICE FOR INFORMATION

Continuing Education Courses, Extension Programs. Annual Melanie Klein and Frances Tustin Memorial Lectureships. James Grotstein, Primitive Mental States, and Infant Observation Conferences. For upcoming events visit our Website at www.psycc.org

Low Fee psychoanalysis and psychotherapy
Referrals available at 310.208.1053

PSYCHOANALYTIC CENTER OF CALIFORNIA PCC

PSYCHOANALYTIC CENTER OF CALIFORNIA
11500 W. Olympic Boulevard, Suite 445
Los Angeles, CA 90064
PHONE: 310.478.4347
www.psycc.org

A Component Society of the International Psychoanalytical Association

ROSE CITY.CENTER

It's a new chapter at Rose City...

We've moved and grown into a new, larger office space! Rose City Center continues to provide:

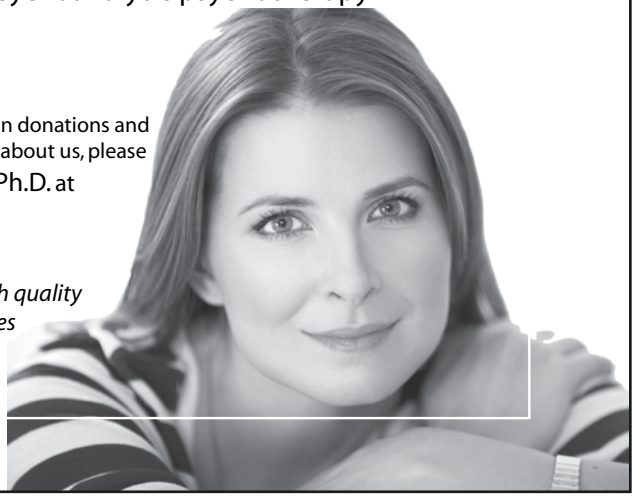
- Affordable, psychodynamic psychotherapy for low-to-moderate income adults, adolescents and couples.
- Our Trauma program provides treatment for survivors of violent crime, abuse, accidents and other trauma

Rose City clinicians complete a two year program of psychoanalytic psychotherapy training and supervision.

Rose City is a 501(c)3 non-profit organization that relies on donations and community support. To donate, volunteer, or learn more about us, please contact Clinical Director Gabrielle Taylor, Ph.D. at

626-793-8609

Thank you for trusting us with your referrals for high quality treatment for adults, adolescents and couples



COME ADVERTISE WITH US!

Members and others are encouraged to take advantage of the opportunity to advertise to nearly 200 SGVPA folks! Members receive 1 complimentary classified ad in the newsletter per calendar year!

Here are the rates:

Advertising Rates for our Bi-monthly Newsletter

	1 edition	3 editions (Half year)	6 editions (Full year)
Quarter Page Ad or Copy of Business Card	**$30**	**$75**	**$150**
Half Page Ad	**$60**	**$150**	**$300**
Whole Page Ad	**$100**	**$250**	**$500**
Insert	**$120**	**$300**	**$600**

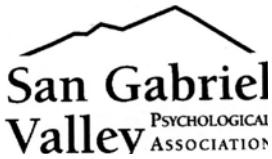
Classified Ads are $. 50 per word

Advertising Rates on our Website

	2 months	4 months	6 months	12 months
Homepage Link	**$25**	**$45**	**$60**	**$120**
Other link	**$20**	**$35**	**$50**	**$100**
**** Homepage Link with newsletter advertising purchased concurrently**	**$15**	**$30**	**$45**	**$60**
**** Other Link with newsletter advertising purchased concurrently**	**$10**	**$20**	**$30**	**$40**

***** Note: Special rates available to advertisers who purchase website and newsletter ads concurrently.***

Be sure to include your license number. Ads should be emailed to Mary Hannon at maryhannon123@gmail.com . Payment must be made before publication and mailed to: Mary Hannon, 1122 Avon Pl., South Pasadena, CA 91030, phone (626) 354-0786.



c/o Suzanne Lake, PsyD, Editor
2810 E. Del Mar Blvd., Suite 10A
Pasadena CA 91107