San Gabriel Valley Psychological Association

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The Official Newsletter of the San Gabriel Valley Psychological Association

www.SGVPA.org AN OFFICIAL CHAPTER OF CALIFORNIA PSYCHOLOGICAL ASSOCIATION May/June 2011

Upcoming Luncheon Meetings

Date: May 6, 2011
Topic: How to Publish Your Psychotherapy Case Study: A Comprehensive Example
Speaker: Paul W. Clement, PhD, ABPP

Date: June 3, 2011
Topic: The Internal Drama Exposed: Key Insights from Object Relations Theory
Speaker: Alan Karbelnig, PhD, ABPP

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 first Friday of the month at the University Club, 175 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 Members,

I want to share a story from CPA's annual Leadership and Advocacy Convention, which occurred recently in Sacramento. Chapter presidents and Governmental Affairs Committee chairs from all around the state gathered to get a more thorough understanding of how CPA engages in political advocacy on behalf of the professional interests of all psychologists in California. We heard about how the Insurance Commissioner, Dave Jones, tries to prevent insurance companies from raising their rates so exorbitantly, and we also heard about the inequities in leadership opportunities between psychologists and psychiatrists in prison settings, and the effects that this has on treatment. In addition, we took a close look at how your CPA donations get spent in Sacramento.

Even though we may lobby strongly on two or three bills a year, CPA is actively analyzing *over two hundred bills* in that time for their effect on the field of psychology. Interestingly, it seems that advocacy comes down to "personal relationships." CPA's lobbyist Amanda Levy spends her time talking with various legislators and legislative aides on behalf of psychology. She informed us that often the aides are more important to have a relationship with than the legislators themselves, because they stay on year after year and keep tabs on who is worth listening to. In a sense, you have to earn your way into being heard!

In parallel fashion, the presidents and GAC reps were getting to know one another over

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coffee breaks and group discussions. We shared stories of what our chapters are doing, how we are organized, and what gets people inspired to participate. The consensus was that events that make people feel welcome and foster relationship keep the chapters alive.

On the last night of the convention we were asked to meet with legislators and put on a "social face." As the evening began, several psychologists--who were very sharp and no doubt had impressive resumes--were sitting around a table waiting for the legislators to arrive. One CPA leader confessed that she is sort of "shy," but would make an effort to make the legislators feel welcome. This led to confessions all around the table of each of us perceiving ourselves as shy, in some manner. This in turn led to rebuttals of "I don't see you that way!" and lots of laughter and personal stories. By the end of the convention, many of us were exchanging phone numbers, ideas for follow up meetings, and even poetry! In addition, two of the legislators said, "I've never talked with such a friendly, interesting group."

I share this story in an effort to say that the inherent introversion, or "shyness," of each of us really fades away when we find ourselves in an environment that values what we have to share, and where there is a spirit of teamwork. I have seen a lot of teamwork on our SGVPA Board this year, and would like to thank everyone for their efforts and good attitudes.

One outgrowth of this is the development of several new and exciting significant interest groups (SIGs) as a means of bringing people together around areas of common interest. Look out for the new Group Therapy SIG, headed by Matthew Calkins, PhD. Don't be "shy" about getting involved.

Finally, a warm welcome to John Nelson, our new SGVPA student representative to CPA. John will host social networking events for students in the near future, and he will bring all student queries and needs to the SGVPA Board for discussion. Last of all, the Membership Committee will be hosting a "Meet and Greet" for prospective new members on May 6th. We hope many of you will come, bring friends who may become SGVPA members, and help visitors feel welcomed to our SGVPA community.

With Spring Cheer,

Deborah Peters, PhD
President

How to Determine Your Effectiveness as a Therapist

By Paul W. Clement, PhD, ABPP

You can make a meaningful contribution to the literature on the effectiveness of psychotherapy as conducted in routine professional practice. In my recently published chapter, "Research in Private Practice: How to Determine Your Effectiveness as a Therapist," I tell just how to do so. The chapter appeared in the recent book, *Understanding Research in Clinical and Counseling Psychology* (2nd ed.), edited by Jay Thomas and Michael Hersen.

The procedures described in this chapter emphasize an empirical approach that can be used with any theoretical/therapeutic orientation. They are consistent with a contemporary emphasis on evidence-based practice, without demanding the use of empirically supported treatments. They focus on the real world rather than the laboratory. They zero in on treatment outcomes of individuals, of sets of individuals, and of all cases seen by a particular clinician, rather than comparing a treated group to a control group. They emphasize magnitude of change during treatment rather than statistical significance. The methods are designed to answer questions rather than to test hypotheses. Here are some of the questions that I have answered based on 42 years of private practice.

How much have my patients improved during psychotherapy with me?

I had 2,084 intakes into my private practice. Of these 228 came only for psychological assessment or consultation without any intervention, 356 dropped out during the first three sessions without receiving any identified treatment, 29 were still in treatment and did not have any outcome data, and 1,471 were in treatment and had produced outcome data or had completed treatment and had produced outcome data. Of these 4 (0.27%) were much worse than at intake, 10 (0.78%)

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were worse, 449 (30.52%) did not change, 503 (34.19%) were better, and 505 (34.33%) were much better.
I have only been calculating treatment effect sizes (ESs) during the past 20 years, and during this period of time I have not been able to obtain sufficient data to determine ESs for everyone. I have obtained 586 ESs with a mean ES of 1.85, a median of 1.54, and a range from –1.61 to +15.22.

How have my outcomes varied with diagnosis?

For patients with no diagnosis on Axis I or II, 100.00% improved; for sexual disorders 81.82% improved; for specific phobia 80.82%; for enuresis 78.57%; for substance abuse 76.92%; for social phobia 76.47%; for anxiety disorders (other than those listed elsewhere) 75.68%; for Tourette's disorder 75.00%; for adjustment disorders 74.12%; for V problems (other than Partner Relational Problem) 73.58%; for major depression 72.70%; for acute stress disorder; for PTSD 71.79%; and for encopresis 70.59%.

Poorest outcomes were achieved for intermittent explosive disorder 61.90%; oppositional defiant disorder 61.46%; specific developmental disorders 60.00%; partner relational problem 57.59%; generalized anxiety disorder 57.23%; bipolar disorders 53.33%; conduct disorder 52.50%; and personality disorders 35.56% improved. The differences in outcome based on diagnosis were statistically significant (Chi Square = 55.31, df = 27, p = 0.001049).

How have my outcomes varied with the age of the patients?

The best outcomes were with children less than 6 years old (86.11% improved) and the worst with patients in their 70s and 80s (57.14% improved). The corresponding mean ESs were 2.58 for children under 6 and 1.35 for patients in their 70s and 80s.

How have my outcomes varied with gender or when a couple was the focus of treatment?

Couples did appreciably poorer than males or females; there was little difference between males and females. On all indices females did slightly better than males.

What percentage of my clients have dropped out before any treatment was delivered?

The overall dropout rate was 17.09%.

For how long have I treated my patients?

The mean was 18.02 sessions, the median was 11, and the range was 1—344.

What has been the relationship between my outcomes and length of treatment?

On average the longer I have treated a patient the greater the improvement.

Has my therapeutic effectiveness changed over time?

There has been no significant change in my effectiveness across 42 years.

How has managed care impacted my treatment effectiveness?

Over-all my managed care cases have not fared as well as patients not coming through a managed care organization.

Dr. Clement practices clinical psychology in Pasadena. Interested readers may contact him, or obtain a copy of the complete chapter, by contacting him at PaulWClement@aol.com

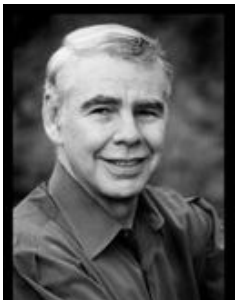
NEW MEMBERS

Licensed:
Bob Connolly, PsyD
Cristalle Sese, PhD

Pre-Licensed:
Tina Bryson, PhD
Meghan Crawford, PsyD
Brooke McLean, PhD

Student:
Donna Cline, MA
Steven Gioielli
Brooke Fullmer Yetter

Psychobiology Notes
A Treatment Rationale for People with an Avoidant Attachment Pattern



By James S. Graves, PhD, PsyD

Nan, a tall, athletic-looking woman in her early 30's, was rejected by her mother as a child. She received little nurturance or emotional support from either parent during her childhood, and it is likely that the parental rejection began at, or shortly after, Nan's birth. As an adolescent, Nan was sent off to boarding school where she engaged in rebellious behavior (e.g., skipping class). She formed only a single friendship at any given time, in which there was always a high level of dependency. Despite her rebelliousness, Nan did well in school, especially in math and the physical sciences.

After college, Nan obtained a Master's degree and currently works as a college chemistry instructor. She has only a few friends, most of whom she describes as controlling and narcissistic people who are similar in these ways to her parents. Nan has no interest in finding a romantic partner or engaging in physical or emotional intimacy. She fills her time with work activities, with an occasional short and not particularly enjoyable outing with a friend.

From an Attachment Theory perspective, Nan's history and current lifestyle are consistent with having an avoidant attachment pattern, which resulted from the rejecting caregiving she received in her early childhood.

In the 1970's Mary Ainsworth described three patterns of attachment –-secure attachment pattern and two insecure patterns-– based on the behavior of one-year-olds in the experimental design called the Strange Situation. Babies who were described as avoidant would largely ignore their mother upon reunion after a stress-provoking separation, in contrast to securely attached children, who sought comfort and soothing from their mothers before returning to play. Avoidant babies had mothers who were often emotionally aloof and rejecting, in some cases literally pushing the infant away from close physical contact.

During the first year of life, when attachment patterns are formed, the vast majority of brain growth and development occurs in the right hemisphere, the more emotional side of the brain. Negative, early caregiving experiences are processed by the right hemisphere, and when frequent, create the basis for a more negatively-toned emotional life. Those with an avoidant attachment also may have great difficulty forming intimate relationships.

Treating someone with an avoidant attachment dynamic is challenging. Neurobiologically, Nan experiences the world of relationships through the unconscious representations of negative caregiving experiences housed in the limbic structures of the right hemisphere. She maintains functionality in other aspects of her life through the more linear, analytical world (e.g., teaching chemistry) of the left hemisphere. Forming a therapeutic alliance in this case requires the therapist to bridge both worlds. Thus, it is important to show appreciation for the client's analytical perspective. For example, early on in my work with Nan I revealed my own history of teaching chemistry in high school. Occasionally, I will make a comment about the chemistry as she discusses her work, which she seems to appreciate. When appropriate, I also describe the neurobiological concepts related to our therapeutic work.

It is also important to demonstrate attunement to the emotional expressions of the client. In addition to the subtle, non-verbal attunements that are perceived by the right hemisphere, it is useful to engage the linguistic left hemisphere with verbalized empathy and support. Activating both hemispheres with empathic messages facilitates communication between the two hemispheres. I sometimes find it helpful to employ the Dialectical Behavior Therapy approach by validating Nan's thoughts, feelings or behaviors, before suggesting the possibility of change.

Beyond creating a strong therapeutic alliance, an important element of treating a client with an avoidant attachment pattern is to activate the right hemisphere with positive experiences. The key to this approach is finding ways to specifically target the right hemisphere. Positive imagery is one effective approach. Recently, Nan revealed a positive memory from her childhood when she felt the most soothed, and, at my urging, she now uses that imagery to re-experience those positive emotions. Other ways to activate the right hemisphere are: meditative practices, creative/artistic activities, and various forms of body work to get in touch with bodily sensations.

Nan is beginning to explore feelings other than "stressed out," and her life-course is taking a turn in a positive direction over the last few months. Repair of the emotional consequences of negative, unconscious memories of relationships established during early attachment experiences is facilitated by taking into account the neurobiological aspects of this emotionally disabling condition.

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Why Do Kids Use Drugs?
A Dimensional Approach

By Daniel Goldin, LMFT
Substance Addictions SIG Chair

I have two very different teenage clients who use drugs. The first we'll call Brittany, a seventeen year old girl whose divorced parents remain kind and available to her. She gets good grades, hopes to become a marine biologist, and smokes weed with friends on the weekends. The second we'll call Brett, a sixteen year old boy whose father physically mistreated him and his mother when Brett was small. His mother sees the father in Brett, and treats him erratically--sometimes with love, sometimes with harsh criticism. Brett smokes weed everyday, often the first thing in the morning, and has begun to experiment with ecstasy and cocaine. He identifies himself as a stoner and hangs out with a group of equally dispossessed children.

How did these two kids end up on different ends of the addiction continuum?

Let us consider the adolescent brain. Puberty initiates a drastic "pruning" of neural connections, a "use-it-or-lose-it" process known as competitive elimination that results in an extensive remodeling of the brain. The remaining, streamlined neural connections develop a fatty coating during adolescence that insulates them and maximizes speed of transmission. All this translates to tremendous, and very sudden, advances in cognitive power. But behind this Ferrari Enzo is a first time driver. For a time the brain jolts and swerves with ideas and associations.

During this same period, the brain's reward system, mediated by dopamine production in the nucleus acumbens, becomes increasingly sensitive to positive rewards, far more so than the brains of adults, while remaining relatively insensitive to negative consequences. In short, teenagers adore ecstatic highs and remain indifferent to "small punishers" such as hangovers.

To top it off, the prefrontal cortex remains under construction until one's early twenties. Children, teenagers and people with damage to the prefrontal cortex tend to make decisions based less on prospective scenarios than on immediate urges.

From the Pleistocene era--when modern humans began their migration across the planet--until fairly recently, adolescence was a time of separation from the family, fraught with great risk. One needed to take chances, explore and focus on immediate survival rather than on long-term planning. However, in the 21st century, the powerful, reward-biased, future-ignoring adolescent brain seems better designed for addiction than survival.

But not all teenagers use drugs, and of those who do, most merely "experiment" and do not become addicted. So what makes the difference between Brittany and Brett?

Let us now consider the adolescent mind. So far we have considered the brain in isolation, as a species template. The mind emerges from a particular brain in interaction with others, and expresses itself in joys, fears, ideas, hopes and all the immaterial stuff of being human that is more real to us, although less definable than a neuron or an amygdala. An adolescent who feels his mind to be in connection to the mind of at least one caring adult, an adult who considers his feelings as well as his future, may well be protected from the deficiencies of his developing brain. By telling his stories to someone who can help him elaborate the happenings of his life, a teenager learns that even his most difficult emotions have the power to connect him to others and to link his past to the future. Such a teenager even in a moment of temptation feels the caring internal pull of a mature mental presence. He may still have trouble generating models of the future, but he retains a faith in the future through his trust in the loving adults who symbolize it for him. This is probably the situation with Brittany, who experiences guilt around using pot and is able to curb her use so it does not interfere greatly with her school work.

Brett is an opposite case. The important adults in his life failed to connect to him, and he was left to the devices of his own undeveloped brain. For Brett it makes sense to consider the brain in isolation, for it feels to be in isolation. Brett seeks physical solutions to his needs and urges, as he cannot dare to trust the minds of others. Drug use emerges from his isolation and also offers itself as a solution to it. Brett smokes weed constantly not only because smoking eases his pain, not only because his immature, isolated brain is biased toward intense rewards and cares little about the consequences, but because smoking with fellow outcasts produces the instant artificial bond of a shared euphoric state.

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

Third Culture Kids
An Embodied Multicultural Self

By Stephanie Law, PsyD
SGVPA President Elect

Have you ever had a client who grew up overseas or lived in a country that was not their parent's home culture? That individual may be a "Third Culture Kid." First used in the 1960's, the term "Third Culture Kid" was coined by Ruth Hill Useem, a social scientist from the University of Michigan who traveled to India to study the expatriates living there. In the course of her research, she began to notice specific enduring personality traits among the children of these families.

The term TCK (Third Culture Kid) refers to an individual who, having spent a significant part of the developmental years in a culture other than the parents' culture, develops a sense of relationship to all of the cultures while not having full ownership in any. Elements from each culture are incorporated into the life experience and personal identity of that individual. Here's an example: an American family with two children moves to the Middle East for the father to be employed as a helicopter pilot for an oil company. The American culture is the "first" culture represented in this family and the Middle East country they reside in is the "second" culture. The amalgamation of both of these cultures, embedded within the children's sense of self, view of the world, and personal identity is the "third culture." The cross cultural experience must occur between birth and 18 years of age - the period of time when that child's sense of identity, relationship with others, and view of the world are being formed in the most basic ways. TCK's incorporate different cultures on the deepest level, as they have several cultures embedded in their way of being. Common populations where one might find TCK's are families whose parents have had careers in international business, the diplomatic corps, the military, religious missions, or those who have studied abroad.

The two circumstances that are key to becoming a Third Culture Kid is not only growing up in a truly cross-cultural world, but also high mobility. Instead of observing cultures, TCKs actually live in different cultural worlds. By mobility, it means mobility of both the TCK and others in their surrounding. The interplay between the two is what gives rise to common personal characteristics, benefits, and challenges. TCKs are distinguished from immigrants by the fact that TCKs do not expect to settle down permanently in the places where they live and are also different from individuals who move to another country as an adult. While the latter may experience some degree of cross cultural adjustment and difficulty, their personality and sense of self is, for the most part, already solidified and stable.

TCKs also tend to have certain personal characteristics in common. TCK's are often tolerant cultural chameleons and highly adaptable. As a result, TCKs develop a sense of belonging everywhere and nowhere, leaving them with a deep sense of not knowing where they belong and sometimes appearing wishy-washy. Asking a TCK, "where are you from?" can spark deep confusion, albeit usually underneath the surface. Additionally, while TCKs usually grow up to be independent and cosmopolitan, they also often struggle with the losses they have suffered in each move, leaving them struggling with feelings of unresolved grief. Having to say goodbye to one's African nanny at the age of nine never to be seen again, can leave a tremendous emotional impact, especially if one's parents do not assist in negotiating the feelings involved. TCK's also frequently experience confused loyalties. Because they deeply understand the complexities of their cultural influences, questions related to poverty, religion, politics, and world issues are not always clearly defined. A TCK raised in Africa and living in Kansas, for instance, may experience some opposing feelings related to issues between the Western industrial powers and those of Third World Countries.

The above mentioned characteristics of TCK's are in no way exhaustive but can provide the reader an accurate initial impression. Underlying issues of unresolved grief, the impact of broken attachments with early caregivers , and how concepts of identity and worldview have been impacted by cultural and mobility issues is worth considering in the course of one's therapeutic work with TCK's. And just in case you wonder how pertinent this issue is to our current world, our very own President is a Third Culture Kid!

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The Practice of Psychology in Hospital Settings
A Surprising New Landscape for Private Practitoners

By Keith Valone, PhD, PsyD, MSCP
Clinical Psychopharmacology SIG Chair

The landmark 1990 CAPP v. Rank ruling by the California Supreme Court ensured the right of psychologists to practice independently in hospital settings. Until 2000, hospital practice was not considered a subspeciality, and it was relatively common for psychologists in private practice to belong to hospital professional staffs, and treat their patients in the hospital as the need arose.

Contemporary private practice of psychology in hospitals bears little resemblance to that era. Dramatic changes have taken place over the past ten years which are the result of vastly increased pressure on hospitals from regulatory agencies such as Centers for Medicare and Medicaid Services (CMS), insurance companies, and hospital accrediting agencies such as the Joint Commission

Those who admit and attend patients in hospitals increasingly are expected to be superspecialists called "hospitalists." Psychologist hospitalists are typically clinical psychologists who conduct high volume inpatient practices, have expertise in psychopharmacology, are intimately familiar with the ever-changing, highly complex regulatory policies, and are involved in hospital administration.

Given that few psychologists in private practice now practice as hospitalists, what happens when your patient needs to be hospitalized? There are two options. You can let the mental health system take over the hospitalization of your patient. Or you can refer to a hospitalist psychologist who can manage your patient's hospitalization. In the remainder of this article, each option will briefly be described.

In the first option, when the mental health system takes care of your patient, he or she would typically be admitted by presenting to a hospital that has a psychiatric facility. In this situation, the patient arrives at the emergency room and is evaluated by intake staff. If the patient meets medical necessity criteria, he or she is admitted to the hospital's psychiatric facility, and the hospital will assign a psychiatrist to the patient. From there on, standard of care involves a daily medical visit by the psychiatrist and milieu therapies by hospital staff. You may not follow your patient, and he or she will not receive intensive psychotherapy from a psychologist.

In the second option, when a hospitalist psychologist manages your patient's hospitalization, services actually begin prior to admission. Since hospitalists are on call 24 hours a day, your call will be taken directly, the situation will be assessed, and an treatment plan will be created immediately. This may involve evaluating the patient in the hospitalist's office, sending the patient directly to the hospital under the hospitalist's care, or by calling the police to transport him or her. If the police are called, the hospitalist will talk with the police and manage the emergent situation.

If the patient indeed needs to be hospitalized, the hospitalist psychologist will select the psychiatrist who will serve as attending doctor. The psychologist is the co-admitting doctor, and co-attends the patient in the hospital. This means that the hospitalist takes responsibility for all aspects of the patient's psychological care in the hospital, provides individual therapy as well as evaluation and management services, and writes orders regarding the patient's care within scope of license). The co-attending psychologist coordinates with you, the outpatient therapist, coordinates with other doctors, reviews the patient's records and medications, communicates with professional staff, engages in treatment and discharge planning, and coordinates with the patient's family. The hospitalist also consults with you to make sure the patient is returned to you upon discharge should you so desire, or takes responsibility for the patient should you no longer wish to be involved in the patient's care.

Inpatient psychological services are not covered by most insurance companies other than Medicare, and are usually paid for on a fee for service basis by patients and their families. Still, many patients and families are pleased to pay for these services because of improved quality of care for the patient, continuity of care with the patient's family and outpatient psychotherapist, and smoother transition to aftercare.

If you are interested in using a hospitalist psychologist for inpatient services, it is best to establish a relationship with one prior to the advent of a crisis incident. Developing procedures together for handling emergencies will make the process of managing a suicidal, homicidal, or psychotic patient much easier at the time the crisis unfolds.

Dr. Keith Valone is a hospitalist psychologist in group private practice in Pasadena, and can be reached at valone@the arroyos.org

Psychology and Family Law

An Uncivilized, Unenlightened and Barbaric System:

The U.S. Family Law Court

By Mark Baer, Esq.

In 1996, the Australian government reformed its family law system in an effort to better serve families. It accomplished this by makingmediation the primary dispute resolution in family law, whether the case involves parenting issues, financial issues, or both. The Australian government recognized that the adversarial nature, expense, and slow pace of litigation inhibited the possibility of an amicable relationship between parents that is essential to families. It determined that resolving family law matters through mediation was more expeditious and less costly, and led to arrangements that were far more likely to meet the needs of those involved.

England and Wales have followed Australia's lead and made similar reforms to their family law system. Divorcing couples must now attempt mediation for child custody and/or financial issues before they are eligible to litigate the case in court (except when the case involves domestic violence or child protection issues). Justice Minister Jonathan Djanogly said, mediation was "a quicker, cheaper and more amicable alternative" to litigation. The Justice Minister added, "Nearly every time I ask someone if their stressful divorce battle through the courts was worth it, their answer is 'no'.... [Mediation] gives people the opportunity to take their own futures in their own hands." According to the minister, "program statistics suggested that more than two-thirds of couples who took up mediation were satisfied with the results."

Many states in the U.S. have a mandatory divorce mediation requirement. However, with few exceptions, the mandatory "mediation" is limited to child custody and visitation matters. California is one such state. The "mediator's" job is limited to assisting the parents in reaching a custody agreement. These "mediators" strong-arm parents into entering into such agreements while parents are often extremely vulnerable emotionally. For example, a parent who was denied access to their child by the other parent for months before the mediation appointment may agree to any custody or visitation arrangement that allows them to finally see their child. Once the agreement is reached, the issue is typically no longer before the court at the upcoming hearing.

The Los Angeles County court system has what are called are "non-recommending mediators." These mediators do not make any recommendations to the court regarding child custody and visitation pursuant to mediation. If the couple is unable to reach an agreement during the course of the mediation, the mediator merely advises the court in writing that the parties were unable to reach an agreement. Attorneys are not permitted to participate in the process, and the mediators simply advise the parties that they may reject any agreement entered into within 10 days or the morning before the court hearing, whichever first occurs. What these mediators fail to explain to the parties is that if they reject the agreement, the judge will often inquire as to the reasons, and unless the rejection is based upon a significant incident that occurred since entering into the agreement, will usually only make a custody order that reinstates the terms of the original agreement.

In California, the legislature made major changes to the family law system in 2011. In essence, the changes are expected to make litigating family law matters take longer than before, more costly and more adversarial.

It is fascinating that when more civilized and enlightened countries are plagued with the same problems with their family law systems, they embrace mediation and other forms of consensual dispute resolution which minimize most, if not all, of the problems with litigation and courts in family law situations. In those countries, litigation and courts are now referred to as Alternative Dispute Resolution means, and mediation has become the Primary Dispute Resolution means. Yet, in the United States, litigation and courts are the still the first choice for the resolution of family law disputes. It is mediation, Collaborative Divorce and the like that are sidelined as alternative dispute resolution

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Obsessive Ruminations
The Selling of DD (Dual Diagnoses)

By Alan Karbelnig, PhD, ABPP

Bolstered by Soren Kirkegaard's lament that "ours is a paltry age because it lacks passion," Dr. Alan Karbelnig writes this regular column to provoke thoughtful reaction from his SGVPA colleagues. He practices psychoanalytic psychotherapy and forensic psychology in South Pasadena.

For better or worse, I have more to say about abbreviations. Brevity is the soul of wit, says Shakespeare's Polonius, but he assuredly isn't talking about three letter acronyms – TLAs – the abbreviations that were the target of my previous rumination. Brevity in the service of subjecting complicated human afflictions to treatment programs with tags like CBT, DBT, FFT and EFT is neither witty nor wise, and indeed Polonius himself, like Shakespeare's other characters, is proof beyond any argument that the mystery of the human person eludes abbreviation, to say nothing of acronyms.

Yet, behold, now we encounter another verbal pigeonhole for complex and individualized psychological difficulties—namely, dual diagnoses, aka, DD (an abbreviation that might have actually fared better as a TLA, since DD sounds for all the world like a new brand of jeans, but I'll save the marvels of pop culture for another time). As I've noted elsewhere, reductionist approaches to mental health problems have reached epidemic proportions. The increasing popularity of so-called dual diagnoses over the past two decades is a prime example of this disturbing trend.

Now, before I am assassinated by one of the multi-million dollar corporations that cater to the dual diagnosis population – one for a fee of $56,000 for a one month residential ranch program in Malibu – please note that my critique does not intend to imply that such disorders do not exist. They do. But their complexity, in which a mental condition and a substance abuse problem coincide, risks obliteration through the simplistic DD label. To be fair, the concept behind DD has added a more dimensional understanding of alcohol and substance abuse disorders, linking them with mental disorders that may be fueling or complicating them. But the benefits of the popular use of the dual diagnosis—aside from a catchy alliterative quality—appear to end there. Remember too that DD is hardly new news: before there were DSMs, nay, before there was even organized civilization, humans relied on any number of substances to cope with mental pain.

One could argue that use of DD allows for shorthanded communication between professionals. But a cocaine abuser with an underlying Major Depressive Disorder is completely different from a benzodiazepine abuser with an underlying Schizotypal Personality Disorder. So in referring a "dual diagnosis" patient, one provides almost no useful information. And the sheer number of substances abused, from recreational to prescription, in relation to the sheer number of potential mental disorders, from psychotic to neurotic to character disorders, creates dizzying permutations. Here, a short-hand designation of "dual diagnosis" may actually prove harmful by implying a uniformity that does not exist.

Perhaps there should be triple, quadruple, and even quintuple diagnoses. This must be true if we are to work on eliminating the mind/body/cultural splits that unfairly carve up the human experience. So a patient who abuses cocaine to deal with depressive feelings may also have a cardiomyopathy that contributes to the depression. He or she may be depressed at the loss of their physical stamina. The cocaine, frighteningly, could be adversely affecting their cardiac condition. If their cocaine abuse has bankrupted them, then they are also facing financial impoverishment which will prevent their stay in one of those $56,000 treatment programs. So now we potentially have a quadruple diagnosis: cocaine, depression, cardiomyopathy, and financial impoverishment. But of course this is ridiculous, an endless reductionism that relegates the human person to a series of categories.

In the harshest light, the term Dual Diagnosis can be seen as a marketing tool, a branding, in Madison Avenue lingo, to enhance shelf appeal and profit margin. Take a fig and a raisin, package and price them as a Dual Prune, and maybe you've got yourself the latest sensation at Trader Joe's. But what you've also got is just a fig and a raisin at twice the price. I mean no disrespect to the folks in Malibu, and perhaps I'm being a little too cynical, but my hope is that they never lose sight of the unimaginable complexity masked by the trendy alliteration of their logo – the human person who may be designated by this highly popular diagnostic designation, but can never be reduced to it.

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

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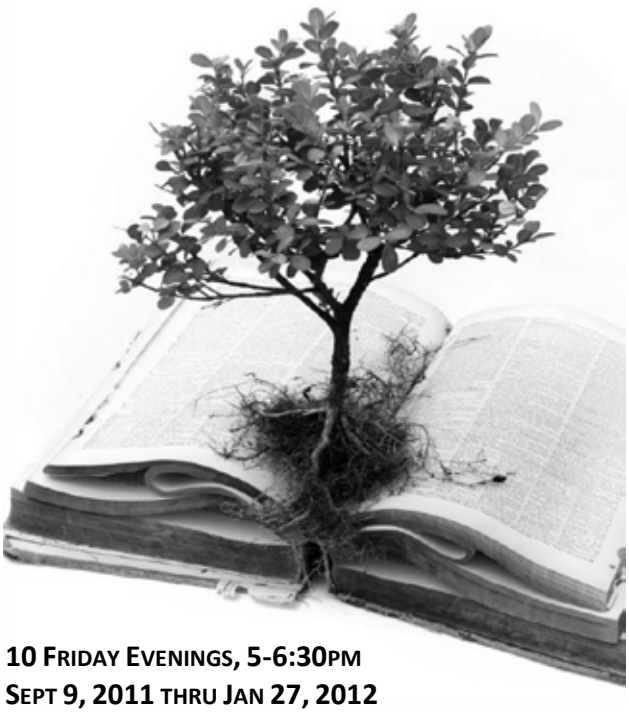

A CONTINUING EDUCATION COURSE TAUGHT BY
ALAN KARBELNIG, PHD, ABPP

Before psychotherapists provide any treatment, they encounter persons who struggle with what it means to be human. In this Friday night seminar, we will explore the humanistic-existential themes that define the human condition—aloneness, meaninglessness, responsibility, and death—all while celebrating life with wine and appetizers! Readings will include recent psychoanalytic articles, Sartre's article on *Existential Psychoanalysis*, Nietzsche's *On the Genealogy of Morals*, Camus' *The Stranger, and* Kafka's *The Trial.*

10 FRIDAY EVENINGS, 5-6:30PM
SEPT 9, 2011 THRU JAN 27, 2012
15 MCEP CREDITS
$550 LICENSEES /$450 STUDENTS

TO REGISTER, CONTACT AMKARBELNIG@GMAIL.COM

AZUSA PACIFIC UNIVERSITY

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- ☑ Cognitive, academic, and psychosocial assessments (learning disorders, ADHD, autistic spectrum)
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- ☑ Identifying study conditions/teaching style/tutoring approach to optimize learning
- ☑ Identifying cognitive/academic strengths/weaknesses for optimal curriculum choices

200 E. Del Mar Blvd.
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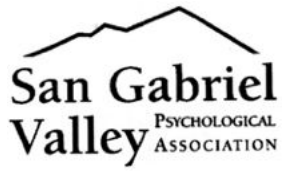

c/o Suzanne Lake, PsyD, Editor
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