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 November/December 2010

GOVERNING BOARD

President
Linda Tyrrell, PsyD
(626)524-1724
drlindatyrrell@mac.com

Past President
Suzanne Lake, PsyD
(626)795-8148
DrSuzanneLake@aim.com

President Elect
Deborah Peters,PhD
(323)340-3991
drdebpeters@gmail.com

Secretary
Elisse Blinder, PhD
(626)795-9718
dreblinder@charter.net

Treasurer
Manny Burgess, PhD
(626)441-6111
manny00@aol.com

Financial Coordinator
Christina Emanuel, MFT
(626)396-9798
christinaemanuel@sbcglobal.net

Ethics
Open

Program & Continuing Education
Kalea Chapman, PsyD
(323)559-4800
kaleachapmanpsyd@gmail.com

Membership
Stephanie Law, PsyD
(626)354-5559
stephanie@drstephanielaw.com

CLASP
Linda Bortell, PsyD
(626)799-7941
lbortellpsyd@sbcglobal.net

Disaster Response
Joe Dilley, PhD
(626)539-2001
phdilley@gmail.com

Early Career Professionals
Colleen Warnesky, PsyD
(310)948-2687
drwarnesky@yahoo.com

Website Management
David Lorentzen, PsyD
(818)523-4628
davidlorentzen@gmail.com

Newsletter Editor
Suzanne Lake, PsyD
(626)795-8148
DrSuzanneLake@aim.com

Governmental Affairs
Linda Tyrrell, PsyD
(626)524-1724
drlindatyrrell@mac.com

Student Representative to CPA
Lina Ponder
linasong@gmail.com

Diversity Liaison to CPA
Linda Bortell, PsyD
(626)799-7941
lbortellpsyd@sbcglobal.net

Representative to CPA and LACPA
Stephanie Law, PsyD
(626)354-5559
stephanie@drstephanielaw.com

Upcoming Luncheon Meetings

Date: November 5, 2010
Topic: Beyond the Couch - How Adjunctive Equine Assisted Psychotherapy Can Help Your Patients
Speaker: Vallerie E. Coleman, PhD, PsyD

Date: December 3, 2010
Topic: Presenting SGVPA's Significant Interest Groups (SIGs)! Hear about Psychopharmacology, Early Childhood Development, Substance Addiction, and More!
FREE HOLIDAY LUNCH! (no CE's)
Speakers: SIG Chairs

PLEASE RSVP NO LATER THAN THE FIRST MONDAY OF THE MONTH TO YOUR INTERNET EVITE, OR TO THE SGVPA VOICE MAIL (626)583-3215. 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 SGVPA Members,

As the 2010 winds down, so too does the term of my presidency come gradually to an end...

This year of leading SGVPA has been an incredibly opportunity, and one that I am most grateful to have experienced. I would like to thank the Board Members for their myriad and constant contributions and dedication. One of the people I am pleased to have worked with along this journey is our incoming president for 2011, Dr. Deborah Peters. I look with great excitement to the year ahead, and know she will use both her head and heart well in strong leadership of SGVPA.

I would also like to urge each of you to consider what you might contribute in terms of time and talent, and to recognize the benefit to be gained from becoming more involved in our wonderful professional association. I promise you will learn so much more about the practice of psychology if you do--and about yourself as well.

While preparing a lecture for my Ethics class last week, the following tip about managing risk in private practice resonated deeply with me--*"It helps to be both confident and humble."* In my opinion, that description might well refer to all aspects of our professional lives, in the many and varied roles we undertake as psychologists. It highlights the importance of balancing different imperatives. It is an attitude I have attempted to adopt myself.

I have learned first hand throughout this year that *balance* is a skill and a reward in itself.

(continued on next page)

Balancing SGVPA business with my practice and personal life, and balancing the varied perspectives of individual members and board policies are just two examples. I have learned to prioritize, think strategically, and weigh a multitude of important considerations in an effort to render fair decisions.

Make no mistake--Leadership is not for the fainthearted! It requires strength and courage to recognize your own biases as well as those of other's, a the willingness to set yours aside, and sometimes, the simple determination to prevail. Leaders continuously need to meet the demand of the moment while navigating through contrasting requirements (e.g., CPA's, APA's, the IRS's and even the future's). Yet I believe that the challenges of leadership almost always deliver more to the leader than what was given.

I say, take a chance and get involved! Join a committee, a significant interest group, or even run for an office on the SGVPA Board. Both you and SGVPA will be better for it. Volunteer service to SGVPA is a win-win situation. It will expose you to issues and people in new ways, and will challenge you to fine tune your best attributes.

The field of psychology is changing rapidly. We will need all the skills we can acquire to change with it and remain aware, remain ethical, and to flourish as a psychologist in the new decade.

My work with SGVPA has opened up many new connections, and helped me look at the profession and myself in ways I could easily have ignored if I'd solely attended to my private practice. As President, I have met a great many dedicated talented professionals throughout the San Gabriel Valley and across California. From each one I take away a piece of knowledge, style and point of view that contributes to my own development.

I am so very pleased to have had this chance to learn and grow and serve SGVPA. I thank you all dearly for your interest, and your support, as I've taken on this magnificent opportunity!

Linda Tyrrell, PsyD
SGVPA President

The Limits of Neuroscience

By Daniel Goldin, MA

When I set about becoming a writer in my twenties, I felt I needed to understand the nuts and bolts of language. I compiled lists of words and learned their etymologies. I broke down the sentence structure of books I admired in the hope of discovering a particle physics behind their greatness. One day I came upon Tolstoy's response to an accusation that he used language in an ordinary way. "You don't need beautiful bricks," he wrote, "to build a beautiful building."

When I entered the field of psychology, I felt I needed to understand the inner workings of the brain. The 1990s promised that we were edging ever closer to Freud's dream of uncovering a "nerve" basis of the psyche. The DMH demanded "evidence-based practice," looking to a reductive medical model imported from the physical sciences. In county clinics, I watched psychiatrists educate patients by referring to diagrams of the brain, pointing out how ADHD arises out of deficits in frontal-lobe processing and PTSD from dissociation of limbic areas from higher cortical regions. I struggled to memorize the specializations of brain areas. I learned about myelination and action potential and absorbed Daniel Siegel's definition of mental health as brain integration.

But psychotherapy seemed to me to happen on a different dimension. Consider the case of a 20 year old client who came to me with "presenting problems" of ADHD and a strange phobia toward motes of dust. He demanded to know exactly what was wrong with his brain and how I could fix it. It turned out that behind the urgency of his desire for a "brain" explanation was a fear that his symptoms proved that he had been cursed by God for his thoughts and behavior. If only his problems could be understood as physical instead of moral.

My client lived at home, under the rule of a father who followed a dogmatic religion and discharged his anger by violently punishing family members for violations of biblical rules. My client's greater difficulty turned out to involve separating out his anger at his abusive father from the much-valued spiritual beliefs he had inherited from him. His phobias and impulsiveness persisted, but as we felt our way toward a larger understanding of who he was, they mattered less. Patients often initially ask for concrete brain-oriented explanations, but they tend after awhile to reject attempts to wrap a species template over their unique adaptations to the world. The natural course of therapy seems less reductive

(continued on next page)

than expansive, moving from symptoms to meaning to narratives of the self in relation to the world. If our subjective experience boils down to chemicals squirting through the brain, why this fundamental human quest for expansive explanations?

Roger Sperry, who won the Nobel prize for his work with split-brain patients, provides the most credible hypothesis. In his view, feelings, ideas, values and other mental states are *emergent properties* of the physical brain, irreducible entities that depend on but cannot be explained in terms of their interacting parts. Furthermore, these mental states exercise a controlling influence over the physical components that give rise to them. In this model, "mind is in the driver's seat in the brain, in command over matter."

The notion of the whole exerting "downward causality" on its parts is best understood as happening in two mutually influencing dimensions. Imagine a rolling wheel. Its molecules obey all the usual laws of molecular physics. But if we consider the fate of those molecules through space and time, the rolling wheel is a more important controlling factor. Furthermore, we could no more predict the rolling wheel by considering its molecules than we can understand the meaning of this sentence by examining the individual words and letters that comprise it, or understand a person's thoughts, feelings and ideals by analyzing the play of neurons in his brain. This is not to say that medication, which intervenes on the level of the brain, has no place in treatment, only that it will never make the kinds of higher-order changes that emerge when two minds connect in the service of one -- not until we invent a pill that understands people.

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

CPA "Tidbits"

By Stephanie Law, PsyD
CPA Representative

If you are a psychologist and not already a member of the California Psychological Association, please consider joining. Hands down, no other organization fights for your California license, and its strenght, the way CPA does. No other organization holds you and your profession in mind when it comes to governmental policy the way CPA does. Seriously, consider becoming a member of this vital organization. Benefits of joining CPA include a bi-monthly magazine (*California Psychologist)*, free CEU credits when you take a short quiz online after reading the magazine, "*TherapySites*" (a service which assists therapists in designing their very own website), a statewide Listserv, free Ethics consultations, and much more!

Please visit CPA's website at www.cpapsych.org for more information.

Here are some updates on what's happened *as a direct result* of CPA's efforts on *your* behalf!:

- SB 880, a CPA sponsored bill, would have mandated the use of helmets on children who ski and snowboard. It passed the Assembly and Senate Floors on bi-partisan votes and was signed by the Governor's Office. However, the bill will not become law. During the legislative process, SB 880 became "tied" to another bill that also related to ski safety (this happens often). While neither bill had any formal organized opposition, the governor's office became concerned that the content of AB 1652 was too onerous to businesses and vetoed it; as a result, SB 880 will not become law this year.

- For the fourth time in a row last week, the Governor vetoed an important piece of legislation to mandate *full mental health parity benefits* in the State of California. AB 1600 would have mandated mental health benefits equal to the coverage received for physical health benefits and would have filled in the gaps of the federal legislation, which does not cover individuals working for a business with 50 or less employees, or people who purchase insurance in the individual market. All provisions for diagnosis-specific Severe Mental Illness still apply and were not overridden by the federal law. The Governor believes this bill will increase health employer costs and is concerned it will be too expensive for California.

- Finally, the governor signed SB 294, the omnibus sunset review bill which extends the sunset of the California Board of Psychology (Board) to January 1, 2013. Over the past several years, CPA has worked tirelessly to justify the existence of the Board and advocate for its renewal as an independent Board.

Psychotherapy and Atypical Antipsychotic Medications

By Keith Valone, PhD, PsyD, MSCP

Clinicians who treat depression and bipolar disorder, severe anxiety states, personality disorders, psychotic disorders, and dual diagnosis patients, often are helping patients cope with severe symptoms of mood, affective lability, impulsivity, psychotic states, disorganized thinking and behavior, suicidal and homicidal impulses, urges to self-mutilate, obsessions and compulsions, and cravings to use substances and engage in other addictive behaviors. Psychotherapy is a mainstay of the treatment of these conditions and is demonstrated to be highly effective, whether the clinician uses psychodynamic psychotherapy, cognitive behavior therapy, "branded" forms of specialized therapy such as Interpersonal Therapy, Interpersonal and Social Rhythm Therapy, Family Focused Therapy, Dialectical Behavior Therapy, EMDR, or other specialized psychological techniques.

Patients suffering from these conditions often will respond well to adjunctive pharmacotherapy in addition to ongoing psychotherapy. There are several classes of medications that can be beneficial to patients with these diagnoses and symptoms. In this article I will briefly review one such class, called atypical antipsychotic medications.

Atypical antipsychotics are a class of medications that are FDA approved to treat bipolar disorder, schizophrenia, major depressive disorder, and autism. Atypical antipsychotics are so named because they are "second generation" antipsychotics, as distinct from "first generation" typical antipsychotics such as Haldol, Thorazine, and Stelazine. There are currently nine FDA approved atypical antipsychotics: Abilify, Clozaril, Fanapt, Geodon, Invega, Risperdal, Saphris, Seroquel, and Zyprexa.

Some atypical antipsychotics are highly effective in treating acute bipolar mania and bipolar depression, and are also effective in bipolar maintenance as a relapse prevention strategy. Other atypical antipsychotics are very useful in treating the symptoms of schizophrenia and schizoaffective disorder. These atypicals are also very effective off-label in the treatment of psychotic symptoms associated with other disorders such as paranoid disorder, personality disorders, obsessive compulsive disorder, body dysmorphic disorder, and psychotic symptoms associated with severe drug use. Some atypicals are effective in the treatment of major depressive disorder, either alone or as an augmentation to other antidepressant medications. Atypicals are prescribed off-label for a wide variety of other uses such as the treatment of anxiety, insomnia, impulsivity, agitation, and are occasionally used to treat behavioral complications of brain injury.

Atypical antipsychotics are nonaddictive, and are often used to treat symptoms in patients with a chemical dependency diagnosis who would otherwise be treated with medications that have a high abuse potential such as benzodiazepines or amphetamines. Atypical antipsychotics are considered to have a lower side effect profile than typical antipsychotics, in particular generally having a lower risk of extrapyramidal side effects (EPS). Nonetheless atypicals can induce EPS and specific symptoms such as akathisia, in which the patient feels restless or exhibits restless movements. Atypical antipsychotics can have potentially serious side effects, and are especially known to have a risk of inducing metabolic syndrome, which puts patients at higher risk for weight gain and triggering hyperglycemia and diabetes. Effective targeted psychotherapy focused on psychoeducation regarding metabolic syndrome and helping the patient make specific changes in lifestyle such as exercise and altering eating patterns can sometimes help counteract this problem. This is a good example of where combining psychotherapy with clinical psychopharmacology can be particularly useful.

Each of the nine atypical antipsychotics has specific FDA indications, common off-label uses, and well-known unique side effect profiles. Clinicians who are interested in learning more about atypical antipsychotics and how they can be helpful to their patients can visit the websites of the manufacturers of each of drugs listed above and also talk with colleagues who are experienced with these medications and how they can be effective as an adjunct to psychotherapy for particular diagnoses, symptoms, and conditions. We are most helpful as informed psychologists when we can assist our patients to make wise choices about when medications might be a useful addition to psychotherapy, how to better understand which medications may be most helpful, what potential side effects are of these medications, and how to talk effectively with their prescribers about medications.

Dr. Keith Valone is a licensed clinical psychologist, psychoanalyst, and clinical psychopharmacologist in private practice in Pasadena. He can be reached at valone@thearroyos.org.

Mindfulness in Psychotherapy:

Down to Earth

and

Supported by Research

In recent years, mindfulness has become a more frequent topic of discussion in psychology circles as research has increasingly supported its efficacy for helping cope with depression, anxiety, ADHD, PTSD, chronic pain, cancer, and a host of other medical conditions. Mindfulness has also been integrated into Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT). As a facilitator of seminars, as well as a weekly group on mindfulness and its application to mental health, I am alert to new perspectives on this form of highly developed awareness.

Dr. Jon Kabat-Zinn is a leading figure, researcher, and theoretician in adapting mindfulness for practice in psychotherapy, mental and medical healthcare, and is the developer of Mindfulness-Based Stress Reduction at the University of Massachusetts Medical School. I recently went to hear Dr. Kabat-Zinn speak, and would like to share some loosely quoted ideas that stuck with me:

1) *"Awareness is like a muscle that we have to exercise – when it is in shape it can help us to heal."* I take this to mean that the practice of being present with ourselves is not easy--whether in meditation or in the psychotherapy process -- and takes some work, but that it can become both more accessible and more fruitful when we develop a rhythm and discipline of it.
2) *"Put out the welcome mat for the good, bad, and ugly because they are already at the door."* I really like this image – it speaks to the non-judging and accepting aspect of being mindful. We are always having thoughts, feelings, and sensations swimming around in us, and mindfulness can help us understand more fully the adaptiveness of having an open-minded relationship with all of them, even the unpleasant ones.
3) *"Meditation is highly suspect – because it looks an awful lot like nothing."* This remark received a lot of laughs from the audience! I think the intention was to admit that it is easy to be skeptical when someone has not experienced the touch of healing and growth possible from meditation or other mindfulness exercises. However, those with continued experience, support, and awareness of how the practice changes them can indeed see that it is far from nothing.
4) *"The brain is an organ of experience. We are always generating new neurons in the brain, as evidenced by research and technology showing that brains of long term meditators look different on brain scans."* This comment from the anatomy perspective is good news, in that the practice of mindfulness over time can in so many ways change who we are, and how we think and act. We have the capacity to change, grow, and improve our lives.

Last week in my mindfulness group, we discussed the commonly expressed notion that mindfulness and meditation are perceived as "New Age," or perhaps too removed from everyday reality to be useful in clinical psychology. On the contrary, mindfulness can certainly be taught and practiced in a manner that is down to earth and accessible. (In fact, if a major component of psychotherapy is to increase awareness, we are in a sense constantly encouraging and facilitating mindfulness with our clients--whether we conceptualize it that way or not.) The increasing publicity and research by people like Dr. Kabat-Zinn bolster the value of mindfulness to emotional and physical health, and help to revise the stigma. In my opinion, these are steps in a positive direction.

Dr Martin Hsia can be reached at MartinHsia@gmail.com

The Survivor Mission: Triumph in Trauma Recovery

By Joseph B. Dilley, PhD
Disaster Response Chair

In the last issue, I relayed findings from the Department of Health and Human Services indicating that initial response efforts to large-scale disasters are often characterized by a collective surge of heroism, which eventually dissipates as the media spotlight, alas, shines elsewhere once again. Society's tendency to make yesterday's disasters "yesterday's news" was recently lamented in a public speech by George Clooney, as he encouraged viewers to persist in aiding Haitian and Chilean earthquake victims despite the relative dearth of media coverage in the aftermath of disasters in those two countries. While lasting collective disaster response efforts may seem like a rarity, as mental health professionals we may find invigorating the notion that there *do* exist enduring and public permutations of disaster recovery that can be catalyzed by individual survivors.

As explicated by disaster expert Dr. Judith Herman, recovery from small- and large-scale disaster is broadly characterized by three stages: establishment of safety, remembrance and mourning, and reconnection with ordinary life. While the sequence of these stages differs across individuals, it is an aspect of reconnecting with one's life that can be marked by a particularly inspiring phenomenon—one that might be said to make the life to which one is reconnecting possibly *extra*ordinary. When the survivor finds a way to transcend her traumatic experience by transforming it into an opportunity to help other victims of the same fate or to prevent it from recurring, she has undertaken the *Survivor Mission*. Perhaps the most oft-cited pop culture example of the Survivor Mission is the LiveStrong Campaign, a cancer awareness and education enterprise that cyclist Lance Armstrong launched in response to his own recovery from multiple cancers. Merely by dawning a rubbery yellow bracelet, Armstrong—and shortly after that, millions worldwide—have called attention to cancer prevention and treatment. A more recent example of the Survivor Mission, or at least its initial steps, is the rescued Chilean miners' reported decision to grant limited one-on-one interviews so that they can collaborate on telling their full account collectively through larger mediums.

But the Survivor Mission can also manifest in ways that, while still public, are less mainstream. Many of us have helped patients who have been victimized and who have subsequently endeavored to use their experiences for a greater good. After having already begun this article, I met in therapy with a woman who had just returned from the conference of an organization that advocates for women's rights worldwide. My patient had joined the organization last year as means of helping others avoid or overcome some of the gender-based oppression she herself suffered during adolescence. She recounted the mutual support and inspiration experienced by conference attendees, citing her attendance as "part of that thing you told me survivors sometimes do." When I reminded her it can be referred to as the *Survivor Mission*, she nodded and smiled proudly, then resolutely repeated, "The Survivor Mission."

A broader clinical manifestation of the Survivor Mission's role in the recovery process is sometimes observable near the conclusion of Trauma-Focused Cognitive Behavior Therapy (TF-CBT), in which survivors are encouraged to formulate a written narrative of their traumatic experience. With therapeutic support, the patient ideally concludes the narrative by recalling or identifying a redemptive theme. A quintessential example would be the survivor of childhood sexual abuse who tells of her assistance to police and prosecution until the perpetrator was ultimately incarcerated: thus, the survivor becomes empowered by the "new" ending of her story, as it tells of the Mission she took in converting from victim to altruistic protector of others.

Whether local or worldwide, the Survivor Mission is a phoenix that can rise from the ashes of trauma and victimization, reconnecting the victim with ordinary—or perhaps what has thereby become extraordinary—life. As mental health professionals, we are in the unique position of identifying and cultivating tendencies toward the Mission in our traumatized patients so that it can become manifest for them. While not necessarily victims ourselves, it is perhaps doubly inspiring to consider that we are, in a sense, facilitating our own Survivor Mission as we bring to bear our own experiences via the sympathy, authentic empathy, and specific interventions we present for the benefit of our patients.

To join or to find out more about the DR Committee,
you can reach Joe at (626) 539-2001 or PhDilley@gmail.com

Membership Corner

By Stephanie Law, PsyD
Membership Chair

One thing I often do is talk about SGVPA membership. (Well, yeah, that's my job, right?) As Membership Chair, I can wax on and on about the merits of membership in this organization... but I recently found myself reflecting on SGVPA membership's true meaning and worth. What do you really *get* for what you pay? The price of full membership can be broken down to $12 per month. (For those in other classes of membership, it is even cheaper. But I digress, back to my original question...) What do you really get for $12 per month?

Since I joined SGVPA nearly four years ago, I have seen the organization transform into a vital, vibrant community and have experienced first-hand the crucial elements of its existence. Let me just give you a taste of what I have seen, and you tell me –- is membership worth it?

Through networking opportunities, SGVPA has provided several employment opportunities for me. It has given me some dear and trusted colleagues with whom I've consulted on difficult cases, from whom I've borrowed testing materials, and with whom I've laughed. Conversations within SGVPA have prompted me toward various training opportunities, honing my clinical skills, and broadening my competence as a clinician. Members of SGVPA have sent me referrals, have advocated for my license and profession, and have encouraged me. In essence, I've learned how to be a *better clinician* and a better *person* from individuals in SGVPA. And another really cool thing-- when I ask for a referral on the list-serve, I actually know the people who respond!

SGVPA has *so many* cool things to offer. Not only do our monthly luncheons provide varying topics, but we now have three special interest groups that are up and running. We also have an award winning newsletter (voted as such by the California Psychological Association, from among 21 chapters in the state of California). And we have some really, really cool people to get to know and work alongside. So…*Come and participate*!

Before you forget, make a mental note to renew your membership for 2011. For the second year in a row, those who renew by February 1st will receive a gift card worth $10 towards the monthly luncheon of your choice! Now isn't that a wonderful deal?!

It has been and continues to be a privilege to serve you in SGVPA. Here's to 2011!

Dr. Stephanie Law can be reached at Stephanie@drstephanielaw.com

SGVPA 2011 ELECTIONS
OFFICER CANDIDATES

President Elect	**Yes**	**No**
Dr. Stephanie Law	___	___
Write in_____	___	___
Secretary		
Dr. Colleen Warnesky	___	___
Write in_____	___	___
Treasurer		
Dr. David Lorentzen	___	___
Write in_____	___	___

The Board of Directors of SGVPA takes pleasure in announcing its slate of candidates for officer positions in 2011. Please take the opportunity to vote by mail, to President Linda Tyrrell, 200 E. Del Mar Blvd., Pasadena, Ca, 91105, or by email ballot to DrLindaTyrrell@mac.com.

Please take the opportunity to vote **before** November 30.

Psychology and Family Law

The Real Problem with the Department of Children and Family Services

By Mark Baer, Esq.

On May 16, 2010, in a news story entitled, "Many tips on LA's child abuse hotline unresolved," the Los Angeles Times reported on the fact that thousands of tips (more than 18,000) go uninvestigated within the time mandated by the State. In response, Troist Ploehn, the Director of the Los Angeles County Department of Children and Family Services (DCFS) blamed the fact that DCFS is short staffed and stated, "All of the things that equate with quality do take time."

Regardless of the funds available to DCFS, the most appropriate allocation of its funding should be the investigation of allegations of abuse and neglect in those situations in which the children are still at risk. Once the children have been removed from a dangerous environment by DCFS, the immediate risk to the children is alleviated. Therefore, resources could be cut from those divisions within DCFS handling situations involving children already removed from a dangerous situation. The County of Los Angeles admits that DCFS has approximately 7,000 employees and an annual budget in excess of $1.5 billion. According to the Los Angeles Times, only 596 of those employees are emergency response unit workers.

It is false and misleading to imply that if fully staffed, DCFS would produce quality results. On May 12, 2010, I wrote a blog entitled "False Allegations and Domestic Violence." In response, an individual who works with Child Protective Services commented that "many things seem to slip through the cracks…within the Department," and about the lack of criminal prosecution for acts committed against spouses and children. This particular individual speculated that the problem could just be "plain laziness." Regardless of the cause, this individual admitted that "lives and families (especially the children) seem to pay the price.... When children are involved with the state, they are the ones to suffer the most."

Family law attorneys are well aware that dealing with DCFS is the last place any family wants to find itself. In fact, many family law attorneys have their clients retain private attorneys who specialize in handling DCFS matters, to try and persuade the case managers to close a file before one is ever opened in an effort to keep the matter out of DCFS. This is not being done in an effort to somehow protect these individuals for wrongs that they might have committed. Instead, the reason for doing such things is because the family law court cannot make rulings on matters with open files in DCFS. With all of the problems in the family law courts, seasoned attorneys still know that the families and children are far better served in the family law court than they would be by DCFS.

Moreover, DCFS does not like the involvement of attorneys during the investigative part of the case. In fact, if someone informs DCFS that they do not want to be interviewed without their attorney, or they make a request for their attorney to be present at a team decision meeting, the children tend to simply be taken into custody by DCFS.

Even in those cases in which DCFS performs thorough investigations, they still manage to get it wrong. It is the luck of the draw whether the investigator assigned to a given case has seniority and is familiar with the ins and outs of the system, and the likely outcome with regard to a particular child. The investigators are not known for properly evaluating situations and could very well worsen a situation by taking a child away from the protective parent and placing the child in the custody of the parent more dangerous to that child. It is also possible that DCFS could take children away from both parents for no good reason, and based upon an improper investigation. According to the Los Angeles Times, "more than a dozen children have died of abuse or neglect in each of the two previous years after coming to the attention of the department." Furthermore, DCFS focuses on family reunification, but without making certain that sufficient safeguards are in place to protect the children.

When "lives and families (especially the children) seem to pay the price" for DCFS' failings, that price is just a bit too high for my comfort.

Mark Baer, Esq. can be reached at (626) 389-8929 or by email at Mark@markbaeresq.com

Obsessive Ruminations
A Tale of Two Narcissists

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.

Though I hope I am well on my way to recovery, I have possessed certain narcissistic features since toddlerhood, when I thought all toys should be mine. As an adult, I fail to entertain grandiose fantasies of success, but certainly display the sensitivity to slights, the need for admiration, the ability to be arrogant, and the envy for others, particularly those with nicer cars than me. As part of my healing, a patient of mine, whom I shall call Carlos, so overshadows my narcissism that I have begun to wonder if I could be totally wrong in my self-diagnosis. Compared to Carlos, I am masochistic, self-defeating, and avoidant. Here are some stories of the dance we do together, the final episode of which gives new meaning to the idea of seeing beneath a grandiose façade.

In one of our sessions, out of desperation to bring his narcissistic features to his attention, I took out the DSM-IV-TR and reviewed the criteria with him. He announced with pride that he met all nine criteria. Attempting to provoke some emotion, I then described the Kleinian triad of narcissistic features: Triumph, contempt, and control. Smiling wildly, he laid claim to these characteristics as well.

When Carlos first entered psychotherapy with me, which was in September 2007, he idealized me in such a fashion that he seemed to create a mirror of himself in me. Of course, he needed to see me as fantastic so that he could be so elevated. He called me the best psychotherapist in Pasadena. Because of what I admitted in the first paragraph, I fleetingly wondered if maybe he was on to something. He later referred to me as an "intellectual giant," a description that propelled my ego into the heavens. The next day, with a touch of admirable timidity, I asked my lunch date, Diane Laughrun, PhD, if my patient's assessment of me could be true. She replied, with admirable kindness: "Certainly not." The swift shattering of my ego, although painful, ultimately helped me to see the power of Carlos' personality style.

As yet another example of my humbling, Carlos quit drinking alcohol and abusing drugs after abruptly terminating treatment when I was hospitalized for endocarditis. Smarting from an acute sense of abandonment, he had written: "I will never pass through your doors again." I smarted a little myself. Recently Carlos returned after a two-year absence and boasted of his healthier, happier lifestyle with which I'd had absolutely nothing to do. But within a few weeks it became apparent that he had simply switched addictions and was intensely pursuing body-building. He had read books on the subject by Arnold Schwarzenegger and Lou Ferrigno. He attended Gold's gym on a seven day per week basis, two hours or more per day, and indeed looked much more muscular than he had in the past. He advised me, with the absolute certitude that Jacques Lacan claims is indicative of psychosis, that he would become the next Mr. Universe.

One day several weeks ago, while dressed in a T-shirt and sweatpants, Carlos was again bragging about his body. Then, without warning, he quickly removed his shirt and pants, rendering himself completely naked except for his black underwear. Needless to say, this was the first time this had happened in my 31 years of practice, and I was somewhat at a loss as to how to respond. He stood across the room in front of me and began to display poses characteristic of body builders. Just as the psychoanalysts would predict, I felt not only surprised by his behavior, but suddenly like a 99-pound weakling.

Fortunately—or unfortunately—my ego is resilient. I immediately noticed that, despite his otherwise muscular physique, Carlos sports more of a pot belly than I, allowing the session to end with *my* feeling somewhat prideful.

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

ADVERTISEMENTS

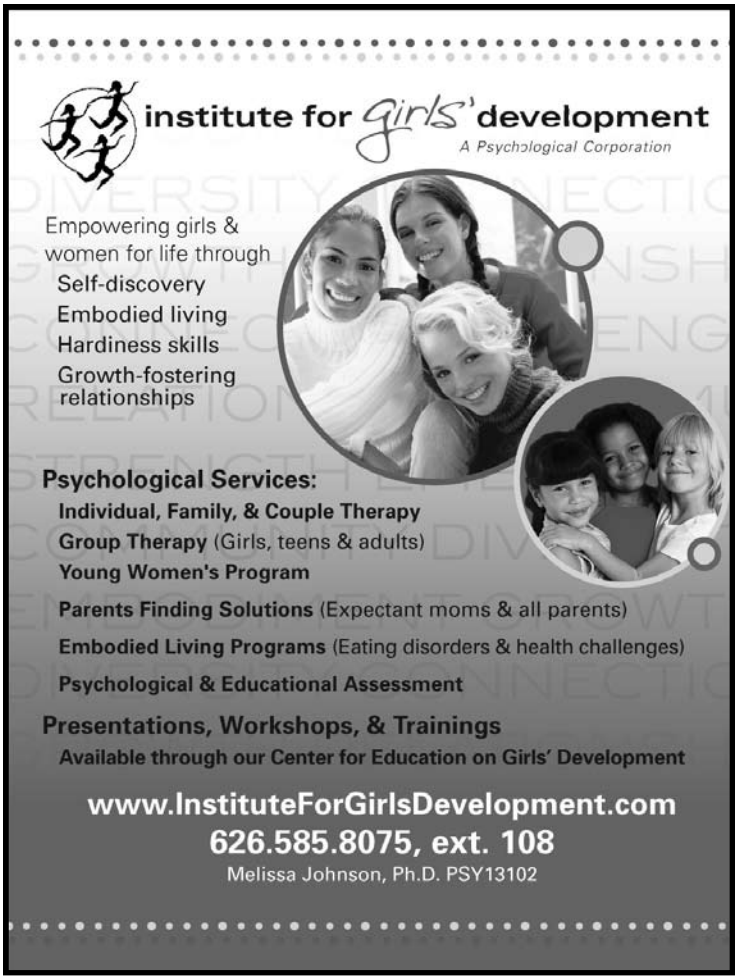
PROFESSIONAL SERVICES

PEACEFULDISSOLUTIONS: In addition to my general psychoanalytic practice, I mediate divorce. Divorce does not have to be adversarial. Couples do not have to go to court. The needs of children can be creatively considered. Elisse A. Blinder, PhD PSY 11598 (626) 795-9718. www.peacefuldissolutions.com.

MINDFULNESS SUPPORT GROUP: Weekly meditation exercises, readings/discussion about mindfulness ideas in daily life, and support for adults or teenagers dealing with depression, anxiety, ADHD, insomnia, addictive behaviors, chronic pain, hypertension. Contact Martin Hsia, Psy.D. at (626)403-3500 x106 or MartinHsia@gmail.com.

OFFICE SPACE

BEAUTIFUL, HISTORIC, CONVENIENT PASADENA BUILDING: Part time office space. Kitchen, call light system, office equipment. Delightful colleague community. Spacious group room for workshops and retreats. 626.585.8075, ext 116; info@InstituteForGirlsDevelopment.com.



NEWPORT PSYCHOANALYTIC INSTITUTE

NEWPORT PSYCHOANALYTIC INSTITUTE
250 W. Main Street, Suite 202,Tustin CA 92780
911 E. Colorado Blvd, Suite 200, Pasadena, CA 91106
Phone: 714.505.9080 • 626.796.2776
FAX: 714.505.9465
admin@npi.edu www.npi.edu

"To awaken a profound understanding of human experience, promoting the art and discipline of psychodynamic psychotherapy and psychoanalysis"

NPI offers

- Doctor of Philosophy in Psychoanalysis
- Doctor of Psychology in Psychoanalysis
- Certificate in Psychoanalysis
- Two Year Certificate in Dynamic Psychotherapy

Warm ambiance
Small colloquiums of talented clinicians
Distinguished faculty from throughout
Southern California
Full programs at our Tustin and Pasadena campuses

WELCOME NEW MEMBERS

Licensed:
Vicki Chiang, PsyD
Siobhan Donovan, PsyD
Christo Franklin, PsyD
Melissa McMullin, PsyD

Student:
Clara Aparicio, M.A.
Mariam Baim
Rebecca Burnside
Thomas Duke
Wendy Edwards
Amy Kim
Kevin Kurian
Phillip Lowe
Ashli Roland
Nelli Walker
Andrew Wong, M.A.

Associate:
Harvey Buzin, MSW

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

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
maryhannon@ymail.com. Payment must be made before publication and mailed to:
Mary Hannon, 1122 Avon Pl., South Pasadena, CA 91030. phone (626) 354-0786.