Philadelphia Society of Clinical Psychologists

Times

Spring 2012

PSCP President's Report

by
Nicole Lipkin, Psy.D., MBA

Greetings to all! It's hard to believe it's already March. I don't know about the rest of you, but I'm still curious about where last summer went! PSCP has been hustling and bustling this year with lots of great events and much progress. Our annual event in January at Eviva Restaurant was quite a hit with wonderful food, great networking, fabulous donations for our silent auction and overall just a fantastic vibe. Special thanks are owed to the chair of the programming committee, **Dr. Nina Cummings**, our Executive Director extraordinaire **Sandi Greenwald**, and all the other members of the committee (**Dr. Shawn Blue and Dr. Robin Parten**) for making the event come to life.

As a membership organization, PSCP values your input. In fact, we recently received the results of a survey composed by **Dr. Ron Fischman**, **Dr. Susan Stuber** and **Natalie Nageeb,** trying to understand the needs and wants of our members. We will be reviewing the results and looking at ways to incorporate the feedback into our programming. Thank you to everyone who took the time to complete the survey!

Some feedback we consistently receive is how much members love our networking/practice building events. You spoke, so we listened, and on March 11th, we hosted a very timely event, featuring two technology experts who spoke to us about how to incorporate technology into our practices appropriately and safely. This served not only as a great educational practice building opportunity, but also as a great day of networking. Many of us can agree that our work can be isolating, so being able to network with our peers as well as learn ways to enhance our practices and professional identity can be quite rewarding. We will be offering these types of practice building/networking events frequently to our members, and we hope you will take advantage of them.

On June 8, 2012, we are also trying something different that we are very excited about. Under the leadership of Dr. Harris Stern and Dr. Takako Suzuki, we will be offering a workshop entitled "Diversity in the Practice of Psychology". We will be offering 4 CEs (for a slight fee) but the rest of the workshop will be free and is intended to give back to our members.

I think this event shows how PSCP continues to lead the way with low cost, innovative and diverse continuing education workshops under the leadership of **Dr. Ron Fischman** and **Dr. Ann Whitehouse**. We are always looking for new and interesting topics to offer our psychology community. Please get in touch if you have a good idea.

Other initiatives that we are continually working on expanding include the peer consultation groups, under the leadership of **Dr. Kristine Boward**, and the student/psychologist mentorship program under the leadership of **Dr. Lillian Goertzel, Dr. Karyn Scher,** and **Student Liaison, Emily Buniva Edelson**.

The Human Services Center (HSC) has also realized exciting new initiatives and the rejuvenation of old initiatives under the leadership of **Dr. Lillian Goertzel** (President of HSC). HSC in collaboration with PSCP has officially launched the Refugee Trauma Initiative, a program spearheaded by **Drs. Carol Gantman, Julie Levitt** and **Judy Eidelson**. Under this vital program, psychologist volunteers through PSCP will be providing pro bono services to asylum seekers and others seeking immigration relief related to human rights abuses. We are always looking for those interested in volunteering their time for this important initiative. If you are interested, please contact the PSCP/HSC office.

Keep an eye out for the election ballots due in your email inbox around April 15th. Thanks to **Dr. Andrew D'Amico** for coordinating the efforts to get us ready for this year's election. As always, thanks to the leadership of our Executive Director, **Sandi Greenwald** and the assistance of the Executive Assistant, **Briana Brady,** our office is running smoothly, and the organization is growing. Thank you, Sandi and Briana for your help and dedication.

Members, we would love to hear your suggestions, input and ideas, and we would love for you to be involved! This is your organization and your input and involvement is what makes us successful! ■

Self-Esteem in Children and Adolescents

By
Andrew J. D'Amico, Ph.D.
Past-President, PSCP
Special thanks to Harris Stern for his contributions.

Since self-esteem is one of the major psychological factors in human wellness and successful functioning, an understanding of how high and low self-esteem comes about is important to the promotion of healthy human development and the treatment of children, adolescents and adults who are having problems. This article will present some of the knowledge we have about the processes and factors which influence the development of self-esteem.

Self-esteem is a term used to define the child's ***value of self***. However, it extends far beyond this because it also plays a major role in directing how the child interprets and responds to the world.

Self-esteem is the result of a complex process defined by constructions between underlying emotional self-images and external experiences in the child's life. Because of this, it may vary from one situation to the next; both tied to specific circumstances, as well as, having a general influence.

While the verdict of whether the child registers healthy views of himself depends on many other factors such as personality traits and temperament, researchers tend to believe that the first phase of self-esteem development occurs within the family, when the child begins to form **secure attachments** with caretakers. This is a process that allows for love, approval, and trust to form within the child; emotional elements that are crucial for the development of self-esteem. How this is internalized, as either acceptable or unacceptable self/other images, depends greatly on those surrounding the infant such as parents and siblings and other significant caretakers who create a complex environment in which the child learns what is compassionate, loving, or approving, and what is mean-spirited, negating, and shameful. **Insecure attachment** to caretakers, a condition commonly linked with the later development of low self-esteem, tends to occur in poorly functioning families in which parents are unavailable, neglectful, controlling, inflexible, victimizing, or overly permissive. (Adler, 1917; Ainsworth, 1967; Bowen, 1966; Bowlby, 1958, 1969; Erikson, 1950; Greenberg and Mitchell, 1983; Freud, 1965; Haley, 1971; Jung, 1910; Horney, 1937; Kernberg and Chazan, 1991; Mahler, 1975; Minuchin, 1974; Sullivan, 1953; Zweig, 1997).

As the youngster moves into mid childhood, separation-individuation increases. Provisions are made for appraisals about self in relationship to the world. Self-esteem development becomes widely influenced by the child's **attributions of success or failure** across a variety of settings such as family, school, or peer group. It is important to note that this period is not independent of the child's earlier experience within the family as studies show that securely attached children tend to make more positive ratings about themselves, whereas insecurely attached children are susceptible to making more negative self-attributions. During this period, the child's ability to interpret and attribute causal outcomes in a positive manner plays a key role in self-esteem building and the achievement of success. High self-esteem appraisals are firmly linked to attributions that connote responsibility-taking and personal control in the child. For example, "The teacher said I did a good job on my spelling because I practiced the words." Here, the child attributes his or her success to something that she or he directly did to enact that success. Attributions that spell personal control and responsibility on the child's part are empowering because the child perceives a linkage between his or her actions and successful outcomes. Low self-esteem attributions, on the other hand, are associated with surrendering personal control and responsibility. For example, "I did not do well on my spelling because the words were too hard." Here, the child attributes her or his failure to something outside her or his personal control, and thus there is no real perception on the child's part, that his or her actions are connected to outcomes. Research on repeated negative self-attributions where the child comes to believe that there is little to do to control outcomes, leads to a condition known as learned helplessness, a mindset that unfolds when a child comes to believe that he or she is powerless. This way of viewing the world is commonly associated with a more pessimistic explanatory style, and is often linked to the development of low self-esteem. More recent research by Martin Seligman elaborates on the concepts of controllability and responsibility. These studies have expanded upon earlier studies to show that the child's interpretations of both positive and negative outcomes are defined along three clinical dimensions; permanence, pervasiveness, and personalization. More empowering self-attributions, in general, are characterized by the adaptation of an optimistic explanatory style along these three axes. (Brooks, 1991; Inhelder and Piaget, 1958; Levine, 2005; McKay, 2000; Pope and McHale, 1988; Seligman, 1975, 2005, 2007).

With the onset of preadolescence/adolescence, new feelings about self emerge which blend with the earlier experiences to form more stable and even more influential **emotional self-images**. As these images appear in the forefront of the child's perceptual field, they have the capacity of altering the child's view of self. This is mainly because the child tends to place credence in the new reality that has been created by these images. If, for example, the self-image is one of determination, then the child, once viewed through this image will come to view herself as a determined person. This in turn will have a bearing on how hard the child tries when faced with a challenging situation. Because of their power to create different impressions and beliefs in the child, these emotional self-images play a pivotal role in shaping the child's external experiences.

Self-Esteem continued on page 3

Self-Esteem continued from page 2

This first part of this process involves a gradual internalization of the numerous self-attributions that have been formed thus far. Once internalized these form deep seated positive and negative self-images. If we were able to give these images a voice, some examples might include "I do not give up", or "I am a loyal friend", or "I am smart", and on the other end of the spectrum, "I am lazy", or "I do not fit in", or "I am stupid". Whether or not these images allow for some degree of acceptability, as explained above, greatly depends on the explanatory style that the child has employed throughout development. The second part of this process occurs when these self-images begin to attach themselves to various feelings about self to form constructed *emotional images of self*, such as "I do not give up"- *determination*, "I am a loyal friend"-*belongingness,* or "I am smart"- *pride*, and/or "I am lazy"- "*failure*, "I do not fit in"- *abandonment,* or "I am stupid"-*humiliation.* The child's self-esteem is now defined in terms of this collection of **positive and negative emotional self-images.** These images, in turn, begin to define the child's inner world, and eventually, through their influence over the child's external experiences, come to play a major role in how the child **interprets** and **responds** to situations in his or her life.

These emotional self-images have a few defining characteristics:

First, emotional self-images do not sit idly by, but rather, **emit energy**, acting as a constructive or disruptive force within the child. Positive emotional self-images emit energy that produce self-respect, optimism, self-confidence, self-reliance, determination, and empathy. Negative emotional self-images emit destructive energy resulting in low -confidence, devaluation, pessimism, and detachment.

Second, emotional self-images assume an **enduring life of their own**. Positive emotional self-images, once formed, have lasting positive effects. Emotions of optimism, determinism, and altruism contained within these images are ever-present potential protagonists allowing the child to draw on their strength in meeting life challenges. Negative emotional self-images, once formed within the child, have an enduring erosive effect. A child who is emotionally wounded within her or his family may come to harbor unacceptable emotional images about self that are associated with this injury long after with wound has occurred. Sometimes these effects remain as life-long negative impressions which influence the person in subtle and not very conscious ways. In the case of trauma or traumatization they may be repeatedly and vividly re-experienced by the child as if the wound had just occurred. With additional positive experiences, the ill-effects of negative images can also improve over time.

Third, emotional self-images have the quality of being **self-directed and self-directive**. That is, they have the characteristic of directing *judgments or emotional judgments about the self toward the self and directing the self to then act in ways that reflect those judgments*. In the case of positive emotional self-images, the internal experiences associated with the specific image -- whether self-determinism, self-confidence, or self-satisfaction-- once directed toward the child, will act as an energizer to help move the person forward toward his or her goals. Negative emotional self- images, have the opposite effect. Feelings of self-victimization, self-loathing, self-contempt, and self-incrimination, unfortunately are like weapons used against the child and her efforts to achieve goals. Once aimed at the child, they lead the child to believe that she or he deserves to be the recipient of victimization, loathsomeness, and incrimination. Over time this will not only have a damaging effect on the child's psyche but also change the child's actions in ways that are self-defeating or dysfunctional or undermining of the achievement of success.

Fourth, emotional self-images often spread their influence at an **unconscious** level. Children, who demonstrate resilience and empowerment in how they interpret and respond to the world, have experienced a gradual induction of positive images into their subconscious throughout development. Emotions associated with these images include self-confidence and security, which are constantly at work within the child's psyche.

Intolerable experiences associated with negative emotional self-images, such as shame, humiliation, rage, and self -loathing, may be rejected by the child's subconscious as well as conscious mind, yet continue to operate unconsciously within the child' psyche, thereby having a deep and pervading influence on how the child interprets and responds to the world. Accessing, managing and changing emotional self-images as well as their effects becomes very difficult, mainly because of the powerful defenses such as denial, distortion, projection, and repression which have driven them into the unconscious.

Fifth, emotional self-images, once internalized, are capable of influencing one another to form an **interdependent relationship**. This might mean that under certain conditions, they amalgamate to form a constellation of images, organized around a particular theme, such as inferiority, abandonment, and/or contentment, or pride. Due to their ability to interact with one another, this may supply a generalized influence that spreads across other themes, thereby offering an overarching impact. For example, in many low self-esteem images, fear is a common emotion, which then interacts with other negative emotions, often having an imposing effect. Their banding together will also tend to strengthen the energy and intensity of the constellation lending to its durability and widespread influence over the child's inner world.

Emotional self-images may also splinter off, as described above, to form fragments within the child, and in doing so, may act as an **independent source of influence** within the child. These autonomous entities within the psyche were called "complexes" by Jung, Adler, and others. We might envision this happening, for example if a particular emotional self-image carries an inordinate amount of energy and intensity, as observed in both positive and negative images. In some cases, this may also mean that these stand-alone emotional self-images work against others, tending to oppose or collide with other images that carry varying message to the child. As a result, this may have the effect of creating internal conflict and disruption within the child, or a state of disintegration, one that is generally depicted as the internal world behaving in a disharmonious fashion.

Self-Esteem continued on page 7

PSCP Extends a Very Special Welcome to New Members

by
Susan Stuber, Ph.D.
PSCP Membership Chair and Board Member

Greetings colleagues! As we head into Spring and Summer, I would like to share a few thoughts on PSCP membership. Sometimes friends and colleagues ask what I get out of this organization. My answer is that I value the sense of connection that I get with other psychologists in the Philadelphia region. During graduate school and at the start of my career, I felt very much in touch with the field; but when I left internship and headed into the work world, I missed having a network of colleagues with whom to consult, commiserate, and share professional ups and downs. I have found that with PSCP. If you would like more of these experiences, I encourage you to get more involved! Come to one of our networking events, join a committee or attend a board meeting. Becoming or staying tied in to the PSCP network of psychologists will strengthen your practice! If you know of a colleague who might be interested in joining, please pass their contact information along; we would be happy to reach out to them by phone or mail!

We would like to recognize and welcome those who joined PSCP from October 2011-March 2012. We hope new and longstanding members alike will enjoy getting to know each other at our social events, at the practice building series, by attending one of our board meetings, or through an upcoming continuing education program.

General Members

L. Stewart Barbera, Jr., Psy.D.	Aston, PA
Christina Gallman, Psy.D.	Folcroft, PA
Marianne Intoccia, Ph.D.	Blue Bell, PA
David Massari, Psy.D.	Philadelphia, PA
Elisabeth Roland, Psy.D.	Philadelphia, PA
Steven Shelly, Ph.D.	Philadelphia, PA
Elizabeth Soucar, Ph.D.	Jenkintown, PA
Marc Tannenbaum, Psy.D.	Berwyn, PA

Associate Members

Theodore C. Lewandowski, M.S..	Drexel Hill, PA
Jane Kowarsky Rosen, LCSW	Bryn Mawr, PA

Student Members

Jennifer Breslin	Immaculata University
Carmen Breen-Lopez	Virginia Consortium
Nicole Centrella	Immaculata University
Krista Coons	Chestnut Hill College
Samantha Coppola	PCOM
Jennifer Diagia	Chestnut Hill College
Breanne Dibble	Immaculata University
Debra Dix	Immaculata University
Frances Ennels	Chestnut Hill College

Brian Esposito	Immaculata University
Meghan Faith	Chestnut Hill College
Patricia Gratson	Chestnut Hill College
Brooke Hoffman	Chestnut Hill College
Michael Hogan	Chestnut Hill College
Andrew Husband	Immaculata University
Devin Hussong	Chestnut Hill College
Charis Liang	Chestnut Hill College
Alyssa Lindahl	Immaculata University
Stephanie Manning	Immaculata University
Molly Marcus	Chestnut Hill College
Courtney Murphy	Immaculata University
Lisa Maria Nail	PCOM
Jennifer Nowak	Chestnut Hill College
Katherine Overman	Immaculata University
Florencia Pahl	LaSalle University
Katie Pierce	Immaculata University
Anthony Powell	Chestnut Hill College
Dane Saunders	Immaculata University
Kerry Lyn Wagner	Immaculata University
Lynanne Williams	Immaculata University

What a wonderful opportunity for students to network with professionals who will soon become mentors, supervisors, and colleagues! Contact the PSCP Office with any questions at 215-885-2562. ■

Become a PSCP Fellow

by
Susan Stuber, Ph.D.
PSCP Membership Chair and Board Member

Become a PSCP Fellow!

PSCP distinguishes those with sustained or superior service to our organization with the Fellow designation. You may be eligible…

▫ Have you been a member for 5 continuous years?
▫ Have you held elective or appointed office within the organization for two years or more?

We would like to recognize your contributions by electing you to the next level of membership!

Please contact Susan Stuber at info@philadelphiapsychology.org to obtain the PSCP Fellow application. The Fellow designation is noted in both our print and on-line member directories. We also enjoy honoring new Fellows at our annual winter gathering. ■

Human Services Center Update

By
Lillian Goertzel, Ed.D.
HSC President

Thank you to all the members who assist us daily to meet our commitment to helping others in our community. We have many ways for you to continue your involvement in our mission and want to let you know what you and other members are doing to create meaningful impact.

We ask you to reserve the date of **May 5, 2012** for the National Alliance of Mental Illness NAMI Walk to benefit this worthy charity. Walk, exercise, expand your professional network, renew friendships, and get a PSCP T-Shirt…all while being part of a TEAM that *will* make a difference. Please visit our website or contact Andy Offenbecher, PhD aeophd@verizon.net , who is leading this effort.

Current programs which merit your ongoing support include:

*student mentorship,
*psychotherapy for Human Services Center clients,
*therapy for refugees, and
*giving talks for our speakers bureau and to the media, in your areas of expertise.

We are currently developing places for doctoral level psychology students to volunteer their time in response to their stated interests.

Any member is welcome to attend our HSC meetings or to share ideas with us. Our next meetings are scheduled for April 22, 2012 and May 20, 2012 at 10 AM in our PSCP office in Jenkintown. If you desire further information you can contact Sandi Greenwald, Executive Director at (215) 885-2562. Thank you for your continued support of the Human Services Center. ■

PSCP Values all HSC Volunteers

Thank You, HSC Client Therapists

PSCP values all volunteers and appreciates the time and effort individual members give to provide services to those in need. The PSCP/HSC staff apologizes for names inadvertently left off of this list. If you saw an HSC client from October 1, 2011 through March 15, 2012, and you are not listed here, or if you are interested in volunteering, please contact Sandi at 215-885-2562.

* *

An HSC client will *never* call for an appointment without the office getting your approval first. Some clients do ask for a clinician who will see them on a "sliding scale". Those clients are referred as self-pay general referrals. Clients often use "low-fee" and "sliding scale" interchangeably, so if you're not sure, call the office. We keep records of all general and HSC referrals.

Volunteer Therapists
Actively Seeing HSC Program Referral Clients
October 1, 2011 through March 15, 2012

Cindy Ariel, Ph.D.
Minna Baker, Ph.D.
Jenna Baum, Psy. D.
Carole Bogdanoff, Ph.D.
Michael Broder, Ph.D.
Amy Cades, Ph.D.
Eileen M. Casaccio, Psy. D.
Steven Cohen, Ph.D.
Jacqueline Duci, Ph.D.
Karen W. Edelstein, Psy.D.
Michael Freidman, Ed.D.
Carol Gantman, Ph.D.
Adrienne Gioe, Ph.D.
Jessica Goodman, Ph.D.
Jane Greenberg, Ph. D.
Paul Himmelberg, Ph.D.
Gail R. Karafin, Ed.D
Susan Kaye-Huntington, Psy.D.
Julie Levitt, Ph.D.
Marjory Levitt Ph.D.
William Liberi, Ph.D.
Marcie Lowe, Ph. D.
Louis Moskowitz, Ph. D.
William Neely, Ph.D
Pamela Nesbit, Ph.D.
Robert Pomerantz, Ph.D.
Katheleen Reidy, Ph.D.
Naomi Reiskind, Ph.D.
Roger Sealy, Psy.D.
Dea Silbertrust, Ph.D., J.D.
Karen Sofer, Ph.D.
Ann Rosen Spector, Ph.D.
Robert Staples, Psy. D.
Harris Stern, Ph.D.
Takako Suzuki, Ph.D.
Ellen Taupin, Ph.D.
Christine Ware, Ph.D.
Shelly Marged Weber, Ph.D.

HSC Volunteers continued on page 6

PSCP/HSC Refugee Trauma Initiative

Political asylum-seekers and other immigrants seeking refuge in the United States make up one of the most underserved populations in Philadelphia. Despite language and cultural barriers, many traumatized refugees would welcome the opportunity to receive psychotherapy, but they cannot afford to pay even a minimal fee.

In order to make psychological services more available to this population, PSCP's Human Services Center and Public Policy Committees are undertaking a new initiative. This program will build on our longstanding tradition of providing low-fee treatment to underserved populations. Since many of us have limited experience working with individuals from different cultures, PSCP/HSC will provide additional support to clinicians who seek to increase their cultural competence and/or their competence in working with survivors of human rights abuses. We propose to do this by offering a range of opportunities including mentoring, peer supervision, and workshops.

Our first step will be to establish a list of volunteer therapists, along with languages spoken, geographical location, accessibility to public transportation, and areas of competence.

If you are interested in becoming a part of this project please respond by email to Judy Eidelson at judyeidelson@gmail.com or Carol Gantman at cgantmanphd@gmail.com.

As always, you will have the opportunity to decide whether or not to accept each specific referral, and you will receive credit for each hour of service in the same way you do when seeing other HSC clients.

Please include the following information in your email:

Your Name:_____

Office address(es): _____
_____

Accessibility to public transportation: _____

Languages in which you are fluent: _____

Prior experience with survivors of forced migration, violence, rape, or torture: _____
_____

Thank you for considering joining this initiative,

Judy Eidelson
Carol Gantman
Julie Levitt

HSC Volunteers continued from page 5

Thanks to these Volunteer Therapists who have notified the office of their willingness to participate
October 1, 2011 through March 15, 2012

Michelle Atkins, Ph. D.
Philip Braun, Ph. D.
Stuart Cohen, Ph. D.
William Dewart, Ph.D.
Jay Efran, Ph. D.
Mary Ertel, Ph. D.
Holly Evans-Schaeffer, Ph.D.
Kathryn Farmer, Ph. D.
Jeremy Frank, Ph.D.
Marion Rudin Frank, Ed.D.
Thomas Gerbner, Ph.D.
Vincent Gioe, Ph.D., M.F.T.
Lillian Goertzel, Ed.D.
Mark Greenberg, Ph.D.
Evlynne Harmon, Psy.D.
Dina Harth, Ph.D.
David Kannerstein, Ph.D.
E. Shireen Kapadia, Ph.D.
Linda Knauss, Ph. D.
Beatrice Lazaroff, Ph.D.
Daniel Lee, Psy.D.
Richard Lowe, Ph.D.
Nicole Machinski, Psy. D.
Susan Mathes, Ph. D.
Leslie Melman, Psy.D.
Greg Milbourne, Psy. D.
Michael Montanaro, Ph. D.
Ruth Morelli, Ph.D.
Andrew Offenbecher, Ph. D.
Maureen Osborne, Ph.D.
Joanne Perilstein, Ph. D.
Pilar Poal, Ph. D.
Linda Polin, Psy.D.
Robin Reichert, Ph.D.
Naomi Rosenberg, Ph.D.
Diana Rosenstein, Ph.D.
Cheryll Rothery, Psy.D.
Karyn Scher, Ph.D.
Vivian Seltzer, Ph.D.
Steven Simminger, Ph.D.
Nancy Small, Ph.D.
Maria Soda, Psy.D.
Andrea Solomon, Ph.D.
Ellen Sterling, Ph.D.
Susan Stuber, Ph. D.
Charlotte Swenson, Ph.D.
Bette Tiger, Psy. D.
Anna Tobia, Ph.D.
Ari Tuckman, Psy. D.
Heather Tuckman, Psy.D.
Jeffrey Walters, Psy.D.
David Wasser, Ph. D.
Julia Weinberg, Ph.D.,J.D.
Gail Zivin, Ph.D.

Self-Esteem continued from page 3

We now turn our attention to examining the mechanism that enables emotional self-images to influence the child's living-in-the-world. Up until now, we have described the formation of the child's emotional self-images, as well as their characteristics-- however clearly-- without explaining how the internal images gain the capacity to extend beyond the child's inner world and into the child's outer experiences of and action in the outer world. Without this mechanism, the emotional self-images will remain embedded, without the capability of altering or shaping the child's experiences. With this in mind, we might envision a process whereby the child's internal and external environments coalesce to form a construction of sorts that will enable the child to see himself in relationship with his outer world.

One possible model put forth by other theorists proposes that during the process through which the many internalized emotional self-images are formed an **internal lens** is created which acts as a mediating agent between the child's inner and outer environments. As such, the child's external world is filtered through this lens, and blends with the child's emotional self-images to form new psychological structures within the personality-- ones that come to influence the child's **interpretations** and **responses** to her or his outer world.

These hypothesized psychological structures-- combining the outward events of the child's life (such as his daily interpersonal experiences, personal relationships, successes and set-backs, as well as his interests, hobbies, goals, and achievements), filtered through the internal lens, and mixing with the child's internal emotional self-images-- are proposed as the mechanism that allows the child's inward environment to influence his or her outer experiences. Within this framework, it is predicted that the child who has internalized mostly positive emotional self-images, will also develop a lens that is likely to interpret outer events more favorably so that these bind together to create mostly positive amalgamated psychological structures. This leads to the expectation that such children not only interpret their experiences as favorable, but also, to respond positively. Possible positive reactions include persistence, resilience, cooperation, and altruism. Negative psychological structures, created from negative emotional self-images combined with negative interpretations of outer events as influenced by a negatively distorting lens, will have the opposite effect and lead to such reactions as pessimism, helplessness, avoidance, withdrawal, anxiety, depression, and detachment. (Greenberg and Mitchell, 1983; Inhelder and Piaget, 1958; Sorensen, 2006; Wozniak, 1985).

The remaining topic to be examined has to do with the rise of **defensive responding**, as a result of the development of low self-esteem. This discussion involves an exploration of the interplay between the child's subconscious, the role of negative emotional self-images, and the appearance of defensive mechanisms as a way of concealing intolerable self-images from the child's awareness. In a child who has developed low self-esteem the subconscious employs defensive responding to protect the child from the experience of painful negative emotional self-images by rearranging his or her perception of reality through the use of defenses such as denial, projection, obsessions, and compulsions. The goal is emotional protection-- but it comes with a cost.

When a child begins to habitually respond defensively to protect her- or him- self from underlying hurtful self-images, that child's interface with the external world begins to change. This can be described as an imbalance in how the child represents his inner and outer worlds. With high self-esteem, we might expect to see a healthy equilibrium between the representation of a child's inner and outer experience. When the child is in need of defensive protection, there tends to be more of a closed-system, one where the internal environment plays a disproportionately larger role in directing and governing interpretations and responses, compared to the child's external environment which begins to play a more subordinate role in being able to influence the child. When this occurs, external influences such as parents, teachers, friends, and other situations such as opportunities, challenges, and activities begin to have less of an impact on the child. This occurs because the subconscious begins to rule over the child's functioning by limiting the scope of certain external experiences.

The subconscious does this because outside influences (parents, teachers, coaches, teammates, and friends) tend to trigger pre-existent negative emotional self-images within the child, thereby threatening exposure of these intolerable feelings. As these threats become more frequent with repeated absorption of outside experiences, the subconscious moves to tighten its reigns on the child's processing of his or her external experiences. It does this by narrowing the lens, so that less of the child's external world is represented. As external exposure elicits increased emotional pain, the subconscious responds by restricting the flow into the internal lens, thereby acting as a control-valve. Because of this, the child begins to function in a "closed-system", one where external experiences are limited.

Reponses on the child's part begin to become more inflexible and constricted, taking on characteristics of resistance, stubbornness, and rigidity. In addition, these children also limit their existence, again a byproduct of a closed system. Thus, increased disengagement, dropping out of things, only being able to "handle" so much, and moving toward less challenging opportunities is frequently observed. The avoided situations carry the potential of threatening awareness of low self-esteem. This may explain why, children who suffer from low self-esteem tend to block others out-- ignoring "sound" parental advice, rearing up at the slightest appraisal from teachers, and keeping friends at arms-length. Over time, the imbalance in how the child represents his internal and external environments has serious implications for personality development mainly because the ongoing negation of external influence at the expense of protecting the child's psyche begins to take a toll. Outside influences such as teachers, parents, and friends, begin to grow intolerant of the child's narrow scope, and begin to withdraw approval-- only further lowering the child's already low self-esteem. In response, the child is at risk for reducing his or her world even more. As the role of the influence of the external world is decreased and it is relegated to looking

Self-Esteem continued on page 11

Executive Director's Report

Sandi Greenwald
PSCP Executive Director

"The color of springtime is in the flowers, the color of winter is in the imagination."
Terri Guillemets

This winter we have been imagining a glorious array of colorful springtime programs, events, and initiatives. These were carefully planned and tended to with patience , dedication, and the hard work of PSCP Committee Chairs. Listed on the left hand side of page 2, these amazing individuals have given of their time and energy for the benefit of all members. On their behalf, I invite each of you to enjoy the variety of CE programs, Networking/Practice Building Events, Social Events, and Peer Consultation Groups that are blooming this spring.

We also invite you to join us for the PSCP Leadership Day on June 1, 2012. This is the time when we evaluate the programs, workshops, and events that took place this year and begin to plan and cultivate workshops, programs, and events for 2012-13. PSCP members recognize the isolation of private practice and enjoy the superior quality Continuing Education Workshops, interesting and useful information that is part of the Networking/Practice Building Events, participate in the important Peer Consultation Groups, and look forward to the Social Events.

Our heartfelt thanks to PSCP President Nicole Lipkin for her dedicated leadership efforts, creative ideas and her ability to prioritize. A very special thanks to Naomi Reiskind for her many years as PSCP Treasurer. Naomi has a deep connection to PSCP and has been a source of historical perspective, information, and programming knowledge. She is a pleasure to work with, and a joy to know. Join us for the June 10, 2012 Picnic in the Park and relax with Naomi, Al, and special guests Dolly Friedman and Marilyn Fischer (PSCP's 1st Administrator and Assistant respectively) .

You are invited to call me anytime and visit the PSCP Administrative Office in Jenkintown.

As your local/regional professional psychology organization, PSCP works hard to keep you educated, informed, supported, and connected to your colleagues ....all close to home.

Sincerely,
Sandi
Executive Director, PSCP
215-885-2562
sandi.greenwald@philadelphiapsychology.org ■

PSCP Student Liaison

Emily Edelson
Student Liaison

This year the Graduate Student Committee has been working hard to expand student membership and create programs to meet student needs in their development as future clinical psychologists. Specifically, the committee has worked hard to address student's desire for professional mentorship. I am pleased to report that the Committee successfully developed and implemented a "Speed Mentoring" event held at PCOM last month! Ten students rotated around the room in small groups to meet with five different professional psychologists to ask questions and gather information about how to navigate the professional world following graduation. The Committee was extremely grateful and honored that Dr. Monica Calkins, Dr. Maria Cuddy-Casey, Dr. Andrew D'Amico, Dr. Cheryll Rothery, and Dr. Takako Suzuki were willing to attend the event and serve as mentors for students. The Committee is also excited to announce that through its collaboration with the Human Services Center it has revised PSCP's mentorship program and will be launching the program. This program will also provide free ongoing individual mentorship for students this fall! Students, keep on the look-out for details in the upcoming months.

It has been such an honor to serve on a board of an organization that is so supportive of graduate students in clinical psychology. As a member, I have learned a tremendous amount from this organization and its mentors. I believe that this feeling of gratefulness and a desire to learn from the experiences and wisdom of professional members is echoed throughout the student membership. Students truly appreciate the willingness of professional members to volunteer their time to provide students with this important experience. If you are interested in becoming a mentor please reach out to Executive Director, Sandi Greenwald.

All of the progress made with regard to mentorship would not be possible without the dedication and commitment of each member of the Graduate Student Committee and I would like to take a minute to recognize the committee members representing four different programs in the Philadelphia area: Ashley Higgins from the clinical psychology program at PCOM, Jill Hersh from the clinical psychology program at Immaculata University, Jon Krigel from the clinical psychology program at Widener University and Jana Rostocki from the clinical psychology program at Chestnut Hill College.

Additionally, I am excited to announce that Amanda Chase, a second year student from the clinical psychology program at Chestnut Hill College, has been selected to continue the Committee's objective of meeting student needs in their development as clinical psychologists as the Junior Student Liaison. She will work with me to represent student interests

Students continued on page 10

Update: Public Policy and Clinical Practice Issues for Spring 2012

By Julie Meranze Levitt, Ph.D.
Chair, Public Policy Committee

There are a number of issues that we as practicing psychologists might want to know about.

First, about Pennsylvania. Samuel Knapp, Ed.D, the Professional Affairs Officer of the Pennsylvania Psychological Association (PPA) recently shared with me (S. J. Knapp personal communication, February 8, 2012) what he believes are major legislative developments for Pennsylvania psychologists. Among these is the passage of the bill that requires clearance by neuropsychologists and physicians for play decisions following concussions in high school athletes. The question of whether insurance companies can refuse to include neuropsychological evaluations from those who are not certified as neuropsychologists will be the next area to tackle. None-the-less, this is an important piece of legislation because it addresses a vitally needed area in which there should be greater oversight, and recognizes the expertise of neuropsychologists as a necessary part of the team to determine whether and when young athletes can return to the playing field.

A second issue is House Bill 1405, introduced by Representative Glen Grell. The proposed legislation already has been passed by the House Judiciary Committee. The bill would allow courts to appoint psychologists to make determinations about insanity. Dr. Knapp says that the bill, with no known opponents, will eliminate the ambiguity about psychologist testimony, at this time accepted in some but not all instances in our court system. In way of background, the Pennsylvania Supreme Court rules permit psychologists to conduct insanity evaluations, and current insanity statutes allow defendants to call upon psychologists to testify on their behalf. However, missing from the insanity statute is *court permission* to appoint psychologists to administer insanity evaluations if the reports also include assessment of competency to stand trial. In other words,
psychologists can only perform competency determinations for the defense, not for the court. This bill, should it become law, will correct an inconsistency in court rules.

Another development of importance to psychologists in Pennsylvania concerns protection of children from abuse. In September 2011, the Pennsylvania General Assembly adopted House Resolution 250, establishing a Task Force on Child Protection. The final report, due 11/30/12, requires recommendations to (1) improve the reporting of child abuse, (2) implement any necessary changes in State statutes and practices, policies, and procedures regarding child abuse, and (3) train appropriate individuals in the reporting of abuse. PPA is seeking opinions from psychologists in preparation of its own recommendations to be submitted to the task force.

Assuming that information will be solicited from the private sector, PPA has decided to submit recommendations to the Pennsylvania governmental task force. In preparation for the submission, Dr. Knapp has looked at statistics related to reporting and substantiating child abuse in Pennsylvania, comparing the data generated since the Pennsylvania child abuse laws were put into effect in 1976, through to 2010, and comparing that data with national averages, with data from states surrounding Pennsylvania, and with data from states with child populations of a similar size to Pennsylvania (Knapp, 2012.) Among the findings are the following:

* The rate of identifying and reporting child abuse in Pennsylvania is lower than any other state.

* The rate of substantiating (proving) suspected child abuse is much lower in Pennsylvania than the national average (15% for Pennsylvania; 23% nationwide.)

* Across states, lower reporting rates compare with lower substantiation rates.

* Rates of substantiation in Pennsylvania have decreased steadily since the 1980's across all types of mandated reporters.

* Only Pennsylvania sexual abuse substantiation rates are close to the national average.

*Pennsylvania is dramatically below other states in substantiating mental injuries or neglect.

Dr. Knapp has reviewed several aspects of the Pennsylvania child abuse laws in order to consider what might be contributing to the low rates for reporting and substantiating abuse over time. He wonders whether the legal definitions of abuse may be too narrow. Investigation budgets have increased over the years and therefore, he reasons, expenditure alone cannot explain the decline in substantiating abuse. There remains a question, however, whether higher budgets for investigations may still fail to provide adequate numbers of well-trained investigators.

Public Policy continued on page 12

Peer Consultation Groups

by Kristine Boward, Psy.D.

Peer Consultation Groups are meeting now!

We are happy that PSCP peer consultation groups are meeting and going strong. Participating members are finding that among the many benefits to being involved, are clinical skill enhancement and professional networking.

Given the challenges of today's professional and economic climate, peer consultation provides a venue for stress reduction, as well as a place to share business practices which can help us find ways to improve the financial success of our practices. PSCP is an ideal organization through which to find professional peers with whom to consult. Participation in peer consultation groups is one of the many benefits of membership in PSCP. There is no charge to participate in any of these groups.

Groups are open to all members who are licensed mental health practitioners. Student members may be permitted to attend some groups (but are not permitted to present cases, due to the liability issues and conflicts that can arise when students receive supervision in multiple settings). Students, please contact group organizers directly to find out whether or not they accept students, as each group has its own unique goals and ground rules, and the decision to open the group to student members is entirely up to each group.

The following Peer Consultation groups are currently meeting and are open to new members:

Mindfulness Peer Consultation Group: NEW
The Mindful Therapists peer consultation group is for mental health professionals, and those in training, who integrate mindfulness into their professional work for self-care and/or client care. A personal daily meditation practice is required of all participants – this can be from a variety of wisdom traditions, including but not limited to the Buddhist traditions from which MBSR/MBCT are derived. Participants in training must be currently enrolled in a graduate program with a focus on mental and/or physical health. We meet in Melrose Park, PA on the first Tuesday of each month from 10am to noon. We begin with a sitting meditation practice. For more information and specifics about location contact Chris Molnar, Ph.D. at metacenter@comcast.net or 267-287-8347.

Diversity Group:
This group meets regularly once a month on Friday from 10am-12pm at PCOM, 511 Roland Hall. The meeting schedule is set for 3/18, 4/22, 5/20, 6/24/2011. The group discusses culturally responsive/adaptive ways to treat individuals, couples, and families with different cultural backgrounds effectively. Diverse cultural groups include: race/ethnicity, gender, sexual orientation, older generation, religious/spiritual beliefs, disability, those with socioeconomic challenges, and more. Issues can be relating to, but not limited to acculturation, cultural identity, interracial marriage and families, intergenerational issues, racism, etc. Participants are asked to bring a case to discuss. Student members are welcome. Group leader is Dr. Takako Suzuki. She can be contacted at takakosu@pcom.edu or at 215-871-6435. Interested participants are asked to contact Dr. Suzuki to inform her of plans to attend the group.

Autism Spectrum Disorders Group:

This group will meet monthly on Wednesdays from 9-10:30am at the offices of Drs. Cindy Ariel and Robert Naseef in Old City, 319 Vine Street, #110. The focus of the group is on the treatment of autism and related disabilities in children and adults, as well as on treatment strategies and support for families/caregivers. Interested participants should contact Dr. Cindy Ariel at cariel@alternativechoices.com or 215-592-1333.

Addictions Peer Consultation Service:

Addictions group is not meeting at this time due to the low attendance. However, Mark Schenker who was organizing this group would like to be of assistance to the PSCP members who may have some consultation questions regarding addiction issues. Feel free to contact him at 215-743-6417 or mschenker@caron.org.

For those who would like to host a group or would like a group listed, please contact Dr. Kristine Boward. 610-878-9330. Dr. Boward will be happy to help facilitate the formation of new groups and to connect new prospective members who are seeking a group. We hope that you will take advantage of the wonderful peer support PSCP can provide through participating in a peer consultation group. ■

Students...continued from pg. 8

on both the PSCP and HSC boards for the next year before taking the reins and replacing me as the Student Liaison. The following is an introduction from Amanda:

"Hello, my name is Amanda Chase and I am incredibly honored to become part of PSCP! I'm so fortunate to have Emily as a mentor through this process and eager to meet the professionals responsible for this esteemed organization. As the new junior student liaison, I'm excited to become actively involved in the creative planning and coordination that go into all PSCP's student events and programs. I look forward to serving as a link between the student representatives and professionals in ways that meet the needs of both groups as well as using the expertise of PSCP members to facilitate positive changes in the Philadelphia community. Thank you for welcoming me to PSCP!"

The Graduate Student Committee is always looking to expand PSCP by representing more local programs and increasing communication between members and the Committee. If you or someone you know would like to represent your program please reach out to me. We would love to have you! ■

Self-Esteem continued from page 7

more like an extension of the child's inner processing. Low self-esteem related interpretations and responding are externalized, thus treating the child's outer world as a "screen" where inward negative images are projected.

As indicated above, the subconscious limits the child's full and accurate access to her or his external experience by employing defensive responding. As more and more painful realities (internal and external) need to be guarded against, there is often a proliferation in the use of defense mechanisms which come to include distortion, reaction formation, fantasy, and repression as well as the denial, projection, obsessions and compulsions indicated previously. The next discussion explains how defense mechanisms operate within the context of the self-esteem model.

We will limit our discussion to the most commonly observed mechanism associated with low self-esteem--that is, **distortion**. The defense 'distortion' has been defined as *an unconscious reshaping of external reality to meet internal needs.* One of the ways the subconscious can operate to protect the child from his or her own low self-esteem is to create diversionary tactics within the child's perceptual field, usually in the form of reality rearrangement. Common distortions include **catastrophic-thinking, control fallacies, blaming, and externalizing**. In distortion, the subconscious implements faulty beliefs about the various events in the child's life, thereby diverting attention away from negative emotional self-images. This occurs when the child views various situations from his external world through the focusing effect of his or her own internal lens. As these external events become filtered through the lens, they are bound in the unconscious to underlying negative emotional self-images. When this happens, outer experiences are experienced by the child in a distorted way because they now carry the child's low self-esteem feelings. The cause of the events, along with their meaning and impact, are altered in the child's mind creating inaccuracies in how they are represented. This leads to the child's misinterpreting the environment, which in turn often leads to the child's becoming angry, sad, fearful, depressed and/or anxious. Research on distortion also suggests that the child engages in positive distortions as well, as is the case when the child has internalized positive emotional self-images. Here the distortions portray a halo effect, where the child's external world is represented in an overly optimistic manner. (Adler, 1917; Freud, 1965; Jung, 1910, 1916; Masterson, 1981; Seligman, 2007; Sullivan, 1953; Zweig and Wolf, 1997).

The child's emotional opinion of self is a complex process; one comprised of early childhood experiences in the family, attachment to significant others, attributions of causal events, and the internalization of positive or negative emotional self-images. Whether the child acquires acceptable feelings about self depends on the constructions between his internal and external worlds, a process that often entails unconscious defensive responding, which ultimately comes to shape the child's world. A clear understanding of these structures and how they operate provides a basis for locating the source of children's, adolescents' and the adults' distress and guidance for how to begin to work to change the structures so the person of any age may become happier and more productive.

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Self-Esteem continued on page 13

Public Policy continued from page 9

In addition, there is a question about whether low rates of reporting may be related to low rates of substantiation. That is, mandated reporters may be less likely to report abuse when their efforts do not result in substantiation and action that prevents further abuse. And also, there is the question as to whether reporting rates reflect definitions of abuse that are too vague and therefore, less likely to be founded. Sexual abuse, perhaps more explicitly defined and generally perceived as more egregious than other forms of abuse possibly with the exception of physical abuse, may be more likely to be reported and then proven. This, of course, does not explain why there may be an under-reporting of physical abuse.

PPA will be considering a number of questions:

* Should Pennsylvania require education in child abuse and child abuse reporting for all health care professionals either before licensing or as part of mandated continuing education?

* Should PA increase penalties for mandated reporters who fail to report suspect child abuse?

* Should PA require all adults to report child abuse?

* Should PA clarify that the special provisions apply to reporting abuse by school officials apply to higher education as well as basic education?

* Should PA expand the definitions of child abuse, especially in the areas of neglect, emotional abuse, and non-accidental injury?

* Should PA increase resources spent on preventing child abuse or rehabilitating those in which abuses occur?

What remains vexing are the questions about how best can we as service providers meet the needs of children and families? How much is the harm to children in Pennsylvania related to what we might call "structural abuse", the discriminations, including marginalizing the power of mothers (Zeliner Grunzke, 2012), the social injustices, embedded in the culture, along with the lack of education and social supports that contribute to the failures of families to adequately care for children? The reporting and substantiating statistics may under-represent a much larger societal problem that does not neatly fall into visible signs and data. Until there are safe neighborhoods, jobs, parent education, community supports, including good schools, and a willingness to strengthen family units whenever possible and provide adequate supports for children, who cannot live with their families, child maltreatment, mostly not visible, unrecognized, and not captured in statistics, will cause harm to children. Therefore, the last question above may be the one in greatest need of answering.

As a last issue, I would like to draw from a recent paper posted on the PPA listserv, ***An Impressive Evolution***, authored by Pat DeLeon, a former President of the American Psychological Association. In his paper, cited on the Pennsylvania Psychological Listserv in February 2012), Dr. DeLeon describes how he sees psychological care fitting into President Obama's Patient Protection and Affordable Act (P.L. 111-148). Under the act, for the first time more than 32 million Americans will have high quality, patient-focused care. The plan will include prevention, wellness care, and the building of comprehensive systems of health care. Dr. DeLeon envisions changes in how psychologists will provide service, with a shift from a small private practice model to one in which psychologists become employees in federally organized community health care systems. Those with prescription privileges may be best able to serve in these federal entities. The idea of a large interdisciplinary model will require new attitudes and skills.

How we prepare for these wide-sweeping changes is unclear. However, for starters, we need to explore the scope of our definitions of our work and the extent to which we now partner with other providers of mental health service and those in other service delivery areas. We should look at alliances that work to increase supports for individuals and families, especially exploring our work for the underserved. Our work as private practitioners will change. We will need to explore questions about how psychology can best provide service as part of inter-disciplinary teams that serve greater numbers of people.

For questions, further discussion, and/or interest in joining the Public Policy Committee, please write me, Julie Meranze Levitt at julie.levitt@verizon.net.

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Self-Esteem continued from page 11

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See Article Page 18

At Home with Hoarders

By
Annette Reyman
All Right Organizing

My work as a professional organizer allows me the opportunity to see how people live and work and to get a first hand perspective of what they face in their daily environs. Prior to accepting a new client, an interview provides me with some insight into what led the individual to contact me and to what they wish gain from our working together. Most often, the individual will relate either an ongoing organizational dilemma such as filing or organizing their children's things; or some situational circumstance like the addition of a new baby, a job change or a move. Upon arrival, I begin by taking a tour of their home or office. This allows me the opportunity to follow them step-by-step through their individual processes so that I can see for myself exactly how their environment is working (or not) for them – some challenges are the physical limitations of space, other the lack of organizational systems. Ultimately, clients are looking to install or restore order so that they may continue on with their lives - more efficiently, less cluttered and with a renewed feeling of control. On occasion, however, it is something different.

Early on in my career, following a group meeting I had facilitated in which participants shared their challenges with home-organization and de-cluttering, I was approached by a soft-spoken and well-dressed woman. This woman, I will call her Eva, confessed to me the reason that had caused her to drive over an hour to join our group that day. She was being threatened with possible eviction from the apartment she had lived in for 11 years after receiving a maintenance repair visit that had led to a warning from the building manager. Eva became my first "hoarding" client.

Not all professional organizers choose to work with hoarders and, I must admit, it is an eye-opening experience. Although I receive ongoing training via my professional association - NAPO - regarding such issues, I learn something new about understanding hoarders with every undertaking.

Upon my first visit to Eva's home, she welcomed me at the door with the warning that I was her only visitor in over 5 years. As I navigated my way through stacks of paper and boxes, my feet never actually touching the surface of the floor, I could see the embarrassment and feel the anxiety radiating from her. I thought that we might start by sitting with a cup of tea and discussing her organizing issues and goals. I was mistaken. Not only was there nowhere to sit – not in the living room, dining room, kitchen or bedroom – she hadn't used her kitchen in over a year and could not heat a cup of water, let alone find a clean cup or a teabag. She explained that since her bout with cancer and the death of her father over 5 years prior, her home life had gotten out of control. Her children would no longer visit with the grandchildren; she ate out for every meal and spent as much time away from her apartment as possible. I realized two things that day. First, there is often (although not always) a major life event that to which a hoarding situation can be traced. Second, and more practically for me as an organizer, is to expect that no appliances or conveniences will be safely or sanitarily usable. A sad but important lesson, as expecting these things only added to my client's feelings of guilt and embarrassment.

According to the Institute for Challenging Disorganization (ICD) there are four categories used to assess the degree of clutter in an environment: Structure, Animals/Pests, Household Functions and Health & Safety. In regard to these categories, environments may be assessed as "low" and "guarded" - levels that are typical of an average and safely functioning environment - to "elevated," "high" or "severe" hoarding conditions. With the exception of animal evidence, Eva's situation qualified as severe. Since then, the circumstances that I encounter that are within these high levels add up to a little more than twenty five percent of my clients.

These jobs are invariably accompanied by challenges for me as an organizer. Some, unique to the individual situation, and others, that are more predictable. For instance, my hoarding clients frequently own more than one pet. The unfortunate yet corresponding truth is that they seldom own a working vacuum. I have entered homes to find out that what at first seem like houseplants, are actually vines growing in from the outside. More often than not, my work uncovers plumbing leaks in areas that have long been inaccessible. Many of my clients sleep on couches or chairs because they cannot reach their beds. I have come to expect the unexpected and arrive dressed and ready for all types of temperatures and conditions. I have also learned to let go of my own desire for completion or perfection and arm myself, rather, with patience and compassion, realizing that the road back from hoarding is proportionate to the road by which one arrived.

Reyman is a member of the National Association of Professional Organizers (NAPO®) and Board Member of its Greater Philadelphia Chapter. To contact Annette Reyman for organizing work, productivity support, gift certificates or speaking engagements call (610) 213-9559 or email her at annette@allrightorganizing.com. Visit her website at www.allrightorganizing.com or follow All Right Organizing on Facebook or Twitter. ■

ADHD is ALL About Executive Functions (and Why You Should Care)

By
Ari Tuckman, Psy.D., MBA

Attention-deficit/hyperactivity disorder is an unfortunate name. It implies that ADHD is mostly about attention and hyperactivity—and it isn't. Those are just the tip of the iceberg. Just as you can't fully understand the size of an iceberg by looking at the little bit that sticks out of the water, you can't fully comprehend the scope of the information processing deficits associated with ADHD without understanding the way that executive functions operate in people with ADHD. The executive functions are self-directed actions we use to modify our own behavior in the pursuit of our goals in the face of distractions and competing demands.

This is not merely an academic matter for our research colleagues and their statistician friends. The executive functioning weaknesses associated with ADHD have profound implications for therapists, teachers, parents, romantic partners, bosses, coworkers, and everyone else who has any dealings with children and adults with ADHD.

You may think to yourself that you don't particularly treat clients with ADHD, especially if you only see adults. I would beg to differ—about 5% of the general population has ADHD, but it's more like 10-20% of the people who seek therapy. That means on a standard day at the office, you probably have one or two clients with ADHD—regardless of what your areas of specialty are.

So going on the numbers, you should care about ADHD. Given the way that these clients' executive functioning weaknesses will affect their daily performance, you should also care about this because your treatment will not be nearly as effective if you don't. Fortunately, by taking these information processing weaknesses into account, you will be much better able to create effective interventions and get stalled therapy going again.

An Executive Functioning Model of ADHD

Russell Barkley's response inhibition theory of ADHD is currently the most detailed model and is based on the premise that the core deficit in ADHD is that of response inhibition. That is, people with ADHD are less able to reliably inhibit their responses to stimuli. These could be internal stimuli such as thoughts and feelings or external stimuli such as a comment from someone else, a ringing phone, a noisy car passing by, etc. Because people with ADHD are pulled more strongly by these events, they tend to react more impulsively and to the more immediate aspects of the situation. By contrast, when someone is able to inhibit that initial response to a stimulus, they are able to process the implications of the situation more fully and then reflect on response options. This makes for more reasoned and thought out responses. It is in this space between stimulus and response that the executive functions operate. Remember, they are self-directed actions we use to modify our own behavior—if someone responds too quickly, there is no time to effectively modify his response. As a result, he will be more pulled by the immediate elements of the situation, even if they conflict with longer-term goals—for example, the person who decides to quickly respond to a new email alert before leaving for a meeting, only to get caught up on the computer and forget that he was supposed to just look quickly at one email.

Examples of executive function failures abound from the lives of people with ADHD. They mean well, but something gets in the way of converting those intentions reliably into actions. Countless rewards and (mostly) punishments haven't helped them mend their ways because rewards and punishments only increase motivation—but do not improve the executive functions that underlie these regrettable actions and inactions. Similarly, lengthy discussions of why they do what they do, whether with a romantic partner or with a therapist, may also improve motivation but do not address the response inhibition failures and therefore are unlikely to lead to changes in behavior.

I have based my model of executive functions on Barkley's response inhibition theory but have broken them out a little differently, mostly for the sake of explanation and applicability. As you read through the following descriptions of the executive functions, you may find that certain clients spring to mind. If so, you may want to consider ADHD as a part of the clinical picture.

Working Memory We use working memory constantly to hold information in mind as we remember what just happened, relate it to long-term memories, and think ahead into the future. Working memory and attention work very closely together, as working memory holds what we are attending to. People with ADHD tend to have unreliable working memories, which cause them to become easily distracted and pulled off task. This makes it difficult to juggle multiple pieces of information simultaneously,

ADHD continued on page 16

ADHD continued from page 15

and makes them less efficient when learning new knowledge.

Sense of Time People with ADHD have difficulty monitoring the passage of time and planning accordingly, a skill that's really important in today's busy world. As a result, they tend to spend too long on some activities and not plan enough time for others. This contributes to their well-known and chronic problems with time management and getting places on time.

Prospective Memory In our busy lives, we all have dozens of little (and not so little) things to remember to do over the course of a day or week, such as phone calls and appointments or returning to something after an interruption. People with ADHD have great difficulty reminding themselves of these tasks at the right time, often forgetting completely or remembering only when it's too late. Their mental to-do list doesn't serve them well.

Emotional Self-Control People with ADHD tend to feel and express their emotions more strongly than others do and are thereby more influenced by their emotions than other people are. This then affects their ability to see beyond their emotions in the moment and to take others' perspectives into account, causing them to react impulsively in the heat of the moment.

Self-Activation Everybody has to use a certain amount of force of will to get going on boring tasks, but people with ADHD have a much steeper hill to climb. As a result, they tend to procrastinate until the pressure of a looming deadline forces them into action. When they start something, they may have trouble finishing it once the spark of excitement is gone.

Hindsight and Forethought We use the lessons from past experiences to make better choices the next time around. We also think ahead about the likely outcomes of various actions in order to choose the plan with the best odds of success. People with ADHD tend to react too quickly in the moment and therefore don't make the time to remember the past or think about the future, so they're more likely to make less optimal choices.

Because people with ADHD are less able to muster their executive functions to meet their obligations, other people often step in to serve as external executive functions. This is somewhat more acceptable for children and teens than for adults, but in both cases leads to complicated interpersonal dynamics wherein the other person doesn't feel like she can step back for fear that the person with ADHD won't pick up the slack.

If you treat clients with ADHD (and you probably do), it's crucial to understand how executive functions weaknesses drive many of the troubles that bring them into therapy. This knowledge will also prove invaluable in designing more effective interventions and coping strategies. ■

Treating Patients with Traumatic Brain Injuries in Outpatient Practice

By
Ian Douglas Rushlau, Psy.D.

Why might a psychologist in outpatient practice consider treating individuals who have suffered a Traumatic Brain Injury (TBI)? In all likelihood, you already are.

At least 1.7 million TBI's occur every year, and can result in chronic somatic symptoms, such as headache, nausea, and fatigue, as well as psychological problems including depression, anxiety, impulsivity, and difficulty with concentration and attention (SAMHSA, 2010). Fann, et. al. (2004) found that both mild and moderate TBI increased the risk of psychiatric illness, including affective, anxiety and psychotic disorders. Complicating diagnosis is the potential for the delayed onset of symptoms, perhaps for months or years, and the considerable variation in the clustering of symptoms post-injury. Consequently, it is not uncommon for the association between the original injury and subsequent symptoms to be missed. Since many TBI symptoms overlap with the most frequently encountered psychological complaints and diagnoses, it is not surprising that the role of TBI as a contributing factor in psychopathology can go unrecognized.

If we already treat individuals who have a history of TBI, it makes sense to incorporate some basic steps into routine practices: screening for TBI with every patient at intake; assessing whether symptoms being treated may be associated with or exacerbated by TBI; determining if the effects of TBI impact the process and effectiveness of psychotherapy; evaluating whether referral for a neurological or neuropsychological consultation is warranted.

Brain Injuries continued on page 17

Brain Injuries continued from page 16

If TBI has played a role in the onset and severity of a patient's presenting concerns, adapting our psychotherapeutic approach to meet the patient's TBI related difficulties is imperative. In this regard, there are a few things I encourage psychologists in outpatient settings to keep in mind: 1) you probably have already treated patients with TBI— successfully—without realizing it; 2) the brain has an amazing capacity to heal, and standard approaches to psychotherapy can facilitate this healing (Linden, 2006); 3) individuals who have suffered TBI derive emotional benefits from acknowledging, and feeling affirmed, that their injury produced 'real' effects, and made their life more difficult (SAMHSA, 2010); 4) the psychological symptoms, diagnoses, and somatic complaints commonly addressed by psychologists in outpatient practice, are the most common chronic effects of TBI—depression, anxiety, attention and concentration problems, impulsivity, anger, headache, fatigue, and relationship difficulties (i.e., you already know how to effectively address these problems).

Additionally, there are specific cognitive rehabilitation strategies and approaches that a clinician can utilize to enhance the effectiveness of psychotherapy with an individual who has suffered a TBI. Targeting aspects of executive functioning (e.g. goal selection, initiation, planning, self-monitoring) for remediation can provide substantial relief for someone who is having difficulty with performing daily activities, especially those struggling with self-regulation of emotions and behaviors. Sohlberg and Mateer (1989) suggest that in dealing with deficits in executive function "clinicians first identify which of the functions appear deficient, and then provide the structure necessary for practicing them successfully" (pg. 240) The focus of the psychologist is to identify specific elements of executive function that appear impaired, and to assist the patient practicing skills that involve those elements.

While I have been emphasizing that unrecognized TBI may be a contributing factor in the problems many of our patients experience, I also believe incorporating elements of cognitive rehabilitation into treatment with patients who have not suffered TBI can enhance the effectiveness of treatment generally. A patient who is depressed may report great difficulty starting and completing ordinary household tasks, due to low energy, poor concentration, and quickly becoming frustrated. We can characterize this person as experiencing problems with executive function, much in the same way as someone who suffered TBI. Targeted strategies to improve planning, sequencing and prioritizing of tasks can greatly improve the depressed individual's overall functioning, which in turn can reduce stress and enhance their self-concept, both important aspects of treating depression.

By increasing our awareness of the prevalence of TBI in the outpatient population, better understanding its role in psychopathology, and adapting our treatment to account for its effects, we can serve all of our patients better.

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See Article Page 14

Why Treat Insomnia and What is CBT-I?

By
Michael Perlis, Ph.D.
Director of the Behavioral Sleep Medicine Program
Associate Professor of Psychiatry
University of Pennsylvania

Is targeted treatment for insomnia warranted?

It is a long standing tradition, both within Medicine and Psychology, to view insomnia as a symptom and not as an independent disease or disorder. As a result, the proper target for treatment has often been viewed as the underlying factors that give rise to the symptom of insomnia (i.e., if the insomnia occurs with depression, the appropriate target for treatment is the depression). Taken together, these considerations have suggested that specific treatment for insomnia is unwarranted. Further, implicit in this point of view, is that successful treatment of the underlying primary disorders will result in an amelioration of the insomnia itself.

This point of view has, within the sleep research and sleep medicine communities, been called into question with the publication of the following data:

* Insomnia is a substantial risk factor for the development of new onset mental Illness e.g., 1

* Insomnia often does not resolve with the successful treatment of the "primary" mental illness conditions e.g.,2,,

* Insomnia represents a risk factor for non-response to standard treatments for "primary" mental illness conditions e.g.,3

* Insomnia is a significant risk factor for relapse and recurrence of mental illness e.g.,4

* Cognitive Behavioral Therapy for Insomnia (CBT-I) has been found to be as effective with Insomnia that occurs co-morbidly with other mental illnesses as it is with Primary Insomnia e.g.,5

* Targeted treatment with CBT-I has been shown to produce improvements in what was previously construed as the Primary Disorders (Depression and Chronic Pain) e.g.,6

The evidence base for these claims has lead to a paradigmatic shift where insomnia will be classified in the DSM V as a disorder which, when it occurs with other mental illnesses, will be classified as a co-morbid disorder. This change in the psychiatric nosology has set the stage for the point of view that targeted treatment for insomnia is warranted e.g.7.

What is the ideal treatment for Insomnia ?

The ideal treatment for chronic insomnia is CBT-I. The claim that CBT-I is the treatment of choice for chronic insomnia is based on the following findings:

1) Pharmacotherapy and CBT-I produce comparable clinical outcomes on pre-to-post, sleep-diary assessed sleep latency, wake after sleep onset, and number of awakenings) e.g.,**8**;

2) CBT-I appears to produce fewer adverse events, though this has not been formally assessed;

3) Preliminary data that suggests that CBT-I, at the end of treatment, has positive effects on sleep macro- and micro-architecture (e.g., produces increases in slow wave sleep and NREM delta activity and decreases in NREM alpha and beta activity) e.g.,9;

4) CBT-I produces clinical effects that persist beyond treatment discontinuation e.g.,10;

5) CBT-I provides for continued improvement over time (for follow up intervals up to 24 months) e.g.,10;

6) The costs of CBT-I in treatment responders can be amortized in health care savings in less than 6 months (i.e., the cost of treatment is typically $800 or less where the 6 month costs of untreated insomnia have been estimated at between $924 [18-64 year olds] and $1143 [65 and older]) e.g.,11.

What is CBT-I?

CBT-I, in specific, is a hyphenated / "randomized" form of the acronym "CBT". The addition of the "I" is intended

Insomnia continued on page 20

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Insomnia continued from page 18

to elicit the response "I know what CBT is, but what the heck is CBT-I ?!". CBT-I stands for Cognitive Behavioral Therapy for Insomnia. This form of CBT is a multi-component treatment that targets specifically sleep continuity disturbance (difficulty initiating sleep, maintaining sleep, or both) and is typically comprised of Stimulus Control procedures, Sleep Restriction therapy, and Sleep Hygiene instructions. While CBT-I often only includes a general form of Cognitive Therapy which is intended to address adherence issues, there are also a variety of specific cognitive procedures that are used with the above three interventions including paradoxical intention procedures, sleep education, decatastrophization, and behavioral experiments. Some multi-component forms of CBT-I also include relaxation training.

How efficacious / effective is it?

Since the 1930's more than two hundred trials have been conducted on either single interventions for insomnia (PMR, Stimulus Control, and Sleep Restriction) or multi-component interventions that may be characterized as CBT-I. This extensive literature has been quantitatively summarized using meta-analytic statistics on at least three occasions [e.g. 12] and there is at least one comparative meta-analysis which evaluates the relative efficacy of CBT-I as compared to benzodiazepine receptor agonists (BZRAs) [e.g.,8]. The data from these literatures suggest, consistent with the conclusions of the NIH State of the Science Conference [13], that 1) CBT-I is highly efficacious, 2) BZRAs and CBT-I produce comparable outcomes in the short-term and 3) CBT-I appears to have more durable effects when active treatment is discontinued.

Beyond the issue of efficacy, is the issue of effectiveness. That is, are the clinical outcomes observed in clinical trials comparable to investigations of treatment outcome in 1) patients with insomnia comorbid with other medical and/or psychiatric illnesses (e.g.,[14]) and/or 2) studies of patients who are treated in clinical care settings [e.g., 15]. To date there have been more than 20 studies in patient samples who suffer such co-morbidities as cancer, chronic pain, depression and PTSD. The data from these studies not only show CBT-I to be effective, the clinical outcomes are, by and large, comparable to those found with patients with Primary Insomnia. In some cases, the effects are actually larger [e.g.,14]. As noted above, there also have been a variety of clinical case series studies. Contrary to what one might expect, the effect sizes for these studies also appear comparable to those obtained in randomized clinical trials.

Concluding Remarks

It is hoped that this brief summary serves as a reasonable introduction to the current conceptualization of insomnia and to CBT-I. We hope the information here will prompt the membership of the PSCP to consider collaborating with CBT-I therapists to produce more robust treatment outcomes for their patients.

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PSCP/HSC Annual Event at Eviva

January 21, 2012 began with a snowy morning, but ended with clear streets and a cold ,crisp evening. The 2012 PSCP/HSC Annual Event at Eviva was a successful, enjoyable, and relaxing evening for all who attended. The parking was easy, the welcome warm and the facility fabulous! We had the place all to ourselves…and we used every square inch.

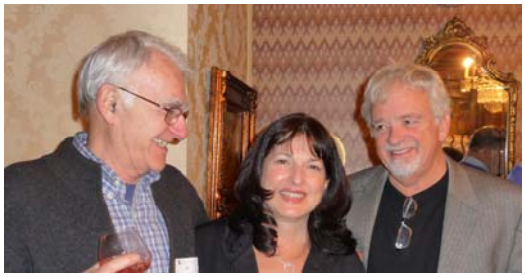
The butlered hors d'oeurves, delicious food and wine, made everyone feel well catered to. The lively bidding for the fabulous silent auction items (week's vacation in Canada, weekends at the shore, delicious upscale dining, spa pampering baskets, beautiful original art, professional organizing, and much more) as well as the special raffles kept us all engaged.

President Nicole Lipkin lauded the many accomplishments of our honorees, Julie Meranze Levitt, Ph.D. for her work as Public Policy Chair, and Lillian Goertzel, Ed.D., as President of HSC. Also recognized were the PSCP Past Presidents in attendance, Andy D'Amico, Ph.D., Dea Silbertrust, Ph.D., JD, Steve Cohen, Ph.D and Lou Moskowitz, Ph.D. Special guest PA Representative Pam DeLissio was warmly welcomed by all.

The event was a wonderful success due to the diligence and hard work of Programming Chair Nina Cummings, and her committee including Shawn Blue and Robin Parten. Many other Board members also worked hard to ensure that we had a lovely evening, including Past President Andy D'Amico, Treasurer Naomi Reiskind , Public Relations Chair and Photographer extraordinaire, Harris Stern, and Acting President-Elect Ron Fischman.

Thank you to all who supported this lovely event with auction items, raffle items, table sponsorships, and their time and energy. Attendees were already discussing next year's event. We sincerely hope YOU will join us for the 2013 Annual Event!

Everyone enjoyed the beautiful rooms, comfortable furnishings, relaxed ambiance, and excellent service at Eviva.



Al Gerstein, Nina Cummings and Allan Tannenbaum enjoyed the opportunity to share time together.

Harris Stern, Steve and Lynne Cohen, Andy D'Amico and Lou Moskowitz were delighted to reconnect.

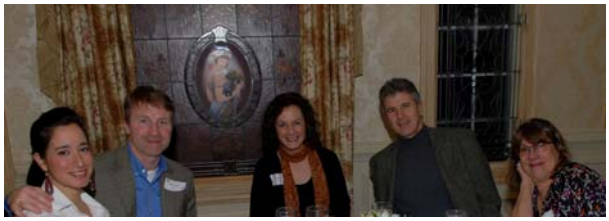
Ron Fischman introduces wife Chaya to Kaila Dickstein.

Annual Event continued on page 22

Annual Event continued from page 21

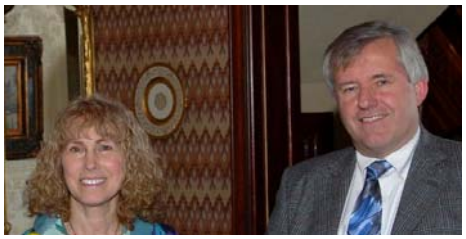
Allison Brannigan and Lou Moskowitz were delighted to join the festivities.

Bob and Lynne Harmon participated in table discussions as well as sharing time together.



Odalis Chacon, Michael Dyson, Eileen and Lee Casaccio, and Marla Isaacs enjoyed their time together,

Eileen and Lee Casaccio enjoyed the beautiful and relaxed atmosphere of Eviva.

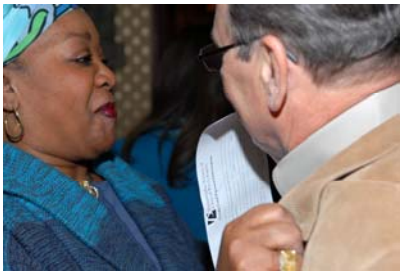


Robin and Bill Parten took time to connect with friends and colleagues.

Julie and Jerry Levitt participated in lively intellectual conversations at their table.

Christine Waanders and Ivan Haskell as they entered the beautiful welcoming area.

Andy Offenbecher and Jane Richenbach had a chance to sit with long-time friends.



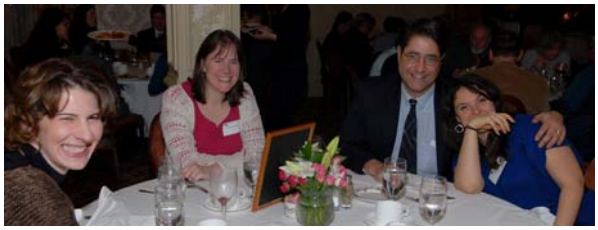
Latrisha and Steve Simminger work on bidding for the silent auction.

Annual Event continued on page 23

Annual Event continued from page 22

Robin Parten, Joe Nagy and Ellen Weisberg toast to a great evening.

Wayne Welsh and Mark Greenberg chat while surrounded by colorful artwork.



Kristine Boward, Christine and Chris Ware, and Nicole Lipkin had a wonderful time!

It is always a pleasure to share time with Paula and Andy D'Amico.

Jane Greenberg and Shawn Blue had the opportunity to get to know one another.

Norm Weissberg brought his lovely wife Lenore and they had a great time.

We were delighted to have Karyn Scher and husband Eddie join us.

Join us in 2013!

Elizabeth Nolan enjoyed sharing the evening with friends and colleagues. We were glad she came!

Federal Government Convenes Commission to Help College and Graduate Students with Disabilities

By
Linda Tessler, Ph.D.

"We have to educate our way to a better economy," says Secretary of Education Arnie Duncan

For the first time in history, a Secretary of Education, Secretary Arne Duncan appointed a government advisory commission to investigate the accessibility of instructional materials for college and graduate students with disabilities. The Commission issued its report on December 6, 2011, and it contained 19 recommendations for improvement.

The government brought together nineteen individuals from various fields to serve a one year appointment. Commission members included leaders in accessible technology, Federal officials including the Assistant Secretary of Special Education and Rehabilitative Services, and the Assistant Secretary for Civil Rights, as well as social entrepreneurs such as the Presidents of Book Share, Learning Ally - RFD&D, National Council for Learning Disabilities, and the Association on Higher Education and Disability - AHEAD. Other prominent individuals with visual and learning disabilities were also appointed to the Commission.

The mere act of bringing these individuals together provided the opportunity for significant beneficial change. Some of the most pressing questions were:

**Has the free market provided adequate access to printed material?
**What accommodations are possible within the limits of technology?
**How can this be done without harming the publishing industry?

The commissioners also explored the synergy of the individuals in the room in order to create positive change through volunteer compliance.

Through national public hearings, citizens had the opportunity to testify as to what is being experienced by the print disabled population, and their supporting communities. Also, suggestions were made as to what is needed to allow all individuals to reach their educational potential.

"This report will be a valuable resource in improving our ability to better serve students with disabilities," states Dr. Alexa Posny, Assistant Secretary of the Office of Special Education and Rehabilitative Services.

Among the nineteen recommendations given to Congress are:

(1) To produce text in a format that allows the print disabled community to have access without the need for conversion,
(2) To create a single website where individuals can identify in which format a specific text is available,
(3) The need for Congress to authorize the United States Access Board to establish guidelines for accessible instructional material.

I am excited to report that publishers and Congress are already moving on the Commissions' recommendations.

"This commission report will be a milestone in accessibility in postsecondary education. Organizations and individuals can refer to this document which provides benchmarks of standards of care," says co-commissioner Mark Riccobono, Executive Director of the National Federation of the Blind.

Please help us let others know about this work and the existence of this report.

More information about the Advisory Commission can be found at
http://www2.ed.gov/about/bdscomm/list/aim/index.html

The above article represents my own opinion.

Written by: Linda Tessler Ph.D., Commissioner, U.S. Department of Education's (AIM) Advisory Commission on Accessible Instructional Material for Post Secondary Education for Students with Disabilities and author of One Word at a Time: A Road Map for Navigating Through Dyslexia and Other Learning Disabilities.

PSCP Mourns the Passing of Valued Members

PSCP mourns the passing of Stephen N. Berk, Ph.D., president of PSCP from 1991-93. Dr. Berk support of PSCP through his Board Membership, Presidency, Committee Chairs, and Continuing Education presentations were deeply appreciated. He was president of PPA in 2004-5, and maintained an active role in that organization as well as serving as the representative from Pennsylvania to the APA Council of Representatives. A respected therapist, specializing in neuropsychology, Steve also taught physiological psychology in addition to other courses in the doctoral program in psychology at Chestnut Hill College. He will be remembered as a caring, concerned and dedicated psychologist who had a kind disposition, positive attitude, great sense of humor, and a love of learning.

PSCP remembers Marv Epstein, Ed.D., as a longtime member-since 1967, Past-President of the Human Services Center, and past Continuing Education Chair. Dr. Epstein taught psychology at Montgomery County Community College for many years and reached out to the community as a treasured leader of the Sea Scouts. It was through Marv's vision and efforts, that continuing education became a significant part of PSCP's mission in the Philadelphia Area psychological community. In 2005 Marv was honored by PSCP for his support and dedication with the Lifetime Service Award.

PSCP remembers Leonard Miller, Ed.D. as a valued member of PSCP since 1971. His contributions to the psychological community in the Philadelphia area were numerous and noteworthy. Dr. Miller had served for thirty-two years on the faculty of the University of Pennsylvania before joining a private practice. Len inspired others, students, clients, friends and colleagues. Perhaps Len's greatest quality lay in his presence. He had intelligence, yet he always remained down to earth. He had many successes in his life and continued encouraging others in the pursuit of their own dreams. He enjoyed telling a joke, even one at his own expense, and was always ready to share another of his stories or humorous remarks with anyone around him at the time. His practice mates said, "He had the gift, most of all, of being himself."

PSCP values each member and appreciates their efforts to forward the field of psychology. In times of loss we look to each other for strength as we remember the positive impact of each individual. The members described above were friends, colleagues, and leaders who will be missed by all who knew them professionally and personally. ■

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* Last name Q-Z: dessert

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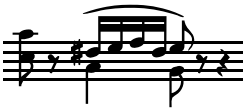

Thanks to all the PSCP Members who contributed articles for this newsletter. We are working hard to create a printed newsletter full of informative articles for all our members. If you are interested in submitting updates on clinical procedures or new research, book reviews, or 3-5 page scholarly and clinically-relevant articles for the next PSCP printed newsletter, you are invited to submit them for review to Sandi Greenwald at sandi.greenwald@philadelphiapsychology.org

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www.PhiladelphiaPsychology.org

PSCP Fall/Winter Workshop/ Event Schedule

DATE	WORKSHOP TITLE/SUBJECT	PRESENTER	LOCATION
April 27	Child Abuse from Legal and Psychological Perspectives: OCY 2012 Update	Marilou Doughty, MS; Chief Randy Floyd; Gregory Gifford, Esq.; Michele Kristofko	MCIU
May 11	Concussion in Youth Sports	Ian Douglas Rushlau, Psy.D.	Villanova University
May 18	Panel on Bullying: Insights into Current Literature, Direct and Consultative Intervention	Kaila Dickstein, Ph.D. and Panel	Friends Hospital
June 8 9AM-1 PM	Diversity in the Practice of Psychology	Takako Suzuki, Ph.D. and Panel	LaSalle University @ the Metroplex
June 10 Noon-4PM	PSCP Annual Human Services Center Picnic	Honoring those PSCP Members who are Gracious HSC Volunteers	Gladwyne Park
Sept. 21	Assessment:: Lost Boys/Failure to Launch	Victor Shklyarevsky, Ph.D.	TBD
Sept. 28 AM	An Executive Functions Model for the Diagnosis and Treatment of ADHD	Ari Tuckman, Ph.D.	TBD
Sept 28 PM	Human Emotions in Life and Psychotherapy: A Wholistic Existential Psychology Perspective	Harris W. W. Stern, Ph.D.	TBD
Oct. 12	Geropsychology	Ann Durshaw, Ph.D., Laura Lipkin, Ph.D., Marcy Shoemaker, Psy.D.	TBD
Oct. 19	Emotional Intelligence	David Mulligan, Psy.D.	TBD
Oct. 26	Positive Psychology	Ronald Kaiser, Ph.D.	TBD
Nov. 9	Adolescent Suicide	Norman Weissberg, Ph.D.	TBD
Nov. 16	Fundamentals of Family Law	Lori Shemtob, Esq.	TBD

All courses are on Fridays, from 9:00 a.m. to 12:00 p.m. unless otherwise noted.

Looking to provide CE credits at your organization's workshop?

PSCP has a simple application process for Co-Sponsorship. For more information, and to receive a co-sponsorship packet, contact PSCP Executive Director, Sandi Greenwald by phone at 215-885-2562 or email at sandi.greenwald@PhiladelphiaPsychology.org.