Philadelphia Society of Clinical Psychologists
Times
Fall/Winter
2010-11

PSCP President's Report

Andrew D'Amico, Ph.D.
President, PSCP

The year 2009-10 has been extremely busy and productive for PSCP. The recent May election utilized online voting for the first time, thanks to the work of Dea Silbertrust, Ph.D. and Sandi Greenwald; it proved far more efficient than using paper ballots. As far as the election results, I want to welcome new Members-at-Large Nina Cummings, Ph.D. and Michele Robins, Ph.D., as well as recognize Andy Offenbecher, Ph.D., Steve Simminger, Ph.D., Ann Whitehouse, Psy.D., and Naomi Reiskind, Ph.D. for their re-election to the Board. Additionally, I want to welcome Addie Smith, Ph.D. as our new Secretary, introduce our new Committee Chairs Harris Stern, Ph.D. (Public Relations) and Nina Cummings, Ph.D. (Program), and thank Steve Simminger, Ph.D. who is now assisting Naomi with our finances. Recognition also goes to Nicole Lipkin, Psy.D, M.B.A. who has done our entire program planning over the last year while serving as President Elect!

We also held an election for the Human Services Center this past spring. Congratulations to Lillian Goertzel, Ed.D., who is our new HSC President, and to Gail Karafin, Ed.D., who fills the Treasurer/Secretary office. I'd also like to introduce our new HSC Board, Carol Gantman, Ph.D., Julie Levitt, Ph.D., Andy Offenbecher, Ph.D. and Susan Thornton (Voting Student Board Member).

Many thanks go to those who served on the PSCP/HSC Boards over the past few years who have opted to step down. These include Judith Blau, Ph.D., who did a splendid job as Secretary (Judith is now serving as PPA President Elect; congratulations Judith!), Allen Tannenbaum, Ph.D., who did a terrific job as Public Relations Chair, and Andy Offenbecher, Ph.D., who served as HSC President for the past ten years. Many thanks to Andy for all his dedication to HSC!

The PSCP office continues to function at an incredibly high level under the leadership of Sandi Greenwald, Executive Director. Sandi does a remarkable job with day-to-day operations, project management, and new business development. Some accomplishments worth noting over the last year – and for which Sandi is directly responsible – include online voting, new continuing education co-sponsorship, the design of our T-shirts and mugs (to be sold at workshops), the membership directory, program planning, and print and online membership newsletters. We owe Sandi our utmost gratitude! In addition, I want to introduce our new Executive Assistant, Nitasha Strait, and thank Jessica Montanaro-Paist for the superb job that she did in this role. Jessica recently received her Master's Degree in Psychology from LaSalle University and is now in the process of pursuing her professional career. We wish her the best!

At the PPA Annual Convention, Past APA President, James H. Bray, Ph.D. described the future of psychological practice as one that would marry psychology to other fields such as medicine, business, and technology. The rational behind this new approach is that increased collaboration leads to better results. Framed as the "Patient Center Home Model," the future psychological practitioner would now be expected to integrate his/her expertise with other specialists. The net result is more cost- and clinically-effective treatment. This parallels the evolution of PSCP as an organization and as a Board, an outcome that has resulted in an outpouring of new ideas. Like the home model described above, what we have seen over the last year is greater collaboration between HSC and PSCP, as well as between Committee Chairs. This has not only resulted in a greater number of training and networking events for student members, early career professionals and seasoned members, but it also has entailed increased community service through the revitalization of our Speaker's Bureau and public relations efforts (for which we give special thanks to Lillian Goertzel and Harris Stern). Other proposals that are being entertained include PSCP's response to problem solving courts, immigration concerns, and local media events. This integration has, furthermore, affected the inner workings of the organization. We continue to have a steady influx of new members/student members, thanks to the work of Christine Waanders, Ph.D. and Susan Thornton. Christine Ware, Ph.D. has begun producing a more scholarly newsletter. Takako Suzuki, Ph.D. is more effectively coordinating the peer consultation groups. Julie Levitt, Ph.D. continues to do an excellent job in updating us about public policy alerts. Our workshop review process is more systemized as a result of the work of Norm Weissberg, Ph.D. and our continuing education program is second to none due to the tremendous

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Anxiety from the Perspective of Wholistic Existential Psychology

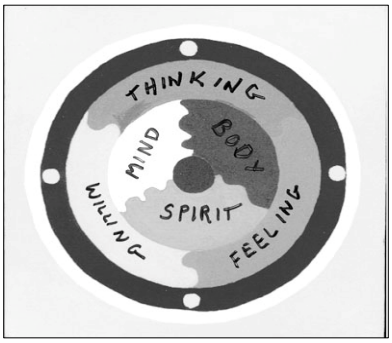
by Harris W. W. Stern, Ph.D.
PSCP Public Relations Chair

Wholistic Existential Psychology: A Framework

Clinical psychology has grown out of concepts of human dysfunction or psychopathology, and psychotherapy has represented a practice intended to help people be healthier and happier by changing their inner and outer world. Wholistic Existential Psychology is the name that I have given to my attempts to create a way of understanding human beings that will be useful for guiding the psychotherapeutic effort to support human health.

Thinking, theorizing, and practicing wholistically is based in a belief that our psychology is embedded in a totality which can be usefully differentiated into articulated aspects (such as body, mind, and spirit). This differentiation is only useful if one never loses sight of the essential unity of these various aspects. If the wholeness and unity of the human being is forgotten, one-sidedness and imbalance result. Such imbalance is one way of defining ill health. Similarly, the "mind" aspects of psychology (and of our being) can be conceptualized with articulated aspects (such as thinking, feeling, and willing), yet these also function together as an integrated, balanced whole in a healthy individual. Figure one is intended to suggest how these two triadic differentiations of existence and of mind might be imagined within a unified, balanced system.

Figure one: Two triads



This existentially-based perspective has three assumptions: (1) that human existence is unique and that a human psychology cannot really be fully developed based on theories or research that is non-human (e.g., animals or behavioral only), (2) that human existence is unique, in part, because it is verbal and conceptual, and, in a fundamental sense, we live conceptually constructed lives (e.g., lives based on a sense of time with a past, present, and future), and (3) that human existence is created and lived in relation to the experience of four universal challenges: death, powerlessness, aloneness, and meaninglessness.

Thus, we are challenged to: (A) exist knowing that we will go out of existence, (B) take responsibility and make choices even though our power over outcomes is limited, (C) create and maintain connections with other humans even though each of us is unique and can never be fully understood by another, and (D) create meaning in a universe that is often chaotic, random, incomprehensible, and not subject to our will.

Existential assumptions 1 and 2 (above) suggest that we humans live in a world which we create through our own psychology. Verbal and conceptual attributes make distinctions and create a world of time, space, causality, meaning, and meaninglessness. This view also implies that directed awareness, consciousness, and self-consciousness are special human functions which are both the instrument and the object of our psychology. Based on those functions, we create a phenomenological world – the world of experience – which is the one in which we live and struggle. This has profound implications for understanding human functioning and dysfunction, as well as how to go about ameliorating dysfunction. Thus, our world view, positive and negative core beliefs, self-concept, catastrophic expectations, perceived threats, optimism/pessimism, sense of agency, sense of purpose, meaning, direction and motivation for living, and relationship to values, eternity and universality all are self-created and part of the background of the individual world within we each live. These cognitions make up our life stories; they play a crucial part in our health and dysfunction.

Anxiety

The Diagnostic and Statistical Manual of the American Psychiatric Association (Frances, Pincus, First, & Widiger, T., 2005) now in its revised fourth edition (with work proceeding on a fifth edition), does not define anxiety at all. This rather amazing fact is documented and given an historical context by

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Anxiety continued from page 2

Wolfe (2005) in his work attempting to formulate an integrated clinical approach to understanding and treating anxiety (and anxiety disorders). He traces the concept of anxiety, central in early Freudian theory and in the earliest editions of the DSM, through the later editions which became more and more symptom-focused and less and less concerned with the etiological or functional aspects of anxiety. This atheoretical approach to anxiety in clinical theory and practice was also prominent in the Harvard Medical School Continuing Education Program on anxiety disorders (Platt, 2009). None of the presenters defined anxiety in a clear way (and most did not even attempt to define it at all). One presentation on brain-related (MRI) research in animals acknowledged that perhaps what was being studied in rats was fear rather than anxiety, but then proceeded to use the word anxiety throughout the rest of the presentation, repeatedly implying that the findings were applicable to human anxiety.

Within the current Wholistic Existential Psychology framework, I propose the following definition of anxiety:
Anxiety is the experience generated by the tightening of various muscles in the body in an effort to block, control, avoid, limit, or constrain awareness of painful inner realities and/or to inhibit the expression or acting out of unacceptable impulses (that is, unacceptable to the person who is creating the anxiety). In managing intra-psychic conflicts in this way, one creates experiences of secondary distress, pain, discomfort, and suffering.

There is historical/linguistic support for this view of anxiety since etymology suggests that the word is related to anguish and anger. All three of these words have linguistic roots indicating a narrowing, choking, tightening and restriction of breathing. Of course, many of the direct symptoms of anxiety that are presented in DSM-IV (Frances, A., Pincus, H., First, M., & Widiger, T. 2005) (e.g., trouble breathing, shortness of breath, speeding up of the heart rate, increased parasympathetic nervous system responses, and an experience of muscle tension), and which are commonly agreed to be part of the experience of anxiety, come from this tightening. Despite this, the DSM fails to indicate that it is physical tensing which produces these symptoms or to explore why a person might tighten up in this way. Phenomenologically, anxiety is experienced as a narrowing – of perception, of attention, of interest, and a sense of the scarcity of time (as in a deadline, and as in death). Anxiety is, moreover, different from fear, as fear is one of the four basic human emotions or feelings and is based in a response to a perceived threat which psycho/biologically causes us to freeze (raising alertness and making it less likely that the tiger in the tree won't see us – and energizing us to prepare for running or fighting- if there is a tiger in the tree and it starts moving toward us).

I propose furthermore that:
Anxiety, as defined above, is the central *psychological* process which contributes to the creation of the imbalances that lead to ill health and psychopathology. The tightening fundamental to the process and experience of anxiety, depletes our energy and restricts our consciousness such that we lose awareness of much more than the particular conflict that is being avoided. It also creates secondary, physical pain which also leads to the development of further avoidance mechanisms (defensive processes) which create distortions (and symptoms) in our bodies and in our overall bio/psycho/social/spiritual (meaning making) functioning.

My perspective is that a clear functional and dynamic definition of anxiety – as given above – embedded in a larger theory of human psychology and existence provides guidance for psychotherapeutic efforts to support clients in achieving healthier, happier lives. The goal is to help people create less anxiety so that they can give up the distortions in functioning and personality that grow out of efforts to defend themselves from the secondary pain of anxiety itself. The method is, therefore, to help clients locate and resolve the underlying conflicts that they have been avoiding. **Supporting clients in such a search for the conflicts underlying anxiety offers them the possibility that the changes achieved can create long-lasting improvements in balance and health.**

Wolfe (2005) also argues that one must know the bio/psycho/social context of anxiety and the meaning of the symptom to the anxious person. He suggests that his clinical experience, as well as research evidence, indicates that, in most cases, treating symptoms alone (through methods such as relaxation or cognitive behavioral therapy) does not result in lasting and comprehensive improvement for the client. Wolfe views the meaning of anxiety for clients more specifically than I do, and doesn't relate broader issues of psychological dysfunction to anxiety.

Table one: Anxiety as the central psychological process in psychological dysfunction

1	2	3	4	5	6	7
Internal Conflict; **Psychological pain**	**ANXIETY** Tightening of Muscles	**Physical Symptoms** **Body Pain** created by tensing	**Defense Mobilization** to reduce tightness and pain	**Defensive Personality Formations** protect against being overwhelmed	**Borderline Personality Formations** Instability/ volatility	**Psychotic Personality Formations** Disorganization/ Fragmentation

Table one represents this model which sees anxiety (a process of tensing) as central to understanding psychological dysfunction, distress, and imbalance. The table is intended to suggest that (1) unresolved internal conflict (and its pain) leads to (2) anxiety (a tightening of muscles in the service of avoiding the conflict/pain) which leads to (3) physical symptoms (which involve physical pain, such as trouble breathing, chest pain, increased heart rate, headache, backache, etc.) which then lead to (4-7) defensive mobilizations in an attempt to reduce these various levels of pain if they continue for an extended period of time. The particular defensive mobilizations in an individual are related to the intensity and chronic nature of the underlying conflict, to the

Anxiety continued on page 8

President continued from page 1

work of Ron Fischman, Ed.D. and Ann Whitehouse, Psy.D.

Our members can expect an excellent line up of CEU workshops, networking events, and community outreach affairs this fall and spring. CEU workshops topics will include addictions, autism, geriatrics, alternative medicine, obesity, court-testifying, and suicide assessment. In addition, we have already had a splendid student workshop on navigating the APPIC Internship Process for psychology graduate students given by Bruce Zahn, Ph.D. at PCOM. Please join us on Oct. 24th for an Open House at Christine Waanders'. This will be an informal gathering to catch up and network. Also in November, please sign up for "TEAM PSCP" as we plan to participate in the 2010 Alzheimer Memory Walk at Citizens Bank. This spring, we plan to have a repeat performance of TEAM PSCP's participation in the NAMI Walk, a networking event on the future of psychology based on an integrative approach, and a family picnic for members and friends.

I would like to thank all of the professionals who have donated their time in conducting splendid workshops last spring! This includes Nicole Lipkin, Psy.D., M.B.A. for her presentation on the Sweet Side of Marketing (thank you to Karen Scher, Ph.D for securing the site), as well as the many CEU presenters: Roseann C. Schaaf, Ph.D.; Mark Schenker, Ph.D.; Bonnie Raynes, Esq. and Joselyn G. Ewart, M.Ed., CFP, CDFA; Vivian C. Seltzer, Ph.D., MSW; Julie M. Levitt, Ph.D. and Linda Shier, Ph.D.; Andrew Faust, Esq. and Dennis McAndrews, Esq.; Christine J. Ware, Ph.D., E-RYT; James Hale, Ph.D.; Harris W. Stern, Ph.D.; Jan C. Grossman, Ph.D., J.D. and Claudia Pine-Simon, M.S., M.A.

The mid-year break is a special time for PSCP as we gather as friends and colleagues at our annual dinner. This year, we plan to not only try a new restaurant, but to honor members who have contributed greatly to PSCP. I look forward to seeing everyone at the Annual Event! ■

Become a PSCP Fellow

by Christine Waanders, 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 Christine Waanders at waandersc@yahoo.com 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. ■

PSCP Extends a Very Special Welcome to New Members

by Christine Waanders, Ph.D.
Membership Chair

We would like to recognize and welcome those who joined PSCP from March through September 2010. We hope new and longstanding members alike will enjoy getting to know each other at one of our social events, at the practice building series, by attending one of our board meetings, or through an upcoming continuing education program.

General Members

Blue, Shawn	Princeton, NJ
Caldwell, Marcy	Philadelphia, PA
Caplin, Wendy	Philadelphia, PA
Esposito, Joely	Philadelphia, PA
Gillis, Carol	Philadelphia, PA
Gounaris, Kathleen	Phoenixville, PA
Gumerman, Steven	Huntington Valley, PA
Horwitz, Wendy	Philadelphia, PA
Hubsher, Melissa	Warrington, PA
Jann, Robert	Newtown, PA
Kovnat, Karel	Jenkintown, PA
Milbourne, Gregory	Media, PA
Molnar, Christine	Abington, PA
Panzarella, Catherine	Philadelphia, PA
Perot, Suzanne	Ft. Washington, PA
Porten, Beth	Langhorne, PA
Reichert, Robyn	Langhorne, PA
Shapiro, Steven	Malvern, PA
Stuber, Susan	Wayne, PA
Vogel, Marlyn	Philadelphia, PA
Zeo, George	Quakertown, PA

Associate Members

Berkowitz, S. Ami	Doylestown, PA
Blank, Robin	Philadelphia, PA
Brnich-Ryan, Margaret	Southampton, PA

Student Members

Adams, Kristin	Chestnut Hill University
Ahmad, Rizwan	Widener University
Ammann, Kristin	Chestnut Hill University
Amodeo, Diana	Chestnut Hill University
Avart. Jessica	PCOM
Avena, Jolie	Widner University
Barker, Jeannine	Widener University
Belasco, Carmen	Widener University
Blessinger, Jackie	PCOM
Carvajal, Michael	Widener University
Centrella, Julia	Chestnut Hill University
Edmunds, Julie	Temple University
Fleischer, Jill	Widener University
Forster, Jennifer	PCOM
Foster, Lindsay	PCOM
Gonzales, Twain	PCOM
Greenbaum, Jacob	Widener University
Greenfield, Rhett	Widener University
Gutin, Rachel	Widener University

New Members continued on page 5

New Members continued from page 4

Higgins, Ashley	PCOM
Huff, Lesley	Chestnut Hill University
Hull-Rawson, Leah	Widener University
Iepson, Heather	Immaculata University
Jaegly, Jason	PCOM
James, Melinda	Chestnut Hill University
Jansen, Lorna	Widener University
Johanning-Gray, Katie	PCOM
Johnson, Gregory	Widener University
Kawka, Douglas	Widener University
Khan, Farah	Widener University
Kiseleva, Tatyana	Immaculata University
Klein, Michael	PCOM
Knaster, Cara	Chestnut Hill University
Krauss, Jeffrey	Widener University
Lenz, Meghan	Widener University
Lindy, Darcy	Widener University
Ludwig, Michelle	Widener University
Luebkert, Kelly	PCOM
Marmer, Paige	PCOM
Martin, Melissa	Widener University
McCuen, Courtney	PCOM
McNamee, Amis	Chestnut Hill University
McTighe, Adam	PCOM
Murray, Alicia	Widener University
Nageeb, Natalie	Chestnut Hill University
Patel, Radhika	Widener University
Paxson, Ashley	PCOM
Post, Candice	Widener University
Preiser, Rebecca	Widener University
Pulley, David	Chestnut Hill University
Schoenfeldt, Kathryn	Chestnut Hill University
Stites, Shana	Chestnut Hill University
Todi, Nisha	Chestnut Hill University
Vogel, Kiara	Widener University
Vojtko, Katherine	Immaculata University
Walker, Ashley	Widener University
Warholic, Christina	Chestnut Hill University
Whalen, Sarah	Widener University
White, Sarah	Widener University
Yang, Lan	Widener University
Yavorek, Kathryn	Widener University
Young, Kate	Widener University
Zubarev, Abe	PCOM

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.
■

HSC Clients

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.

Sandi Greenwald, PSCP Executive Director

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 in the 2nd and /or 3rd quarters of 2010, and you are not listed here, or if you are interested in volunteering, please contact Sandi at 215-885-2562.

Volunteer Therapists
Actively Seeing HSC Program Referral Clients
March 1 through September 30, 2010

Steven Adelman, Ph.D.
Cindy Ariel, Ph.D.
Michelle Atkins, Ph.D.
Minna Baker, Ph. D.
Philip Braun, Ph. D.
Michael Broder, Ph.D.
Amy Cades, Ph.D.
Steven Cohen, Ph.D.
Andrew D'Amico, Ph.D.
Elaine DeSilva, Ph. D.
Edward DiCesare, Ph. D.
Jacqueline Duci, Ph.D.
Karen Edelstein, Psy.D.
Holly Evans-Schaeffer, Ph. D.
Jeremy Frank, Ph.D.
Marion Rudin Frank, Ed.D.
Michael Freidman, Ed.D.
Carol Gantman, Ph.D.
Adrienne Gioe, Ph.D.
Lillian Goertzel, Ed.D.
Jane Greenberg, Ph.D.
Sandra Hart, Ph.D.
Paul Himmelberg, Ph.D.
David Kannerstein, Ph.D.
E. Shireen Kapadia, Ph.D.
Gail Karafin, Ed.D.
Susan Kaye-Huntington, Psy.D.
Lawrence Ladden, Ph.D.
Beatrice Lazaroff, Ph.D.
Julie Levitt, Ph.D.
Marjory Levitt, Ph.D.
William Liberi, Ph.D.
Marcie Lowe, Ph.D.
Richard Lowe, Ph.D.
Marilyn Luber, Ph. D.
Leslie Melman, Psy. D.
Arlyn Miller, Ed.D.
William Neely, Ph. D.
Victoria Neely, Ph. D.
Andrew Offenbecher, Ph. D.
Eve Orlow, Ed.D.
Robert Pomerantz, Ph.D.
Robyn Reichert, Ph. D
Naomi Reiskind, Ph.D.
Cheryll Rothery, Psy. D.
Roger Sealy, Psy.D.
Dea Silbertrust, Ph.D., J.D.
Nancy Small, Ph. D.
Andrea K. Solomon, Ph.D.
Harris Stern, Ph.D.
Ellen Taupin, Ph.D.
Ari Tuckman, Psy.D.
Heather Tuckman, Ph.D.
Jeffrey Walters, Psy.D.
Julia Weinberg, Ph.D., J.D.

Thanks for these Volunteer Therapists who have notified the office of their willingness to participate
March 1 through September 30, 2010

Carole Bogdanoff, Ph.D.
Eileen Casaccio, Ph.D.
Nina Cummings, Ph.D.
Kate Farmer, Ph.D.
Janice Goldman, Ph.D.
Mark Greenberg, Ph.D.
Judith Jackson, Ph.D.
Susan Mathes, Ph.D.
Michael Montanaro, Ph.D.
Ruth Morelli, Ph.D.
Louis Moskowitz, Ph.D.
Pam Nesbit, Ph.D.
Maureen Osborne, Ph.D.
Linda Polin, Psy.D.
Joyce Rafidi-Tatum, Psy.D.
Naomi Rosenberg, Ph.D.
Diana Rosenstein, Ph.D.
Karyn Scher, Ph.D.
Kenneth Sheinen, Ph.D.
Steven Simminger, Ph.D.
Maria Soda, Psy.D.
Charlotte Swenson, Ph.D.
Allan Tannenbaum, Ph.D.
Bette Tiger, Psy.D.
Anna Tobia, Ph.D.
Christine Ware, Ph.D.
David Wasser, Ph.D.
Martin Zlotowski, Ph.D.

Executive Director's Report

Sandi Greenwald
PSCP Executive Director

"Believe in yourself, your neighbors, your work, your ultimate attainment of more complete happiness. It is only the farmer who faithfully plants seeds in the Spring, who reaps a harvest in Autumn." - B. C. Forbes

We are delighted and "completely happy" to welcome aboard new members, welcome back renewed members, and congratulate graduating student members and the newly retired members. PSCP has much to offer each of you.

PSCP congratulates Jessica Paist on her new position, thanks her for an easy transition, and wishes her well as she hands the baton to our new Executive Assistant, Nitasha Strait. A LaSalle graduate student, Nitasha has helped us attain more complete happiness by making a two year commitment to PSCP. Be sure to introduce yourself to her at CE Workshops.

The PSCP Office worked diligently from late spring to assure a wonderful harvest of benefits for PSCP Members, including Continuing Education Workshops, Peer Consultation Groups, Student Workshops, 2010 PSCP Membership Directory, Practice Building/ Networking Events, the Annual Event, and a special Spring Outing.

With strong, dedicated leadership, committees have been working through the summer to plan and prepare for this year. We invite each of you to "harvest" education, CE credits, friendships, relationships with colleagues, information regarding building your practice, opportunities to consult with knowledgeable colleagues, and fun.

Please feel free to visit or call our office at 215-885-2562 with any questions. We always look forward to assisting you.

Sincerely,
Sandi
Executive Director, PSCP
215-885-2562

SAVE THE DATE
PSCP Annual Event
January 22 or 23, 2011
eat, drink, network, relax, enjoy!

PSCP 2010 Student Workshop

Susan Thornton, MA
4th Year Psy.D./MBA
Student Liaison

Student initiatives are off to a fast start for this 2010-2011 school year! PSCP is steadily building relationships with local graduate programs in fields related to clinical psychology. This process has been facilitated by the appointment of representatives from a number of local programs, who serve as liaisons between PSCP and student members at each program. I hope that you all will join me in welcoming this year's program representatives: Christy Barbone from the school psychology program at PCOM, Emily Buniva from the clinical psychology program at Widener University, Kevin Giangrasso from the clinical psychology program at PCOM, Jill Hersh from the clinical psychology program at Immaculata University, and Natalie Nageeb from the clinical psychology program at Chestnut Hill College. These reps have all expressed a commitment to serving PSCP student members and have already recruited many new members from their respective programs. As the central PSCP Student Liaison, I am looking forward to continuing to coordinate the reps in order to continually assess and provide for the needs of our student members.

PSCP continues to try and recruit student members and representatives from other local graduate programs in fields related to clinical psychology. To this end, letters about PSCP student membership and student leadership opportunities were sent to all local programs this fall. If you are or know of a local graduate student who would be interested in serving as a PSCP representative for another program, please contact me.

I am also excited to announce the success of this year's first student program: a workshop entitled "Successfully Navigating the APPIC Internship Process." This workshop was developed out of a collaboration between PCOM (represented by Dr. Bruce Zahn, Professor and Director of Clinical Training) and the PSCP CE committee (chaired by Dr. Ron Fischman). It addressed a crucial need for students aiming to procure limited APPIC Internships. Seventeen students attended from various local programs, including PCOM, Chestnut Hill College, and Immaculata. PSCP President Andy D'Amico, HSC President Lillian Goertzel, PSCP Executive Assistant Nitasha Strait, and I were present to welcome students and facilitate networking. I am very much looking forward to similar program offerings in the future and a successful year overall! As always, I welcome any thoughts/suggestions. ■

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amount and duration of the tensing that is required to control it, to previously learned styles of defending, and to various biological characteristics and tendencies of the individual.

The reason for erecting this "elaborate theoretical scaffolding" is to support the idea that **psychotherapists should assume that anxiety is a major process feature of every individual who seeks therapy.** Furthermore, psychotherapy must always include a sensitivity to the likelihood that there are underlying conflicts in the individual which are being avoided because they are painful and threatening. Table two indicates some of the types of internal conflicts which create psychological pain in human beings. **A resolution of such conflicts represents the most positive potential outcome of psychotherapy**.

Table two: Important categories of inner conflicts

Experiential Challenges
Impulse expression vs. impulse inhibition
Unacceptable feelings (anger, sadness, fear, excitement)
Unacceptable thoughts (images or words)
Conflicting goals or values
Overwhelming affects (trauma, including traumatic loss)
Negative core beliefs about the self (narcissistic wounds)
Existential Challenges
Awareness of death
Meaninglessness
Powerlessness
Loneliness

Certainly, different kinds of dysfunction and different levels of psychopathology suggest important differences in where the work begins, how it proceeds, how fast it proceeds, and its likely ultimate level of success. **It is important to remember that all dysfunction has its function**. For example, if "personality disorders" are seen as serving to protect the individual from experiencing intense anxiety, they are often extremely successful. In fact, many people with personality disorders do not come to therapy, even though another component of every personality disorder is a pattern of self-defeating behavior that keeps the individual from attaining important personal life goals (such as intimacy or occupational success). The people who have personality disorders and who seek therapy generally come in because they are depressed due to failure to attain such life goals and without insight regarding the reasons for their difficulties. The dismantling of a personality disorder involves the risk that the individual will experience great anxiety. The resolution of the underlying conflict (which is ultimately responsible for the person's "stuck", self-defeating behavior) is not possible without exposure to this anxiety and the pain of the conflict itself, but the individual may be unable to tolerate it.

Wolfe (2005) and I both maintain that treating anxiety requires attention to both the anxiety symptoms and to the underlying dynamics which have created it. The anxiety disorders in the DSM include panic disorder with and without agoraphobia, specific phobia, social phobia, obsessive-compulsive disorder, posttraumatic stress, acute stress disorder, and generalized anxiety disorder. Treating the specifics of each of these different disorders may differ in terms of both symptom management and the building of a therapeutic alliance with the client, but since anxiety and its creation through tensing is common to them all, certain common ways of responding to the symptom of anxiety are also appropriate. Common ways of helping people manage the symptoms of anxiety include relaxation training, desensitization experiences (direct and imaginative), meditation, medication, improved patterns of exercise, eating and sleep, and contextualizing the symptoms through education regarding the nature of anxiety.

The proposition central to the conceptual model proposed here is that the psychotherapist should always be aware of the anxiety dimension underlying all psychological dysfunction. Furthermore the therapist should also be working toward knowledge of the client's underlying conflicts and how they might be resolved. Psychotherapy based on various "depth" psychologies has many ways of conceptualizing and implementing conflict discovery and resolution. These include paying attention to the clients' history, current reports of experiences of internal conflict, as well as evidence from such sources as the clients' body posture, tone of voice, dreams, and transference reactions.

Wholistic Existential Psychology adds to all of the above with a focus upon the articulations and rewriting of personal narratives. At one end of the spectrum, these narratives are similar to the Core Beliefs that are often the focus of Cognitive Behavioral Therapy. At the other end of the spectrum, these narratives may be long and elaborated (e.g., "a life story") and involve the struggle to resolve the existential challenges that all human beings face – especially the struggle with meaninglessness and death.

Inner conflict is usually created and maintained by stories which are limited, outmoded, only partially true, or completely false. There are many common examples of such stories, such as "I am a victim" (e.g., "My son died and my life is over" or "The storm destroyed my home and ruined my life"), "I am the rescuer," "I am the incompetent one" (e.g., family scripts), "If I am angry I will kill someone," "I have wasted the last ten years of my life," "I am unlovable" or "My father will not love me if I am successful" and "Sex is sinful and I am a bad person if I enjoy it." Such stories, and many others, are responsible for inner conflict and can benefit from

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being brought into awareness and considered for rewriting. However, the existential viewpoint suggests that part of the reward of our freedom from conflict is our ability to make our own choices. With that in mind, therapists should always remember that while we can articulate alternative versions or interpretations for our clients, the right and responsibility for creating their own narratives is theirs.

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Should We Fear the Field of Neuropsychology?

by Marcy A. Shoemaker Psy.D.

As professionals, we are often questioned by our patients about the causes of their disorders and often requested to provide reassurance and evidence that our approaches will result in positive outcomes. Due to my training in Cognitive Behavioral Therapy, I believe that one of the most efficacious treatments for anxiety disorders includes both challenging negative beliefs (that are usually represented in the form of fears) and changing one's behavior. Even though Cognitive Behavioral Therapy still remains an empirically proven treatment, many researchers believe that findings in the field of neuropsychology should be incorporated into a comprehensive treatment approach for anxiety and other related disorders.

According to Arden and Linford (2009) neuroscience and the scientific study of psychotherapy can be viewed as identical twins separated at birth and reared unaware of one another. The fields were once closely connected in the work of Joseph Breuer and Sigmund Freud. Neuroscientists, after Freud, refocused their efforts and did not highly regard the field of psychotherapy. At the same time, many psychotherapists did not accept the relevance of neuroscience research in their clinical work. Recently, a number of texts and research articles by therapists have demonstrated that there are strong reasons to incorporate findings in neuroscience into clinical work (Cozolino, 2002).

According to David Barlow (2000), emotions that are stored in memory occasionally fire inappropriately. In individuals who are vulnerable both biologically and psychologically to anxiety, such emotions are experienced as uncontrollable and threatening. Gray and McNaughton (2002) supported their long held beliefs that the hippocampus' function is not just to process information and contribute to long-term memory consolidation, but to perform the more encompassing function of goal conflict. Goal conflict is defined as the ability to eliminate equally primed incompatible goals. Central to their account is the concept of a defensive approach; the anatomical structure that they refer to as the septo-hippocampus is responsible for the management of information, motivation, affect, and action plans which are involved in leaving, escaping or avoiding aversive situations. In another study, Airaksinen, Larsson and Forsell (2004), studied people diagnosed with anxiety disorders as compared to healthy controls. They determined that the anxiety sufferers exhibited significant impairment in episodic memory and executive functioning. Another interesting study conducted at the University of Illinois (2007) demonstrated that emotions can have an impact on various cognitive mechanisms that influence memory depending on the nature of the task, the type of emotion, and the circumstances under which the individual is engaged in cognitive work. Emotion can affect memory mechanisms via state conditions (e.g. anxious arousal) as well as via more chronic or trait conditions (e.g., dysthymia, posttraumatic stress disorder, and avoidance temperament).

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Ethics Corner
Professional Wills: Planning for the Unthinkable

by Dea Silbertrust, Ph.D., J.D.
Ethics Committee Co-Chair

The unexpected death of a PSCP colleague this summer got me thinking: if I suddenly died or was incapacitated, my clinical and professionals obligations would fall on the other clinicians in my group and, to some extent, on my husband. Would they be able to access the information they needed? Had I told them how I wanted my clients to be notified?

Making a professional will has been on my "to do list" for years, but other tasks have always taken priority. I rationalized my procrastination by telling myself that my officemate knows where all of my important information is kept. And it's true, sort of.

But I know the real reason that I've put this off: I don't want to think about dying. Yes, of course I know I'm going to die, but I imagine it happening years after I've retired, after I've tied up all the loose ends, and said farewell to my practice. What I don't want to think about is dying or being incapacitated in the middle of my life. So, I put off making a plan for such an event.

A professional will is similar to a personal will except that it focuses on your professional practice. It's a written document that spells out who will manage your professional affairs and how that person will carry out your wishes. The will needs to include not only what you want done, but how someone can obtain the information needed to perform those tasks.

There are several reasons that all psychologists should do this, particularly those in private practice: (1) most importantly, to ensure that clients will be adequately cared for if suddenly you become unavailable. This is part of our ethical obligation to do no harm. Most of us prepare patients for our upcoming vacations or other short-term absences. We should take at least as much care to prepare for an unplanned absence, whether temporary or permanent. (2) The other reason to make a professional will is to reduce the burden on our loved ones. If we ensure that one or more of our colleagues is prepared to handle our clinical and business matters, it means that there is one less thing for family and close friends to do. But preparing colleagues means more than giving them a key to your office and showing them where your files are kept. More and more information is being stored electronically; we need to make sure colleagues can access all of the information that they need to contact clients, tie up business matters, and provide continued access to records.

I want to make sure my clients are contacted quickly and given appropriate support, including referral information. I want to know that other clinicians in my practice can easily find our legal and financial information, both written and online. I want my family to know that colleagues are handling these issues and that there is little that they need to do.

So I've begun drafting my professional will. If you have put this off too, here is what psychologists should consider including in this document.

Designate a Professional Executor: Include the name and contact information for the person who will handle your professional affairs. Consider one or two back-ups in case the executor is not immediately available. All executors should be mental health professionals, and remember to talk to them before including their names.

Give Explicit Authority to the Executor: Include a statement that authorizes the executor to act on your behalf and to carry out the tasks listed in the will.

Include Contact Information for Partners and Consultants of your Practice: Complete and current contact information should be provided for all professionals who are involved in your practice, including business partners (if not executors); attorneys who handle legal matters for the practice, as well as those who handle your personal will; your accountant; your billing person, and your secretary or other clerical staff. The executor may need to contact these people for information or may delegate certain tasks to them.

Provide Contact Information for Current and Recent Clients: Keep an up-to-date client list with addresses, phone numbers, and emails. Be specific in the will about where this list is kept and how the executor can access it.

Describe the Method of Contacting Clients: State in detail how you want your clients to learn about your death or incapacity. For example, you may want current clients to hear directly from the executor or someone he/she designates (versus leaving a message on voicemail), but allow former clients to be contacted by letter. All clients need information about access to records, referrals to other therapists, and, if you want, details about a memorial service.

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Provide for Transfer and Maintenance of Client Files: Include specific information about the location of all client files, past and present, written and electronic. Include a plan for where the files will be transferred and who will be responsible for maintaining them. (This need not be the executor, but it should be another psychologist or someone who knows about the ethics and laws governing the release of information, maintenance of records, and proper destruction of obsolete files).

Enable Access to other Clinical and Business Information: The executor needs to know how to access all pertinent files. This includes the location of physical keys to your office, filing cabinets, and any other locked storage systems. It also includes the location of your computer(s), pertinent file names, user IDs, and passwords. Additionally, the executor will need to access your voicemail system to pick up messages and change the outgoing message, so include the necessary information. If the executor will be handling unfinished business matters, such as collecting unpaid bills and depositing checks, include all billing and banking information. Include how you want to handle unpaid bills (e.g., do you want the executor to collect out-of-pocket payments from clients?). You may include this information in the body of the will or specify where this information will be kept. In either case, review the file containing this information periodically to ensure that the information is still accurate.

Miscellaneous Matters: An executor may expend considerable effort to execute a will, so often compensation is provided for the executor's time. Be specific about how this should be handled (e.g. lump sum/ percentage of earnings/bank balance vs. hourly pay; and from which account payment should be drawn).

Sign and witness the document; consider getting it notarized. Keep a copy for yourself and make sure that all appropriate parties have a copy of the will: especially the executor(s) of your professional will and the executor and attorney of your personal will. Schedule time for a yearly review; update your will to reflect any recent changes.

If you haven't already prepared for the unthinkable, you may be ready to do so now. Hopefully this description makes the task less daunting. Below are some resources used in writing this article which contain additional information. Feel free to contact me with your questions regarding or experiences in creating a professional will.

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Based on such research and information, it seems helpful to incorporate the scientific advances in neuropsychology and the related discipline of brain-based therapy into our present treatment approaches. Brain mechanisms underlying anxiety are being studied, allowing treatment to be based on insights into what happens in anxious patients' brains. It is also helpful for clinical psychologists to be aware of the intersection between various independent traditions in science including neuroscience, genetics, psychotherapy research, and studies of the mind, in order to provide our patients with a clearer understanding of their diagnoses. Advances in imaging technology allow us to view the effects of psychotherapy on the brains of patients who are suffering before and after therapy. Although there are critics of the incorporation of neuoropsychology that suggest that psychotherapy will not survive as a branch of neurology, we should not be afraid of gaining a greater understanding of the processes of the brain in treating our patients. Since there is significant evidence that psychotherapy results in measurable neurodynamic changes in the brain, we can only gain a greater perspective in understanding our patients' distress and demonstrate to them that therapy can promote successful changes in their lives if we incorporate such knowledge.

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Marcy A. Shoemaker, Psy.D. is a licensed clinical psychologist in Pennsylvania. She has diversified experience treating anxiety disorders, depression, and women's issues that affect diversified populations, including children and adults. She presently is employed at the Abramson Center for Jewish Life in North Wales, PA where she provides therapy to geriatric patients and their families. Dr. Shoemaker's approach to therapy incorporates Cognitive Behavioral principles and theories. She can be contacted at marcyshoemaker@comcast.net. ■

Peer Consultation Groups

by Takako Suzuki, Ph.D.

Peer Consultation Groups are meeting now!

We are happy that PSCP peer consultation groups are meeting and going strong. Participating members are finding many benefits to being involved. They are finding that their clinical work and their work lives are improved by both the support and the skill enhancement gained through their involvement. They are finding themselves challenged intellectually and bolstered by the opportunity provided to reflect on their work, to challenge assumptions, and to gain perspective on best practices from professional peers. 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:

Addiction Peer Consultation Group :
The Addictions Group will resume, after a well-deserved summer break, on September 24, 2010, from 9 to 11. Our schedule has been the last Friday of the month, although we are open to re-negotiation based on the needs of our membership. Attendance is open to anyone with experience working in addictions treatment or with an interest in this population. Discussion is casual and wide-ranging. Feel free to attend and sample the process. The group meets at the Plymouth Meeting Office of the Caron Treatment Center, adjacent to the Blue Route, the PA Turnpike, and Germantown Pike: 450 Plymouth Road, # 301, Plymouth Meeting, PA 19462. For any questions or information, please contact: Mark Schenker, Ph.D. at 215-743-6417.

Adult Psychotherapy Group:
This group specializes in adult psychotherapy cases and meets in Center City. Meetings are monthly, on Thursdays, from 1-2:30pm. New members are welcome. To inquire, please contact Nancy Small at 267-679-8712 or email at nancy496@comcast.net.

Diversity Group:
This group meets regularly on Fridays from 10am-12pm at PCOM, 511 Roland Hall. The meeting schedule is set for 9/24, 10/29, 11/12, and 12/3/2010. The group discusses culturally sensitive/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 215-592-1333 or cariel@alternativechoices.com .

General Group:
Several Center City Psychologists have been meeting informally to listen, talk, and learn from each other. We would like to enlarge our group. We alternate the time and meeting place. Contact us by phone to find out when and where the next meeting will occur at 215-732-5687 or via email to one of us: Dr. Arlyn Miller: arlynm@juno.com or Dr. Nancy Small: nancy496@comcast.net.

For those who would like to host a group or would like a group listed, please contact Dr. Takako Suzuki at takakosu@pcom.edu or at 215-871-6435. Dr. Suzuki 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.

■

PSCP Remembers Julie O'Malley, Ph.D.

Dr. Sybil "Julie" O'Malley of Wyndmoor, Montgomery County, died at the age of 67 in a drowning accident in July. She had maintained a private practice in Chestnut Hill area of Philadelphia. Earlier she had been a counselor at the Child Study Institute at Bryn Mawr College, where she earned a Ph.D. in human development in 1988. She had also worked as a staff psychologist at the Washington Square Institute in New York. An active member of PSCP and HSC since 1998, Julie always had a warm smile, kind words, and time to help others. She will be greatly missed. ■

Human Services Center Update

by Lillian Goertzel, Ed.D.
President, HSC

Welcome back to HSC! We have an active Board with dynamic plans for this year. In an effort to strengthen our community outreach, we are revitalizing the Speakers' Bureau. Thank you to members who have offered to speak on psychological topics. Harris Stern, Ph.D., is heading our public relations and media efforts. We also plan to participate in two charity events: the Alzheimer's Walk in the fall and the NAMI (National Association for the Mentally Ill) Walk in the spring. These walks embody the value we hold as professionals of contributing to the community, while also providing opportunities for members and students to become better acquainted. Susan Thornton continues to contact students and faculty who may benefit from HSC and PSCP. If you know professors who would be supportive contacts, please contact Susan or myself. HSC and Susan plan to focus more intensely this year on programming for early career psychologists. Carol Gantman, Ph.D. and Julie Levitt, Ph.D. are developing projects to help refugees which will be detailed in a future newsletter. I am continuing work with client services to provide mentors and therapy for both graduate students and the public. We have been working diligently over the summer and hope that you will continue to support our efforts to make all of our plans successful. We wish to send out additional and special thanks to Gail Karafin, Ed.D. for her comprehensive minutes, as well as updates on issues facing school psychologists, to Naomi Reiskind, Ph.D. for her dedicated assistance with financial information, to Dea Silbertrust, Ph.D. for her legal expertise and much more, and to both Andy D'Amico, Ph.D. for his presence and support of HSC, and to Andy Offenbecher, Ph.D. as past president of HSC for his ongoing support. Our next HSC meeting is scheduled for Sunday, Sept 26 at 10am in the PSCP office in Jenkintown and is open to all members. ■

Join us for a "Mew Member Welcome to PSCP" Open House on October 24th from 2-4 PM

Hosted by Membership Chair, Christine Waanders and Ivan Haskell, this will be an opportunity to network, enjoy light refreshments and great conversation! RSVP by October 18th by emailing PSCP Office at sandi.greenwald@philadelphiapsychology.org or calling the office at 215-885-2562. Details available through PSCP Office. **ALL MEMBERS WELCOME!**

Never Retire!

by Marcy A. Shoemaker, Psy.D.

We spend our careers waiting for the golden day when we can retire. Unfortunately, most people don't find a perfect utopia in retirement; what often seems to be experienced instead is a life without meaning and purpose. When I suggest that we not retire, it doesn't mean collecting a paycheck for the remainder of one's life. But when one speaks to seniors on a daily basis, the common complaint expressed is that they "don't have a reason to get up in the morning" or that they "are bored." Everyday seems the same and eventually one forgets the day, date, and month. Memories seem to weaken and depression often occurs.

Is there an answer to the retirement dilemma? It is helpful to examine successful seniors to understand why their retirement years are prosperous. In some cultures, known as "Blue Zones," people are reported to live into their hundreds. Such areas include Sardinia and Loma Linda, California. This is due to exercise and nutritional choices, as well as to inclusion in family and societal life. Doing something meaningful and worthwhile during the retirement years has been identified by centurions in the Blue Zones as one of their secrets to longevity and health. This statement has been shared repeatedly by seniors in nursing homes. They do not necessarily live lives without stress, but have a reason(s) to get up each morning that make them feel necessary in the world. One group of seniors makes hats for children who are ill. Another group meets with school children to share life lessons. Some have learned new hobbies, including bridge and computers. Other seniors have embraced previously enjoyed hobbies, such as reading, singing in choirs, and volunteering in hospitals, businesses and schools.

One disturbing definition of the word "retire" is "to go away, retreat, or withdraw to a private shelter or secluded place." Based on the discussion above, this is the last advice that a psychologist should give a geriatric client. Today, I saw a colleague wearing a button which read, "Retired." I could not think of this vital woman retreating or going away to a secluded place. She had too much to offer the world. Of course, she also had the right to stop working at the same task and to start anew. Possibly it is time to retire the word "retire" and wear buttons that read "Reborn" instead. ■

Health Care and Ethics: Changing Times

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

In my last newsletter article, I described revisions to the APA Code of Ethics and possible ramifications for psychologists. Here, I will further consider the impact of the revisions. In addition, I will look at recent national health care legislation, especially focusing on 2010 health care reform law and on the possible ways that it may affect the practice of psychologists.

Ramifications of the revised APA Ethics Code:

Let me start with ethics and the revisions of the 2002 Code of Ethics. To briefly review:

The changes in the Introductory and Applicability section, in addition to Standards 1.02 and 1.03 are printed below in bold italics. The previous (2002) wording that was removed is shown in parentheses.

Revised Introductory and Applicability section

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner (If the conflict is irresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing authority) ***in keeping with basic principles of human rights.***

Revised Ethical Standard 1.02: Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists ***clarify the nature of the conflict***, make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict ***consistent with the General Principles and Ethical Standards of the Ethics Code***. (If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.) ***Under no circumstances may this standard be used to justify or defend violating human rights.***

Revised Standard 1.03: Conflicts Between Ethics and Organizational Demands

If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and (to the extent feasible, resolve the conflict in a way that permits adherence to the Ethics Code.) ***take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.***

Regarding Standard 1.02: if the standard of conduct is higher in the Ethics Code than in the law, psychologists are expected to conform to the Code. Conflict in 1.02 refers to mutually exclusive obligations, such as when the psychologist's legal obligations will require violating ethical obligations, or the reverse, namely in situations in which one cannot adhere to both law and Code simultaneously. Such clashes are rare and when they occur, they are more likely related to working for an institution or a government than to private practice. Private practitioners are not going to be affected by disclosures of information, as Ethical Standard 4.05 (see the footnote below) addresses most such concerns, according to Stephen Behnke, J.D., Ph.D., Director of Ethics, APA in discussion with me on 9/13/10. He pointed out that the revisions of the Code were prompted by and related to the circumstances of Bush-era harsh interrogation of so-called enemy combatants who were not formally charged, but who had been incarcerated in sites such as Guantanamo. Dr. Behnke cautioned that the context that prompted the change in the Code is the one most germane to Code revisions.

It is still unclear how situations in institutions and governmental departments will be affected by the now unequivocal language that the Code cannot be used to justify conduct in which human rights are violated. In previous articles, I have raised questions about the kinds of services that may increase vulnerability for psychologists, such as (1) treating death row inmates to alleviate psychosis in preparation for execution and (2) in hospital and nursing home situations in which institutional regulations regarding the treatment of patients could be construed as human rights violations. Dr. Behnke emphasized that the amendments to the Ethics Code would not affect roles in which psychologists have served ethically, such as the termination of parental rights or determining competence in forensic settings and institutions. Rather, he explained, the amendments address situations in which the Ethics Code may be used as a defense to charges of unethical behavior. Another unclear area is how the Code will hold up in

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court in situations in which psychologists seek restitution for lost pay after refusing to follow orders and/or resigning rather than violate the Code's human rights provision. In time, case law will be developed and the interplay between the revised code and the law will become clearer.

Changes in Health Care Legislation and impact on psychologists in practice:

In the last few years, Congress has passed health care laws that may have profound effects on psychologists' practice. Psychologists may be affected by health care parity, cuts in Medicare reimbursement (that have temporarily been halted), and in this year's comprehensive health care reform bill (passed in 2010).

There have been various predictions about how psychologists will be affected. Some argue that recent legislation will increase public access to needed mental health services because of parity, increased benefits and lessened deductibles and co-payments. In contrast, others note that changes regarding the health care reform bill will not be phased in until 2014, and between now and then Congress may water down the law. Critics also point out that with large federal deficits, reimbursement for Medicare may not return to the higher rates of the 1990s and, in fact, today's lower rates may decrease. The problem with lower Medicare rates is that Medicare is the standard for private reimbursers of service, or to coin an older slogan, as Medicare goes, so goes the country. An additional caveat is that mental health parity only exists for employers with 50 or more employees. Small businesses will not be required to offer the same kinds of benefits for mental health service as they do for physical health care. And of course, small employers are exempt from having to consider diagnoses and also from the requirement for equality in non-quantitative parts of treatment, raising questions about how managed care oversight may continue to play a prominent part in regulating reimbursement.

Samuel Knapp, Ed.D., Public Affairs Officer of the Pennsylvania Psychological Association (PPA), believes that mental health parity can be expected to increase utilization in Pennsylvania by about 10% and that the coverage of the uninsured will add another 8% to those having access to mental health services. He points out that Pennsylvania's percentage of uninsured (8%) is among the lowest in the country. He cautions, however, that the possible increase in populations served needs to be considered in the context of high unemployment (which lessens usage) and the pressures to reduce Medicare reimbursement (also related to an economically depressed economy) that may limit access because psychologists either are blocked from performing some of their clinical services and/or choose to no longer be Medicare Providers (Samuel Knapp, unpublished paper, shared 8/25/10).

It is also uncertain whether psychologist reimbursement will further decline when new provisions, under prevention services, are added. Dr. Knapp wonders if the added programs will simply be "window dressing quality programs that only increase administrative burdens on providers with no demonstrable impact on patient care." In addition, Dr. Knapp notes that, as one Medicare spending cut is averted, another potential cut surfaces that requires attention. Health care and economic uncertainty are parts of big political movements. The outcomes, at this point, for both service and reimbursement are unclear.

Doug Walter, a legislative and regulatory counsel for the APA Practice Organization, talked with me on 9/9/10 about the implications of the recent health care legislation. He explained that while the passage of health care reform legislation is a great win for psychology, the main current focus of his office is to maintain Medicare payment rates, because, as indicated by Dr. Knapp as well, Medicare rates set the reimbursement rates of private insurers. In addition, Mr. Walter stressed that his office is concerned with ensuring that psychologists within Medicare can provide all the services within their licensing statute and that mental health services are fully integrated into Medicare.

Regarding national Health Care Reform Legislation, Mr. Walter stressed that since the legislation was so broad, the Practice Organization has had to focus advocacy efforts on provisions in the bill with the greatest impact for practicing psychologists. In addition, because Congress has five years to implement the new Health Care Reform legislation, one must keep in mind that many changes may occur in the body of the health care law, especially if the November midterm elections change the ratio of the major political parties in each house.

Mr. Walter furthermore expressed skepticism about how much of the new law can be carried out in these difficult economic times. As an example, he pointed to the various mandates for integrated care in the new law, many of which need to be annually funded. In order to further this development, exploratory and demonstrated programs need to be further investigated in order to provide models of care. Funding for such research simply may not be possible.

Mr. Walter went on to look at other possible difficulties to delineating good service models. States will have to implement "Exchanges" based on the Massachusetts Model, which has been in existence for only two years. The idea behind Exchanges is to develop market places in which health care insurance providers compete on equal terms for clients, with clients defined as persons without employer-provided health care coverage.

To clarify this, families with annual incomes ranging between $30,000 and $88,000 (four times the national poverty rate) will be eligible for federal insurance premium subsidies; families with annual incomes under $30,000 will be eligible for Medicaid. The law further requires that states create Small Business Health Options Programs ("SHOP exchanges") that will help qualified small business employers to enroll in qualified health care

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business employers to enroll in qualified health care plans offered for the small group market in that state. Definitions of which employers and health plans will qualify are to be developed as part of the regulatory process. It is unclear how the process is actually going to work (Bill Leonard, *Health Care Exchanges Will Alter Competition and Choice*, Society for Human Resource Management, 3/12/2010).

As a positive development, the health reform law will require plans in the Exchange to provide parity coverage for mental health and substance abuse services. This is an add-on to the 2008 Mental Health Parity Law that requires such coverage for health plans with more than 50 employees. The 2008 Parity Law is currently in the implementation process.

Mr. Walter mentions that the new law provides for *new* fundamental protections, such as the deletion of lifetime limits on reimbursement, preventive services at no cost to consumers (which may or may not cut into mental health reimbursement, according to Dr. Knapp), extension within family insurance plans to cover older children, and prohibition of discrimination in coverage for people who apply (based on previous health status, current medical conditions, other evidence of insurability, etc.).

Psychologists have become sophisticated in finding new ways to package their services while maintaining high quality.

The implications of recent health care legislation for practicing psychologists are not yet known. Health Psychology may become a much more needed service and might be an area for more psychologists to pursue, particularly with regards to helping clients acquire skills to prevent health problems. Diversifying psychology practices to cover larger scopes of service, in opposition to greater specialization in niche markets, may also bring in greater numbers of clients over the next five-to-ten years. The trend for shorter number of sessions with use of evidence-based practice models may continue, as well as the integration of physical health medical practices with psychological evaluation and brief treatment. Boutique practices should continue to be viable because there will always be clients who can afford mental health services outside of the insurance system. Psychologists have become sophisticated in finding new ways to package their services while maintaining high quality. I suspect that good psychological services will continue to be desired by faith-based communities, individuals and families who want to maintain privacy by working outside of the reimbursement systems, research-based programs in which expert clinicians follow identification and treatment protocols, and public policy (local and national) institutes and governments. It may also be time to consider why we choose to be psychologists and whether we are more guided by the dollar or by our values and morals. After all, there are still great ways to bring together psychology and public service, public policy reforms, and other areas that are concerned with the public good.

Please consider joining our public policy committee. For questions or comments please email me at julie.levitt@verizon.net. My thanks to Drs. Behnke and Knapp, as well as Mr. Walter, for their assistance with this article.

Footnote regarding APA Code of Standard 4.05: **4.05 Disclosures**
(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. (See also Standard 6.04e, Fees and Financial Arrangements). ■

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feedback that they offer to be unwelcome. In many cases, such colleagues may feel or be powerless to address the situation adequately. APA and other organizations that both serve and regulate mental health professionals have recognized this problem, yet better protocols must be developed to address it. It would be heartening if such procedures could become yet another dimension of Albert Ellis' vast legacy.

This is the short "abstract" version of my article: "The Final Years of Dr. Albert Ellis and the Lessons for All of Us." For the complete article, that contains a detailed discussion of many more of the extraordinary and often shocking aspects of this situation about which I am still frequently asked, please go to http://drmichaelbroder.com/articles/albert_ellis.htm.

Michael S. Broder, Ph.D. is a psychologist, author, CE seminar leader and former PSCP board member. He is president of Media Psychology Associates and a past president of APA Division 46. ■

Historical Forces Impacting Practice with Adolescents

by Vivian Center Seltzer, Ph.D.

Many factors impinge upon success in treating adolescents. Among them are: who or what influences adolescents? Does this influence come from individuals or groups? Are they few or many? Certain sources of influence are understandable: parents, family members, and friends of similar ages. Others are not very obvious; some are hidden. Who do adolescents admire or seek out? Does the literature enlighten us? This article goes back more than half a century to examine varied historical and contemporary insights as background in understanding the beginnings of a new model for diagnosis and therapy.

A New Conceptualization of Adolescence

A new dawn broke nearly 50 years ago with James Coleman's publication of *The Adolescent Society* (1961). It heralded a new way to think about adolescence and adolescents. Coleman suggested that psychological development from childhood to adulthood was no longer direct. He argued that it involved becoming part of a new postwar social phenomenon that was not yet completely understood. Coleman further argued that adolescents were members of a greater society of same age peers with its own values, habits and goals. They had become members of a new society – an adolescent society – obvious and powerful. To many, Coleman's conceptualization appeared viable given the upheaval accompanying the transformative 1960s movement. Some of the sociological literature attributed unknown and strange adolescent behaviors, and possibly even mental illnesses, to unsteady adolescents who had been psychologically abdicated by parents set on fulfilling their own needs (Friedenberg, 1959). Later in the decade when Bandura (1964) added his description of the prevailing social structure as a split level society – one for children of all ages and one for parents – Coleman's depiction of a growing and increasingly powerful age-mate phenomenon seemed even more incisive. This new option challenged the field of psychology to pay greater attention to interactionism as a mid-point between psychoanalytic and behavioral conceptualizations, and a growing third force championing the interaction of nature and nurture. Allegiance to just one formulation began to wane.

Former Models of Adolescence Revisited

Coleman (1961) was not the first to highlight the significance of peers in psycho-emotional behavior and maturation. We all are familiar with Erikson's contributions and recognize their brilliance. His seminal article on adolescent identity and his theoretical elaborations (1956, 1959, 1963) on the adolescent search for identity remain influential. He described the function of a peer group as a safe place to try out varying aspects of identity, offering a refuge from unconscious libidinous conflict, as well as access to same-age peers upon whom to project libidinous desires. Some years prior, Ausubel (1954) contributed a complementary image of the peer group describing it as an "island away" where adolescents could psychologically "de-sattelize" and eventually "re-satellize." These well respected theorists each testified to power lessening at home and transferring to groups of peers. New and separate adolescent norms and mores were forming. The considerable time that adolescents were spending together, thinking about and debating serious present and future concerns, added to their sense of competency about managing their age-related society. They pursued new non-adult authority and new freedoms. The power of their numbers and of their ideas increased the psychological distance between adolescents and all adults, not just their own parents.

Changes in the Family

This adolescent initiative for new rights and responsibilities was followed some ten years later by a crusader for a different group in American society. Betty Friedan offered her argument for equality for women in *The Feminine Mystique* (1963). Her book not only identified goals for women's independence and opportunity, it was also a bid for power. Although Coleman described potent social change among youth, his book was not a bid for political or social power. Friedan, on the other hand, sought to begin a political movement in service of a socioeconomic goal: equal opportunity for women in the workplace and in society. Yet, these ideas were not altogether new. World War II had resulted in a number of unexpected consequences. For example, the production needs required to support the military during World War II abruptly altered the role of many women; they went from housewives to workers. Since men were overseas or training in army camps to go to war, women (including young mothers) replaced them in the workplace. Childcare was handled by older siblings, friends, neighbors, daycares, or available grandparents. Inherent in these changes were contradictions to long-held perceptions of family. Due to such changes, the structure of the family was altered. Despite this, the psychology literature of the 1950s did not reflect this change but rather loyally sustained the "family dream." This was apparent in the new field of social learning theory, with its family model of father, mother, daughter, and son, in which the father carried economic and regulatory duties (i.e., instrumental tasks) and the mother was responsible for social-emotional tasks (Sears, 1957). While a number of psychologists remained faithful to the Freudian adolescent rebellion model, it was beginning to be diluted by the rumbles of change in social thought and practice.

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Social Psychology's Secret Beginnings: Notions of Group Dynamics

Social psychology gained momentum in the early 1950s, although its beginnings had its origins a decade earlier. Now familiar concepts such as power, leadership, and conformity were developed in the early to mid 1940s by military officers preparing for enemy occupation. US trained intelligence officers who were in charge of occupying forces needed training in effective psychological strategies with which to handle hostile and frightened groups of conquered people. A small group of talented officers was selected to develop written materials to distribute to intelligence officers. Kurt Lewin, the man who eventually would earn the title of "father of group dynamics" was selected to lead this effort. This scholarship, including fascinating experiments, led to formulation of basic concepts in group dynamics theory such as norms, mores, conformity, social power, types of leadership, etc. When the war ended, a number of men from this elite intelligence corps became academics; some of them founded the field of social psychology of which group dynamics was a part.

Adolescent Influence Sources: Expanding from Dichotomy to Multiplicity

Several decades after social psychology's entrance on the academic scene, a review of the adolescent developmental literature still revealed only two adolescent influence sources – parents and peers. Because this seemed like a limited dichotomy, the current author developed an exploratory study using the Adolescent Reference Group Index (ARGI) to examine which reference groups 11th grade adolescents consulted regarding a variety of different issues (e.g., "what movie to see" and "should there be capital punishment"). Of the 14 possible reference groups, parents were included, as well as five different peer groups. Respondents identified which reference groups they perceived would be helpful in making decisions with respect to each issue. Findings revealed that neither parents nor peers were selected for all issues. Instead, different reference groups were chosen depending on the issue, and the percentage of influence per group varied per issue. This suggested that adolescents were seeking information from a variety of sources (Seltzer, 1980). It seemed that the scope of adolescent reference fields had been underestimated. Moreover, the comprehensiveness of the adolescents' response patterns indicated that each respondent could consider the possible influence and benefits of consulting members of various reference groups, only then selecting which groups would be most effective to consult. To be able to possess sufficient cognitive growth to hold so many variables in mind at the same time, these adolescents had to be capable of abstract reasoning (Piaget, 1932; Inhelder and Piaget, 1958). This further suggested that properly structured questionnaires could be used for cognitive assessments of such skills.

Because adolescents are often seen congregating in large groups, it is natural to wonder whether peers, particularly large peer gatherings, play a part in adolescent psychological maturation. Although this is reminiscent of the perspectives of Erikson and Coleman, alternative theories from the social psychology literature are also informative, such as Leon Festinger's theory of social communication, theory of social comparison, and theory of cognitive dissonance (1950, 1954, and 1957). In particular, Festinger considers how each of us tends to search for similarity in others in order to find reassurance in being like others. This similarity reduces anxiety about oneself or "frameworklessness" (Seltzer, 1982, 1989). Elaborating on Festinger's notion of social comparison, Stanley Schacter (1959), one of Festinger's students, examined what adults do in threatening situations. He found that adults tend to consider the behavior of other anxious individuals in order to determine whether they are themselves doing the right thing. A similar response by others relieves anxiety which accompanies one's own uncertainty. Connecting social psychological concepts to adolescent behaviors opens a new lens to understanding adolescents. Moreover, the current author's cross-national research has further validated the idea that adolescents' comparisons of their own acts to those of groups of peers foster their psychological growth (Seltzer 2004, 2009).

Conclusions

This article examined alternate sources in the literature regarding the developmental aspect of adolescents in groups – whether one labels this an "adolescent society" or a "peer arena." The discussion was intended to highlight the functional, development-oriented nature of adolescent group activity, bringing attention to the complex, multilayered, and simultaneously internal and external nature of such activity.

Integrating the many relevant theories and research findings explored above yields new insights into adolescent dynamics and the maturation process involved in identity formation. Such integration also produces a picture of internal and social growth that develops as a result of both nature and nurture.

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Vivian Center Seltzer, Ph.D. is Professor of Human Development and Behavior at the University of Pennsylvania and has a part-time private practice. She has written three books. Her book Peer Impact Diagnosis and Therapy: A Handbook for Successful Practice with Adolescents *(2009) contains examples of problems, thirty protocols to be used as a guide in interviewing, as well as discussions of diagnosis and treatment, particularly with respect to a new method of adolescent-led group therapy called* Peer Arena Lens (PAL) Group Therapy. *During her years of very active service to PSCP, she developed the HSC recognition of service ladder towards the Fellow of PSCP designation that is still in use today. More information on her theory and therapy are included in a second article in this newsletter.* ■

Toward an Integrative Model of Mental Health

by Michael K. Montanaro, Ph.D.

As a clinician who began the practice of psychotherapy in 1977, it is impossible to not be astounded by the changes that have occurred within our profession since that not-so-long-ago time. My earliest experiences in community mental health were shaped by the professional tension between those who were firmly embedded in traditional psychoanalytic theories and practices and those who eschewed the dreaded "medical model." Frequent and vigorous debates would occur in case conferences as psychology and psychiatry struggled to manage the growing diversity of opinion about diagnosis and treatment. As a young psychotherapist, I felt there was much to be learned from both sides. A few years later, as a doctoral student, I learned about "systems" approaches. This required further adjustments in order to be able to accommodate and synthesize disparate ideas and concepts that appeared to be in conflict, yet somehow seemed to all hold important parts of the "truth."

Over the past several decades, yet another dramatic development has occurred. Both in the general public and the healthcare professions themselves, there is a growing awareness of the limitations of traditional Western healthcare. Words and concepts such as "holistic," "mind-body" and "alternative therapy" have become a part of our everyday dialogue. A wide array of techniques, ancient practices and "new age" approaches has emerged into a new and exciting, though frequently confusing, area of healthcare. Not wishing to be only free of disease, the goal of many people is "wellness" or "optimal health."

At the same time, many of these same people frequently report that their lives are under tremendous, unrelenting stress, and they feel helpless to create a balanced and

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The Final Years of Dr. Albert Ellis and the Lessons for All of Us

by Michael S. Broder, Ph.D.

Dr. Albert Ellis famously and often boasted that he would die in the saddle at age 110 – right in the middle of a normal workday – preferably while teaching his beloved REBT theory and techniques to yet another fresh group of eager students. Although doing the hard work necessary to reach one difficult goal after another was his specialty, this final "goal" would elude him. He died peacefully of natural causes while at home at age 93 on July 24, 2007. He had suffered from a serious and prolonged illness that caused him to spend his last 4 years bedridden most of the time, with private, nursing care twenty-four hours a day. In fact, the majority of his last year was spent in the hospital or at a nursing home. Most people would see that as a rather ordinary end to an extraordinary, long, and profoundly distinguished life. But there was nothing ordinary about Al (as he preferred everyone to call him). Furthermore, I believe he would have been the first person to tell you that his medical issues were not even close to being what bothered him most at the end of his life. What haunted him more was that, for his last two years, he was not permitted to continue doing much of the work he loved at the Institute he had founded.

As executive director of the Albert Ellis Institute (AEI) at the time, it was ultimately my job to sign off on his work restrictions. However, I did not make the decision lightly or alone. It was made in consultation with and by the consensus of those whom Al had selected to oversee AEI and the quality of its professional services. We painfully determined that Al was no longer able to perform to the minimum standards that that he himself had championed for AEI professionals. To use our attorney's metaphor, we had the same obligations that a hospital would have if it had on its staff a "surgeon with shaky hands." Another metaphor for the actions we had to take is the one of being in the painful role of having to take the car keys away from an aging parent who still believes that he/she can drive as safely as always. This is analogous to what my AEI colleagues and I had to do in order to protect the public and the long-standing reputation of Al and Al's beloved Institute. It was the last thing any of us would have ever wanted to do. However, our entire senior clinical staff along with a majority of AEI's Board, as well as many other professionals who had been AEI staff or consultants for as long as 50 years, agreed.

Al ferociously opposed the decision, and, from that point on, considered all of us who participated in making the decision to be his "enemies." High profile lawsuits were filed, which have since been settled amicably. Some of his supporters who did not know and/or care about the well-documented facts, as well as the implications of Al's condition, mounted a vicious and intensely deceitful campaign in the New York media, in some professional publications, and on the Internet, trying to brand many of us as "villains" in this bizarre saga. Al died denouncing the internationally acclaimed training Institute that he had spent his life building, along with many of those he had selected to serve it. To most of us involved, that is saddest part of this story.

However, Albert Ellis's decline triggers an issue that speaks to us all. More and more mental health professionals are aging, coming to the stage of life where they could potentially face retirement dilemmas and other situations similar to those of Al's in his final years. Many colleagues may find themselves in positions similar to mine and the other AEI board members if well-considered plans for "phasing out," that include strategies for succession and the determination of competence, have not been carefully developed. These are extremely delicate and difficult decisions. Everyone in our field must consider this for our colleagues and for ourselves as we age. The irony was that until very close to his death, Al could – at times – perform nearly as well as always; unfortunately, at other times, he simply could not and refused to hear feedback, even from those with whom he had worked and whom he had trusted for decades. We could not find a mutually agreeable way to have him independently evaluated. Since this is another potentially serious concern as we age, it may be wise to have in place a living will, clarifying all of the relevant issues that can be triggered, if needed.

Most of us would agree that practicing competently a mere 30, 40 or 50% of the time is not enough. The "surgeon with shaky hands" cannot be left in a position to do harm no matter how much he loves to perform operations or how much his patients love him. Obviously, regardless of a professional's specialty, nobody deserves to be the recipient of services during those times when a professional is not up to the minimum standards of practice. Colleagues who try to help impaired professionals may recognize a fellow professional's blind spots and difficulties, but may also find the feedback that they offer to be unwelcome. In many cases, such colleagues may feel or be powerless to address the situation

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Adapted From
"Navigating the Peer Arena"

by Samuel Hughes

"It's an imperative to be together – a growth-related imperative. And when adolescents are together, this whole big process goes into subliminal action. There's a force that becomes ignited. That force is psychological growth, and it's ignited by the electricity of the comparison behavior that goes on between them." – Dr. Vivian Seltzer

Dr. Seltzer has been studying adolescents, crafting a unique and cogent view of them buttressed with research and clinical observation. At the heart of her work is the theory of Dynamic Functional Interaction (DFI) which spotlights the central role of adolescent peer groups as a Peer Arena, and the impact of that arena on adolescent psychosocial development. She has written three books on the subject, the most recent and accessible of which is last year's *Peer-Impact Diagnosis and Therapy: A Handbook for Successful Practice with Adolescents* (2009). It serves as a detailed guidebook and contour map to adolescents and their precarious habitat, the Peer Arena.

Dynamic Functional Interaction (DFI)

The DFI theory takes up where developmental psychologist Erik Erikson and social psychologist Leon Festinger left off, roughly half a century ago. For some of those in the field, what sets DFI apart and makes it fresh is the quality of the synthesis, the thought behind the organizational framework, and the amount of research, not just on American adolescents but in places as far-flung as Costa Rica, Scotland, and the Philippines, South Africa and Malaysia. Dr. Seltzer's book, *Peer-Impact Diagnosis and Therapy* (2009), also offers an exhaustive list of protocols for practitioners, including a step-by-step approach to the group-therapy treatment that she developed called the Peer Arena Lens (PAL). Unlike the prevailing view of adolescents individuating by rebelling against parents, the DFI model posits that the "core of adolescent behavior" is created by "responses to psychological interactions with peers," in Dr. Seltzer's words. "Comparison dynamics, as adolescents assess and evaluate themselves in relation to their age-mates in order eventually to settle on the self they wish to have, forge the axis of the adolescent wheel." The functional part (and name) of the theory comes from her conviction that all gatherings are at a deep, evolutionary level, and thus functional. "They're not just for fun and games, though they may appear so," she says. "And they're not to escape from all the libido that's going around. They have a developmental reason."

The setting for this development is the Peer Arena, which encompasses all of an adolescent's peer groups, real and virtual. Dr. Seltzer's research discloses that school and neighborhood friends constitute a large part of that arena, but not all of it (especially with the explosive growth of texting, Facebook, and other virtual media). Furthermore, not all peers are created equal, especially in the later stages of adolescence, and not all types of peers have the same impact.

"The relationship in adolescence between kids is not friendship," says Dr. Seltzer. "It is peership, because it is growth-dominated. Parents want to teach kids about friendship and loyalty. But it's not a time for loyalty. It's a time for growth. Adolescents reach out for what they need. When they've gotten enough in a close friendship with one kid, they're going to drop that kid. And it's not because they're a dirty rotten kid. Kids drop one another and on a deep structure level, it is understood." This is a condition of "functional reciprocity." During this period, at one time or another, adolescents all drop and add relationships. The growth process requires "lots of inventory" as Dr. Seltzer puts it, and there are many different kinds of comparative acts utilized in the Peer Arenas (e.g., Upward, Downward, Similar Other, Range Establishment) with different functions and goals. She likens the accumulation of peer interactions to a library filled with reference materials and internet access, all of which provide mountains of data to ponder. "They do hundreds of comparisons daily, mostly subliminal, and they have a score for themselves on each as well as an overall score," she says. "'Am I better than—?' 'Was I worse than—?' 'Who's on my level?' 'How does that feel?' 'How does it go over with the crowd?'"

Glitches in Development

Dr. Seltzer explains, "When one doesn't score very well as they assess and evaluate their comparison findings, it's pretty hard. Nobody likes to really feel bad, so they psychologically run away. They defend themselves against the pain of what they're experiencing." The responses to pain take the form of what Dr. Seltzer terms defensive glitches.

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"Glitches are really another word for what people call deviance or even pathology" says Dr. Seltzer. "I like glitch because it's reversible." Dr. William Fullard, professor of psychology at Temple University, appreciates the elasticity of that diagnosis. "As you know, we are a society that is very much concerned with pathology," says Dr. Fullard, whose areas of expertise include adolescent development. "Dr. Seltzer sees these glitches not as pathologies, but as adaptations, giving kids a chance to undo things, and that this can be simply part of the normal developmental process." Dr. Seltzer also believes that it is essential to assess the degree of glitch gravity.

While most "glitch adolescents" soldier on, suffering the slings and arrows of outrageous comparisons, many find ways to avoid peer gatherings altogether by skipping school, staying there but checking out psychologically, or taking on destructive, defensive behaviors. Dr. Seltzer has compiled seven categories of glitches encompassing 13 specific types, ranging from Isolated Game-Player Loner, to Veiled Mission-Dedicated, to the more graspable False Façade. While such defensive responses may temporarily ease the pain, they can also bring the adolescent's development to a grinding halt or at least slow it down, depending on how early or at what point and in what manner they "took flight." As Dr. Seltzer notes in her 1989 book, *The Psychosocial Worlds of the Adolescent,* rejection from the group "means reduced access to the raw materials of development." Dr. Seltzer has a number of detailed case studies in *Peer-Impact Diagnosis and Therapy*. The book also offers insights and tips gleaned from her private practice to help practitioners understand and treat their adolescent patients.

Examples from other Professionals

Dr. Leslie Stein, a clinical psychologist with a practice in the Philadelphia suburbs, recalls a girl she treated with a "major glitch." "She was school-phobic, and she was avoiding the Peer Arena altogether because of her discomfort within it," says Dr. Stein. "She was terrified to immerse herself in any arena with peers because of her tremendous feelings of self-consciousness. She became obsessed with how embarrassing it would be to throw up, and so she had to withdraw completely. Our primary work together was in getting her back into school and talking through her fears of humiliation, embarrassment, shame, etc., and slowly having the Peer Arena available to her, so she could see that she was not so different from kids her age. I remember thinking that this was a defensive glitch, and how we needed to get her back to the arena to pick up on the work that had not been done."

Peter Capper, director of student support at the Crefeld School in Philadelphia, is a "longstanding systemic therapist" who has been "immersed in the viscera of adolescent communities," to use his pungent phrasing. He doesn't have to think very long to come up with an example of a "glitch adolescent." "I worked very closely with a False Façade kid," he says. "He was an only child, with a lot of difficulty being connected to other kids, quite isolated, and acting like a pseudo adult. He seems to be resolving that now, and is becoming more social and more rebellious with his parents, with whom he had previously been very compliant and fused." Apart from Dr. Seltzer's work, "there's not very much theory that guides us on how to respond to the constant comparisons and evaluations by other kids, and how traumatic that is," Capper adds. "There is something very refreshing about having a framework regarding how to make sense of the tremendous hyperactivity of teenagers' relationships and the whole kind of feverish interaction that goes on between kids."

Like social psychologist Kurt Lewin, whose work she admires, Dr. Seltzer believes strongly in the continuous feedback loop between theory and research and practice. "I was working out the theory all these years before I was ready to put it into practice mode," she says. "I put the theory out, did all the research, then all the cross cultural work. I had to do it. If I was going to take on the family-centric psychiatric world we're all in, I had to have good evidence."

Frameworklessness

There are two distinct stages of growth within the DFI model (though each adolescent develops according to an internal schedule). Early adolescence is marked by a sense of "frameworklessness," owing to the growing psychological distance from parents. "When that hits, your previous view – which is like the frame of a picture – disintegrates, says Dr. Seltzer. It's not a conscious thing. It's something you know because you're looking for answers, and you're looking for new things, and your peers are very important. You're wafting around in the wind. But you want something to hang onto. So you look to others to find others most similar to yourself to see what they are doing, or how they are feeling. Who are most similar? Their peers. So they begin to cling to each other because it's a port in the stormy seas," she continues. "That's why they are so important to one another, in seventh and eighth grades. The teachers seem unimportant, as is the subject matter, because they have to find where they are in relation to other kids." While DFI Stage 1 involves interacting with large numbers of peers, who offer a "supermarket of characteristics, talents, attitudes, and opinions to select and try out," Stage 2, four or five years later, requires far fewer peers, since many were already eliminated by the end of Stage 1. The simplest way to

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describe the two stages is that the first addresses the question "What can I be?" while Stage 2 deals with "What will I be?" There's a good deal more to it than that, of course, including the achievement of abstract thinking. "If they can't abstract," says Dr. Seltzer, "then they're still in the first stage."

Dr. Seltzer has data drawn from 4,000 Penn students, as well as 6,000 protocols from adolescents around the globe, including minority and gay adolescents. "The statistically significant global findings supported my prior U.S. findings on adolescent peer comparison dynamics," she recalls, "and provided the confidence of a more comprehensive lens with which to write my book introducing a model for practice with adolescents." Of the number of interviews and the number of protocols Dr. Seltzer has pursued in this country and all over the world, Dr. Fullard admires this "very distinct departure. Most of our developmental literature is based on Western, home-reared children or Western college students" and that "most of the social-psychology literature has to do with adults." Dr. Fullard acknowledges that "Dr. Seltzer felt that some of the broader concepts in Festinger's work could be applied to adolescents. They also needed to be taken in the context of three or four very broad categories that adolescents go through – physical, social, emotional, and cognitive development" because if "you don't look at all of these things in combination, you really can't understand what's going on. Dr. Seltzer says that she aims to look "at adolescence through the eyes of an adolescent," rather than through the eyes of an adult.

A Serendipitous Change in Direction

Dr. Seltzer credits a talk by Jean Piaget, the Swiss psychologist and seminal theorist of cognitive development with stimulating her to understand how thought develops and how the way that you can think at one age is different than the way you can think at another age. She has wondered, "How can you treat behavior if you don't understand development? How can you treat children if you don't understand how they grow, and how their thinking is so different at one age than at another?" Reflections on her own adolescence, as well as on the prevalence and reasons for crowds of adolescents, stimulated her dissertation research on comparison behavior. She was also heavily influenced by Leon Festinger whose social comparison theory argues that people evaluate themselves and their beliefs by comparing themselves to others. But Dr. Seltzer suspected that the dynamics of adolescents' comparative acts were different, since they serve as the very establishment of self. She says that the birth of the theory of Dynamic Functional Interaction was in her taking concepts from the two fields of adolescent psychology and of social psychology and blending them into a theory of adolescence, adolescent development and its relationship to observed behavior.

References

Seltzer, V. (1982). *Adolescent Social Development: Dynamic Functional Interaction*. Lexington, MA: Lexington Books, D.C. Heath and Company.

Seltzer, V. (1989). *The Psychosocial Worlds of the Adolescent: Public and Private*. New York: John Wiley.

Seltzer, V. (2009). *Peer Impact Diagnosis and Therapy: A Handbook for Successful Practice with Adolescents*. New York: New York University Press.

This is an abridged version of Alone Together*, a feature article in the May/June 2010 edition of the Pennsylvania Gazette (University of Pennsylvania alumni, faculty, and university community journal) where senior editor Samuel Hughes reviewed Dr. Vivian Seltzer's scholarly work over the course of her academic career, based on conversations, several taped interviews, reviewing her three books and discussions with professionals and academics. Certain sections have been paraphrased, added, edited, or deleted by Dr. Seltzer and by the PSCP newsletter editor due to space constraints in this newsletter. The complete article by Samuel Hughes may be accessed at http://www.upenn.edu/gazette/0510/feature1_1.html.*

Dr. Vivian Center Seltzer would appreciate feedback regarding her interest in offering a limited series of training sessions in Peer Arena Diagnosis and Therapy, at no cost to members. She can be contacted at seltzer@sp2.upenn.edu or at 215-735-5455. ■

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and healthier lifestyle. The use of antidepressants is widespread and continues to grow. Between 1995 and 2002, the use of these drugs rose 48%. Of greater concern is the fact that benzodiazepine anti-anxiety medications are among the most widely prescribed psychotherapeutic drugs in the U.S. In addition, there is ample evidence that alcohol, illicit drugs, overeating, and overspending are used by many people to reduce negative emotions.

As people have become increasingly aware of the side effects and the limited effectiveness of using medications to address their problems, there has been a corresponding increase in interest in non-pharmacological means of reducing stress and promoting health and wellness. There are, however, significant challenges to the average consumer who seeks to navigate the complex array of “holistic” practices.

Complementary and Alternative Medicine (CAM) is an increasingly accepted paradigm in establishing an operational and organized way of comprehending and implementing these practices. In 1998, the National Institutes of Health (NIH) created the National Center for Complementary and Alternative Medicine (NCCAM). NCCAM defines CAM as a group of diverse medical and health care systems, practices and products that are generally not considered part of conventional medicine. “Complementary medicine” refers to the use of nontraditional practices together with conventional medicine. “Alternative medicine” refers to the use of nontraditional practices in place of conventional medicine. “Integrative medicine” refers to the practice of combining both conventional and nontraditional practices for which there is demonstrated safety and efficacy.

A significant body of empirical research has demonstrated that human issues and problems are best diagnosed and treated in a coordinated and comprehensive manner. The mission of the NCCAM, with a 2010 budget of $128.8 million, is to use “rigorous science” to assess the efficacy of a variety of complementary and alternative approaches, to train researchers in this area and to disseminate authoritative information to the public and professionals. The five major domains designated for investigation are alternative medical systems, mind-body interventions, biologically based treatments, manipulative and body-based methods, and energy therapies. It is becoming increasingly apparent that the most up-to-date, safe and effective means of conceptualizing and treating illness involves an "integrative” approach to healthcare. This is best accomplished by considering and implementing both traditional Western medical and psychological treatments with complementary and alternative healing practices that incorporate physical, psychological, emotional, and spiritual capacities of humans to heal. The burgeoning evidence accumulating in the field of psychoneuroimmunology attests to the importance of continuing to learn how to integrate various therapies from the medical, psychological and psychiatric specialties.

The other driving force toward an integrative model is the growing interest in complementary and alternative approaches on the part of the general public. As far back as the late 1990s, there was evidence of “growing dissatisfaction with the quality of medical care in general because of concerns over efficacy and safety of conventional treatments, complaints about the often impersonal manner of health care delivery, and the increasing cost of medical care to the average consumer” (Lake, 2007, p.4). Given today’s healthcare climate, with increases in copay amounts, elimination of mental healthcare from medical insurance coverage, and increasing utilization review, there is ample reason to believe that these concerns have actually increased.

This dissatisfaction is associated with evidence that the utilization of nontraditional approaches is growing. Estimates of the number of people who utilize complementary and alternative therapies are impressive, ranging from one in three to two in three adults, depending on the study and the types of techniques included (Lake, 2007). In a comprehensive survey of the use of complementary and alternative approaches, the 2007 National Health Interview Survey (NHIS) showed that about 38% of adults use CAM.

Of particular interest to mental health professionals is the finding that the reliance on nonconventional therapies by people who are diagnosed with a psychiatric disorder is significantly higher than in the general population. Furthermore, there is evidence that mental health patients participate in both traditional and nontraditional therapies concurrently, frequently without disclosing the nonconventional approach to their conventional health provider.

As we look to the future, there is much to consider. Ever since the emergence of an American vision of “wellness” in the 1980s, there has been an increasing disconnect between that ideal and the reality of many Americans’ lives. In addition to the increased use of psychotropic medications, an obesity epidemic has beset our society. In the late 1980s, the percentage of overweight Americans was about one-third. It is presently over two-thirds, I ncluding a significant number of our children. Health experts are warning of very serious consequences as obesity related health problems continue to show up at earlier ages. This is occurring at a time of great national debate and conflict over how medical insurance will be available to assist people in receiving the care they need to actually be “well.”

There seem to be certain critical elements for consideration. As research continues to offer evidence that comprehensive therapies are superior to individual approaches, there is a need for all health providers to become more familiar with CAM. This will allow the requisite education of the public, including demystifying unfamiliar approaches and helping people understand how CAM can be combined or integrated with traditional measures. Another important component is the enlistment of primary care providers and other medical specialists.

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While receptivity among today's physicians regarding CAM is greatly improved from years past, there is much to be done to help them to understand how to assist their patients in incorporating these approaches with their traditional medical care. Importantly, it is likely that non-psychiatric mental health providers will be the optimal lead in this collaboration due to our increased time and experience in the provision of treatment. In addition, there is a need for increased collaboration and communication between traditional and CAM providers. In order to truly create integrated treatments that are more than merely multidimensional in nature, a certain degree of contact between all involved service providers is necessary. Finally, one must consider economic issues. The utilization of multiple approaches can easily overwhelm the patient's ability to pay for such services, particularly since many CAM services are not reimbursable by insurance companies. Patients may need guidance and assistance in deciding how best to use limited resources. New paradigms will be required to address these issues.

References

Lake, J. (2007). *Textbook of Integrative Mental Health Care.* New York: Thieme.

Dr. Montanaro practices at Jenkintown Psychological Associates (JPA). While continuing to provide individual, marital, family and group therapy, JPA is transitioning from a traditional program of mental health treatment and wellness consultation to an expanded program that includes additional healthcare activities designed to optimize clients' physical, psychological, and spiritual wellbeing. The JPA Center for Integrated Health offers a variety of stress-reduction practices along with activities that can promote general wellness, such as Acupuncture, Massage Therapy, T'ai Chi/Qigong, Meditation Training, Yoga, Biofeedback, EMDR, Neuromuscular Integrative Therapy, Pilates, Reiki, and Substance Abuse Recovery. The Center also offers consultation for Integrative Holistic Medical Treatment and Integrative Chiropractic Care, and is developing classes in childbirth and prenatal/postnatal care. In addition, the JPA Growth and Development Center offers specialized services for people with Autistic Spectrum Disorders. JPA's mission is to explore the best practices of integrative mental health in the hope of providing clients with individualized, relevant, and realistic plans for treatment, stress-reduction, and self-efficacy. For more information, please call 215-885-1252 or visit www.jenkintownpsychologicalassociates.com.

You Are Invited to a PSCP New Member Open House

Please join us for
an open house event to
welcome new members and students to PSCP.

All members are welcome to come, network, and enjoy light refreshments and great conversation.

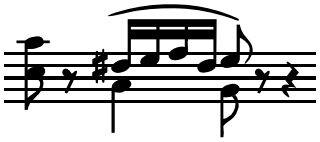
October 24, 2010 from 2PM-4PM

At the home of Christine Waanders and Ivan Haskell

Please RSVP by October 18th by emailing us

at sandi.greenwald@philadelphiapsychology.org or

calling the PSCP Office at 215-885-2562



NOTES:

Congratulations to the 2010-11 PSCP Executive Board, and thank you to the 2009-10 Executive Board. We had a wonderful year and look forward to the stimulating workshops, social action opportunities and new programs the new board will work on this year.

Join us for A "Welcome to PSCP" Open House on October 24th from 2-4 PM: Hosted by Membership Chair, Christine Waanders and Ivan Haskell, this will be an opportunity to network, enjoy light refreshments and great conversation! RSVP by October 18th by emailing PSCP Office at sandi.greenwald@philadelphiapsychology.org or calling the office at 215-885-2562. Details available through PSCP Office. Looking forward to meeting YOU!

The Annual January Event: We were delighted last year when so many PSCP Members joined us for the Annual January Event at White Dog Café. Now we need a bigger venue! SAVE THE DATE: JANUARY 22 or 23 and look for more information in email newsletters.

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 Dr. Christine Ware at citrini@mindbodyservices.com.

You can have your very own PSCP mug and T-shirt. Beautiful white ceramic mug with our colorful logo on two sides and cotton T-shirt with our colorful logo and motto- "Advancing the field of psychology for over 50 years". Mugs are only $10 each and T-shirts just $15. Order by calling the office 215-885-2562.

Community Outreach

TEAM PSCP Needs YOU!

Walk, exercise, expand your professional network, renew friendships...all while being part of a TEAM that *will* make a difference.

Alzheimer's Memory Walk

Sunday, November 14, 2010
Citizens Bank Park
Philadelphia, PA

Check in: 9:30 a.m.
Walk Begins: 11:00 a.m.

Join Team Leader Andy D'Amico
Sign up to walk by...

clicking on the Alzheimer's Memory Walk website direct link to "TEAM PSCP"
(or cut and paste in your browser):

http://memorywalk2010.kintera.org/philadelphia/pscp

TEAM PSCP looks forward to a wonderful and successful walk!
Can't walk that day?
Sign up to support TEAM PSCP at the same website address.
Need more information?
Contact the PSCP Office at 215-885-2562 or email sandi.greenwald@PhiladelphiaPsychology.org

What is Act 48?

Act 48 Credits are required for all professionals holding a public school certificate in PA in order to work for a public school entity. A public school entity is a public school district, a charter school, or an intermediate unit. This requirement includes school psychologists, guidance counselors, school home visitors, etc. 180 Act 48 Credits are required every 5 years after the granting of your certificate. PSCP is an approved provider of Act 48 Credits.

NOTE: PA Act 48 now requires Pre/Post Test to be taken, self-graded, and sent in with the Request form and evaluation in order for credit to be granted.

Interested in

placing a business, practice, or classified ad in a PSCP printed newsletter, directory, or email newsletter?
Contact :
Sandi at the PSCP office at
215-885-2562 or
sandi.greenwald@philadelphiapsychology.org

Accepting materials for PSCP Times Spring 2011 printed newsletter.

If you would like to submit 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.

Please send submissions via email to **Dr. Christine Ware at** citrini@mindbodyservices.com.

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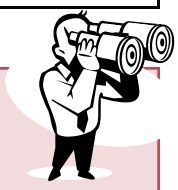
215-885-2562 or info@PhiladelphiaPsychology.org
PSCP Executive Director
and Layout Designer: Sandi Greenwald

PSCP Fall/Winter Workshop/ Event Schedule

DATE	WORKSHOP TITLE/SUBJECT	PRESENTER	LOCATION
Oct. 8	Sex, Drugs, and Rock-n-Roll: A Primer on Understanding, Assessing, and Treating Addictive Behaviors	Victor Shklyarevsky, Psy.D.	Villanova University Health Services Bldg. Room 200
Oct. 15	Improving Social Relatedness in Individuals with Autism Spectrum Disorders: What Neuroscience Tells Us	Mary Riggs Cohen, Ph.D.	Friends Hospital Scattergood Auditorium
Oct. 22	The Role of Psychology in Geriatric Settings	Jerry Leider, Ph.D.	PCOM Evans Hall 202
Oct. 24	Open House to welcome new members	All members invited	Call PSCP Office for details
Oct. 29	Complementary and Alternative Medicine (CAM) and Psychological Practice	Brother/Dr. Bernard Seif, SMC, Ed.D., DNM	Villanova University Health Services Building, Room 200
Nov. 14	Alzheimer's Memory Walk 2010 Registration 9:30 AM; Walk 11 AM	"Team PSCP" Leader: Andy D'Amico, Ph.D	Citizens Bank Park, Philadelphia,PA
Nov. 19	Getting a Grip on Obesity: The Role of Parents in Childhood Obesity Onset and Treatment	Myles S. Faith, Ph.D.	LaSalle University Montgomery County Center @ Metroplex, Plymouth Meeting
Dec. 3	The Psychologist as a Testifying Expert: Direct and Cross Examination	Philip Spergel, Ed.D.	PCOM Evans Hall, Room 326 A/B
Dec. 10	Suicide Risk Assessment	Norman C. Weissberg, Ph.D.	PCOM Evans Hall, Room 326 A/B
Jan. 21	Child Abuse from Legal and Psychological Perspectives: Office of Children and Youth 2011 Update	Marilou A. Doughty, M.S.; Chief Randy Floyd; Gregory R. Gifford, Esq.; Michele Kristofco	Villanova University Health Services Building, Room 200
Jan. 22 or 23	PSCP ANNUAL EVENT	Special time to gather, network, honor colleagues, and enjoy!	New Venue-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.