Title of Course: Psychotherapy Practice Tips, Part 1

CE Credit: 2 Hours

Learning Level: Intermediate

Author: The National Psychologist

Abstract:

This course addresses a variety of brief clinical topics in the form of 15 archived articles from The National Psychologist. Topics include:

- Anger, violence and radical ideologies: mental illness or different beliefs?
- Psychopathy important to understand in clinical practice
- Is marijuana an appropriate treatment for ADD/ADHD?
- Internet pornography addiction cause discomfort to some therapists
- Talking to lifers, dilemmas and opportunities
- Are mad and genius peas in the same pod?
- Mad and genius are separate states of mind
- Complex traumatic stress disorders in a general practice setting
- Better serving victims of sexual assault
- Using mindful affirmations in clinical practice
- Army to train its own in positive psychology
- Health redefined by National Academies of Practice
- Encouraging a psychotropic medication evaluation
- Latino immigration: Humanizing communities and unifying voices
- The impact of learning disabilities on the self.

Learning Objectives:

1. Differentiate between mental illness and different beliefs in radical ideologies
2. List causes of therapist discomfort with internet pornography addiction
3. Identify similarities and differences between madness and genius
4. Describe the complications of clinical work with victims of complex PTSD
5. Name ways to better serve victims of sexual assault
6. Identify techniques for using mindful affirmations in clinical practice
7. Describe the impact of learning disabilities on the self

About the Author:

The National Psychologist is a private, independent bi-monthly newspaper intended to keep psychologists informed about practice issues. Contributions and letters are invited. The editor reserves the right to edit articles and submissions for clarity and/or to meet specific space limitations. Publication staff is not responsible for opinions or facts in bylined articles.
Psychotherapy Practice Tips, Part 1

Anger, Violence and Radical Ideologies: Mental Illness or Different Beliefs?

By Thomas W. White, PhD
TNP Jan/Feb 2010

The Fort Hood shootings raise issues about whether the alleged killer was a terrorist, a religious extremist or both and whether political correctness and/or paternalism trumped patient care in decision-makers’ judgments.

Absent an accepted guilty plea, one thing seems likely – this case will devolve into a protracted battle of experts opining on the mental health of the killer, considering statements of his former colleagues and instructors at Walter Reed Army Medical Center.

Several were quoted as saying they feared he might become violent and debated whether he was psychotic. The operative word is psychotic; not disturbed, not troubled, not incompetent, but psychotic (i.e., “out of touch with reality”).

That is not a term to be used casually. Given the overwhelming weight of the evidence, it seems likely his attorney will seize upon the Walter Reed statements to build a case for insanity or diminished capacity. After all, if colleagues, supervisors and administrators at the Army’s premier psychiatric teaching hospital debated whether the shooter might be “psychotic,” is that not prima facie evidence that he was mentally ill and not responsible for his actions?

The psychiatrists were also quoted as saying they saw no signs of mental problems and no risk factors that would predict violent behavior. Yet we know they convened several meetings to discuss the killer’s behavior and speculated he might kill other soldiers and questioned whether he was psychotic.

Aside from explaining the apparent contradictions, the staff will certainly be questioned about their ultimate decisions in the absence of any formal assessment, particularly given the gravity of their concerns.

It is easy to criticize in hindsight than to make difficult decisions contemporaneously. Many of us have been in similar situations but without the tragic consequences.

Nevertheless, this is what happens in court and it is where the Walter Reed staff now find themselves.

It is where practitioners facing their own legal challenges can also find themselves. This case emphasizes the importance of basic clinical and risk management practices: comprehensive assessment; data based decision-making; objective, thoughtful documentation and adequate follow up. Let’s hope we can all learn from the experience.
Our traditional mental health model has never been successful at predicting idiosyncratic behavior whether or not the individual has a psychiatric diagnosis. This is most apparent when we attempt to understand or predict violent or dangerous behavior.

Any correctional psychologist in a high security institution has routinely confronted this reality. As one of those psychologists, I quickly discovered the difference between diagnosable mental illness and acknowledged abnormal behavior was often a distinction without a difference when it came to violence.

One case I will never forget involved a biker I evaluated who agreed to kill his friend’s wife for a $150 down payment. He beat her to death with a skillet in her kitchen after she made his breakfast. He never received full payment for his work and was much more concerned about not receiving the money than about killing the woman.

I repeatedly encountered inmates who would assault and kill another inmate simply because he was a different race, sat in the wrong section of the dining hall or was wearing opposing gang tattoos. I also knew many good-natured organized crime figures that ordered or participated in scores of violent murders.

Perhaps most incomprehensible were seemingly ordinary men who detonated trucks loaded with explosives that killed and injured hundreds of people or zealots who killed people who disagreed with their political or religious beliefs. All of these men were rational, often friendly people that easily justified their actions and showed little or no remorse.

Are violent people like those mentally ill? Are they out of touch with reality? The diagnostic answer is, “No.” Are those offenders abnormal? Do they represent a threat to others? The practical answer is, “Yes.”

There were, however, some individuals who were abnormal as well as diagnostically mentally ill. Some hallucinated, hearing voices from God or radio waves beamed by the CIA. Others were delusional, believing they possessed knowledge or information that gave them special insights. But while the number of those inmates is increasing, they still are only a subset of offenders and they often are not violent. In fact, of the tens of millions of Americans diagnosed with mental illness, few are violent.

Most violent offenders I encountered were not mentally ill or easily diagnosable, save the ubiquitous but superfluous diagnoses of Antisocial Personality or Borderline Personality Disorders, and those are not considered mental illnesses for purposes of a legal defense.

In short, any nexus between abnormal, violent behavior and mental illness is at best tenuous and very person-specific. When it comes to predicting any behavior, but specifically violent, personally intrusive and/or criminal behavior, I have rarely found that the presence or absence of a psychiatric diagnosis was highly informative for understanding what was going on in a person’s head or foreseeing future acts.

In my experience, most violent behavior evolves from a set of values and beliefs that were naturally acquired, not from mental illness. Although for some, these beliefs may become profoundly extreme over time, the process by which they were acquired is the same as for all of us. We see this every day as people use the same information to arrive at very different political, religious and cultural conclusions.

Even in cases of premeditated murder, hate crimes and genocide, the beliefs and actions that flow from them are rarely considered in the context of mental illness. Thus, holding different beliefs, unless they are the product of qualitatively different thinking processes, is not mental illness even when they become radical, clearly abnormal and in some cases lead to horrific acts.

Let us not forget there are people who openly praised the Fort Hood shooter and many more that would readily commit similar acts if given the opportunity.
A critical question raised by the shootings is whether the killer’s actions are best understood when viewed in the context of psychiatric illness or are more parsimoniously explained as a function of different values and cognitive constructs. I would support the latter and have come to question whether the former really offers more than the illusion of understanding.

Certainly for a small subset of people whose behavior clearly stems from a qualitatively different cognitive process (e.g., hallucination or delusions), diagnosing them as mentally ill and treating them accordingly is an appropriate course of action. For them, the guilty but mentally ill verdict adopted in some jurisdictions may be a fair and humane accommodation to acknowledge the need for both treatment and incapacitation.

For others, however, there is little evidence that a psychiatric diagnosis, with its underlying assumption of mental illness, has been elucidating or instructive for clinicians seeking to predict behavior. We simply cannot do it with any reasonable degree of precision, and our current mental health model offers little or no guidance.

The question is not whether the killer’s mental status should become an issue, because it will, and the tentative marriage between the legal system and the traditional mental health model will play itself out again as it has many times before.

The more fundamental question going forward is whether our old ways of doing business are still applicable today. We should ask if our 19th Century McNaughton-inspired insanity model is the right tool for understanding our 21st Century legal concepts of responsibility.

I hope this tragedy encourages a more robust professional conversation about the utility of the traditional symptom-based mental health model and whether a more objective, research-based approach would advance our understanding of this and other abnormal behaviors.

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**Psychopathy Important to Understand in Clinical Practice**

**By Polly Shepard, PsyD**

TNP Jan/Feb 2010

If you look to Hollywood, you would think that psychopaths live in an isolated world of serial killings or, at the very least, incarcerated populations. This perception is not reality. Only a small fraction of psychopaths are serial killers (estimated to be fewer than 500) and they represent a small portion of the incarcerated population – only 15 percent to 20 percent of adult male prison population.

Psychopaths live and breathe all around us, which is what makes them more dangerous than a typical criminal. They are social chameleons that may initially appear intriguing until you become their prey. They are bankers, businessmen, lawyers, doctors, drug dealers, salesmen, spouses and child abusers. As a clinician, they may be your patient or client, but they are more likely living with or associating with your patient.

What is most striking about psychopathy is that it is not a recognized epidemic akin to other medical and psychological disorders. Even most psychologists, experts in the field of behavior and personality, have little to no knowledge of psychopathy. Millions of dollars fund research to explore colon cancer that is estimated to have 150,000 new cases and deaths per year. Tremendous research and education is spent on schizophrenia, a disorder affecting up to 2.2 million Americans. Alternatively, the psychopath population has been estimated to be between 2 million and 3 million in the United States, yet you do not hear about psychopath telethons or NIH funding awarded for this cause.
Despite the fact that the sheer number of psychopaths is well-within comparison of other more prominent disorders and diseases, there is a lack of awareness, funding, and education about it. While it certainly may not be noteworthy to endorse psychopathy as a social “cause,” if you take into account the lives and finances that are affected in the wake of a psychopath, one might argue there is no comparison.

Victims of psychopaths are emotionally abused, manipulated, embezzled out of finances and are victims of violence. Promoting awareness of psychopaths outside the field of psychology is challenging in part because it is not broadly accepted as a concept within our field. Specifically, the Diagnostic and Statistical Manual does not support or utilize psychopathy as a diagnostic category because it is felt that the diagnosis of Antisocial Personality Disorder (APD) suffices.

Purporting that APD and psychopathy are the same entity only fosters confusion that psychopaths are violent, aggressive criminals – which is simply not the case. Research has shown that APD and psychopathy only overlap to a moderate extent. Ultimately, it is no wonder that education about psychopathy as a construct has been largely absent from a psychologist’s training.

In the 1940s, Hervey Cleckley, MD, defined hallmarks of psychopathy that were later honed by world renowned psychopath expert, Robert Hare, PhD. As a result of Cleckley’s work, clinicians now have a common language to describe psychopaths akin to criteria typically provided for other disorders by the DSM.

These characteristics were defined to embody both personality makeup as well as behavior. These attributes include: glibness, grandiosity, pathological lying, manipulation, lack of remorse and empathy, shallow affect, failure to accept responsibility for actions, need for stimulation, parasitic lifestyle, behavioral problems, lack of realistic long-term plans, impulsivity, irresponsibility, juvenile delinquency, promiscuity, many short-term relationships, criminal versatility and revocation of conditional release.

So why is it important for psychologists to understand the construct of psychopathy? As behavioral analysts, we are uniquely qualified to identify psychopaths’ characteristics and potentially reduce their impact on others. Most people – including many clinicians – want to believe that people are good, fair and honest and can be motivated by the thought of how their behavior might impact others in a negative way. This is not the case for psychopaths.

They know right from wrong but are incapable of empathy or concern of how their behavior may affect others. They are emotionally colorblind. Feelings such as pain, anguish and discomfort are only understood as abstract and intellectual concepts, if at all. Traditional techniques involved in psychotherapy including behavioral management and empathy building do not work in this population.

In fact, studies have shown that the typical approaches proven to be successful with incarcerated populations make psychopaths better psychopaths by allowing them the opportunity to learn how to speak the language of a feeling human. In essence, they become better manipulators of other people.

Additionally, inherent in being amenable to psychotherapy is the acknowledgement of needing and wanting help for an emotional problem. However, since psychopaths are well satisfied with their emotional makeup and lack concern about consequences, there is no motivation or reason to change. They operate by their own standards and values that are very different than the rest of society that values social cooperation and responsibility. They know right or wrong but are undaunted by consequences of what is typically socially accepted as wrong.

Most psychologists will come across psychopaths in their practice. While you may think that psychopaths solely exist in forensic practices or in incarcerated settings this is not the case. While psychopathy is a more prominent consideration in forensic context, psychopaths are certainly prevalent in any clinical context.
For example, in the last decade studies have focused on the prevalence of psychopaths in the business world where industrial organizational psychologists may cross their paths of destruction. Why? Hard core business provides positive reinforcement for behaviors prominent in psychopaths: using money, power and a “dog-eat-dog” approach to success. If you consider qualities of those who excel in the world of business, they are individuals who are narcissistic, assertive, self-centered and dominant. These are all qualities shared by psychopaths.

In a more treatment-oriented setting, it may be less likely that psychopaths would be the identified patients, but they may certainly be a parent, spouse, colleague or acquaintance of a patient.

Therefore, it is important for psychologists to understand fundamental characteristics and behaviors ingrained in psychopaths not only for forensic assessments/treatment but to protect themselves and their patients from becoming the next victim.

**Is Marijuana an Appropriate Treatment for ADD/ADHD?**

By John Caccavale, PhD, ABMP
TNP Jan/Feb 2010

Recently, an article appeared in the New York Times reporting on the use of marijuana for treating children with ADD/ADHD. The Times article is just one of several that have been popping up since medical marijuana initiatives have been passed in a handful of states.

Initially, the use of marijuana to treat pain and suffering related to the side effects of chemotherapy and to increase appetite in HIV patients were used as the rationale for the medical marijuana initiatives. Now, however, a patient can get a prescription for almost any type of complaint. Anxiety, depression and other behavioral disorders are at the top of the complaint list, so it is not surprising that more disorders are being added to the list.

**The Pharmacology of Marijuana**

Briefly, marijuana is of the plant genus Cannabis. There are at least 66 active compounds found in marijuana but the most psychoactive compound is delta9-tetrahydrocannabinol (THC). The human brain contains several groups of cannabinoid receptors where they are concentrated and distributed in different areas. These receptors are activated by the neurotransmitter anandamide, which THC mimics.

The main neuropsychological effects of THC and, perhaps the other 65 identified compounds, are on short-term memory, coordination, learning and problem solving. Physical endurance and performance functions also are affected by cannabinoids. THC is recognized as a very powerful psychoactive compound.

**Drugs and Paradoxical Reaction**

The foundational premise related to the medication treatment of attention deficit symptoms is rooted in the concept of paradoxical reaction. That is, these patients seem to react contrary to the mechanism of action for the class of drugs. Psychostimulants, for example, activate, produce heightened alertness, increased energy, appetite suppression and sometimes euphoria.

The main symptoms of ADD/ADHD include inattention, hyperactivity and impulsivity. Psychostimulants, as a class of drug, should enhance many of the negative behaviors that are seen in ADD/ADHD, but behaviorally they do not. This is an example of paradoxical reaction.
Marijuana, generally, decreases alertness, memory, hyperactivity and impulsivity. It increases appetite and is a euphoric. The paradoxical reactions to marijuana may include heightened awareness and performance, paranoia, depression, anxiety, increased activity and impulsivity. Advocates of marijuana, such as psychiatrist Dr. Leonard Grinspoon, say that they would have no hesitation in giving youngsters with ADHD a trial of oral marijuana.

Moreover, they assert, “for some kids, it appears to be more effective than traditional treatments.” They also contend that marijuana has fewer potential dangers and side effects than the psychostimulants.

However, if psychostimulants do hold an edge over marijuana, it is that these drugs are standardized as to their composition, potency, dose and experience? Presently, there is no standardized marijuana compound, unless one wants to include Marinol, a drug synthesized from cannabis which is not under consideration as a treatment option.

Potency of marijuana varies significantly from plant to plant, region of origin and potency, among other variables. Moreover, there is no real control over the concentration of the other compounds found in marijuana, which clearly affect the mechanism of action of THC. Lastly, there is no control over potential adulteration through additives.

**A Paradoxical Reaction to a Paradoxical Reaction**

Without trying to use a play on words, it is easy to see that whatever the drug of choice, paradoxical reaction brings into question the entire treatment of ADD/ADHD with all medications. Adding marijuana into the mix, in my opinion, is questionable, at best.

There may be many good medical uses for marijuana but we need solid research and data to find out what they might be to justify its use in children and adults. There is sufficient data that casts significant doubt on the diagnoses of ADD/ADHD. There is a significant body of data that supports behavioral interventions as a first line treatment of these symptoms.

The common psychopharmacological treatment for attention deficit disorders is psychostimulants, but there is a growing body of data on the potential danger of psychostimulants. Ritalin, Concerta and Strattera typically are the drugs of choice prescribed by physicians and psychiatrists.

Adding marijuana to the current list of medication options is very premature. Before even considering marijuana, it seems to me that the current use of psychostimulants also should be scrutinized as a treatment option. Many of the patients that I have treated after being referred for ADD/ADHD had long standing but undiscovered sleep disorders. Not surprisingly, psychostimulants do produce gains in performance with these patients. For too long many have accepted that ADD/ADHD are established conditions that need medical as opposed to behavioral treatment.

To date, not a solitary cause has yet been identified for ADHD. ADHD will likely prove to be an umbrella term for a number of behavioral and/or neurologically based disorders.

Furthermore, there hasn’t been any identified cause specific to ADD leaving open the likelihood that ADD may be a catch-all condition. The National Institutes of Health Consensus Development Conference and the American Academy of Pediatrics agree that there is no known biological basis for ADHD.

The more we review the literature on hyperactivity or ADD, the less certain we are as to what it is or whether it really exists as a standalone disorder. So, at issue, is not only the question of marijuana as a potential treatment for attention deficit problems, but should the use of psychostimulants in children also be re-evaluated?

Given the myriad, unknown pharmacological variables involved in the mechanism of action of marijuana, I believe that marijuana, at this time, is not and should not be taken as a serious treatment option for attention deficit symptoms.
Internet Pornography Addiction Causes Discomfort for Some Therapists

By Stefanie Carnes, PhD
TNP March/April 2010

When a client enters your office complaining of internet pornography addiction, your first response may be to run, hide from him or to refer him to another therapist. For many therapists discomfort in dealing with sexual issues will keep them from asking the most important question: “What kind of internet pornography are you viewing?”

Consider the difference in the pathology of the patient viewing videos of women being degraded and humiliated or other exploitive forms of pornography such as child porn or elder erotica (sometimes referred to as “granny porn”). The patient may be viewing consensual “vanilla” sex, “wife swapping” or voyeuristic websites.

For many individuals, the type of pornography that they are viewing may be reflective of a past trauma or deep-seated psychological issue, or it may tell a story about their sexual development. Our early childhood years can be formative for our developing sexuality.

Many clinicians use the term “arousal template” to describe an individual’s erotic map – or what it is they are stimulated by or attracted to. The arousal template includes things such as body types, partner characteristics, behaviors, sex acts, objects and settings that cause sexual pleasure for an individual.

For example, if one of your first sexual experiences included oral sex, this could be a powerful element on your arousal template. It is not uncommon for individuals who have arousal templates that are considered “deviant” to have experienced childhood trauma that distorted their sexuality at an early age.

The internet affords the opportunity for people to explore the far reaches of their sexuality, including viewing and/or participating in behaviors that they would be afraid to indulge in an intimate relationship. Cybersex users can explore new powerful templates that, when viewed repeatedly, can be strengthened and fixated. This is especially dangerous when the arousal template is unhealthy, such as child pornography.

The reality is that most therapists are unaware of the genres of pornography and the numerous typologies of fetish behaviors that exist online. Additionally, therapists may be uncomfortable exploring these issues with their clients. When this occurs, important assessment information is missed and clients are unable to process traumatic issues around their sexuality that may be confusing for them.

It is helpful for clinicians to have a general understanding of the common types of internet porn, so that they can ask pertinent questions during the assessment process. A brief description of major categories of internet porn is listed below. This is not intended to be an exhaustive list, but rather to give the clinician an overview of typologies.

References

Common Genres of Internet Porn

Pain exchange – A large genre of pornography that encompasses the variety of sadomasochistic websites where power, domination and submission are a key component of arousal.

Fantasy – Fantasy sex typically has a relational component and can include e-mails, chat rooms, instant messages, erotic literature and dating websites.

Fetishes – The internet has numerous websites dedicated to various types of fetish behaviors. Some examples of fetishes are spanking, bestiality, transvestism, lingerie, bodily fluids, disability, incest, robots/dolls, hair, shoes, adult babies, military gear and fat admirers.

Exhibitionism – This usually includes the use of web cam technology whereby the individuals expose themselves or upload video with sexual content. This is increasingly popular among youth.

Paying for sex – This includes use of the internet to market sexual services, such as escort services.

Exploitive sex – This genre includes pornography that exploits vulnerable populations such as the elderly and children or drunk and passed out women.

Seductive role sex – This genre includes seduction as a major part of the arousal. It can encompass e-mails, chat rooms or dating services where users can generate profiles, communicate and arrange meetings.

Anonymous sex – Cybersex users can arrange to meet for anonymous sexual encounters.

There are more than 420 million identified pages of internet pornography online, reaching more than 40 percent of the total internet audience. With the vast amount of sexual content, the easy access and availability, clinicians will continue to see an increase in the number of clients seeking treatment for compulsive or addictive sexual behavior.

As a clinician, it is important to understand this emerging issue and be prepared to help. One of the ways clinicians can be more prepared is to understand the variety of sexual behaviors accessed online and be open to discussing them with their clients.

Talking to Lifers: Dilemmas and Opportunities

By John L. Gannon, PhD
TNP March/April 2010

Therapists who encounter lifers may feel a good deal of discomfort. To offset this we must accept that there are surprisingly many paths to a life sentence and a remarkable array of people who find themselves in that position, that mentally ill lifers have a right to mental health services and that the more or less standard array of good clinical practices, good listening, humane respect, etc., all apply.

The existential issues of doing life can sometimes throw therapists off track, creating professional uncertainty and anxiety in the therapeutic environment. Looking at the lifer across from him, the therapist must believe that when the gavel fell and a life sentence was pronounced, it seemed that all was lost and life hardly worth living. But is this response by the lifer or vicariously by the therapist warranted?
Therapy with lifers includes acknowledging those feelings that will by necessity arise from the past but simultaneously being firm in shifting the thinking toward a more realistic understanding of and devising a life plan for the future. All is not lost.

What do lifers lose? The principal losses are personal autonomy, geographical restriction and, typically, absence of sexual expression with opposite-sex partners.

Yet, myriad people have not only forgone those very opportunities but found their renunciation ennobling and satisfying. Sailors, fishermen and sea-borne shipping crews are in restricted areas for long periods, subject to dominating authority and limited in sexual expression.

Faithful husbands and loving fathers voluntarily leave their families to serve in remote locations with insects, unbearable heat or cold and immediate dangers while on military or scientific missions.

No doubt personal choice about the lives they are living makes the phenomenology of these groups different, but new life choices are made every day by lots of people, and it is possible to choose even that which is imposed.

And wouldn’t it be profoundly ironic should a murderer doing life complain about comparisons with these groups based on their choices given the deprivation of the choice of life itself they imposed on their victims.

Paradoxically, talking to patients, including lifers, begins with listening first to understand their own view of their existential condition. Determining the criteria of reference is crucial here. Comparisons of their own expected life sentence with a fantasy life of no work and non-stop sex and drugs and rock and roll they would like to think they are missing will lead only to envy, frustration and unhappiness.

They may have had a good life waiting outside the walls, but in many cases they would not. Eventually, the lifer must come to realize that while things are indeed bad, all is not lost.

Furthermore, if other, reasonable human beings actively seek the very conditions the lifer seeks to avoid, it is likely there are opportunities available to him that have not been explored.

What might those opportunities be? First, what I call my “fundamental formula,” QLQR where Q = Quality, L = Life and R = Relationships. Virtually the totality of the wisdom and religious literatures, whatever its origins, makes it clear that pursuit of things is futile, while developing the discipline to become something worthwhile and building good relationships with those loved and those loving is everything.

Geographical range and sexual expression are frosting, but the cake of life satisfaction is the love we give and receive. For a high QL the lifer must develop and maintain high QR. In addition, a good lover must learn to control those characteristics of impulsivity, entitlement, narcissism and irresponsibility often found in lifers, and working on QR can be the guiding star that allows for progress down the path toward the personal fulfillment they fear they’ve lost.

In addition to the basic formula, consider philosopher Owen Flanagan’s observation that human flourishing depends on the ability to participate in The Beautiful, The Good and The True.
Creating and experiencing beauty, growing in goodness within oneself and supporting it in others, working diligently to avoid delusions of either grandeur or helplessness and recognizing that deceiving others is only one step on the staircase of self-deception can be a life plan unto itself.

There are important messages to be conveyed to lifers that may help them to avoid the paralyzing despair that might settle in when clarity about their situation comes into focus.

First, all is not lost. Restrictions in a life behind bars are substantial and emotionally devastating but, as can be seen in the lives of those who chose similar restrictions voluntarily, the restrictions are manageable. If it is being done, it must be possible.

Second, though the lifer’s narcissism and anti-social behavior may belie the truth, we are in fact social animals. The failure to recognize this while he was on the outside is likely part of the reason the lifer is on the inside. Improving QR is not only good for the lifer, it is part of the change that he needs to undergo to become a non-criminal (a prosocial goal worth pursuing regardless of his imprisonment).

Third, The Beautiful, The Good and The True are characteristics of the world that integrate immediately, importantly and intensely with the human psyche. For thousands of years they have been recognized as foundations of human flourishing. They are subtle and complex by nature, so they are always challenging and can’t be boring. Their permutations are infinite, so they cannot be exhausted during any man’s lifetime. Their accomplished pursuit demands self-discipline, thoughtfulness, dedication, optimism, honesty and active engagement with others, all things that help us become worthwhile human beings.

Each of us would do well to pursue the fundamental formula and the Flanagan’s trine and so should lifers.

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**Are Mad and Genius Peas in the Same Pod?**

**By Dean Keith Simonton, PhD**

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Ever since the ancient Greeks, thinkers have associated madness and genius – especially creative genius. This view became particularly conspicuous in the 19th Century, when many psychiatrists argued that both psychopathology and creativity were manifestations of a deeper genetic disorder. Genius was not only born, but also born mad.

This position was not universally accepted. Most notably, humanistic psychologists like Abraham Maslow, Carl Rogers, and Rollo May argued that exceptional creativity was linked to mental health. Creators were self-actualizers. This positive viewpoint has also been adopted by leaders in the positive psychology movement. Which side is correct? In a sense, they both are.

To understand why, we first must begin by defining creativity. To be creative, a person must generate an idea or behavior that’s both novel and useful. Yet we immediately have to ask, novel and useful to whom?

At one extreme, these two criteria may apply just to the person who came up with the useful novelty. An example would be everyday problem solving, such as changing a recipe when some key ingredient is not available in the pantry.

At the other extreme, the idea or behavior may be viewed as novel and useful in the context of a whole culture or civilization. Instances include Edison’s phonograph, Newton’s Principia Mathematica, Tolstoy’s War and Peace, Michelangelo’s Sistine Chapel frescoes and Beethoven’s Fifth Symphony.
All of these ideas were both novel and useful in the sense that they satisfied some practical, scientific or artistic criterion. All worked.

The first extreme is often styled “little-c” creativity, the second “Big-C” creativity. Even so, the dramatic contrast between these two extremes should not blind us to the fact that they represent endpoints of a continuum. After all, both novelty and utility can be considered quantitative variables that vary from nothing to a lot.

Reinventing the wheel has zero novelty, and inventing a wheel out of soap bubbles has zero utility. In contrast, Einstein’s special and general theories of relativity are both extremely novel and highly useful. Not only are these theories indispensable for understanding the basic phenomena of our physical world, but they also provided the basis for nuclear energy and satellite navigation systems.

That said, recent research suggests that the connection between creativity and psychopathology depends on whether the creativity is Big-C or little-c. At the everyday creativity end of the spectrum, creativity is positively related to mental health.

Indeed, creativity is a tremendously useful ability that helps a person adapt to the stresses and challenges of daily life. Creativity at this level is also associated with many beneficial traits, such as an extraversion and affability that ensures that a person has a strong social network on which to rely when times get rough.

At the Big-C end of the spectrum, by comparison, the creativity-psychopathology linkage becomes far more complex and nuanced.

On the one hand, a positive relationship does seem indicated by historiometric, psychiatric, psychometric and behavioral genetic research. Creative geniuses appear to display psychopathological symptoms with higher rates and intensities than found in the general population, and certainly relative to little-c creators.

Genius-caliber creators are also more prone to come from family pedigrees that feature higher than average psychopathology. Even if the creator displays no preliminary signs of mental illness, some close relative most often will.

Moreover, not only have creativity and psychopathology been found to share a genetic basis, but high-level creators also exhibit a number of cognitive and dispositional traits that are often allied to psychopathology. These traits include allusive thinking, defocused attention, primary process thinking, introversion, nonconformity and even anti-social behaviors.

On the other hand, Big-C creativity is also associated with various compensatory characteristics that mitigate the impact of the previously mentioned traits. For example, such creators enjoy exceptional intelligence, self-sufficiency and ego-strength. These give highly creative persons a superlative degree of meta-cognitive control over their mental and emotional wanderings.

And although they are very high in divergent thinking, they also score strongly in convergent thinking. So eventually, they manage to rein in the excesses of their imagination. Because of this self-control, although the psychopathological symptoms exhibited by high-grade creators are higher than the average person on the street, they are still lower than those individuals who succumb to their symptoms, and thus become mentally ill.

In fact, when the symptoms get too pronounced, and are no longer sub-clinical, creative people cease to be creative, just like everybody else. For this reason, creative geniuses should not fear that their creativity would be destroyed by medication or therapy. Such interventions can actually more help than hinder.

The surrealist painter Salvador Dali may have captured the critical contrast: “The only difference between me and a madman is that I’m not mad.” And he always knew the difference.
Mad and Genius are Separate States of Mind

By Judith Schlesinger, PhD
TNP May/June 2010

Great talent always comes at a great price. To be a genius means to suffer – if not the chronic paralysis of depression, then surely the emotional whiplash of bipolar disorder. The exquisite sensitivity of creative artists is hard-wired with their pathology; moreover, their willingness to brave the treacherous rapids of the unconscious for inspiration makes them even more vulnerable to psychotic collapse.

This is the heart of the “mad genius” myth that has been integral to Western culture for centuries.

It is also hogwash.

The fact is that, despite the efforts of numerous investigators, and decades of confident pronouncements by a few, there’s still no concrete, empirical proof that highly creative people are any more likely to be mood-disordered than any other group. What we have instead, passing for “evidence,” are such items as hand-made lists of allegedly bipolar artists – all of them much too dead to protest – unverifiable experimental variables like “anger at mother” and histrionic quotations about artistic despair from poets who are famously florid about everything.

A careful look at the so-called “landmark” studies in the field – the work by psychiatrists Nancy Andreasen and Arnold Ludwig and psychologist Kay Redfield Jamison – reveals gaping holes in their design, methodologies and conclusions. Yet these studies continue to be passed along by other professionals, and often appear in psychology textbooks, where they train budding clinicians to expect their most talented clients to be chronically wobbling on the edge of sanity.

This, in turn, encourages highly creative people to believe they are only marginally in control, and that treating their “disorder” may even compromise their gifts. The kindest explanation is that everyone assumes this work has been properly vetted by somebody else, an impression strengthened by leading creativity researchers who keep citing it in their own writings without acknowledging how weak it really is.

Part of the problem is that much of the information, however spurious, is rather sexy.

For example, the most prolific and vociferous “mad genius” proponent has always been Jamison, whose 1989 study is frequently cited as providing its modern “proof,” and whose 1993 Touched with Fire: Manic Depression and the Artistic Temperament remains the de facto Bible for those who believe that there can be no great art without suffering.

Chockablock full of passionate conjecture, this book also contains an often-cited list of 166 allegedly bipolar artists that was invented by Jamison and based on little beside her own personal desire to put them there. But this list is so thrilling that it has been embraced by any number of otherwise credible researchers and referenced as if it offered something profound and worthwhile. Worse yet, even some who acknowledge its lack of empirical validity can’t resist quoting this exciting – if mythical – list.

Similarly, Ludwig’s 1995 The Price of Greatness: Resolving the Creativity and Madness Controversy seems to solve the problem by its title alone, and is also cited by too many people who apparently haven’t read it. It turns out that this book provides yet another collection of inconclusive conclusions, although in this one, the author himself helpfully points out its shortcomings.
To be fair, Jamison’s original 1989 study is rather difficult to find, since it was published in a relatively obscure local journal and takes some digging to uncover. But as it turns out, the whole field is full of research landmines. For instance, when every writer uses a different definition and measurement of creativity and madness, it precludes combining the studies together into convincing proof of anything.

In fact, trying to connect one fuzzy notion to another in any kind of credible empirical fashion has taken on the proverbial dimensions of a mythic quest – one at least as epic and frustrating as getting a bipartisan health care bill out of Congress.

In May 2009, a detailed and long-overdue analysis of Jamison’s work, as well as the other hollow yet influential research in this area, appeared in the peer-reviewed APA journal, Psychology of Creativity, Aesthetics, and the Arts.

My article, “Creative Mythconceptions: A closer look at the evidence for the mad genius hypothesis” (Vol. 3, No. 2, pp. 62-72), is both scholarly and eminently readable, and was even called “a public service” by the late, great creativity pioneer, Colin Martindale.

References


Complex Traumatic Stress Disorders in a General Practice Setting

By Christine A. Courtois, PhD
TNP May/June 2010

refers to traumatic events or experiences that occur repeatedly and chronically in the context of betrayal by attachment figures. Courtois and Ford (2009) defined complex psychological trauma “as resulting from exposure to severe stressors that (1) are repetitive or prolonged, (2) involve harm or abandonment by caregivers or other ostensibly responsible adults and (3) occur at developmentally vulnerable times in the victim’s life, such as early childhood or adolescence (p.13).

Complex posttraumatic sequelae are the changes in identity, emotions, mind-body and relationships that occur in the aftermath of such traumatization. These can begin at the time of the trauma and emerge over the course of the individual’s life and include problems with emotion regulation, stable sense of self, relations with others, somatic distress, dissociation and spiritual alienation.

These aftereffects have been consolidated into a diagnostic conceptualization, Complex Posttraumatic Stress Disorder (CPTSD)/Disorders of Extreme Stress Not Otherwise Specified (DESNOS) by Herman (1992) or complex traumatic stress disorders by Courtois and Ford (2009). The criteria of CPTSD co-occur with or are above and beyond the criteria for “classic” PTSD as defined in the DSM IV-TR, but are currently only included in the DSM as associated features (American Psychiatric Association, 2000).

It is to be hoped that the DSM-V will include Complex PTSD as a full diagnosis for adults in recognition of these additional criteria. Another related diagnosis, Developmental Trauma Disorder (van der Kolk, 2005) has been proposed to the committee charged with revising the DSM. Both diagnostic conceptualizations are undergoing field trials at the present time.
What is the relevance of complex developmental trauma to the general psychological practitioner and why the need for diagnostic changes? It is likely that all practicing psychologists will have these clients in their caseloads at one time or another. This has to do with the prevalence of child abuse (including relational or attachment abuse) in the population and the resultant high need for psychotherapeutic services – figures differ by study but one study estimated that as many as 90 percent of clients in psychotherapy have a history of childhood abuse of some sort (Pilkington and Kremer, 1995).

What is most disconcerting about these practice implications is that, even today, most practitioners have not had training in identifying, assessing and treating trauma (Courtois and Gold, 2009) and therefore are likely to miss it as an etiological factor and misdiagnose its aftereffects, thereby not treating it.

If they have had any training in trauma, it likely was directed towards “simple” or “classic” forms of PTSD resulting from adult-onset trauma (disasters, accidents, one-time assaults and warfare) rather than the more complex developmental variant under discussion here. They may be trained only in cognitive behavioral techniques (especially prolonged exposure) since these techniques have the most empirical support as to their effectiveness.

Unfortunately using such techniques prematurely with complex trauma clients can re-traumatize rather than heal, something learned the hard way when treatment for incest/child sexual abuse trauma was first under development in the mid-1980s.

Complex trauma clients often present with a multitude of problems that span Axis I, II and III and may be massively destabilized in their lives and therapy presentation, even as some of them have outwardly successful lives and careers. In many cases, their degree of destabilization is such that they qualify for the diagnosis of Borderline Personality Disorder (BPD), a fact that makes some providers avoid them or to refer them elsewhere.

The complex traumatic stress formulation can be helpful in this regard. It encompasses the same set of symptoms and presentations but does so in a way that is less pejorative and more comprehensible to client and therapist alike. A number of books and articles are now available and preliminary treatment guidelines have been published to assist practitioners in organizing this treatment (Courtois, Ford, and Cloitre, 2009; Ford, Courtois, Van der Hart, Nijenhuis, and Steele, 2005).

The clinical consensus (needed until more empirical evidence is available – a number of studies are now under way) is to organize treatment into three phases, the first geared toward the establishment of safety, the development of skills for emotional-regulation and personal stabilization, education about trauma and trauma response, the treatment alliance, and co-occurring problems such as substance abuse and self-injury.

Phase 2 is directed toward approaching and processing the trauma using techniques such as exposure (prolonged or graduated; experiential, imaginal or in writing). Phase 3 is devoted to life reconstitution post-trauma resolution.

In sum, most clinicians already work with this population and benefit from a diagnostic conceptualization and treatment recommendations that help them organize the complex symptom picture and the treatment of complex traumatic stress disorders.
Better Serving Victims of Sexual Assault

By Carolynn Gray, MA
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Conservative estimates indicate that at least one in every six women (17.6 percent) and nearly one in 10 men (8 percent) in the United States have been sexually assaulted in his or her lifetime.

Other estimates expand those ranges to one in three women and one in four men. Additionally, studies indicate that the overwhelming majority (81 percent) of persons who have been sexually assaulted experience psychological distress severe enough to impede upon the victims’ lives.

These two figures together suggest that, as practicing clinicians, we can expect regularly to encounter clients who have been sexually assaulted and whose troubles are, at least in part, contributed to by that assault.

Despite this, our profession does not require that we obtain any training in the treatment of sexual assault, especially in regard to adults who have been assaulted. (I am aware that most states require child abuse training, which often includes training on sexual abuse). Frankly, I find this lapse surprising and upsetting, as well as one which is easily amendable.

From my work as a rape crisis counselor and through research for my dissertation, it has become clear to me that we – as a profession and as individuals – could do so much more to support survivors of sexual assault and that means being prepared.

Sexual assault and its attendant effects are most often complicated, long-lasting, and deeply impacting. Despite this, there are some features of the repercussions of sexual assault which are reasonably consistent. Persons who have been assaulted may experience the following emotions: denial, fear, guilt, shame, anger and depression. These emotions can take many forms and it is easy to see the potential for deep and significant distress.

I suggest the following when encountering a client with a history of sexual assault:

1. Remember that, no matter what, the assault was not the victim’s fault, nor was it deserved.
2. Listen to the story without judgment of the victim’s actions and show your client that you can handle listening to the horrific nature of his or her story.
3. Validate and normalize the victim’s feelings, as irrational as they may be.
4. Never make assertions regarding what your client “should” do or have done, feel or have felt.
5. More than anything, remember that sexual assault is about control. Give your client control over treatment without overwhelming her with choices.

This list could go on almost interminably, but these ideas cover the core concepts and may provide a launching point for further learning.

Sexual assault is something that happens with alarming regularity and it often leads to at least significant discomfort and distress. It is incumbent upon us as mental health professionals to be prepared to support our clients and work through it with them. I urge everyone in this field to make an effort to learn something about what this means to those who are victimized and how we can support them in their healing process.
Using Mindful Affirmations in Clinical Practice

By Arlene K. Unger, PhD
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What is Mindfulness?

A concept of mindfulness has been around for thousands of years in the earliest Buddhist teachings (2,500 years ago). However, the way we use the term here, Mindfulness should NOT be confused with inward focused mysticism or spirituality.

Mindfulness is simply an introspective method for grounding your thoughts, emotions and behaviors in the reality you are currently experiencing, so you can stand back, observe, understand yourself more fully and take care of your needs. It is a method for coping with your reality.

Mindfulness has been shown to bring calmness, patience and mental resiliency to those who embrace the practice.

What are Affirmations?

Affirmations are declarative statements about something you now know, did or intend to do. When you use an affirmation you are not only being aware of your thoughts but are taking conscious control of them. When you say, write, read or even think of an affirmation you are, in effect, taking steps to acknowledge what is worthwhile about you.

What are Mindful Affirmations?

“Mindful Affirmations,” introduced in my book Presence of Mind - Mindful Affirmations, are not just spontaneous, inspirational sayings but are thought provoking phrases that loosely derive from Mindfulness ideas of Jon Kabat-Zinn, PhD (in molecular biology), who founded the medical and meditative models of Mindfulness.

Mindful Affirmations incorporate one or more of these active stations into each passage in order to support the Mindful notion of keeping an “open mind,” where possibilities have no limits. They are NOT meditations as used by Zinn and others. Mindful Affirmations take ordinary affirmations such as “Your self-confidence will carry you on” and make them more reality based.

Expanding the above affirmation into a Mindful Affirmation would be “I barely thought of my own self-worth until I saw myself going backward in life. Letting myself go and losing all I had gained made me feel stuck and dependent. I now see how harnessing my self-esteem can help me not only find my way but carry me through life.”

It has been my clinical experience that when I ask patients to read a Mindful Affirmation, they mention to me that they now see their old problems in a different way. One of the core values of Mindfulness is to be able to see yourself and the world around you with a “new set of eyes.”

Relationship to ACT, CBT, and DBT

Mindful Affirmations support the theories of modern day psychotherapies and can serve as an adjunct to:

ACT – Acceptance Commitment Therapy: Embracing one’s reality can lead to healthier life choices. Mindful Affirmations help the reader accept and tolerate their past mistakes without criticism and self-imposed judgments.
CBT – Cognitive Behavior Therapy: Identifying faulty thinking can lead to healthy thought restructuring and more adaptive behaviors. Mindful Affirmations encourages the reader to step back and look at mental blocks, resistance and maladaptive behaviors.

DBT – Dialectical Behavior Therapy: Being aware and accepting the totality of one’s experience can bring about the motivation to change. Mindful Affirmations support conscious living, self-validation and gradual change.

Program Hopes to Reduce PTSD - Army to Train its Own in Positive Psychology

By Richard E. Gill, Assistant Editor
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The Army trains soldiers for physical readiness. Can it train soldiers to be psychologically stronger, also? That’s a question that will be answered with the start of a historic program that will provide education and psychological training to military personnel before they’re exposed to traumatic events on the battlefield.

With the overwhelming number of soldiers returning from Iraq and Afghanistan battlefields with post-traumatic stress disorder, something had to be done to alleviate the problem.

That’s why the Army turned to a proven program at the University of Pennsylvania called “emotional resilience.” It was based on research by Martin Seligman, PhD, director of Penn’s Positive Psychology Center, and other researchers, said Army Research Psychologist Capt. Paul B. Lester, PhD.

The Penn program teaches concepts such as focusing on what is right, expressing appreciation and correcting negative views of ambiguous events. Researchers at Penn found that when you teach the teachers different skills they will successfully pass along what they’ve learned. The Army took Penn’s resilience program and adopted it to the needs of the Army.

“Essentially what the Army did was to develop an integrated approach to developing psychological resilience,” said Lester who has served in both Iraq and Afghanistan.

The Army trusts that this program will help people face some of the stressors they are going to face on the battlefield, as well as at home. Another positive factor to emotional resilience training is that family members will also be able to join in the program.

So, stressed Lester, the Army will provide soldiers and family members the tools to deal with some of the things they are going to face during deployment.

Lester explained that the basics of the program are “teachers teaching teachers.” About 150 non-commissioned officers report to the university every month for a 10-day intensive course in emotional resilience. Then they return to their individual units and share the information they’ve learned.
Lester denied accusations that these non-commissioned officers might be described as pseudo psychologists – providing professional guidance without training or that emotional resilience is a ploy to put soldiers back into battle more quickly.

“They are all leaders in the Army. So in many ways they are in the psychology business to begin with, whether or not they have been formally trained. It’s part of their job to work with people on a day-to-day basis to help them perform better and to help them develop as long as they continue in the Army.”

And he added, “It’s not so much of putting soldiers back onto the battlefield, but to make them more resilient to what happens while they’re in the field.”

Eventually the Army’s 1.2 million soldiers will be trained in the philosophy of emotional resiliency. “We don’t know when the global war on terrorism is going to end so we’re preparing to have to be engaged for a long period of time,” he said.

Lester, who leads the assessment of the program, said the program would develop a soldier’s “communication skills, cognitive reforming skills and help soldiers not to catastrophize – don’t think the worst case scenario about every potential problem.”

The ultimate desire is that emotional resilience will reduce PTSD. “That’s our hope,” Lester said. Determining if it reduces PTSD is several years away.

“As far as I can tell this is the largest, deliberate psychological intervention in human history. It will potentially impact millions of people over time. We’re trying to do something good here, and I think it’s needed,” Lester said.

Seligman, who has been working with the Pentagon, described emotional resilience as “the most tremendous program I’ve ever been involved in.”

Seligman said he and Gen. George Casey, the Army’s chief of staff, first discussed the program September 2008. Then in December he met with Brig. Gen. Rhonda Cornum to discuss in depth using the program to decrease the unprecedented number of soldiers returning with PTSD.

Seligman’s idea was to train the entire Army in the way of growth. “What you basically want to do is increase the health of the whole distribution,” he stressed.

“We don’t send soldiers into a malaria-infested area unprepared. We don’t just wait until they get malaria and then give them quinine. We give them mosquito netting and malaria prevention training. In the same way you don’t wait until your people are falling apart and then devote all your resources into treating them,” Seligman reasoned.

The point is to train an Army that is both physically and mentally fit. So the better idea was to bolster the psychological fitness and if not prevent PTSD at least reduce it. A reduction of PTSD is “a prediction” of emotional resilience, Seligman said.

“But even more important in my point of view it will create human beings who are more resilient and a larger percentage will grow from the experience.”

To accomplish this three different programs were created that give soldiers better ways to cope. The first was to create a 105-question Global Assessment Tool that would measure psychological risk factors and psychological health assets. None of this information is available to commanders. It’s strictly personal and not available to anyone but the soldier taking the test, he said.

Scores on the questionnaire are used to introduce the second part, five online courses that are supposed to introduce a soldier to factors that might reinforce their training in social fitness, spiritual fitness, emotional fitness and family fitness.
A third part, which Seligman thinks is the most important, is the explicit training of the entire Army in positive resilience. “I told Gen. Casey that this would be nearly an impossible chore because of the enormous number of teachers required.”

Casey replied that the Army had 40,000 teachers. “You do?” Seligman said. “Yes, they’re called drill sergeants,” Casey retorted.

Now 150 sergeants come to Penn each month to take an intensive course in positive resilience. “Hopefully, someday the Army will have their own teachers to teach resilience and positive psychology.”

“I believe the Army is moving in the right direction. I’d call it foresighted, training never given before in history. They can come out of the Army both physically and psychological fit,” Seligman said.

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**Health Redefined by National Academies of Practice**

By David A. Rodgers, PhD
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On April 7, 2010, as Health Care Reform was being enacted, the National Academies of Practice (NAP) adopted a new definition of health: “Health is an individual’s state of well-being based on integration of biological, psychological and social functioning within the context of social, cultural, family, and other environmental conditions.”

This action was largely in response to the tortuous health care debate in Congress that focused more on illness treatment and insurance management than health. The definition is a refinement of the 1948 World Health Organization (WHO) definition, one that has generally been ignored in the United States: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

NAP is an honorific group of practitioners, scholars and public policy experts from the 10 major health care professions – dentistry, medicine, nursing, optometry, osteopathic medicine, pharmacy, podiatry, psychology, social work and veterinary medicine.

It was started by Nicholas Cummings, PhD, in 1982 to try to provide cooperative, multi-disciplinary, practical health advice to governmental groups and other policy makers. Henry Saeman, founder of *The National Psychologist*, was an honorary member.

Throughout the recent national debate, NAP sponsored hearings on health reform, held educational forums, published policy papers, talked with legislators and other decision makers and tried to develop collaborative approaches with various professional organizations and congenial advocacy groups.

NAP emphasized the importance of universal coverage, the inclusion of all health care disciplines in both coverage and policy decisions and the importance of outcome effectiveness as a criterion for recognition. NAP was pleased with the progress made toward universal coverage and toward expanding the scope of innovative approaches that are to be supported under health policy.

However, the debate increasingly focused on insurance regulation in commercial terms and on specific requirements for coverage in ways that addressed neither practice efficiencies nor cost control.
The redefinition of health is a part of NAP’s commitment to address some neglected issues. Representing experienced practitioners, NAP is convinced that real economies and real equities of health care must come from attention to health enhancement, health maintenance and illness prevention and must come from utilizing effectively the skills of all health care professionals, including those focused on psychological and sociological as well as biological dimensions of health.

There must also be attention to dimensions of health not directly part of treatment activities. For example, veterinarians must address potential animal vectors of disease that follow the changing climate patterns.

Their work should be a critical part of health care policy. Similarly, attention to carcinogens, atmospheric pollution, social stressors and other environmental factors can reduce health care costs more than direct attention to treatment processes. Addressing these conditions and other dimensions of illness prevention should be a more major part of national health care policy.

Health is ultimately the functional well-being of the whole person, not just his/her biological parts. That requires functional psychological and sociological processes as well as biological ones, functional societies and families as well as functional care facilities. It means health policy must attend to the family, the community and cultural issues if it is to be effective. Not surprisingly, WHO emphasizes the “social determinants of health.”

NAP hopes that the new definition will make a difference. It will not correct the current omissions in health care policy, but it does call attention to them. For psychologists, the definition should provide an opportunity to emphasize our contributions to health as psychologists, not as ancillary assistants in biological illness treatment.

For all practitioners, it should emphasize the importance of, and the opportunity for, interdisciplinary collegial practice to address the full spectrum of health problems.

For the nation, it emphasizes that health policy should have national well-being as its primary goal, not just crisis intervention. “Health is an individual’s state of well-being based on integration of biological, psychological and social functioning within the context of social, cultural, family and other environmental conditions.”

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**Encouraging a Psychotropic Medication Evaluation**

**By Joe Wegmann, PharMD**

**TNP July/August 2010**

You’re so familiar with this scenario that it plays like a broken record in your head. You’ve been working with Ms. J for eight weeks now and have dug deep into your psychotherapy bag of tricks – yet there’s still no discernible improvement. So you broach the issue of augmenting therapy sessions with medication.

In a decidedly resistant tone of voice, Ms. J responds: “I don’t like to take medicine. I don’t even like to take Tylenol. I may consider it after we’ve had more sessions and you’ve gotten to know me better.”

There are many reasons that psychologists might consider a psychotropic medication evaluation in their work with clients. Here are a few:

- Despite an adequate trial period, the client is either not improving or getting worse through psychotherapy alone.
- The client has a complicated medical history and is taking multiple medications.
- An undiagnosed medical condition is impinging on what the client sought treatment for in the first place.
• The client initially presents with prominent mood and behavior instabilities or mood and behavior become more markedly labile as psychotherapy continues.
• The client exhibits an active and identifiable presence of psychotic features.
• The client presents with a prolonged personal history or significant family history of mental disturbance.
• There is a co-occurring substance abuse disorder.

Even when one or more of the above indicators are present, psychologists at all levels of experience know that getting a client on the road toward a medication evaluation is not necessarily easy. Many clients assess the odds associated with considering alternative treatment options for some time before actually committing to the behaviors that drive the initiation of the change process. Therefore, a client’s decision to follow through with a medication referral may be long and drawn out.

Often, clients are willing to consider taking psychotropic medication, as opposed to actually to start taking it. Client ambivalence, therefore, is a common occurrence. When facing such ambivalence, psychologists should take the opportunity to continue strengthening the therapeutic relationship. Patience is the key here. Any attempt to rush the client into a premature decision is likely to backfire and could also compromise the relationship.

Of course, waiting for clients to decide does not mean the psychologists must withhold their opinions. On the contrary, if a psychologist knows that evidence-based literature supports a pharmacological treatment of a client’s condition (for example, bipolar disorder), that information should be conveyed to the client. Offering reading material or websites can also help ensure that clients have as much information as possible. In this way, the client can make an informed choice regarding future treatment.

Families and Psychotropic Medication

Family members can also influence a client’s initial decision to attempt medication. They can also influence the client’s willingness to adhere to a treatment regimen once it has been started. For these reasons alone, a psychologist should welcome input from members of the client’s family. After all, the responsibility of caring for a client usually falls on family members. They are not simply uninvolved bystanders.

For example, it is common for family members to prompt or even coerce a client into making the initial appointment with the clinician. However, due to the stigma of mental illness and the client’s concerns about being a burden to family members, the family may not be fully aware of the client’s mental health status. This lack of knowledge often results from fractured relationships in the family and the client’s preference to keep family members out of the loop.

Although only a few studies have examined the interaction between families and psychotropic medication, we can still extract some clinical wisdom from the sparse literature. It makes sense that families would be concerned about their ill family member and would therefore be affected by his or her behavior. These studies tell us, however, that while a collaborative approach to treatment – one that includes family members – works best, seldom are families consulted about medication or educated about the ill client’s condition.

Why not? Well, family work is time-consuming and psychologists are often hamstrung by clients that won’t submit to signing informed consent documents to allow the family to participate in treatment. In spite of these obstacles, psychologists are encouraged to engage clients in permitting family to participate in treatment decision-making.
Clients who believe their family members have a supportive interest in their improvement are often more willing to submit to a psychotropic medication evaluation. That’s because caring families hope that medication will ease their loved one’s suffering. This can also improve relationships between the clients and their families.

For understandable reasons, the decision to pursue psychotropic medication is a challenge for many clients. Psychologists should encourage clients – and clients’ family members – to ask questions. Straightforward answers help to demystify the decision-making process. It’s worth remembering that when it comes to medication, clients will make their choices – on their own terms and in their own time.

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**Latino Immigration: Humanizing Communities and Unifying Voices**

By Miguel E. Gallardo, PsyD  
TNP July/August 2010

The discussion on immigration in the United States has two sides. In one discussion, our borders are boundless in our willingness – and need – to exchange goods and services internationally and encourage free trade. Simultaneously, the other discussion encourages controlled borders, restricted migration flow and increased levels of policing and militarization.

The psychological impact these dialectical perspectives have on Latino communities nationally is often misguided and misunderstood. In fact, it is critical that our understanding of borders extend the physical and geographical to include also the mental and psychological (Davies, 2009).

Dr. Ron Takaki (2008) states, “We are dependent upon and indebted to one another.” Our immigration histories and current realities indicate such and our future is dependent upon it. However, the current climate in the United States promotes an “us vs. them” mentality and an environment that is hostile for both immigrants and non-immigrants alike. When a climate of hostility is borne, it is an attack on our country’s morale and the very foundation our country is founded upon.

Our ability to be culturally responsive as psychologists depends on our willingness to understand the “other” within a cultural context. As readers reflect on their own personal assumptions, biases and belief system, Deaux (2006) suggests that we reflect on three critical questions: (1) What does the immigrant bring? (2) What does the immigrant encounter? and (3) What does the immigrant do?

If upon reflection, the answers to these three questions reflect negativity, misguided or narrowly defined concepts without recognizing the strengths and sources of resilience and overall contributions of immigrants, then it is essential that the reader continue to seek further education, experiences and reflect critically how our own limitations negatively impact our current views, ability to culturally respond therapeutically and in the development of social policy.

Latino immigrants are incredibly diverse (Alegria et al., 2007). In beginning to understand the Latino immigration experience, it is important that we not assume all experiences are the same. In fact, Alegria et al. (2007) found differences between Latino subgroups and the prevalence of psychiatric disorders among Latinos in the United States. Some of the findings indicated that time of immigration, whether before the age of 6, or after, accounted for differences in psychiatric disorders between various Latino sub-ethnic groups.

For example, Mexican immigrants who arrive in the United States after age 6 demonstrated a lower risk of depressive disorders than those Mexican individuals who arrived prior to age 6 or who were born in the United States.
Additionally, in comparing Mexican individuals who immigrated prior to age 6, or who were born in the United States to Cubans who immigrated prior to age 6, or who were born in the United States, indicated that Cubans differed in their levels of perceived discrimination, believed they lived in safer neighborhoods and endured less family conflict that contributed to decreased prevalence of depressive disorders.

The study’s findings also highlight the importance of understanding reasons why Latino immigrants might leave their country of origin.

Voluntary vs. involuntary immigration status (Ogbu and Simons, 1998) is an important distinction for psychologists to understand.

Voluntary immigrants are those individuals who voluntarily engage in intercultural contact. This group consists of some immigrant groups, sojourners and various ethnocultural groups.

Involuntary immigrant groups are those individuals who have been forced by necessity into involuntary interactions as a result of war, genocide, poverty and political instability, to name a few. These groups would include refugees, asylum seekers and indigenous peoples (Ward, 2008).

Differentiating immigration history, reasons for immigration and issues such as mobility, permanence and voluntariness are critical. These distinctions become important as we situate the immigration experience within a U.S. cultural context.

How we socially stratify Latino immigrant communities in U.S. society based on power and wealth, or lack thereof, greatly impacts overall health and wellness. Therefore, it is central that we consider an ecological framework (Bronfenbrenner, 1979). Taking an ecological perspective helps us expand our own understanding of how to best respond to, and respect, immigrants from diverse backgrounds.

Deaux (2006) uses an ecological framework to conceptualize the immigrant experience on three different levels, the micro, meso and macro.

According to Deaux, the micro-level is the individual immigrant’s “attitudes, values, expectations, identities, motivations and memories” (p.5). The meso-level includes “intergroup attitudes and behaviors, stereotypes and social networks” (p.5). The macro-level includes immigration policy and law.

In comparing U.S. immigration policies to Canada’s, Deaux found that one notable difference between the United States and Canada is the adoption of the “mosaic” metaphor by Canadians to describe immigration as opposed to the “melting pot” metaphor widely adopted in the U.S.

An example of the impact social policy and law (macro-level) can have on individuals and families (micro/meso-levels) are recent legislation in Arizona (SB 1070; SB 1097; HB 2382; HB 2281). Passage of such legislation creates fears of deportation, increased anxiety, fear of retribution and racial profiling that impact an individual’s overall psychological health.

Living in unsafe neighborhoods, ethnic discrimination and perceptions of low social status all play an important role in the increased risk for psychological challenges among many Latino immigrants.
Additionally, resultant outcomes of macro-level social policy influences include the fears of the children of immigrants who worry that their parents will be deported.

The immigration process is an on-going process for most families. Symptoms such as depression, anxiety, psychosomatic illnesses and behavior problems can appear at any point for family members, including the time of departure, during the migration process, at the time of a life-cycle event (death, divorce) or during reunions among separated family members (Falicov, 1998), and where women may be sexually assaulted.

The process of serial migration, or the “step-wise” manner (Hondagneu-Sotelo, 1992) in which families migrate can have detrimental effects on both the children and parents. It is not uncommon for one parent to immigrate first, leaving mom and children behind or for both parents to migrate first, leaving children with grandparents or extended family.

Consequently, children may leave their country of origin together to reunite with parents or leave separately depending on the circumstances of the family and country of origin. This process could take months to years before all family members are reunited together. A consequence of this process is that family relationships can become strained, siblings may differ in acculturation levels, intergenerational differences may create conflict between parents and children and potential conflict between the parents as gender roles may also shift, post-migration (Hondagneu-Sotelo, 1992).

In concluding, international migration can greatly improve human welfare and development when understood within context and when fear is suspended. Deaux (2006) states, “the trend over the past 40 years in the United States has been toward diminished support for immigration” (p 43).

She attributes two salient reasons for negative attitudes toward immigration, including perceived economic threats and beliefs in a status hierarchy. It is the development of negative attitudes, driven by fear, which has led to increased racism and discrimination faced by Latino immigrants, resulting in increased psychological challenges for these communities as a whole.

Nothing remains as critical as our ability to see Latino immigrants as human beings first and foremost and not as the culmination of our own individual and societal fears.

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**The Impact of Learning Disabilities on the Self**

**By Allison Waterworth, PsyD**

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The evaluation of learning disabilities and ADD has proven to be a surprisingly satisfying and enriching focus for my clinical work. I have conducted more than 250 evaluations over the course of five years and I have found this testing to be both meaningful and heartfelt.

My training as a general clinical psychologist enables me to examine cognitive, social and emotional factors in order to offer a more comprehensive clinical perspective and evaluation than other testing professionals. I would like to share my experience and offer some guidance regarding the importance of identifying learning disabilities and attention problems in both children and adults.

As Erikson highlights, the development of mastery and competence represents one of the most important developmental stages of the self. This occurs in the elementary school years, a critical timeframe during which children develop a sense of themselves as learners. Children may develop a sense of competence or inadequacy. Often, perceived intelligence is intricately but not accurately intertwined with this sense of learning competence.
Children who struggle with reading or spelling and are consequently sent to “special learning groups” will often be considered as less intelligent than their peers. Most significantly, these children will perceive this about themselves and the damage from this incorrect perception will follow them into adulthood.

As adults these individuals have often concluded that they were “stupid” and exerted tremendous energy to avoid detection of their deficiencies. During their moments of crisis and discovery in the assessment process my clinical skills permit me to comfort, console, empathize and educate the client.

The client learns that it is normal and understandable to feel sad, embarrassed, and frustrated about areas of weakness that have long been buried. The decision to engage in the evaluation process, to learn more about weaknesses as well as strengths, is framed as an empowering and potentially life-changing event.

Thus, the examinees have the opportunity to shift their perceptions of themselves and move ahead with new understanding. They are now challenged to integrate specific knowledge about their strengths and weaknesses accurately and proportionately.

Consider a person who has dyslexia: After testing a person with dyslexia can accept and integrate this condition as one area of weakness while also fully acknowledging other, unrecognized or taken-for-granted, areas of strength.

Further, it can be very useful and validating for persons with learning disabilities to gain the perspective that all individuals have their domains of strength and vulnerability. Viewing themselves in a larger context rather than viewing themselves as a damaged or dysfunctional few can be profoundly unburdening and a source of tremendous relief.

It can also offer untold empowerment to have a name assigned to a perplexing and distressing phenomenon experienced but not examined until adulthood. Consider the relief offered by the realization that years of ineffective behavior stemmed from a real and diagnosable condition, not a character flaw, personal failing, laziness or low intelligence.

Because of the detrimental impact undiagnosed learning disabilities have on self-perception; many people with these disorders suffer from depression or anxiety. It has been my observation that many individuals who have been diagnosed with anxiety or depression as a primary condition have an underlying and untreated diagnosis of ADHD.

A number of potential red flags may help illuminate undiagnosed ADHD or learning disabilities in the therapeutic setting: Embarrassment about reading, spelling, or writing skills at work, reported problems with memory, avoiding the pursuit of real vocational or academic goals due to fears of failure, rarely reading or report of being a “slow reader,” disorganization in one or several parts of life, poor time management, a general sense of incompetence or feeling like a fraud, difficulty staying on topic in conversations and poor reported school performance despite seeming intelligence. The presence of a few or several of these symptoms, as endorsed by a therapy client may suggest that a more thorough screening of symptoms is warranted.

Not every assessment requires a full battery of tests and comprehensive write-up; some clients benefit from a brief evaluation that might include IQ screening with targeted subtests detecting deficits associated with learning disabilities. At the culmination of the testing the client will have a more accurate and empowered understanding of strengths and weaknesses.

This information will cast a new light on experiences from the past, which may require exploration and processing, as well as open new ideas and avenues for personal enrichment. The broadened possibilities and alternate paths ensuing from such testing will provide optimism as well as many new directions for growth.
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